Decentralised Health Governance in Practice: Kerala Public Health Act (2023) As a Model for Pandemic Preparedness

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Abstract

The Kerala Public Health Act 2023 is a transformative legislative policy that marked a paradigm shift in the state's public health governance framework. The act addresses evolving health challenges from pandemics, climate-induced hazards, and noncommunicable diseases with a right-based and decentralized framework. Against this backdrop, this study aims to analyze the Kerala Public Health Act 2023 and examine how regional health policies contribute to global health governance. Comparative assessments were employed to evaluate Kerala's model and public health act in relation to global health governance frameworks. While its scope is localized, its principles of pandemic preparedness, prevention, equity, and community participation resonate with international frameworks such as the International Health Regulations (IHR), Universal Health Coverage (UHC), and Sustainable Development Goals (SDG-3). This visionary Act has the potential to inspire other regions, especially in developing countries, to strengthen their own health systems. The Act exemplifies localized efforts can drive progress toward achieving international health goals such as "Health for All." Kerala's proactive measures through the KPHA set a powerful example, demonstrating that even smaller states can effectively prepare for future pandemics. The Act makes it a potential blueprint for other regions, positioning Kerala as a role model for global health governance.

***Keywords**:* Kerala Public Health Act 2023, global health governance, health policy, decentralisation, Kerala and regional health policies

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The COVID-19 pandemic exposed unprecedented health challenges and structural weaknesses worldwide, underscoring the necessity of comprehensive, equitable, and resilient health governance. After the outbreak of the COVID-19 Pandemic, the world realised that existing measures, healthcare capacity, and national governance structures are insufficient to face future pandemics. To address these challenges, States must, therefore, take responsibility for building an effective public health system and be prepared to be held accountable, both by its own people and given the externalities of the international community (National Academy of Medicine, 2016). Most importantly, Global health governance is needed to address transboundary health challenges such as pandemics and health inequalities. Indeed, the importance of regional or national core capacities has been recognised by some individual governments and the international community, as reflected in the International Health Regulations (2005), which establish health security as a global public good (WHO, 2008).

In this context, Kerala, a state in southern India, is renowned for its robust public health systems, and its model has consistently prioritised health and social equity. Kerala is known for its public health achievements, including high health indices such as high life expectancy, low infant mortality rate, birth rate and death rate, maternal mortality rate, high literacy rate, and high immunization coverage (State Planning Board, 2018). However, lifestyle diseases, climate-induced health crises, and emerging communicable diseases like Nipah and COVID19 pose significant Challenges to Kerala's public health. Kerala is addressing these challenges by strengthening its public health system and enhancing preparedness for future pandemics by implementing the Kerala Public Health Act, 2023. The KPHA- 2023 represents a holistic approach to safeguarding public health through a well-structured governance framework, emergency response mechanisms, disease surveillance and institutional mechanisms, and provision for health equity and accessibility (Karpagam, 2024).

The KPHA can be an example of a sub-national or regional health policy that aligns with international health norms and practices in global health governance. It reflects a growing trend in health governance where local-level responses are essential to achieving global health goals, such as those set by the World Health Organisation (WHO) and the United Nations Sustainable Development Goals (SDGs). Moreover, Kerala can contribute to global health governance through its progressive health policies focusing on equity and social justice, sharing its experience in disease management, healthcare infrastructure, and public health preparedness with other regions, particularly during health emergencies (Adithyan et al., 2024).

