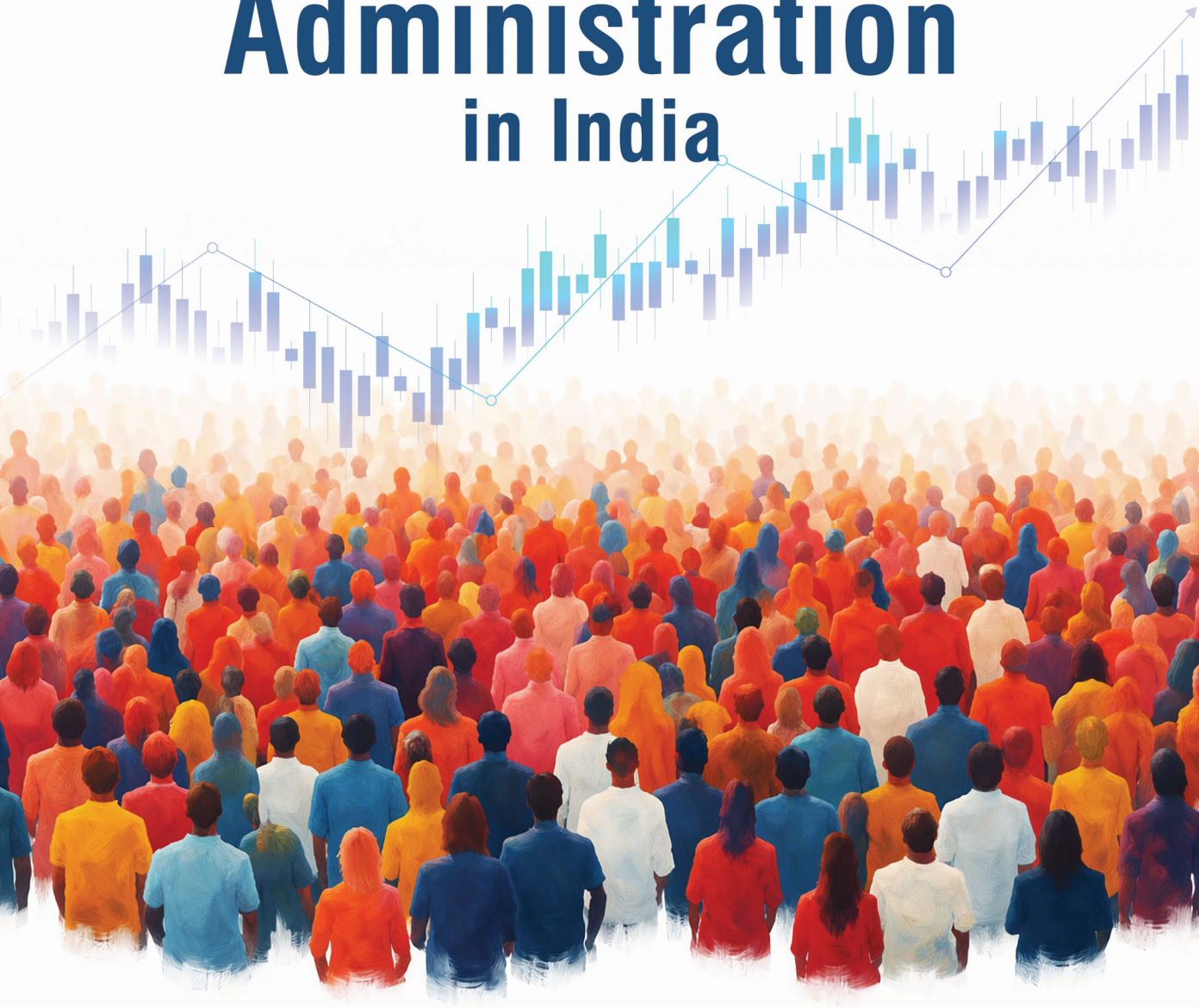
on public health books, visit our website www.ejaypee.com, for detailed information on public health books, visit our website www.ejaypee.com

Navigating Public Health Administration in India



Editors-in-Chief
Suneela Garg
K Madan Gopal

Editors
Purushottam Giri
K S Uplabdh Gopal
Aditi Aikat

Forewords
Vinod K Paul
K Srinath Reddy

JAYPEE

CONTENTS

1. **Introduction to Public Health and Administration in India** 1
   K Madan Gopal, Suneela Garg

2. **Constitutional and Legal Frameworks of Public Health in India** 22
   Suneela Garg, K Madan Gopal

3. **Structure and Organization of Public Health Services in India** 46
   Suneela Garg, K Madan Gopal

4. **Public Health Promotion and Education** 60
   Aditi Aikat, Suneela Garg

5. **Management and Leadership in Public Health** 77
   Sonu Goel, Kritika Upadhyay, Mahesh Devnani, Sanjiv Kumar

6. **Technological Integration and Role of Artificial Intelligence in Public Health Administration** 86
   Sonali Kar, Dhrubajyoti J Debnath, Manikandan Srinivasan

7. **National Health Programs and Policies** 94
   U Venkatesh, Varkey Nadakkavukaran Santhosh, Ashoo Grover, Om Prakash Bera

8. **Human Resources for Health in India** 108
   Ritesh Singh, Subhodip Mitra, Suneela Garg, K Madan Gopal

9. **Financing Public Health in India** 117
   Sonu H Subba, Suneela Garg, K Madan Gopal

10. **Public Health Surveillance and Epidemiological Intelligence Services** 133
    Soumik Ghosh, Siddharth Singh, Gurusanganabasava Hawaldar, K Amulya Sanghamithra, Sudip Bhattacharya

11. **Healthcare and Hospital Administration in India** 152
    Manish Chaturvedi, K Madan Gopal, Ramya Jyothi

12. **Monitoring, Evaluation, and Accountability** 176
    K Madan Gopal, Suneela Garg, Sudip Bhattacharya, K S Uplabdh Gopal

13. **Equity, Gender, and Inclusion in Public Health Administration** 206
    Aditi Aikat, Suneela Garg, K Madan Gopal

14. **Climate Change, Environmental Health, and the One Health Approach** 219
    Pankaja Raghav, Suneela Garg

15. **Research, Innovation, and Capacity Building in Public Health** 241
Ashoo Grover, U Venkatesh, Varkey Nadakkavukaran Santhosh, Om Prakash Bera

16. **Health Systems Strengthening: A Systems Lens** 252
Arun K Aggarwal, Stuti Pramod

17. **The Environmental and Occupational Health Administration in India: Bridging the Workplace and the Ecosystem** 272
Warisha Mariam, K Madan Gopal

18. **Urban Health Governance and Urban Local Bodies** 290
Smita Shrivastava, K S Uplabdh Gopal, Nidhi Bhatnagar, K Madan Gopal

19. **Disaster Risk Reduction and Public Health Emergency Preparedness** 309
Abhay Gaidhane, Quazi Syed Zahiruddin, Deepak Saxena

20. **Public Health Ethics, Law, and Decision-making in India: Between Rules, Rights, and Realities** 320
K S Uplabdh Gopal, Arvind Garg, K Madan Gopal

21. **Regulating Public Health Technologies and Medical Devices in India: Challenges and Opportunities** 337
Quazi Syed Zahiruddin, Punit Fulzele, Abhay Gaidhane

22. **Future Directions and Global Health Diplomacy** 360
K Madan Gopal, Suneela Garg

23. **Mental Health Systems and Administration in India** 369
Rambha Pathak, Shruti Singh, Kiran Jakhar

24. **Public Nutrition Systems and Administration** 386
Little Flower Augustine, Naveena Natarajan

25. **Outreach, Transport, and Home-based Care Systems in Public Health** 408
Yamini M, K Madan Gopal

