COMMENTARY

Public health ethics and the Kerala Public Health Act, 2023

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Abstract

This commentary looks at the Kerala Public Health Act (KPHA), passed on November 28, 2023, through the lens of public health ethics. While the Act recognises the importance of prevention and strengthening of social systems, it falters in the public health ethics and human rights framework, ignoring international public health principles such as the Siracusa Principles and guidelines for individual diseases such as tuberculosis. The Covid-19 pandemic in India itself offers ample learnings, which have been disregarded, on the need for caution against state overreach. Principles such as autonomy, privacy/confidentiality, transparency, accountability, rule of law, least harm etc have not even been given token consideration, making this law a potential tool of abuse, particularly against already vulnerable communities.

Keywords: *Kerala Public Health Act (KPHA), public health ethics, Siracusa principles, rule of law accountability*

The Kerala Public Health Act (KPHA) [1] was passed on November 28, 2023 with the intention of replacing existing public health laws in Kerala using a "one-health for public healthcare" approach. The Act encompasses numerous issues of public health concern such as water supply, sanitation, communicable and non-communicable diseases, solid waste, community gatherings and food safety, among others. It recognises the need to move beyond diagnosis and treatment to prevention, to strengthening social systems that contribute to good health and weakening or eliminating those conditions that may cause disease. It invokes support from existing institutions such as the *panchayat*, and puts into place other authorities such as health inspector, public health officers, public health committees etc from the local to the state level. Public health committees can formulate, implement and evaluate government programmes. Public health officers (PHO), who can be given additional powers during emergency situations, can conduct inspections and enquiries, issue notices, formulate guidelines and take legal action. If the PHOs feel that they are not able to satisfactorily implement the KPHA, they can take the support of local self-government structures and also recover the cost incurred from the person or institution concerned, under Sec 66 of the Act.

> *The Local Public Health Officer shall have the power to direct any person or institutions to do or refrain from doing any activity, or to change any situation that may be deem necessary for ensuring public health, within such time as specified.*

While the broader vision of the KPHA recognises the importance of prevention and the need to "strengthen social systems that provide health", other sections of the Act make ill-health appear like a crime, legitimising punitive action by state bodies, without clarity on state responsibility and how broader ethical principles of public health such as rule of law, reciprocity, transparency, accountability, etc, will be upheld.

Whether it is Ebola virus, severe acute respiratory syndrome (SARS), tuberculosis, HIV or the more recent Covid-19, ethical concerns related to the prevention and management of infections of public health importance must necessarily go hand in hand with addressing public health issues. The Siracusa principles [2] — which specify that any restrictive intervention should be time bound, evidence-based, constantly evolving, in pursuit of a legitimate objective of general interest and premised within the rule of law — came into being because of concerns that governments have abused the "state of emergency" to repress and deny the fundamental rights and freedoms of people [3]. It is important that social justice that factors in the social, economic and political milieu, should be the implicit premise of public health interventions. The United Nations (UN) defines social justice as concerned with (a) understanding the rights and obligations of persons as members of societies and communities; (b) the fairness of social and political structures and processes; (c) the relationships between persons, and between persons and the state. Upshur illustrates how clinical ethics is not an appropriate model for public health ethics because public health focuses on prevention more than treatment or cure, and on populations, communities and broader determinants of health [4]. In public health ethics, there is a need to look at past experiences as well as future implications. Interventions should be such that they produce benefits, minimise or remove harms, distribute benefits and burdens equally,

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ensure public participation (including that of affected parties), respect autonomy, protect privacy/confidentiality, fulfil promises/commitments and are transparent [5].

The KPHA, when viewed through the public health ethics lens, falls short on several fronts and these are discussed below.

Principles of public health

The harm principle is the idea that people should be free to act as they wish as long as their actions do not cause harm to others. If the government feels that a disease can cause harm to others, it may feel justified in restricting the liberty of an individual or group. In such an instance, other principles of least restriction/coercion, reciprocity, solidarity, proportionality, respect, dignity, privacy, confidentiality and the common good mandate equal consideration, especially if the individual is also socially marginalised [4,6,7].

Even though it is important that evidence-based, standard treatment protocols are created through consultations, the language and tone of subclauses 8 and 9 of Section 7 of the KPHA[a] appear to take away agency from people, people's representatives and even the healthcare system, by stating that the State Public Health Committee will decide on a "common protocol" to be followed for surveillance of diseases, prevention and control of communicable diseases and life style diseases, health hazards and "any other diseases that may be notified by the Government from time to time". This indicates a move from the framework of a short, necessary, proportionate intervention during a public health crisis, to an institutionalised framework without any clear endpoints.