Kerala's exceptional performance in the healthcare sector, despite having modest economic resources, has attracted considerable scholarly attention. Several studies focused on historical evolutions, governance structure, healthcare achievements, initiatives and emerging challenges of the Kerala health model. However, Nabae (2003) highlighted the role of decentralisation and argued that Kerala's success was closely linked to community participation and local governance. Current studies have adopted a broader health system perspective. Thekkumakara et al. (2023) examined Kerala's progress through the lens of equity and showcased remarkable health indicators such as maternal and child health, life expectancy, and universal access to basic healthcare. Several studies explored the contemporary challenges confronting Kerala’s health system. Muraleedharan and Chandak (2022) analysed emerging challenges in Kerala's health system, such as the growing burden of non-communicable diseases, population ageing, and climate-related health risks. Their findings suggest the need for adaptive governance mechanisms capable of responding to evolving public health threats. Similarly, Rahim et al. (2024) examined Nipah outbreaks in Kerala and underscored the importance of robust disease surveillance, intersectoral coordination, and public health preparedness.

However, despite the growing literature on Kerala's healthcare achievements, limited scholarly attention has been given to the KPHA (2023). After the enactment of the KPHA, scholarly attention has shifted towards public health governance and legal frameworks. Karpagam (2024) critically analysed the KPHA from a public health ethics perspective and raised concerns regarding surveillance, transparency, accountability, privacy, confidentiality, and the balance between public welfare and individual rights. In response, Fernandez et al. (2024) argued that the Act is a significant step towards Kerala's public health governance and integration of the One Health approach. Collectively, these studies emphasise the significant role of regional health policies and their relevance in achieving international health goals.

Despite the extensive amount of information about Kerala's health system and governance, there exists a dearth of research specifically examining regional health policies and its relevance to global health governance. Existing studies have insufficiently examined how subnational health legislation can contribute to broader global health governance objectives such as pandemic preparedness, health equity, disease surveillance, and community participation. Therefore, this research is quite essential to address the gap by analysing the KPHA-2023 within the broader framework of decentralised health governance and global health governance. Against this backdrop, this study aims to analyse the KPHA- 2023 and examine how regional health policies contribute to global health governance.

Methods

The study adopts a qualitative comparative policy analysis approach to evaluate Kerala's model and public health act in relation to global health governance frameworks. The study adopted thematic document analysis to examine the selected documents. The study applied inclusion criteria focused on recent and Scopus-indexed literature published between 2000 and 2025. Though published materials were prioritised, a few authentic websites from the

WHO and the government of Kerala were also included. The outdated reports and non-scholarly sources unrelated to the study objective were excluded. The articles of potential interest were identified by searching popular databases such as Web of Science, PubMed, Scopus, OVID, and Google Scholar and search engines using keywords “Kerala Public Health Act 2023,” OR “Global Health Governance,” OR “Health policy,” OR “Regional health policies,”. Primary data sources such as Official policy documents and reports from Kerala’s Department of Health and Family Welfare and relevant international health organizations (such as WHO reports) were examined to ensure an understanding of healthcare strategies, healthcare infrastructure and pandemic response. To enhance the reliability and validity of the findings, peer-reviewed literature, relevant government sources and recent newspaper articles were analysed. Exclusion criteria included non-peer-reviewed sources and outdated reports unrelated to healthcare governance.

Conceptual Framework: Decentralised Health Governance

The term “decentralization” often means transfer of responsibilities, planning, management, decision-making authority and resources from the national to sub-national government entities (for example, regional, state and district/municipal levels) with the aim of tailoring the health system to meet local needs more effectively and responsively (Mahmood et al., 2024). Moreover, decentralisation of health is an essential element for achieving universal health coverage. It is usually argued that a decentralised governance of health services bridges the gap between communities and decision-makers; improves equity, accessibility and accountability of local service providers; and fosters innovation and technical efficiency in healthcare provision (Mahmood et al., 2024). In the long run, decentralisation can help increase the efficiency of health delivery when there is adequate capacity and accountability at lower levels of the national health system (UIA, 2022). The significance of decentralized governance

of health systems lies in improving decision-making at local levels in different tiers of health service delivery (Panda & Thakur, 2016). Strengthening public health systems through local governance is critical for improving accessibility, equity, and efficiency, particularly in diverse and resource-limited settings (Bisht, 2025). Effective health governance demands local-level engagement and decentralised decision-making to ensure that health services are responsive to the diverse and context-specific needs of communities (Bisht, 2025).