26. **Digital Health Governance and Ayushman Bharat Digital Mission** 424
Pankaj B Shah, Iqra Ather

27. **Public Health Communication and Media Management** 434
Amod Laxmikant Borle, Hemangini K Shah, Anika Sulania, Suneela Garg, K Madan Gopal

28. **Health Policy Development and Strategic Planning** 461
Purushottam Giri, Ashwini Katole, K Madan Gopal

29. **Migration, Labor Health, and Urban Resilience** 478
Purushottam Giri, Ashwini Katole, K Madan Gopal

30. **Public Procurement and Supply Chain Management in India** 492
Amod Laxmikant Borle, Shweta Goswami, M Meghachandra Singh

31. AYUSH Systems and Public Health Integration **506**
Tanu Anand, Suneela Garg, Arvind Garg, Iqra Ather

32. Public–Private Partnership in Healthcare Service Delivery **515**
Manikandan Srinivasan, Medha Mathur

33. Tribal Health Governance and Particularly Vulnerable Tribal Groups Outreach Models in India **525**
Sunil Vilasrao Gitte, K Madan Gopal, K S Uplabdh Gopal

34. Use of Geospatial Intelligence and Earth Observation in Public Health Planning in India **535**
Sunil Vilasrao Gitte, K S Uplabdh Gopal

35. Integrating School and Adolescent Health into Primary Healthcare **546**
Rajesh Ranjan, K Madan Gopal

36. The Role of Training in Indian Public Health Administration **555**
VK Tiwari, K Madan Gopal

37. Operationalizing One Health in District Administration: Governance, Surveillance, and Field Convergence **568**
Anil Ramesh Koparkar, Rama Shankar Rath, Pradip Kharya, Komal Digambar More, Anand Mohan Dixit

38. Navigating Dual Frontiers: Community Medicine Classroom and Public Health Administration: An Experience of a "Pracademic" Public Health Officer from Chhattisgarh **582**
Kamlesh Kumar Jain

39. Innovating Public Health in India: Case Studies in Resilience and Reach **589**
Warisha Mariam, K Madan Gopal

40. Role of Think Tanks in Public Health Administration in India **604**
Oommen C Kurian

41. Managing Extreme Heat in Urban India: A Public Health Governance and Administration Approach **613**
Mahaveer Golechha, Priyanka Shah

42. Life-course Approach in Immunization **621**
Madhu Gupta, Manjeet, Anupam Parashar, Arvind Garg

43. Pharmacovigilance: A Public Health Administration Tool **634**
Anoop Kumar, Iqra Ather, Gaurav K Jain

44. Role of Academic Institutions in Public Health Administration **644**
Iqra Ather, Arathi Rao

45. Working with Industry Bodies, Professional Associations, and Development Partners in Public Health Administration **655**
Arvind Garg, K S Uplabdh Gopal

46. Technical Support Units in Indian Public Health Administration: Evolution, Governance, and System Strengthening **660**
Ritu Agrawal, Andrea K Blanchard, Marissa Becker

47. Case Study: HUMAR Lab—Transforming India's Public Health Laboratory Ecosystem **669**
Mayank Dwivedi, Iqra Ather

48. Reimagining Public Health Administration in India: From Programs to Systems, from Compliance to Outcomes **673**
Suneela Garg, K Madan Gopal

Index **677**

CHAPTER 1

Introduction to Public Health and Administration in India

K Madan Gopal, Suneela Garg

JAYPEE BROTHERS

INTRODUCTION

Public health is the foundation of a nation's well-being. It is not only about treating illness but also about preventing disease, promoting healthy living, and ensuring that every citizen has access to quality health services. In India, with its population of over 1.4 billion, the importance of public health cannot be overstated. The health of communities determines productivity, social stability, and economic growth. Strong public health administration is therefore central to national development.

The rationale for studying public health administration in India lies in its complexity and scale. India is one of the world's largest democracies, with a federal structure where health is primarily a state subject but guided by national policies. This creates a unique administrative framework that combines central direction with state-level innovation and local participation. From designing national programs to implementing them in remote villages, public health administration operates across multiple levels and actors.

Over the years, India has witnessed major transitions in its health system. The early years after independence focused on communicable diseases and maternal and child health. Later, the country faced the dual burden of noncommunicable diseases (NCDs) and reemerging infections. More recently, challenges such as climate change, air pollution, antimicrobial resistance, and pandemics like coronavirus disease 2019 (COVID-19) have expanded the scope of public health. These shifts highlight why administration, coordination, and governance are as important as medical care itself.

Public health in India is also about *equity and justice*. Despite economic growth, health outcomes remain uneven. States such as Kerala and Tamil Nadu perform much better than others, such as Bihar and Uttar Pradesh. Within states, rural–urban and gender divides persist. Vulnerable groups such as tribal populations, slum dwellers, and migrants often lack access to even basic services. These disparities show that public health administration is not only a technical function but also a moral imperative to reduce inequality.

The COVID-19 pandemic was a turning point. It exposed weaknesses in health infrastructure and human resources but also demonstrated resilience through community participation, digital tools like CoWIN, and public–private collaboration. It reinforced the idea that health is not just a sector but a cross-cutting determinant of national security, economic recovery, and social cohesion.

This book begins with an introduction to the concepts, history, and current landscape of public

health administration in India. The purpose is to set the stage for deeper exploration in subsequent chapters on governance, human resources, financing, technology, community engagement, and reforms. The reader will see that public health administration is not an abstract subject but a lived reality that touches every household in the country.

CONCEPTS OF PUBLIC HEALTH AND PUBLIC HEALTH ADMINISTRATION

Public health is both a science and an art. It is the science of understanding the causes of disease, determinants of health, and the design of preventive measures. It is also the art of applying this knowledge to improve the health of communities through policies, programs, and services. The focus is not only on curing the sick but also on preventing illness, promoting well-being, and creating healthy environments.

Definitions of Public Health

Several definitions capture the essence of public health. The *World Health Organization (WHO)* defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". This holistic definition underlines that health includes physical, mental, and social dimensions.

One of the most cited definitions of public health is by *Charles Winslow (1920)*, who described it as "the science and art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of communicable infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of social machinery which will ensure to every individual a standard of living adequate for the maintenance of health."

In the *Indian context*, public health has always carried a community orientation. Ancient ayurvedic texts emphasized sanitation, balanced diet, and seasonal regimens, showing that health was viewed as a social responsibility. The *National Health Policy 2017* continues this tradition by stressing preventive and promotive care, equity, and financial protection.

Definitions of Public Health Administration

Public health administration refers to the structured organization of people, resources, and systems to achieve the goals of public health. It involves *planning, financing, staffing, monitoring, and evaluation* of health programs. While medicine is about treating patients, administration ensures that medicines, doctors, vaccines, and services reach the population efficiently and equitably.

In India, public health administration includes the Ministry of Health & Family Welfare (MoHFW) at the center, state health departments, district health societies, and local bodies such as Panchayati Raj Institutions (PRIs) and urban local governments. It also involves partnerships with private providers, nongovernmental organizations (NGOs), and international agencies.

Dimensions of Public Health

Public health is broad and covers multiple dimensions:

- *Preventive health*: Immunization, screening, and outbreak control
- *Promotive health*: Health education, lifestyle changes, and nutrition programs
- *Curative health*: Clinical services at primary health centers (PHCs), community health centers (CHCs), and hospitals
- *Rehabilitative health*: Restoring health and dignity through physiotherapy, counseling, and support for disabilities.

JAYPEE BROTHERS

TABLE 1: Scope of public health administration in India.

