

DISCUSSION

Reflections on the Kerala Public Health Act 2023: A response to Dr Karpagam's commentary

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Abstract

In this response, we seek to analyse and rebut the observations of Karpagam S using an understanding of the Kerala Health system and the general purpose of the Kerala Public Health Act (KPHA). The KPHA was crafted with a greater focus on a one-health and preventive approach. It does not seek to interfere in an individual's preferred choice of treatment, except in the case of public health emergencies. KPHA is not a standalone document, but a supporting tool to the existing Kerala Health Policy and various other health policies and programmes instrumental in improving the health and quality of life of the people of the State. The KPHA is intended to be an enforcement tool for legal provisions to ensure welfare maximisation of the society at large, and thus detailed discussions regarding actions to be taken beyond these legal provisions do not fall within the purview of the Act.

Keywords: Kerala Public Health Act, public health ethics, Kerala Health Policy, communicable diseases

We read with great interest the recently published commentary by Dr Sylvia Karpagam titled "Public health ethics and the Kerala Public Health Act, 2023" [1]. In this response, we aim to analyse and rebut the author's observations by elaborating on the context of the public health system in Kerala and the aims of the Kerala Public Health Act (KPHA) [2].

The overall objective of the KPHA was the unification and refinement of the provisions in the Madras Public Health Act, 1939, and the Travancore-Cochin Public Health Act, 1955, with the incorporation of lessons from the Covid-19 pandemic and a greater focus on social determinants of health, while adopting a one-health approach and a preventive approach.

Being more concerned with disease prevention, the Act does not seek to interfere in an individual's preferred choice of treatment or system of treatment, except in the case of public health emergencies.

KPHA must be viewed in the context of the Kerala Health Policy 2019 (KHP), which outlines the government's vision for protecting and promoting the citizens' physical, mental and social health and wellbeing [3]. The KHP explicitly recognises the duty of the government to protect the rights of citizens to a healthy life; and to provide facilities and circumstances for healthy living. Chapter VII of the KHP recognises that a healthy life cannot be achieved only through measures such as health education or lifestyle changes; but legal measures would also need to be initiated and strictly implemented. It therefore emphasises the intention of the government to bring in a unified and updated public health Act for Kerala. The KHP also details the need for implementing the Food Safety and Standards Act 2006, The Kerala Medical Practitioners Act, The Environment (Protection) Act 1986, The Maintenance and Welfare of Parents and Senior Citizens Act 2007, pollution control laws and the Hospital Protection Act. KPHA is only one among the many legal measures envisaged by the government of Kerala for the protection of the health of its citizens. It also needs to be emphasised that the KHP talks about legal measures only in the last chapter, after describing the various challenges faced by the citizens and the government in the health sector and detailing various measures to overcome those challenges. For example, while Chapter 1 details the challenges faced in the health sector, Chapter 2 gives an outline of the Action Plan of the government. In subsequent chapters, it talks about the restructuring of the health system and the responsibilities of health personnel, human resources in health, health services delivery, health of vulnerable groups and legal measures [3]. KPHA is not a policy document, rather it deals with the legal provisions that may be used for the benefit of the community [2]. As described earlier, the KPHA should not be viewed in isolation, but against the backdrop of the overall social milieu of Kerala, including the mechanisms in place to ensure citizens' welfare.

The article by Karpagam commences with a mention of the principle of harm, which, based on JS Mill's account of liberty, succinctly states that action against an individual or community is justified to prevent harm to others. It is important to note that there might be instances where the principles that apply to the care of individual patients are not

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analogous to those that pertain to public health, with potential conflicts and trade-offs between individual and community rights being a locus of reflection in the latter [4]. Even though there is bound to be a perennial tension between individual and community rights, the interest of the community is the focal point in public health [5]. Roses' prevention paradox states that preventive measures may not benefit individuals to the same extent as they do populations. The social justice perspective, thus, requires systematic action to promote the wide-ranging freedom of many and state passivity has been shown to result in great damage to society. Gostin's article titled "A Broader Liberty: JS Mill, Paternalism and the Public's health," questions the Millian logic of dichotomy that individuals either have free will or lack capacity to make autonomous decisions and that state passivity can be either liberty-enhancing or liberty-limiting. He argues that it is the government's duty to inform and empower right choices in order to prevent collective costs due to countless individual decisions; and that governments have a responsibility towards populations and not just individuals [6].