Kaur et al., (2012) argue that decentralisation has, to some extent, improved the functioning of health services in India. According to Bossert and Mitchell (2011), decentralisation in health improves service delivery by increasing local autonomy and encouraging citizen participation in health governance. Another important argument in the literature is that decentralised governance improves accountability and public participation. Scholars such as Oliveira, Santinha, and Marques (2023) argue that decentralisation contributes to enhanced equity in healthcare, improved service efficiency and effectiveness, and greater resource utilisation. Similarly, Manor (1999) argues that decentralisation enhances transparency and public participation because local governments remain more directly accountable to communities. Further, Bisht (2025) argues that, by bringing governance closer to the community, LSG enables responsive decision-making, efficient use of resources, and active citizen participation. However, Saltman, et al., (2007) argue that decentralisation alone does not guarantee better healthcare outcomes; it requires local institutions, clear administrative responsibilities and adequate resource allocation to local government.

In this context, Kerala's decentralised governance model has been globally recognised. Kerala is a notable leader in decentralizing healthcare, demonstrating a bottom-up approach to government that emphasizes local empowerment and community involvement (Singh & Singh, 2024). In India, health services are organised and financed by state governments as the

Constitution of India affirms health as a state subject (Kaur et al., 2012). The Government of India has adopted decentralization/devolution as a vehicle for promoting greater equity and supporting people-centred, responsive health systems (Rao & Kothai, 2019). Hence, several national health and family welfare programmes are planned and financed by the Central Government but are implemented by the state governments (Kaur et al., 2012). As a result, healthcare being mainly a state responsibility, there are wide disparities in healthcare quality and access across the country. Therefore, the National Population Policy (2000) and Health Policy (2002) emphasised the importance of decentralisation (Kaur et al., 2012). Thus, the conceptual framework of decentralised health governance provides an appropriate lens for analysing the KPHA, 2023. The Act institutionalises the role of local self-government, community health participation and civil society organisation in public health decision making.

Historical Context of Kerala's Health System

Kerala's health infrastructure stands out among Indian states due to its robust primary healthcare system, decentralised governance, high health indicators, emphasis on human development and community participation. Kerala has a long history of organised health care, rooted in pioneering public policies and progressive governance. The foundations of Kerala's healthcare system can be traced back to the 19th century, when the princely rulers of the erstwhile states of Travancore and Cochin (which later were integrated into the state of Kerala along with the Malabar district of the Madras presidency in British India) took the initiative in making the western system of care available to their subjects (Kutty, 2000). By the time India gained independence, spectacular advances had already been made in medical care in Travancore (Kartha, 2020).

The government of Kerala in the post-independence period has taken several steps to improve the general socio-economic status of the people and preventive and curative health

care through primary, secondary and tertiary level health care Institutions (Kartha, 2020). The period from state formation to the early 1980s was characterized by great growth and expansion of the government health services. The unswerving governmental support for the welfare sectors till the mid-1980s catalysed the development of health services in Kerala. This was also reflected in the expansion of health infrastructure (Patrick, 2017).

From 1961 to 1986, the state greatly expanded its government health facilities (Radeena & Velluva, 2022). Health sector investments continued till the mid-1980s. But, thereafter, the pace of growth of the public health care system slowed (Mubeena & Akram, 2016). The public health care expenditure decreased by 35% between 1990 and 2002, making Kerala one of the states with the highest reductions in public sector contributions and the highest increase in private funding for health care. (Mubeena & Akram, 2016). However, increased purchasing power among poorer sections, along with high demand for modern health services, by the mid-1980s, made a shift towards private health care institutions (Oommen, 2018).