Domain	*Activities in the Indian context*
Disease prevention	Immunization (universal immunization program), vector control, epidemic surveillance, and screening for noncommunicable diseases (NCDs)
Health promotion	School health programs, nutrition campaigns, yoga promotion, and Information, Education and Communication (IEC) campaigns
Environmental health	Clean water, sanitation (*Swachh Bharat* Mission), air pollution control, and waste management
Curative services	Primary, secondary, and tertiary care under National Health Mission (NHM) and *Pradhan Mantri Jan Arogya Yojana (PM-JAY)*
Rehabilitative and palliative care	Disability support, physiotherapy, and palliative care in health facilities
Health system governance	Policymaking, financing, human resources for health (HRH) management, and regulation of the private sector
Equity and inclusion	Special focus on women, children, the elderly, tribal and slum populations, and migrant workers
Emerging areas	Digital health platforms [*Ayushman Bharat* Digital Mission (ABDM) and eSanjeevani], One Health, and climate change adaptation

Source: Ministry of Health & Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.

- *Palliative care*: Ensuring comfort and quality of life for patients with chronic and terminal illnesses.
- *Emerging dimensions*: Digital health, climate and health linkages, and One Health approaches linking human, animal, and environmental health

Scope of Public Health Administration in India

The scope of public health administration in India reflects its wide responsibilities across disease prevention, health promotion, governance, and equity (**Table 1**).

HISTORICAL EVOLUTION OF PUBLIC HEALTH IN INDIA

The history of public health in India is long and layered. It reflects ancient traditions, colonial influences, and postindependence reforms. Understanding this evolution helps explain why India's public health system is both diverse and complex today.

Ancient and Medieval Traditions

Public health in India has roots in antiquity. The *Indus Valley Civilization (c. 2500 BCE)* had well-planned cities with drainage systems, public baths, and wells, reflecting an early concern for sanitation and hygiene. Ancient Ayurvedic texts such as the *Charaka Samhita* and *Sushruta Samhita* highlighted prevention, balanced diet, personal hygiene, and seasonal regimens. They also discussed epidemic management and the role of environment in health.

Kings and rulers often appointed officers responsible for sanitation, waste disposal, and water supply. Veterinary care was also considered important, reflecting an early form of One Health. During the *Mauryan and Gupta periods*, hospitals, dispensaries, and herbal gardens were established.

In the medieval period, Unani medicine introduced new perspectives on the balance of diet and temperament. Community-based practices of cleanliness, dietary rules, and charity hospitals supported health in society.

JAYPEE BROTHERS

Colonial Period

The colonial era introduced modern institutions, but with selective priorities. Public health interventions were initially designed to protect British troops, administrators, and trading interests. Rural India, where most of the population lived, received little attention.

Key milestones included:

- *Sanitary commissioners (1864)*: Appointed in presidencies to supervise sanitation
- *Municipal acts*: Empowered local bodies to manage water supply, waste disposal, and drainage
- 74th Constitutional Amendment Act (1992) gave constitutional status to urban local bodies (ULBs) (municipalities)
- *Twelfth schedule* lists functions of municipalities, including:
  - Water supply for domestic, industrial, and commercial purposes
  - Public health, sanitation, conservancy, and solid waste management
  - Urban planning, slum improvement, and environmental protection (Constitution of India, 74th Constitutional Amendment Act, 1992)
- *Epidemic Diseases Act (1897)*: Enacted to control plague outbreaks, later applied during COVID-19
- *Medical colleges*: Established in Calcutta (1835), Madras (1835), and Bombay (1845), institutionalizing Western medicine in India

Colonial public health thus focused on sanitation, epidemic control, and urban infrastructure but neglected rural health needs.

Postindependence Period

Independence in 1947 shifted the focus to building a national health system. The *Bhore Committee Report (1946)* recommended a comprehensive health service with integration of preventive and curative care. It proposed PHCs as the foundation, serving as the first point of contact for rural populations.

Key developments after independence included:

- *First Five-Year Plan (1951)*: Prioritized PHCs and rural health infrastructure
- *National Programmes (1950s–1970s)*: Malaria Eradication Programme, Family Planning Programme (1952), and Expanded Programme on Immunisation (1978)
- *National Health Policy (1983)*: First comprehensive policy emphasizing preventive care.
- *74th Constitutional Amendment Act (1992)* gave constitutional status to ULBs (municipalities).
- *Twelfth Schedule* lists functions of municipalities, including:
  - Water supply for domestic, industrial, and commercial purposes
  - Public health, sanitation, conservancy, and solid waste management
  - Urban planning, slum improvement, and environmental protection (Constitution of India, 74th Constitutional Amendment Act, 1992)
- *National Rural Health Mission (NRHM) (2005)*: Strengthened rural health systems with Accredited Social Health Activists (ASHAs), *Rogi Kalyan Samitis* (RKSs), and community monitoring.
- *National Urban Health Mission (NUHM) (2012)*: Addressed the health needs of the urban poor.
- *National Health Policy (2017)*: Committed to universal health coverage (UHC) and higher public spending.
- *Ayushman Bharat (2018)*: Launched health and wellness centers (HWCs) and *Pradhan Mantri Jan Arogya Yojana (PM-JAY)*, the world's largest health insurance scheme

Contemporary Phase

In the 21st century, new challenges such as NCDs, mental health, ageing, and pandemics have expanded the scope of public health. Digital tools such as *eSanjeevani teleconsultations, CoWIN vaccination platform*, and the *Ayushman Bharat*

JAYPEE BROTHERS

TABLE 2: Key milestones in Indian public health.

Period	*Key milestones*	*Focus area*
Ancient (2500 BCE–1200 CE)	Indus Valley sanitation, *Charaka* and *Sushruta* texts, and Mauryan hospitals	Hygiene, Ayurveda, and early prevention
Medieval (1200–1750)	Unani medicine, community hospitals, and charity practices	Balance and holistic health
Colonial (1757–1947)	Sanitary Commissioners, Municipal Acts, Epidemic Diseases Act (1897), and Medical Colleges	Sanitation, epidemic control, and urban focus
Postindependence (1947–1980s)	Bhore Committee (1946), Five-Year Plans, National Health Policy (NHP) 1983, and disease control programs	Primary care and rural health
Modern reforms (1990s–2025)	NRHM (2005), NUHM (2012), NHP 2017, *Ayushman Bharat* (2018), ABDM, and CoWIN	Universal health coverage (UHC), digital health, and equity

Source:
1. Ministry of Health and Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.
2. Mukhopadhyaya G. History of Indian Medicine. New Delhi: Munshiram Manoharlal Publishers; 1982.

Digital Mission (ABDM) reflect India's growing reliance on technology.

The COVID-19 pandemic exposed weaknesses but also highlighted resilience through innovations in governance, community participation, and public–private collaboration.

Timeline of Public Health in India

The history of public health in India shows a shift from *community practices in ancient times*, to *colonial institutions*, and then to *nation-building after independence*. Today, India is working toward UHC while also addressing modern challenges such as digital health, equity, and resilience to pandemics. This historical perspective helps us appreciate both the achievements and the gaps that shape public health administration today **(Table 2)**.

SCOPE AND DOMAINS OF PUBLIC HEALTH ADMINISTRATION IN INDIA

Public health administration in India covers a wide spectrum of responsibilities. It combines disease prevention, health promotion, curative and rehabilitative services, and the governance mechanisms that ensure equity and accountability. Its scope is not static; it evolves with demographic changes, new health challenges, and innovations in technology.

Traditional Scope of Public Health

Traditionally, public health in India focused on *sanitation, safe water, immunization, epidemic control, family planning, and population stabilization*. These activities dominated the early years after independence because infectious diseases and high fertility rates were the main causes of poor health and poverty.