The Siracusa principles hold that the restriction of liberty must be legal, legitimate and necessary, use the least restrictive means available, and applied without discrimination. Education, facilitation and discussion should be the de-facto mode of functioning. The expression "least restrictive or coercive means" recognises that there may be a variety of means to achieve public health ends but that *"the full force of state authority and power should be reserved for exceptional circumstances and more coercive methods should be employed only when less coercive methods have failed."* [2]

The principle of reciprocity views the management of infectious disease as larger than a biomedical intervention and beyond an individual patient's responsibility. Patients and their families who agree to isolate themselves could be doing so by setting aside their own basic human rights, such as employment, social interaction and public life. Rather than viewing the isolation as the burden only of patients and their families, society has to pull its weight by offering them physical, psychological and economic support. Expecting individuals to perform the duty of protecting society while absolving the state and society of reciprocity which compensates the patient and family for lost income, employment or social support is unethical, and leads, not surprisingly, to high dropout rates and non-co-operation [6,7].

Tuberculosis (TB), which has been included by the KPHA along with other diseases as notifiable, has been established as closely inter-related with social determinants of health — with TB driving people into poverty and social inequities increasing vulnerability to TB. Experts on TB management insist that management has to move beyond the biomedical model and be situated within a framework of equity, ethics and human rights. It also requires policy makers to address the underlying social, economic and political conditions that are barriers to effective management and increase the likelihood of infection [5].

According to Bhargava et al, when undernutrition, which is a common co-morbidity of tuberculosis, is addressed, the hazard of tuberculosis mortality reduces substantially. They recommend that, in order to improve treatment outcomes, nutritional support needs to be an integral component of patient-centred care'. They also found that nutritional intervention in household contacts was associated with substantial (39-48%) reduction in the incidence of TB among contacts over two years of follow up [8,9].

It is imperative that socially disadvantaged persons should not be discriminated against when they receive treatment and it is equally important that factors that predispose individuals to non-adherence are addressed. The individual's responsibility to provide accurate information, follow prescribed treatment and other management protocols can be properly met only if the responsibilities of the government and communities are met first.

As per Section 35(1) of the KPHA, if the local public health officer (LPHO) finds that the person suffering from a notifiable communicable disease satisfies certain 'conditions', they can be shifted to a "required place" in order to prevent the spread of disease and treatment. These conditions include:

- residing in a place where more than one family resides;
- if there are no required measures for prevention of the spread of disease and for the supervision of treatment;
- if the presence of this patient in such place is detrimental to the health of others;
- if the public health officer is reasonably satisfied that for the safety of the patient or for treatment or for any other reasons, the patient should be shifted to hospital or places where such patients are taken care of.

Any person in a government or private hospital, clinic, laboratory or research institute who does not report a notifiable communicable disease to the public health officer and also anyone who obstructs shifting of the patient to a hospital or other place, is liable to be fined under Section 65

of KPHA. The Act does not explain why this is the first option, and neither does it follow the principles of reciprocity and least restriction.

In the context of the KPHA mandate for infectious diseases, the first option should have been patient counselling about the risks of infectious disease to themselves, their families and communities, rather than shifting them to a "required place". Efforts should have been made to identify and address possible barriers to maintaining treatment continuity. Proportionality of outbreak response is important as also the awareness that restrictions could disproportionately and adversely affect some communities, sometimes permanently, and lead to other negative outcomes.

For patients who are willing to undergo effective treatment, isolation is usually neither necessary nor appropriate. For example, in the case of TB, studies have shown that treating infected persons at home with appropriate infection measures in place generally imposes no substantial risk to other members of the household [10]. By the time a diagnosis is made, it is often the case that the household contacts have already been exposed to the patient's disease and the possibility of contracting infection goes down quickly once effective treatment is started. Early case detection is the most important intervention for reducing the risk of TB transmission [10]. Campaigns for basic infection control behaviour change should be part of any community information/communication and should include the importance of early identification and adherence to treatment.

Public health officials cannot have unrestricted, unbridled or very broad powers which have the potential to arbitrarily restrict personal liberties, especially if these powers of coercion are used before less restrictive measures are attempted [7]. The state needs to put in place social safety systems to improve adherence, rather than opting for deprivation of the liberty of those whose social circumstances could make adherence difficult. Using detention or punitive methods as a first option can soon lead to these becoming the primary option, as can be seen with the KPHA.