The major growth phase of health care facilities in the government sector occurred before 1986. Policies of political parties, both the left and the right front, focused on the needs of the poor, including land reforms and the institution of social welfare measures (Radeena & Velluva, 2022). Whatever their political leaning, investment in health infrastructure has been a consistent policy of all elected governments in Kerala (Radeena & Velluva, 2022). Strong political will and commitment among governments in power, irrespective of their political leanings, have been catalysts for change in the state (Kartha, 2020).

Despite the increasing presence of private healthcare, Kerala continued to maintain relatively high public investment in the health sector compared to many other Indian states. One of the landmark reforms behind Kerala's success in healthcare is its early adoption of the

People's Campaign for Decentralised Planning in 1996. Kerala launched a radical decentralisation policy in 1996, by which most development functions were transferred to local governments with the aim of transforming society by promoting people's participation and injecting a degree of efficiency (Nabae, 2003). Through decentralised administration in 1990 and decentralised planning in 1996, decision-making power in social welfare was transferred to the people at the level of the Gram Panchayat (Oommen, 2018).

Kerala's healthcare system is also distinguished by its people-centric and preventive approach. The state consistently introduced innovative healthcare programmes aimed at improving accessibility, equity, and quality of care. The Aardram mission, launched in 2017, transformed primary health centres into family health centres, ensuring people-friendly outpatient services, electronic health records, and care for marginalised and vulnerable populations (Government of Kerala, 2025a). Similarly, Kerala integrated the Ayushman Bharat scheme with its own insurance programs to form the Karunya Arogya Suraksha Padhathi (KASP), providing financial protection of up to ₹5 lakh per family to economically weaker sections. Despite having a long history of implementing various publicly funded health insurance (PFHI) schemes and a higher state budget allocation for health than other states in India, Kerala has the highest out-of-pocket expenditure (OOPE) on health (Adithyan et al., 2024). Similarly, Amrutham Arogyam is a state-run initiative aimed at combating non-communicable diseases. It focuses on raising awareness about healthy eating, regular exercise, and the harmful effects of addiction (Kerala Health Portal, 2025). The other government flagship health initiatives, like Thalolam (2010), Shrutirangam (2012), and Arogya Kiranam (2013), provide free treatment and allied medical services to eligible patients.

In recent years, Kerala has further modernised its healthcare system by implementing electronic health records, regular NCD screening for adults aged 30 and older, emergency and

trauma units due to the high incidence of accidents and injuries, the Weekly Iron and Folic Acid Supplementation (WIFS) Program, and Adolescent Friendly Health Clinics (AFHCs) to improve adolescent health (Israelsen & Malji, 2021). Pioneering programs such as the Kerala TB Elimination Program (2018) and the KARE initiative for rare diseases (2024) highlighted Kerala's proactive role in tackling emerging health issues. The KARE initiative focuses on prevention, early detection, advanced treatment, home-based care and psychosocial support for both patients and caregivers (The Hindu, 2025). These features are often lacking in many other states, making Kerala a model of comprehensive, equitable and forward-thinking healthcare delivery.

The Kerala public health model relies on a decentralised three-tier governance framework that integrates state-level planning with strong grassroots participation. Under this decentralised framework, Primary Health Centres, Community Health Centres, and district hospitals were placed under the control of gram panchayats, block panchayats, and district panchayats, respectively. Kerala allocated 40 per cent of the funds to local self-government institutions (LSGIs), which then allocated 25 per cent to the service sector, i.e., health and education (Muraleedharan & Chandak, 2022). Public healthcare facilities in Kerala are structured into three levels for providing primary, secondary and tertiary care (Comptroller and Auditor General of India, n.d.). At the state level, the Department of Health and Family Welfare plays a central role in formulating health policies, allocating budgets and overseeing the functioning of tertiary healthcare institutions such as medical colleges and specialised hospitals. At the district level, the district medical officer supervises healthcare administration and ensures the effective implementation of government health policies.