National programs such as the *Malaria Eradication Programme, National Smallpox Eradication Programme,* and the *Universal Immunisation Programme (UIP)* tackled communicable diseases, while the *National Family Planning Programme (1952)*—the world's first national-level family planning initiative—addressed high fertility and maternal–child health risks.

This combined approach of disease control, immunization, and family planning laid the foundation for improving life expectancy, reducing maternal and infant mortality, and moving toward population stabilization.

JAYPEE BROTHERS

Expanded Scope in Modern India

Today, the scope has expanded to include *NCDs* such as diabetes, hypertension, and cancers, as well as *mental health, road traffic injuries, ageing, and environmental health*. Issues such as *air pollution, antimicrobial resistance, and climate change* are now part of the public health agenda.

Digital health, One Health approaches linking human–animal–environment health, and social determinants such as housing, education, and employment are also integral to the scope of public health administration.

Domains of Public Health Administration

Public health administration operates across several domains, each requiring coordinated planning and execution **(Table 3)**.

Visual Framework of Public Health Scope

A visual way to understand the scope is to see it as *concentric circles of responsibility*:

- *Core services*: Prevention, promotion, and cure
- *Supportive services*: Rehabilitation, palliative care, and occupational health
- *System enablers*: Governance, financing, human resources for health (HRH), and regulation
- *Emerging domains*: Digital health, One Health, and climate and health resilience

This framework shows that public health administration is not only about medical services but also about creating enabling systems and adapting to new challenges.

TABLE 3: Domains of public health administration in India.

Domain	***Key activities in the Indian context***
Preventive health	Universal Immunization Programme (UIP), Integrated Disease Surveillance Programme (IDSP), vector control, and epidemic preparedness
Promotive health	Information, education, and communication/behavior change communication (IEC/BCC) campaigns, nutrition programs *(POSHAN Abhiyaan)*, school health, and yoga promotion
Curative health	Primary care through health and wellness centers (HWCs) and primary health centers (PHCs), secondary and tertiary care under District Hospitals and *Pradhan Mantri Jan Arogya Yojana (PM-JAY)* empaneled facilities
Rehabilitative care	Disability support, physiotherapy, rehabilitation centers, and community-based rehabilitation
Palliative care	Palliative care units in hospitals, home-based end-of-life support, and integration into National Health Mission (NHM)
Environmental health	*Swachh Bharat* Mission, water safety, pollution control boards, and biomedical waste management
Occupational health	Factories Act provisions, employee health services, and occupational safety standards
Health system governance	Policy-making, health financing, human resource management, regulation of clinical establishments, accreditation [National Quality Assurance Standards (NQAS) and National Accreditation Board for Hospitals (NABH)]
Equity and inclusion	Programs for tribal populations, urban poor, migrants, women, children, and the elderly
Emerging areas	Digital health [*Ayushman Bharat* Digital Mission (ABDM) and eSanjeevani], One Health [zoonoses and antimicrobial resistance (AMR)], and climate change and health

Source: Ministry of Health & Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.

JAYPEE BROTHERS

Relevance of Defining the Scope of Public Health Administration in India

In a country as large and diverse as India, *defining the scope of public health administration is crucial.* Without a clear definition of what falls within its remit, services risk becoming fragmented and inequities widening. A well-articulated scope helps administrators, policy-makers, and frontline workers to set priorities, allocate resources, and measure progress consistently across states and districts.

By clearly outlining *preventive, promotive, curative, rehabilitative, palliative, occupational health, and system-wide responsibilities*, and linking them to governance, financing, and emerging areas such as digital health and One Health-India, the country can move steadily toward *UHC* with equity.

A clearly defined scope also makes it easier to coordinate between the center, states, and local bodies. It provides a common language for national programs, state innovations, and community participation, thereby reducing duplication and ensuring continuity of care.

INSTITUTIONAL LANDSCAPE OF PUBLIC HEALTH ADMINISTRATION IN INDIA

Public health administration in India functions through a complex multilevel structure. The federal system divides responsibilities between the center and states, while local governments ensure implementation at the grassroots. This layered arrangement allows flexibility but also requires strong coordination to achieve national health goals.

Central Level

At the national level, the MoHFW is the apex body responsible for policy, planning, and overall direction. It operates through two departments:

1. *Department of Health and Family Welfare*: Responsible for national health programs, primary and secondary healthcare, family planning, and health policy
2. *Department of Health Research (DHR)*: Oversees biomedical research, including the Indian Council of Medical Research (ICMR)

National Medical Commission (NMC), marking a structural reform in the governance of medical education. This shift aims to improve transparency, reduce regulatory capture, promote competency-based curricula, and ensure uniform quality of medical training across the country. The NMC also provides a stronger framework for accountability and aligns medical education more closely with public health priorities.

Other important central-level institutions include:

- *National Health Authority (NHA)*: Governs *Ayushman Bharat*–PM-JAY, India's flagship insurance program
- *National Centre for Disease Control (NCDC)*: Leads disease surveillance and outbreak response
- *Regulatory bodies*: NMC, Pharmacy Council, and Nursing Council
- *Technical agencies*: National Health Systems Resource Centre (NHSRC) and Health and Family Welfare Training Institutes

The center provides policy frameworks, guidelines, financing support, and monitoring mechanisms for nationwide implementation **(Fig. 1)**.

State Level

States are the primary actors in health service delivery. Each state has a *State Health Department*, headed by a Health Minister and a Principal Secretary/Commissioner of Health. Key responsibilities include:

- Implementing national programs according to state needs
- Recruiting and managing the health workforce
- Budgeting and managing state health funds
- Regulating private healthcare providers

Most states also have *State Health Resource Centres* or *State Institute of Health & Family Welfares (SIHFWs)* for training and technical support.

JAYPEE BROTHERS

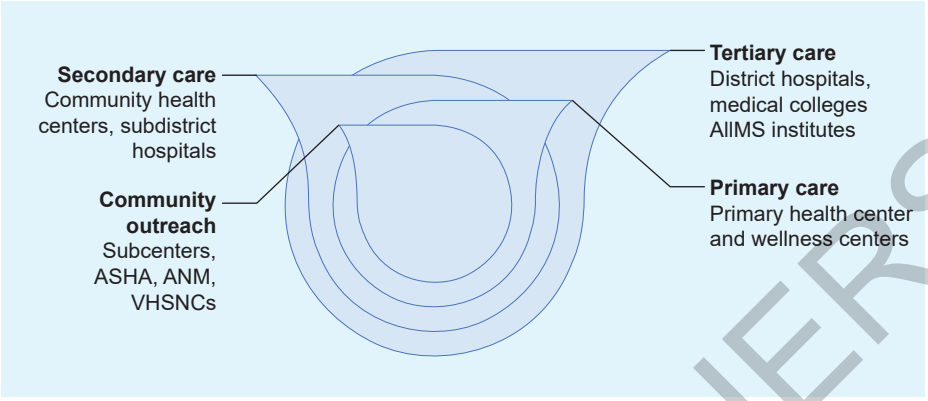


Fig. 1: Three-tier Indian public health delivery system.

Source: Ministry of Health & Family Welfare. National Health Mission: Framework for Implementation. New Delhi: Government of India; 2023.

District Level

The district is the operational backbone of health administration. *District Health Societies (DHS)* manage NHM funds and programs. The *Chief Medical and Health Officer (CMHO)* or *Civil Surgeon* heads the district health administration.

Responsibilities include:

- Supervising PHCs, CHCs, and district hospitals
- Coordinating vertical programs [tuberculosis (TB), malaria, and NCDs]
- Monitoring ASHAs, Auxiliary Nurse Midwives (ANMs), and other field staff
- Ensuring intersectoral coordination with education, women and child development, and rural development departments.