Kerala has an elaborate social policy and a per capita expenditure on health and education consistently higher than those of other Indian states, with multiple schemes in place to benefit the deprived in society [7]. While the author's comment regarding isolation of patients with infectious disease, that "society has to pull its weight by offering them physical, psychological and economic support" needs to be heeded, it is important to know that the Government of Kerala has played a key role in response strategies in both health-related emergencies and in the social welfare of those with disease conditions or other marginalities [8,9]. For instance, during the Covid-19 pandemic, the state government directly and through various local self-government institutions (LSGs) provided services such as establishing community kitchens to distribute free food, issuing ration kits, transportation and free accommodation and quarantine facilities [10,11].

The observation in the commentary, that "Sections 8 and 9 of the KPHA appear to take away agency from people, people's representatives and even the healthcare system" [1] needs to be justified for the following reasons:

1. Section 7(8) deals with protocols restricted to notified diseases and those under national health programmes, which require protocols in the interest of public good. Treatment and prevention protocols being technical and scientific documents, can only be prepared by the experts in the field and cannot be left to the "agency of the people". The Act actually takes away the agency from the concerned Officer and entrusts the responsibility to a panel of experts.
2. Sec 7(9) does not deal with the treatment of any individual but with prevention and control strategies under the domain of public health. Moreover, the

recommendation of the Public Health Officer is placed before the Public Health Committee led by elected representatives and experts of non-health sectors for approval. This is the best that can be achieved to bring about a collective decision in matters which concern public health.

3. The idea that everything related to people needs to be decided by the people themselves will have some exceptions, and rapidly spreading infectious diseases with public health significance is one among them. In matters of public interest [as is the case in sections 7(8) and 7(9)], it is neither practical nor scientific to go by individual preferences.

In reality, the KPHA has democratised the process by bringing in public health committees at various levels presided over by elected representatives.

The commentary, when discussing the liability to be fined under Section 65, comments that "the Act does not explain why this is the first option" and propounds that counselling for patients and their families should be the first option. The two circumstances alluded to by Karpagam are mentioned in Sections 31 and 35 of the KPHA. Section 31 deals with the notification of communicable diseases by medical practitioners, which is the responsibility of any registered medical officer practising in this country. KPHA only adds a legal mandate to it since early notification is essential to prevent the spread of diseases. Section 35 deals with the shifting of infected persons to or from hospitals in conditions where there is deemed to be a risk to the safety of the diseased individual, their family or society at large. The KPHA supports the rationality of counselling patients and their families by explicitly describing the role of treating medical officers in educating concerned persons on treatment and prevention aspects. There is a logical flow in the sequence of actions to be taken from sections 31–35 beginning with the notification of communicable diseases, followed by educating people on disease prevention and culminating with shifting of the patient if adjudged to be necessary in section 35. It is also important to note that existing disease-specific guidelines of the State suggesting treatment, prevention and control of infectious conditions reiterate the importance of awareness generation [12,13].

The article also states that multiple spaces including dwelling places can be inspected by the Local Public Health Officer without prior notice. This appears to be an erroneous reading of Section 76, for the following reasons:

1. Business establishments are public places and some situations may warrant inspections without prior notice to prevent opportunities to hide public health hazards. Even in these cases, sub-clause (a) of Section 76 expressly prohibits entry and inspection between sunset and sunrise.
2. Sub-section (b) of Section 76 also explicitly prohibits

entry into a dwelling house without permission, unless two hours prior notice has been given.

3. Section 76 also needs to be read with section 39 which deals with the power of entry of Local Public Health Officers, wherein again the Act explicitly states that houses and residences can be inspected only after giving two hours prior notice.

We are also at variance with the author regarding the statement "The KPHA ... effectively converts illness into a crime". In our opinion, it is the actions that contravene efforts to prevent the spread of disease (non-adherence to guidelines and notices issued in the interest of safeguarding the community's health), that are an aberration. Restrictions come into play only when an individual's action poses a risk to their own or others' health.