At the primary level, Kerala's health system is supported by Sub Centres (SCs) and Primary Health Centres (PHCs), which form the foundation of rural healthcare delivery. Sub-

centres serve the smallest populations and do not have inpatient capacity, while PHC facilities serve about 26,000 citizens and provide maternity services and limited inpatient services (Nabae, 2003). Under the new system, the PHC centres and their referring sub-centres were brought under the jurisdiction of villages in order to engage more closely with the community to identify and implement effective changes to respond to local health needs and encourage of use of PHC centres and sub-centres as the first point of care (PHCPI, 2022). This decentralised governance model significantly improved local participation, accountability and resource allocation, distinguishing Kerala from many other states that continue to operate under centralised health governance.

Most importantly, community participation forms one of the strongest pillars of the Kerala public health model. Frontline health workers such as Accredited Social Health Activists (ASHAs) and women's empowerment networks like Kudumbashree played a vital role in coordinating marginalised communities and government healthcare institutions. These grassroots networks significantly contribute to health awareness campaigns, maternal and child healthcare services, vaccination drives and emergency response activities. The Kerala model stands out in terms of community participation, especially Accredited Social Health Activists (ASHAs) and Anganwadi workers, and the Kudumbashree mission actively delivers health services, especially in maternal and child health and supports marginalised communities.

Another distinguishing feature is that Kerala adopted an inclusive approach that integrated education and the health sector. The state has a high literacy rate, especially among women, which leads to better health awareness, higher immunization rates and improved maternal and child healthcare. Additionally, Kerala maintained a strong tradition of Ayurveda alongside allopathic care, providing people with wider healthcare choices and further strengthening Kerala's healthcare model.

During the Nipah outbreak, Kerala's model showcased the effectiveness of long-term investments in health, education and decentralized governance. The state also showed exemplary disease surveillance and management, particularly during the Nipah virus outbreak and the COVID-19 pandemic. Its swift response, characterized by rigorous contact tracing, isolation measures, tracing the epidemiological link to an index case, quarantine of suspect cases, public awareness campaigns and a trans-disciplinary approach in managing pandemics (not only the Department of Health but other departments were involved in the management process), helped contain the spread effectively (Muraleedharan & Chandak, 2022).

Kerala stands out from other states due to its state-specific and progressive health policies addressing emerging public health concerns. Unlike many other Indian states where private healthcare dominates, Kerala consistently prioritised public investment in healthcare, providing free treatments, accessible diagnostics, and well-equipped government hospitals. Additionally, Kerala placed significant emphasis on often overlooked social determinants of health, such as nutrition, sanitation, and women's empowerment, creating a strong foundation for long-term health outcomes.

While many states tend to overlook emerging health issues from climate change impacts, lifestyle diseases, and communicable and non-communicable diseases in their policies and actions, Kerala addresses these challenges promptly and effectively. Kerala integrates climate resilience into health planning more effectively than most states, conducting health risk assessments and establishing an early warning system for disease outbreaks linked to environmental changes. Programs such as Amrutham Arogyam and Swasthya Keralam target early detection and management of lifestyle diseases like diabetes and hypertension. Kerala

was the first Indian state to introduce a Palliative Care Policy in 2008, focusing on community-led home care.

Despite its low per capita income, Kerala's development model had excelled, consistently attracting national and international attention, and was comparable to developed countries (Varughese, 2024). These efforts resulted in better health indicators than the rest of India, including low infant and maternal mortality rates, high life expectancy, and near-universal immunisation, distinguishing Kerala as a leader in public health (Table 1) (Government of Kerala, 2025b).

Table 1

Major Health Indicators in Kerala and India

Health Indicators	**Kerala**	**India**
Birth Rate	13.2	19.5
Death Rate	7.0	6.0
Infant Mortality Rate	6.0	28.0
Under- 5 Mortality Rate	8.0	32.0
Maternal Mortality Ratio	19.0	97.0

Note: Birth rate, death rate, Under-5 Mortality Rate, and Infant Mortality Rate are expressed per 1,000 population/live births. Maternal Mortality Ratio (MMR) is expressed per 100,000 live births

Table 1 represents a comparative analysis of the major health indicators between Kerala and India based on data from the Government of Kerala (2025b). The Birth rate, under-5 mortality rate, infant mortality rate, and Maternal Mortality Ratio in Kerala are significantly lower than in India. The death rate in Kerala is slightly higher than in India.

