DISCUSSION

KPHA 2023 should explicitly include state accountability: Response to Fernandez et al

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Abstract

The commentary "Public health ethics and the Kerala Public Health Act, 2023" published on January 27, 2024 in the Indian Journal of Medical Ethics (IJME) has received a response from members of the State Health Systems Resource Centre and Government Medical College, Malappuram, Kerala. They explain that the Kerala Public Health Act (KPHA) is a legal document and not required to explicitly include accountability mechanisms and social obligations of the state.

Given the very real danger of state over-reach as was evident during the Covid-19 pandemic, these checks and balances should, in fact, be non-negotiable. The position of KPHA on healthcare of migrant workers and patients with tuberculosis goes against existing public healthcare principles. There is, therefore, a need to revisit the Act to explicitly include state accountability.

Keywords: *Constitution, discrimination, KPHA, public health crisis, accountability*

Fernandez et al [1] have responded to the commentary "Public health ethics and the Kerala Public Health Act, 2023" published on January 27, 2024 in the *Indian Journal of Medical Ethics (IJME)* [2]. They explain that the Kerala Public Health Act (KPHA) [3] is not a standalone document, but a supporting tool to the existing Kerala Health Policy and various other health policies and programmes. They clarify that it is intended to be an "enforcement tool for legal provisions to ensure welfare maximisation of the society at large" and that detailed discussions regarding actions to be taken beyond these legal provisions do not fall within the purview of the Act.

The Commentary in *IJME* was not based on the assumption that Kerala does not have other public health policy documents, but if, as the authors themselves state, it provides a legal framework for individuals, then the legal responsibility of the state should also be stated explicitly rather than assumed or implied. The Act specifically mentions that it will **replace** (emphasis added) existing public health laws in Kerala using a "one-health for public healthcare" approach [3]. In fact, the concern is that it is these very pre-existing safeguards that are likely to exist in other policy documents may be relaxed or violated during a crisis.

The authors quote Roses' prevention paradox according to which preventive measures may not benefit individuals to the same extent as they do populations. The issue is not about whether individuals benefit as much as populations do, but rather about how and why certain individuals or certain communities bear disproportionate burdens during a public health crisis, based more on prejudices rather than on science.

For instance, Sec 29 (i) and (iii) of the Act state that health check-ups will be arranged for migrant labourers at regular intervals and if anyone in the dwelling places of migrant labourers is affected with communicable disease, then treatment will be made available and steps will be taken for prevention and control of the disease in such places. Is there any rationale for the Act to specify "migrant labourers" who are usually those engaged in physical work in the unorganised sector? Why has the law not mentioned other migrant workers who are not labourers? Why is the radar not on international travellers who, ironically, carried the Covid-19 virus into the state? [4]

The authors have not commented on the concerns regarding tuberculosis which the Act recognises as a notifiable disease and is therefore subject to the clauses mentioned there — namely, that an infected person can be shifted to hospital if the Local Public Health Officer is satisfied that any person resides 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; or if the presence of this patient in such place is detrimental to the health of others etc [Sec 35(1)]. Further such a person who knows that their presence or conduct can cause risk of infection to others is prohibited from accessing any public space, including the market and workplace [Section 36 (1)]; neither should they engage in trades or occupations that put them in contact with others [Sec 37 (1)].

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First of all, the WHO Policy on TB Infection Control in Health-Care Facilities, Congregate Settings and Households [5] makes it clear that whether a newly diagnosed person remains at home or is shifted to a treatment facility, it has little impact on household transmission provided the patient is diagnosed early and managed effectively. The KPHA does not clarify why these restrictions have been imposed, or also, crucially, how those who are legally denied access to employment, income or public spaces will be supported. The Indian Constitution places obligations on the State to ensure protection and fulfilment of the Right to health for all, and the Right to non-discrimination (Article 21) and also urges the State under the Directive Principles of State Policy, to strive to provide to everyone certain vital public health conditions such as the rights to work, to education and to public assistance in certain cases (Article 41) [6]. There is no doubt, as the authors have clarified, that the Government of Kerala has provided many essential services required during an emergency. The provision of these essential services should be legally binding on the State rather than optional, similar to the expectations being placed on individuals during a public health crisis.

The authors misinterpret the observation in the commentary that Sections 8 and 9 of the KPHA appear to take away agency from people [2]. They state that the Act "does not seek to interfere in an individual's preferred choice of treatment, **except in the case of public health emergencies"** (emphasis added) [1]. It is exactly this exception that has been highlighted in the commentary [2]. At no point does the Commentary suggest that treatment and prevention protocols should be left to individuals and that "everything related to people needs to be decided by the people themselves" [1]. Rather it questions the underlying premise that since patients are not experts, they cannot be informed participants in their own treatment.

While public health powers can legitimately be used to restrict human freedom and rights to achieve a collective good, they must necessarily be exercised with constitutional and statutory constraints on state action [6]. Laws can be coercion-based or rights-based. While the latter is harder to implement, it is clearly the better model. It is important to ask whether constitutionally mandated rights of citizens are being supported with the same enthusiasm by governments as laws are imposed. In fact, the Task Force on Public Health Act considers the Kerala Public Health Bill, 2009 to be coercive [6].

The Task force reaffirms the interpretation by the Committee on Economic, Social and Cultural Rights set up under the International Covenant on Economic, Social and Cultural Rights (ICESCR) of health as closely associated with underlying cultural, economic and political determinants [7]. It also acknowledges that a legal commitment to social determinants of health may be difficult, but the law should be aware of how existing social norms may disproportionately affect some individuals or communities.

Legally delegating power to any government authority without specifying accountability and regulatory mechanisms leaves the door open for authoritarianism by the State, particularly during public health crises, and this is not an exceptional phenomenon. The KPHA would have been a much more far-sighted document if it had explicitly factored in these accountability mechanisms.

If Kerala is envisaged as a model of healthcare for the rest of the country and even the world, then ideally the KPHA should be part of that model. Since the Act goes to great extents to elaborate on individual responsibilities, it would be an oversight not to include State responsibilities as well.

References

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