District Health Action Plans (DHAPs) under NHM allow tailoring of programs to local needs.

Subdistrict and Facility Level

Below the district, the network includes:

- *CHCs*: Act as First Referral Units (FRUs)
- *PHCs*: First point of contact for curative and preventive care
- *Subcenters and HWCs*: Deliver comprehensive primary healthcare with ASHAs, ANMs, and Community Health Officers (CHOs)

Community and Local Governance

Community participation is embedded through:

- *ASHAs*: Community volunteers linking households with health services
- *Village Health Sanitation and Nutrition Committees (VHSNCs)*: Local bodies managing untied funds and planning village health activities
- *PRIs and ULBs*: Play a growing role in monitoring and supporting health services

Civil society organizations, NGOs, and private providers also collaborate at the community level, often filling gaps in awareness, outreach, and specialized services.

Organogram of Public Health Administration in India

India's public health administration is a multitiered system. The center provides vision and resources, states adapt and deliver services, districts operationalize programs, and communities ensure accountability. This layered structure is both a strength and a challenge: It enables contextual solutions but demands strong coordination **(Table 4)**.

JAYPEE BROTHERS

TABLE 4: Institutional framework of public health administration.

Level	*Key institutions/actors*	*Functions*
Central	MoHFW, DHR, ICMR, NHA, NCDC, NHSRC, regulators	Policy, financing, surveillance, research, regulation
State	State Health Departments, SIHFWs, and SHSRCs	Service delivery, HR management, and budget planning
District	District Health Society, CMHO, Civil Surgeon	Program implementation, facility supervision, and coordination
Subdistrict	CHCs, PHCs, HWCs, subcenters	Preventive, promotive, and curative services
Community	ASHAs, VHSNCs, PRIs, ULBs, NGOs	Outreach, mobilization, monitoring

(ASHAs: Accredited Social Health Activists; CHCs: community health centers; CMHO: Chief Medical and Health Officer; DHR: Department of Health Research; HR: human resource; HWCs: health and wellness centers; ICMR: Indian Council of Medical Research; MoHFW: Ministry of Health & Family Welfare; NCDC: National Centre for Disease Control; NGOs: nongovernmental organizations; NHA: National Health Authority; NHSRC: National Health Systems Resource Centre; PHCs: primary health centers; PRIs: *Panchayati Raj* Institutions; SHSRCs: State Health Systems Resource Centre; SIHFWs: State Institute of Health & Family Welfares; ULBs: urban local bodies; VHSNCs: Village Health Sanitation and Nutrition Committees)

Source: Ministry of Health & Family Welfare. National Health Mission: Framework for Implementation. New Delhi: Government of India; 2023.

COMMUNITY PARTICIPATION IN PUBLIC HEALTH ADMINISTRATION

Community participation is the heart of public health in India. The idea that people should have a voice in planning, implementing, and monitoring health services was strongly emphasized in the *Alma-Ata Declaration (1978)*, which recognized primary healthcare as people-centered. India has taken this principle forward through policies, programs, and institutional mechanisms.

Rationale for Community (Participation/Engagement)

Health systems work best when communities are involved.

- Participation improves trust between people and the health system
- Ensures accountability of health workers and administrators
- Helps adapt programs to local needs and cultural practices
- Encourages collective ownership and sustainability of services

Accredited Social Health Activists

The *ASHA program*, launched under the NRHM in 2005, is one of the most recognized community-based innovations. ASHAs are trained women volunteers selected from their own villages. Their responsibilities include:

- Mobilizing women for antenatal care, institutional delivery, and immunization
- Supporting community health activities like Village Health and Nutrition Days (VHNDs)
- Facilitating home visits for maternal and newborn care
- Acting as a link between households and health facilities

Today, over 10 lakh ASHAs are working across India. Their role during the COVID-19 pandemic-tracking contacts, spreading awareness, and supporting vaccination-demonstrated the critical role of community health workers in crises.

Village Health Sanitation and Nutrition Committees

The VHSNCs are community-level bodies under the NRHM. They include ASHAs, *Anganwadi*

JAYPEE BROTHERS

workers, schoolteachers, PRI members, and local volunteers. They manage untied funds provided to villages and prepare local health plans.

Functions include:

- Identifying local health needs
- Organizing health promotion campaigns
- Monitoring service delivery at the village level
- Managing untied funds for sanitation, safe water, and emergency transport

Active VHSNCs have improved community ownership and accountability. However, in many areas they remain underutilized due to a lack of training and awareness.

Rogi Kalyan Samitis

The RKSs, or Hospital Management Committees, function at the level of PHCs, CHCs, and District Hospitals. They include local leaders, citizens, and health officials. RKSs manage user charges, donations, and untied funds for facility improvement. They are designed to make hospitals more responsive to people's needs by creating community ownership.

Panchayati Raj Institutions and Urban Local Bodies

The *73rd and 74th Constitutional Amendments (1992)* gave PRIs and ULBs a formal role in health governance. PRIs at village, block, and district levels oversee health services, manage VHSNCs, and ensure accountability. ULBs in cities are responsible for urban health infrastructure, sanitation, and local health campaigns.

Kerala's *People's Plan Campaign (1996)* is a successful example of PRI involvement. Local governments were empowered to prepare health plans and allocate funds, resulting in stronger primary care and better health outcomes.

Civil Society and NGOs

Community participation also extends through NGOs, self-help groups, and civil society organizations. They often work on awareness, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) prevention, mental health, and rights-based advocacy. In tribal and remote areas, NGOs are critical for mobilizing communities and delivering services where government presence is weak.

Community participation strengthens health systems by ensuring accountability and responsiveness. Mechanisms such as ASHAs, VHSNCs, RKSs, and PRIs demonstrate India's commitment to involving people in their own health. However, participation must be institutionalized through training, resources, and recognition to move from token involvement to real empowerment **(Table 5)**.

TABLE 5: Community participation in public health administration.

Mechanism	*Level*	*Key functions*	*Example*
ASHAs	Village	Mobilization, health promotion, and referral	ASHA supports immunization drives
VHSNCs	Village	Local planning, sanitation, and untied funds	Water safety in Rajasthan villages
RKSs	Facility	Facility improvement and local accountability	Hospital repairs from unspent funds
PRIs/ULBs	Local government	Planning, monitoring, and resource allocation	Kerala's People's Plan Campaign
NGOs/SHGs	Community	Awareness, outreach, and advocacy	HIV/AIDS awareness campaigns

(AIDS: acquired immunodeficiency syndrome; ASHAs: Accredited Social Health Activists; HIV: human immunodeficiency virus; NGOs: nongovernmental organizations; PRIs: *Panchayati Raj* Institutions; RKSs: *Rogi Kalyan Samitis*; SHGs: Self-Help Groups; ULBs: urban local bodies; VHSNCs: Village Health Sanitation and Nutrition Committees)

Source: Ministry of Health & Family Welfare. Guidelines for Village Health Sanitation and Nutrition Committees. New Delhi: National Health Mission, Government of India; 2015.

JAYPEE BROTHERS

CONTEMPORARY CHALLENGES IN PUBLIC HEALTH ADMINISTRATION IN INDIA

India has made significant progress in expanding its public health system. Life-expectancy has increased, maternal and child mortality have declined, and access to services has improved. However, the country continues to face serious challenges. These challenges are structural, financial, and social. They affect equity, efficiency, and quality of health services.

Governance and Policy Fragmentation

India's federal structure creates complexity. Health is a *state subject*, but national programs guide direction and financing. This sometimes results in overlapping roles and fragmented accountability. For example, central schemes such as NHM, *Ayushman Bharat*, and vertical disease-control programs often operate in silos. States also differ in their administrative capacity and political commitment, which creates disparities across regions.