Under the KPHA, a person who has been informed by the medical officer or LPHO that they have a notifiable communicable disease "shall not" cause the "risk of infection" by her presence or conduct in any public space. Public spaces include schools, markets, theatres, hostels, factories, workshops or workplaces, public conveyance and even rented homes. In addition, the person "shall not" engage in any activity that can cause the spread of infection to others, including any trade related to food for the consumption of others.

Restrictions on freedom of movement impose significant physical, psychological, social and economic burdens on individuals and communities and should be considered only if there is considerable evidence of their benefit. Importantly, does the state have the capacity, commitment and political will to take over a major share of responsibility such as ensuring that people have incomes, food, water etc? Bringing in the police or military to "enforce" restrictions is best avoided.

The transparency principle entails the involvement of all legitimate stakeholders in the decision-making process. The process should be as clear and accountable as possible and free from political interference, coercion or domination by specific interests. If a government intervention has to override such values as individual liberty or justice, the burden is on the state to demonstrate how these actions are necessary to protect public health, over and above other less restrictive measures [5].

In the early 1990s, the resurgence of tuberculosis had led health officials to recommend the use of involuntary detention for persistently non-adherent patients. Detained people were found more likely than other TB patients to come from socially disadvantaged groups, with barriers to adherence often rooted in poverty, homelessness, and other untreated medical or psychiatric conditions, including alcoholism. Coercion, even if used by health officials as a last resort and following due process can lead to non-infectious patients being detained for months or years. Non-co-operation with institutions can be used as a marker of non-adherence. As with HIV, some groups of people such as inter-state migrant workers, truck drivers, the transgender community, commercial sex workers, etc, can be perceived as less likely to be compliant to treatment [7]. Measures such as Directly Observed Therapy (DOT), in which patients take their medication under the supervision of an assigned healthcare worker, have been found effective. Patients must be given the right to choose the place and person responsible for having their adherence monitored via DOT [6].

Powers under KPHA with regard to food-borne notifiable infections

According to Section 76, KPHA, the LPHO can *"without prejudice to the safety and privacy of persons enter into and inspect any place where any nuisance[b] is taking place, offensive trade is conducted, article of food or beverage is handled, which can facilitate the spread of an epidemic"*. They can also inspect, without any notice or assistance, any place — factory, workshop, workplace, office, cinema hall, hospital and also dwelling places — from which communicable diseases are reported or which are suspected to be contaminated, and take the necessary measures to prevent the spread of disease. All public servants are expected to extend support to the LPHO and any refusal or non-co-operation can be taken as a breach of conduct and indiscipline, liable for disciplinary action.

Further, in the interest of controlling or preventing communicable diseases the PHO can, with permission from the District Collector, enter into and take over any building and take measures as necessary to prevent the spread of

disease. A lodging house or place where articles of food are sold, prepared, exposed for sale or distributed can also be shut down.

There is no mention in the Act of supporting these businesses, individuals or families till such a time as they are again able to earn income from these premises. Shutting down residences and businesses, even temporarily, without providing any kind of alternate options criminalises individuals and can lead to corruption and attempts to bypass the system. Vague, arbitrary powers leave the door open for abuse [11,12].

Although appeals can be filed, this is primarily to the Public Health Committees, with the decision of the government being final. As per Sec 71 and 72 of the KPHA, no civil court has the jurisdiction to entertain any suit, application or petition against any proceedings or decision done or purported to be done or taken or purported to be taken by the Public Health Officer, or by any other officer authorised by her or the Public Health Committee by exercising any powers as per this Act or Rules, The KPHA, with seemingly unconditional judicial backing, effectively converts illness into a crime, and those affected or likely to be affected are deemed "guilty" without any recourse to proving their "innocence" or vulnerabilities! There is no justification offered by the Act for the doors of the Court being shut pre-emptively to those who may feel that their constitutional rights are being disproportionately violated.

KPHA targeting migrant workers

As per Section 29 of the KPHA, health checks will be conducted specifically on migrant workers, and if they are found to have a communicable disease, then "steps" will be taken for prevention, treatment and control, including transporting them to treatment facilities, hospitals and wards. The Act does not explain why targeted interventions are required specifically for migrant workers. If migrant workers are indeed a group that requires a "special focus" and differential treatment, the scientific reasons for this should have been clearly spelt out in the Act in the spirit of public justification, non-discrimination, transparency and accountability. This transparency stems from the requirement to treat citizens as equal and offer moral reasons for interventions that treat them differently. Public accountability imposes an obligation on decision makers to provide honest information and justification for their decisions.