The author takes objection to the fact that no civil court can entertain any petition against the actions of the Public Health Officer. What the author fails to see is that the KPHA is essentially a criminal law, offences under which shall be triable by a Court of Judicial Magistrate of the First Class, vide sections 66(2) and 67 of the KPHA. It is the basic principle of criminal law that any offence against society is a penal offence of a criminal nature and is considered an offence against the State. Parallels can be seen in the Indian Penal Code wherein several acts harmful to the health of individuals and society have been considered criminal offences triable only in criminal courts. Several other Central and State Acts dealing with offences that can cause health hazards to individuals or society fall into this category such as The Cigarettes and Other Tobacco Products Act, 2003, The Epidemic Diseases Act, 1897, and The Kerala Epidemic Diseases Act, 2021. Even violations of rules for individual protection such as helmet and seat belt laws are treated as criminal offences and tried in criminal courts. The section alluded to by the author (Section 71) only restricts jurisdiction by civil courts and not by criminal courts. The statement by the author that appeals can be filed only before the Public Health Committees and the decisions of the government shall be final is misleading, since any aggrieved person can use all legal remedies available to him through the criminal courts of the country starting from the Court of The Magistrate of the First class (as evident from sections 66(2) and 67).

The moral foundations for justifying punitive damages are grounded in the concepts of freedom, utility and equity. When an individual's zone of rights is violated by another, it effectively diminishes the victim's autonomy and punitive damages help to restore an equitable balance. Also, punitive actions can lead to increasing confidence in society that those who err will be held accountable, thus discouraging self-serving people from maximising personal welfare at the expense of the welfare of the larger society [14]. This holds true especially in a state like Kerala with various vulnerable groups such as the elderly and those with other comorbidities, who need to be protected from the greater risk of

contracting infectious diseases, and associated mortality [15]. This is particularly vital in the case of pandemics and other previously unknown diseases where simultaneous, and sometimes coercive actions may need to be employed till the disease dynamics are better understood. Additionally, this priority given to the protection of community rights over an individual's choice applies only in the case of certain diseases as listed in Chapter 7 of the KPHA, which due to their epidemiological nature, have the potential for devastating social consequences.

Though we appreciate the concern raised by the author about targeted interventions for migrant populations, one of the State's concerns is the spread of infectious diseases endemic to their native areas, such as malaria and lymphatic filariasis [16,17]. Migrants are normally a floating population with inaccessible baseline health data and the State is keen to detect any spread of infections early to protect them and the community. As per Section 29 of the KPHA, the Public Health Officer is instructed to arrange health check-ups for migrant labourers and ensure that supportive steps are undertaken for the prevention and control of communicable diseases. The same attitude of positive discrimination can also be seen in dedicating a chapter (Chapter 10) to the welfare of other vulnerable groups. While diligence may be warranted in preventing the othering of certain groups, it is vital to note that Kerala has always promoted inclusivity of its migrant workers (whom the state has, in the interest of equity, named "guest workers"), while offering them the highest wages in the Indian sub-continent alongside a host of other welfare mechanisms [18]. The article also decries the "shrill propaganda" especially by media houses that could further othering of certain communities, disregarding the fact that the KPHA has declared (Section 21(xix)), that spreading false propaganda that could adversely affect public health activities is a "nuisance" and warrants legal action (Sections 23 and 65).

Conclusion

We feel that efforts should have been made to highlight the improvements the KPHA made over previously existing Acts from 1939 and 1955. Comparing and contrasting the perceived progressiveness or repressiveness of KPHA with Public Health Acts of other states and countries would have contributed to a more comprehensive ethical analysis of the KPHA [19,20]. Such a reading would have led to a better understanding of the construct of a public health act and fostered a deeper comprehension of how KPHA could be analysed critically. It is important to remember that the formulation of the public health Act was motivated by the desire to uphold the state's ability to implement modest restrictions, especially in emergencies, through competent independent bodies as endorsed by the Siracusa principles [21].

A stringent and meticulously crafted law is imperative during emergencies to avoid dependency on antiquated, colonial-

era laws such as the Epidemic Diseases Act (1897) that was used in India during the Covid-19 pandemic [22]. In conclusion, strong legal mandates are very often required to move towards a desired public health outcome [23]. KPHA is intended to be an enforcement tool for legal provisions, rather than the health policy for the state, and thus detailed discussions regarding actions to be taken beyond these legal provisions do not fall within the purview of the Act. We are optimistic that the KPHA will be refined further as more amendments and revisions come into place and urge the academic community to continue to evaluate it in the context of other national and international public health Acts.

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