Frequent transfers of health administrators disrupt program continuity. Weak enforcement of regulations in the private sector further complicates governance.

Financing Gaps

Public health financing in India remains inadequate. Government health expenditure is around *2.1% of gross domestic product (GDP)*, which is lower than the global average of 5–6%. Out-of-pocket expenditure by households still accounts for nearly *48% of total health spending*.

This creates catastrophic health spending and pushes millions into poverty. Moreover, budget allocations are skewed toward tertiary care, while primary healthcare often remains underfunded. Delays in fund release and low absorption capacity at the state level further weaken financing efficiency.

Human Resource Shortages

India faces acute shortages and maldistribution of health workers. According to the *Rural Health Statistics (2022)*, about 80% of specialist posts at CHCs are vacant. Rural and tribal areas face the greatest deficits.

Contractual appointments under NHM create job insecurity and high attrition. Training gaps persist in emerging areas such as digital health, geriatrics, and public health management. The *Public Health Management Cadre (PHMC)*, although introduced, is not yet fully operational across all states.

Infrastructure Deficits

Many health facilities still function without adequate infrastructure. Subcenters operate from rented or dilapidated buildings, while PHCs often lack laboratory and diagnostic services. CHCs are supposed to act as FRUs, but many do not have specialists, blood storage facilities, or newborn care units.

Urban health facilities also remain weak. The *NUHM* created urban PHCs, but many are understaffed and underequipped to handle the growing needs of urban poor populations.

Service Delivery and Quality

The delivery of health services suffers from fragmentation. Preventive, promotive, curative, and rehabilitative services are often not integrated. Referral systems are weak, leading to overcrowding at tertiary hospitals while primary facilities remain underutilized.

Quality assurance remains inconsistent. Although initiatives like *National Quality Assurance Standards (NQAS)* exist, only a fraction of facilities are certified. Patient satisfaction surveys point to long waiting times, absenteeism, and poor communication.

Digital Divide

India has made strides in digital health through platforms such as *eSanjeevani, ABDM,*

JAYPEE BROTHERS

TABLE 6: Contemporary challenges in public health administration.

Challenge area	*Key issues*	*Implications*
Governance	Policy silos, weak regulation, and frequent transfers	Poor accountability and uneven outcomes
Financing	Low spending, high OOP, and skewed allocation	Catastrophic expenditure, inequities
Human resources	Shortages, maldistribution, and contractualization	Poor access, high attrition
Infrastructure	Dilapidated buildings, weak UPHCs, and FRUs underequipped	Poor service quality, overload at the tertiary level
Service delivery and quality	Weak referral, fragmented services, and poor NQAS coverage	Inefficiency, patient dissatisfaction
Digital divide	Connectivity gaps, low literacy, and privacy concerns	Limited adoption of digital health
Equity and access	Geographic, gender, and socioeconomic inequities	Persistent health disparities
Community participation	Inactive VHSNCs, weak monitoring, and trust deficit	Low accountability, weak ownership

(FRUs: First Referral Units; NQAS: National Quality Assurance Standards; OOP: out-of-pocket; UPHCs: Urban Primary Health Centres; VHSNCs: Village Health Sanitation and Nutrition Committees)

Source: Ministry of Health & Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.

and CoWIN. However, rural areas face poor connectivity and digital literacy gaps. Many frontline workers struggle with electronic data entry. Concerns about privacy and data security also need stronger safeguards.

Equity and Access

Health outcomes remain unequal across geography, gender, and socioeconomic status. States like Kerala perform far better than states such as Bihar and Uttar Pradesh. Vulnerable groups-tribal communities, migrants, and urban slum dwellers-often face poor access and poor quality care.

Gender inequities also persist. Women face barriers to reproductive health, while elderly populations struggle with chronic diseases and limited geriatric services.

Community Participation Gaps

Although ASHAs, VHSNCs, and PRIs are institutionalized, their effectiveness varies. Many VHSNCs remain inactive due to a lack of training and funding. Community monitoring is weak in several states. Trust deficits persist where services are irregular or perceived as low quality.

Summary Table

These challenges highlight that India's public health administration is at a crossroads. The country has built a wide health infrastructure, but gaps in governance, financing, human resources, and equity continue to hinder progress. Addressing these issues requires systemic reforms, stronger political commitment, and active participation of communities **(Table 6)**.

OPPORTUNITIES FOR STRENGTHENING PUBLIC HEALTH ADMINISTRATION IN INDIA

Challenges in public health administration are real, but they also create opportunities for reform and innovation. India's demographic advantage, digital momentum, and policy frameworks offer a chance to strengthen the health system in ways that are more inclusive, efficient, and resilient.

Digital Health Transformation

The COVID-19 pandemic accelerated the use of digital health tools. Platforms such as *CoWIN* for vaccination, *eSanjeevani* for teleconsultations,

JAYPEE BROTHERS

and the *ABDM* for interoperable health records demonstrated India's ability to scale technology quickly.

Future opportunities include:

- Expanding electronic health records for all citizens
- Using artificial intelligence (AI) for diagnostics and disease prediction
- Bridging rural–urban gaps through tele-medicine
- Ensuring digital equity by training frontline workers and improving connectivity in remote areas

Community Engagement and Social Participation

India has a strong base of community health workers through the *ASHA program*, VHSNCs, and RKSs. By expanding their roles in NCDs, elderly care, and mental health, community participation can be deepened.

Empowering communities through training, digital tools, and local accountability mechanisms can help build stronger trust between citizens and health systems.

Public–Private Partnerships

Public–private partnerships (PPPs) have helped improve diagnostics, dialysis, and ambulance services in many states. Gujarat's *108 Emergency Medical Services (EMS)* and Rajasthan's *Free Diagnostics Scheme* are successful examples.

Future opportunities lie in:

- Scaling PPPs to underserved areas.
- Developing transparent contracts with performance-linked incentives
- Setting clear quality standards and safeguards to protect public interest

One Health Integration

India faces growing threats from zoonotic diseases, antimicrobial resistance, and climate-sensitive health risks. A *One Health approach* that integrates human, animal, and environmental health is essential.

Opportunities include:

- Creating national and state-level One Health governance platforms
- Strengthening integrated surveillance across veterinary and human health systems
- Incorporating One Health concepts in medical, veterinary, and environmental education

Governance and Policy Innovations

The *National Health Policy 2017* and the *Fifteenth Finance Commission health grants* have created a base for innovation in governance and financing.
Opportunities include:

- Scaling the *PHMC* across all states
- Expanding performance-linked financing to district and block levels
- Using the *NITI Aayog Health Index* model to drive competition and accountability

Harnessing India's Demographic Dividend

India's young workforce is a major asset.
Opportunities lie in:

- Training youth in emerging health technologies
- Developing new cadres of health workers such as community paramedics and digital health coordinators
- Encouraging health entrepreneurship and innovation

Opportunity Matrix

India's path to stronger public health administration lies in *scaling innovations* and *closing gaps*. By embracing digital health, community engagement, PPPs, One Health, and governance reforms, India can build a system that is resilient, equitable, and future-ready. These opportunities, if pursued with commitment, will bring the country closer to *UHC* and the vision of *Viksit Bharat 2047* **(Table 7)**.

JAYPEE BROTHERS

TABLE 7: Opportunities in public health administration.