The State vs the individual: lessons from the Covid-19 pandemic

As observed during the Covid-19 pandemic, infectious disease outbreaks create unstable and uncertain situations — decisions have to be made, research has to be ongoing, communication has to be ensured and resources have to be mobilised, even diverted from other sources. The capacity of bureaucrats and healthcare providers, as well as allied sectors, can be stretched, often indefinitely. Demanding that all of these are situated within a broad framework of public health ethics may seem daunting, but this is the basic premise on which effective public healthcare can be delivered.

These ethical principles have to be established well before the pandemic occurs. If a media channel's modus operandi is shrill propaganda that targets one or the other community, this can get significantly worse during a crisis and contribute to aggravating insecurities and prejudices. In the absence of a moral framework for public health, government laws, guidelines, circulars, orders etc, can rapidly deteriorate into tools of abuse and misuse. A government may justify compromising on an individual's right to consent, privacy or confidentiality as a "larger good". The prevailing public sentiment that it is acceptable for the "larger good" to overrule and disregard individual agency and rights is rationalised by implicit assumptions that some individuals (who do not fit into stereotypical mould of what constitutes a "good citizen") hold lesser rights. The Covid pandemic visibilised how the state machinery targeted migrant workers — based more on "othering" people rather than on any scientific basis.

The government is, however, not a wielder of unrestricted power. It is an elected representative body that has specific Constitutional mandates which cannot be set aside lightly and which is accountable to both individuals and population groups [2, 13].

The proportionality of response to an outbreak is important and failure to consider this could lead to adverse outcomes. During the Covid-19 pandemic, senior citizens were forced to stay indoors and children from marginalised communities suddenly faced the prospect of having nothing substantial to eat (even from the Integrated Child Services Scheme and Midday meal scheme), with consequent rise in malnutrition, other nutritional deficiencies and a host of other illnesses. Senior citizens who were already a high risk group in the pandemic were made more vulnerable due to poor nutrition and reduced access to their regular medications. The urban elite who continued to be paid while working from home, became the reference point for lockdown-related decisions; while daily wage labourers, who constitute a vast majority of the population, were devastated by prolonged lockdowns.

When an illness is identified and is linked to specific social categories, lines are drawn between "us and them". The affected persons can be actively targeted by more powerful individuals, communities, and even the government itself. Unless the state intervenes proactively, these distinctions of "us and them" can form quickly and can be devastating not only to individuals, families and communities, but to larger public health goals as well [14]. In India during Covid-19, the Muslim community was disproportionately targeted by elected representatives, the media, and sadly, even by healthcare workers — the pandemic opening up a fertile field for prejudices to operate without inhibition [15]. The KPHA ignores all these realities and makes no effort to

protect individuals and communities from targeting, discrimination or stigma.

Public health offers ethical, legal and policy challenges to balancing individual rights with larger societal ones. If individual rights, privacy and confidentiality are being affected, the principles of necessity, effectiveness, proportionality, minimum infringement and justice should simultaneously be applied while being sensitive to the real possibility that some communities and individuals can be disproportionately affected [16]. It is concerning that the KPHA has left out these crucial non-negotiables for public health interventions that can, as we have seen with Covid-19, give unlimited (often abused) powers to state authorities, while destabilising many constitutionally mandated rights, often permanently.

Kerala, because of its already well-functioning public health system and educated/literate population, occupies an important position as a potential model for other states and countries. It is imperative that Kerala's policy makers actively foreground the principles of trust, transparency and accountability, especially during an outbreak or pandemic. They have to apply procedural principles fairly and consistently, be open to newer evidence and be responsive to the affected communities. If individuals who have infectious diseases are treated as criminals, it is a death knell for truly beneficial public health outcomes.

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Notes:

[a]*The Kerala Public Health Act 2023, Section 7, Subclause (8) When it is satisfied that there is necessity to have a common protocol for the treatment or prevention of diseases notified under this Act or diseases included in the National Health Programmes, the State Public Health Officer shall with the assistance of experts determined by the Government, prepare recommendation and shall submit to the Government. Such protocol as directed by the Government shall be followed by all Government and private healthcare providers and healthcare institutions.*

Section 7, Subclause (9) The State Public Health Officer shall give recommendation to the State Public Health Committee for the fixation of health protocols, to be followed by the public for surveillance of diseases, prevention and control of communicable diseases, life style diseases, any other diseases that may be notified by the Government from time to time and health hazards.