Area	*Current strengths*	*Future directions*
Digital health	CoWIN, *eSanjeevani*, and ABDM	AI-driven care, EHRs, and rural digital equity
Community participation	ASHAs, VHSNCs, and RKSs	Expanded roles in NCDs, elderly care, and mental health
Public–private partnerships	Diagnostics, EMS, and dialysis models	Quality-regulated PPPs in underserved areas
One health	AMR plan and pilot projects	National governance and integrated zoonotic surveillance
Governance innovations	NHP (2017), Finance Commission grants, and Health Index	PHMC scale-up and outcome-based financing
Demographic dividend	Large youth workforce	Skill development and health entrepreneurship

(ABDM: *Ayushman Bharat* Digital Mission; AI: artificial intelligence; AMR: antimicrobial resistance; ASHAs: Accredited Social Health Activists; EHRs: Electronic Health Records; EMS: Emergency Medical Services; NCDs: noncommunicable diseases; NHP: National Health Policy; PHMC: Public Health Management Cadre; PPPs: Public–private partnerships; RKSs: *Rogi Kalyan Samitis*; VHSNCs: Village Health Sanitation and Nutrition Committees)

Source: Ministry of Health & Family Welfare. National Health Policy 2017. New Delhi: Government of India; 2017.

CASE STUDIES AND BEST PRACTICES IN PUBLIC HEALTH ADMINISTRATION

India's states have experimented with innovative approaches to strengthen health systems. These experiences show how good administration improves medicines, emergency response, and community trust. Among them, *Tamil Nadu stands out* with two flagship successes—*Tamil Nadu Medical Services Corporation (TNMSC)* and a *high-performing 108 EMS*. Other states such as Kerala, Rajasthan, Andhra Pradesh, and Gujarat also provide lessons that have shaped national policy.

Tamil Nadu—Medicines and Emergency Services Leadership

First of its kind, it is established in 1994. Its key functions are centralized procurement. Storage and distribution of medicines, vaccines, and surgical items.

- Ensures transparent, cost-effective tendering with strict quality control
- Maintains a three-tier drug distribution system with district drug warehouses
- Computerized inventory management to prevent stock-outs

Impact: It is regarded as a model for other Indian states and has even international recognition by the WHO.

Tamil Nadu Medical Services Corporation

The TNMSC, established in the 1990s, is a pioneering model for drug procurement and supply chain management. It uses transparent e-tendering, strict vendor qualification, independent quality testing, and computerized warehouse systems. Medicines are stocked in district warehouses and distributed to facilities based on demand.

This system has:

- *Reduced stock-outs*, ensuring patients get prescribed medicines
- *Lowered prices*, because of competitive bidding and bulk purchasing
- *Improved public trust*, as medicines are reliably available in government facilities
- *Influenced other states*, which have set up similar corporations, such as Uttar Pradesh Medical Supplies Corporation (UPMSC) in Uttar Pradesh.

JAYPEE BROTHERS

The TNMSC is widely recognized as one of the most successful health system reforms in India and remains a benchmark for supply chain transparency and efficiency **(Fig. 2)**.

Tamil Nadu's 108 Emergency Medical Service

Tamil Nadu also operates one of the fastest and most reliable *108 ambulance networks* in India. The state has modernized its fleet, balanced Advanced Life Support (ALS) and Basic Life Support (BLS) ambulances, and deployed vehicles using Geographic Information System (GIS)-based location tracking. District control rooms monitor calls, assign vehicles, and review monthly performance.

Recent reports show significant improvements:

- *Trichy district* reduced its average response time from 11 minutes 26 seconds to *9 minutes 48 seconds* in May 2025.
- *Madurai district* improved from 11 minutes 50 seconds to *11 minutes 18 seconds* in early 2025.

The state has added hundreds of new ambulances under health reform programs, further strengthening coverage. Continuous monitoring through the Tamil Nadu Health Systems Project (TNHSP) dashboard has helped administrators quickly fix bottlenecks and improve service quality **(Flowchart 1)**.

Although the *108 EMS model originated in Andhra Pradesh in 2005* through a PPP, Tamil Nadu has become one of the *best performers today* with consistent investments and disciplined administration. Its experience shows how sustained attention to detail-fleet upgrades, GIS tracking, and real-time monitoring-translates into lives saved.

Kerala—Decentralized Health Governance

Kerala's *People's Plan Campaign (1996)* devolved powers and funds to PRIs. Local governments were empowered to prepare health plans, hire staff, and allocate budgets. This decentralization

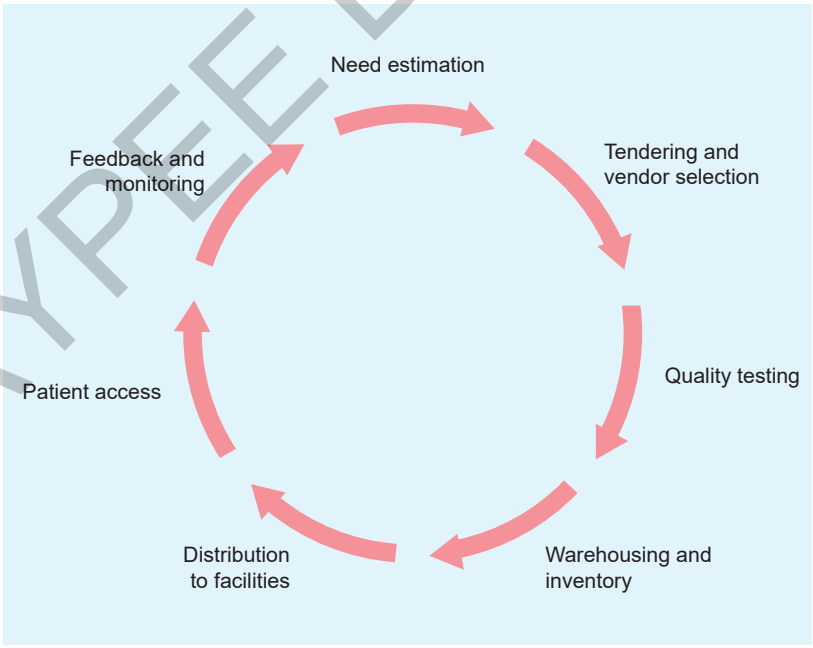
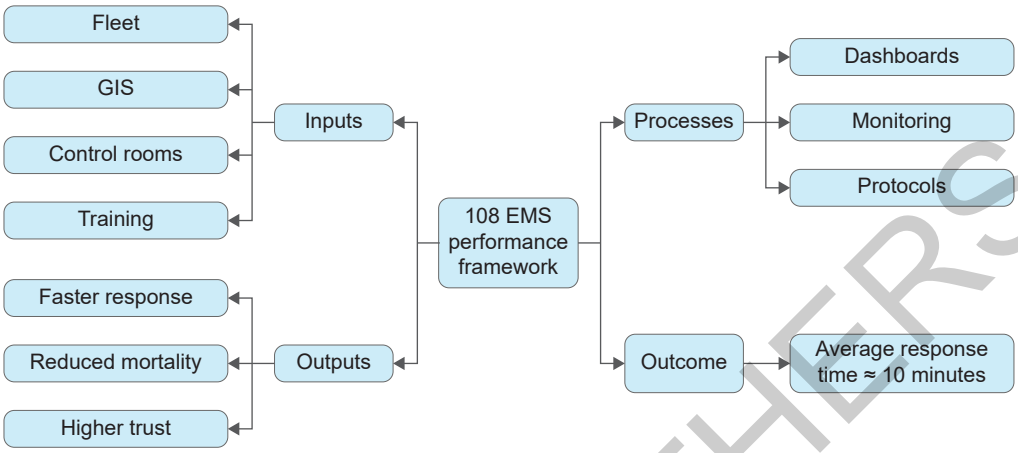


Fig. 2: Tamil Nadu Medical Services Corporation (TNMSC) supply chain management cycle.