[b]*"nuisance" as defined in the KPHA means any act or abstinence of place or thing which causes any hindrance, injury, danger or annoyance to sight, smell and hearing or causes annoyance to rest or sleep or cause or likely to cause danger to life or injury to health.*

References

1. Fifteenth Kerala Legislative Assembly. The Kerala Public Health Act, 2023. Act No. 28 of 2023. 2023 Dec 1[Cited 2023 Dec 7]. Available from: https://www.kltonline.in/ckfinder/userfiles/files/kerala%20public%20health%20act.pdf
2. American Association for the International Commission of Jurists. The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights. New York: 1985[cited on 2023 Dec 7]. Doi: 10.2307/762035. Available from: https://www.icj.org/wp-content/uploads/1984/07/Siracusa-principles-ICCPR-legal-submission-1985-eng.pdf
3. World Health Organization (WHO). Guidance for Managing Ethical Issues in Infectious Disease Outbreaks. Geneva: WHO; 2016 [Cited 2023 Dec 9]. Available from: https://www.who.int/publications/i/item/978924149837
4. Upshur REG. Principles for the justification of public health intervention. *Can J Public Health*. 2002 Mar-Apr;93(2):101-3. https://doi.org/10.1007/bf03404547
5. Childress JF, Faden RR, Gaare Rd, Gostin LO, Kahn J, Bonnie RJ, et al. Public health ethics: Mapping the terrain. *J Law Med Ethics*. 2002 Summer;30(2):170-8. https://pubmed.ncbi.nlm.nih.gov/12066595/
6. World Health Organization. Ethics guidance for the implementation of the End TB strategy. Geneva: WHO; 2017 [Cited 2023 Dec 09]. Available from: https://iris.who.int/bitstream/handle/10665/254820/9789241512114-eng.pdf
7. Lerner BH. Catching patients: Tuberculosis and detention in the 1990s. *Chest*. 1999 Jan;115(1):236-41. https://doi.org/10.1378/chest.115.1.236
8. Bhargava A, Bhargava M, Meher A, Beneditti A, Velayutham B, Sai Teja G, et al. Nutritional Supplementation to Prevent TB Incidence in Household-Contacts of Patients with Pulmonary Tuberculosis: Results from the RATIONS, a Field-Based Open-Label Cluster-Randomized Controlled Trial in Jharkhand, India. *Lancet*. 2023 Aug 19[Cited 2023 Dec10]; 402(10402):627-640. Available from: https://doi.org/10.1016/S0140-6736(23)01231-X
9. Bhargava A, Bhargava m, Velayutham B, Thiruvengadam K, Watson B, Kulkarni B, et al.The RATIONS (Reducing Activation of Tuberculosis by Improvement of Nutritional Status) study: A cluster randomised trial of nutritional support (food rations) to reduce TB incidence in household contacts of patients with microbiologically confirmed pulmonary tuberculosis in communities with a high prevalence of undernutrition, Jharkhand, India. *BMJ Open*. 2021 May 20;11(5): e047210. https://doi.org/10.1136/bmjopen-2020-047210
10. World Health Organization. WHO Policy on TB Infection Control in Health-Care Facilities, Congregate Settings and Households. Geneva: WHO; 2009 [Cited 2023 Dec. 10]. Available from: https://iris.who.int/bitstream/handle/10665/44148/9789241598323_eng.pdf?sequence=1
11. Sun N, Christie E, Cabal E, Amon JJ. Human rights in pandemics: criminal and punitive approaches to COVID-19. *BMJ Glob Health*. 2022 Feb;7(2):e008232. https://doi.org/10.1136/bmjgh-2021-008232
12. Spitale G. COVID-19 and the ethics of quarantine: a lesson from the Eyam plague. *Med Health Care Philos.* 2020 Dec;23(4):603-609.https://doi.org/10.1007/s11019-020-09971-2
13. Valecha M. The Kerala Public Health Act- a Gateway to Medical Tyranny in India. *Real Left*. 2023 Dec 14 [Cited 2023 Dec17]. Available from: https://real-left.com/the-kerala-public-health-act-a-gateway-to-medical-tyranny-in-india/
14. Rewerska-Juko M, Rejdak K. Social Stigma of Patients Suffering from COVID-19: Challenges for Health Care System. Healthcare (Switzerland). 2022 Feb 2;10(2):292. https://doi.org/10.3390/healthcare10020292
15. Newsclick Report. Unscientific epidemiological example in Microbiology textbook promotes Islamophobia: Activists, Doctors write Open Letter. *Newsclick*. 2021 Mar 22]Cited 2023 Dec. 17]. Available from: https://www.newsclick.in/Unscientific-Epidemiological-Example-in-Microbiology-Textbook-Promotes-Islamophobia-Activists-Doctors-Write-Open-Letter
16. Rothstein M. Public health and privacy in the pandemic. *Am J Public Health*. 2020 Sep;110(9):1374-1375. https://doi.org/10.2105/ajph.2020.305849