Source: National Health Systems Resource Centre. Assessment of IT-enabled Supply Chain Management of Medicines. New Delhi: National Health Systems Resource Centre; 2025.

JAYPEE BROTHERS



Flowchart 1: 108 Emergency Medical Services (EMS) framework.

(GIS: Geographic Information System)

Source: National Health Mission, Uttarakhand. (2026). 108 Emergency. [online] Available from https://nhm.uk.gov.in/service/108-emergency [Last accessed March, 2026].

JAYPEE BROTHERS

improved responsiveness and accountability. Kerala's effective handling of the *Nipah virus outbreak (2018)* and early *COVID-19 response* reflected the strength of community-owned governance.

Rajasthan—Free Drugs and Diagnostics

Rajasthan launched the *Mukhyamantri Nishulk Dava Yojna (2011)*, ensuring free availability of essential medicines, followed by the *Free Diagnostics Scheme*. These reforms:

- Reduced out-of-pocket expenditure on medicines and tests
- Increased utilization of public facilities
- Influenced the national Free Drugs and Diagnostics Service Initiative under NHM

Andhra Pradesh and Gujarat—Early Emergency Care Innovators

The *108 EMS model was first launched in Andhra Pradesh in 2005* under a PPP with Emergency Management and Research Institute (EMRI). It developed practices such as centralized call centers, triage protocols, and GPS tracking. This model expanded to many states.

Gujarat was an early adopter and has now integrated emergency numbers under the unified *112 Jan Rakshak system*, leveraging EMRI's experience to coordinate health, police, and fire emergencies.

Andhra Pradesh—Digital Health and Telemedicine

In addition to EMS, Andhra Pradesh has invested in *telemedicine and mobile diagnostic vans*. Platforms like *eSanjeevani* connect patients in rural PHCs with specialists, reducing travel time, and improving early diagnosis **(Table 8)**.

These case studies highlight how *state-level innovation drives national policy*. Tamil Nadu stands out as a leader in both medicine supply and emergency response. Kerala demonstrates the power of decentralization, Rajasthan shows the benefits of free access, and Andhra Pradesh and Gujarat highlight the value of early emergency innovations and digital health. Together, they show

TABLE 8: Best practices in public health administration.

State/UT	*Innovation/Intervention*	*Key features*	*Outcomes*
Tamil Nadu	TNMSC drug procurement	Transparent e-tendering, quality testing, and warehouse IT	Fewer stock-outs, lower costs, national replication
Tamil Nadu	108 EMS (high performing)	GIS-based deployment, fleet modernization, dashboard monitoring	~10 minutes response times in districts, high utilization
Kerala	Decentralized health governance	PRIs prepare health plans, allocate funds	Strong outbreak response, community accountability
Rajasthan	Free Drugs and Diagnostics	Free medicines and tests in public facilities	Reduced OOP, improved facility utilization
Andhra Pradesh	108 EMS (origin) and telemedicine	Centralized call center EMS; *eSanjeevani*, mobile vans	EMS scaled nationwide; better rural access to specialists
Gujarat	EMS integration (Jan Rakshak 112)	Unified emergency number using the EMRI base	Coordinated response across services

(EMRI: Emergency Management and Research Institute; EMS: Emergency Medical Services; GIS: Geographic Information System; PRIs: *Panchayati Raj* Institutions; TNMSC: Tamil Nadu Medical Services Corporation; UT: Union Territory)

Source: National Health Mission, Uttarakhand. (2026). 108 Emergency. [online] Available from https://nhm.uk.gov.in/service/108-emergency [Last accessed March, 2026].

JAYPEE BROTHERS

that good governance, community participation, and innovation are the building blocks of stronger public health administration.

FUTURE DIRECTIONS AND VISION 2047

India will celebrate 100 years of independence in 2047. The government has set the goal of creating a *Viksit Bharat (Developed India)* by then. Public health administration will play a central role in this vision. A healthy population is not only a social goal but also an economic necessity. Strong health systems reduce poverty, improve productivity, and ensure social stability.

Universal Health Coverage

By 2047, India aims to achieve *UHC*. This means that all people, regardless of income, gender, or location, should have access to quality health services without financial hardship. The expansion of *Ayushman Bharat*, strengthening of Health and Wellness Centres, and scaling up of PM-JAY are key steps in this direction.

Primary Healthcare as the Foundation

Strong primary care must be the backbone of the health system. HWCs need to be expanded and upgraded to provide comprehensive services, including NCD screening, mental health support, and palliative care. Referral linkages between primary, secondary, and tertiary care must be strengthened to ensure continuity.

Equity and Inclusion

Future reforms must address health inequities not only across states and social groups but also within communities, where disparities are often hidden. Equity is more than reaching vulnerable groups; it requires ensuring fair access, quality, and affordability of care for all. Special focus should be given to tribal populations, migrants, slum dwellers, women, the elderly, persons with

for detailed information on public health books, visit our website www.ejaypee.com, for detailed information on public health books, visit our website www.eja

Navigating Public Health Administration in India

Public health administration is where policies succeed or fail, because it converts intent into services and budgets into outcomes. In a country as diverse and rapidly changing as India, administrators must manage complexity across programs, institutions, levels of care, and sectors while protecting equity, quality, and public trust. "*Navigating Public Health Administration in India*" offers a practice-oriented guide to this work, bringing together the insights of seasoned practitioners, academicians, and policy leaders.

The book goes beyond concepts to show how systems are planned, governed, financed, regulated, and improved in real settings. It covers health systems strengthening, digital health governance, emergency preparedness and resilience, quality and patient safety, regulation of medical technologies, outreach and referral systems, and the disciplined use of data for decision-making and accountability. Chapters combine policy perspectives with operational frameworks, tools, and case-based learning that readers can apply.

Written in clear, accessible language, this volume is essential reading for students, public health professionals, administrators, and leaders working to build a resilient, equitable, and people-centered health system for India.



Suneela Garg is a distinguished public health leader, medical educator, and policy advisor with over four decades of experience in shaping India's health systems. She has held senior academic and governance roles, including Professor of Excellence and Sub-Dean at Maulana Azad Medical College and Chair of the Programme Advisory Committee at the National Institute of Health and Family Welfare. Her work spans medical education reform, HIV medicine, adolescent and geriatric health, occupational health, and health systems strengthening.

She pioneered India's first Fellowship in HIV Medicine and contributed to national frameworks on syndromic management of RTIs, maternal death surveillance, and elderly care. A trusted advisor to the Ministry of Health and Family Welfare, ICMR, and WHO-SEARO, she has served on global and national expert platforms, including Lancet Commissions. An accomplished author with 240+ publications, she continues to guide policy, practice, and leadership for equitable, quality public health administration in India.



K Madan Gopal is a distinguished public health professional with over three decades of experience shaping health sector reforms and strengthening health systems in India. An MBBS and MD in Preventive and Social Medicine, he has worked across community, state, and national levels, contributing to some of India's most significant health policy transformations. He has served in key leadership roles, including Senior Consultant (Health) at NITI Aayog, CEO of the State Health Agency in Chhattisgarh, and Senior Technical Expert with the Indo-German Social Security Programme.

Dr Gopal is the author of influential policy works such as Senior Care Reforms in India, Insurance for the Missing Middle Population, and Health Systems for a New India: Building Blocks. His work has informed national initiatives, including Ayushman Bharat, the Aspirational District Programme, State Health Index, and public health surveillance reforms. Widely respected for his evidence-based approach and collaborative leadership, Dr Gopal continues to shape India's health systems through policy, research, and practice as Advisor with the National Health Systems Research Centre.

Shelving Recommendation
PUBLIC HEALTH

ISBN 978-93-6616-441-0

9 789366 164410

Buy from ejaypee

JAYPEE BROTHERS