Kerala stands out among Indian states due to its relatively high public spending on the health sector. Table- 2(National Health Profile, 2025).

Table 2

State-Wise Health Expenditure as a Percentage of Gross State Domestic Product (GSDP),2020-2023

State	Total Health Expenditure (2020-2021) % of GSD	Total Health Expenditure (2021-2022) % of GSD	Total Health Expenditure (2022-2023) % of GSD	Population (In Crores)
Assam	3.2	3.6	2.9	3.5
Andhra Pradesh	3.4	3.4	2.8	5.3
Bihar	3.8	4.5	3.3	12.2
Chhattisgarh	3.3	3.6	2.9	2.9
Gujarat	1.9	2.0	1.8	6.9
Haryana	2.3	2.4	2.0	2.9
Jammu and Kashmir	3.7	4.3		1.4
Jharkhand	4.3	5.1	3.8	3.8

Karnataka	2.5	2.6	2.2	6.7
Kerala	5.3	5.2	4.5	3.5
Madhya Pradesh	2.6	3.0	2.5	8.4
Maharashtra	3.3	3.4	2.8	12.4
Odisha	3.9	3.9	3.0	4.6
Punjab	3.1	3.1	2.9	3.0
Rajasthan	3.4	3.6	3.1	7.9
Tamil Nadu	2.5	2.5	2.0	7.6
Uttar Pradesh	5.5	5.6	5.0	23.0
Uttarakhand	2.0	2.3	1.7	1.1
West Bengal	4.8	4.9	4.1	9.8
Telangana	2.3	2.2	2.0	3.8
Himachal Pradesh	3.6	3.9	3.2	0.7

(Source: National Health Profile 2021,2022,2023)

As presented in Table 2, Kerala consistently allocated a relatively high proportion of its gross State Domestic Product (GSDP) to the health sector between 2020-2021 and 2022-2023. Despite having a smaller population, Kerala spends the highest percentage of GSDP on health. This reflects Kerala's dedication and sustained commitment to public health financing.

Overview of Kerala Public Health Act 2023

After the outbreaks of the Nipah virus and COVID-19, Kerala underwent a major overhaul and reshaped the Public Health System. The emerging and resurgence of communicable and non-communicable diseases, rising health inequities, and the growing privatization of healthcare underscored the importance of initiatives such as the KPHA- 2023. These measures aim to address evolving health challenges effectively. 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 (Fernandez et al., 2024).

These precedents laid the groundwork for the KPHA 2023, institutionalizing the state's commitment to equity, inclusion, and resilience. The KPHA-2023 provides a comprehensive framework for strengthening public health systems, focusing on governance, institutional mechanisms, and ensuring health equity and accessibility. The Act further explores its governance and institutional framework, public health surveillance and response mechanisms, health and hygiene standards, emergency preparedness strategies, and commitment to equity and accessibility. The KPHA is based on the understanding that public health is a shared responsibility requiring a robust governance, intervention, and surveillance system.

The KPHA establishes a robust governance structure to coordinate and regulate public health initiatives. At its core, it creates a multi-tiered public health structure at the state, district,

and local levels. Section two of the Act enhances decentralised governance by empowering local self-governing bodies and establishing public health boards and committees, each led by designated officers, to oversee and coordinate public health initiatives statewide. These committees are tasked with formulating programs to ensure public health at their respective levels and evaluating the effective implementation of health-related action plans aligned with SDGs (Government of Kerala, 2023). The State Public Health Officer can collect public health data from public or private healthcare institutions (Section 2(6)). They may also issue directions on public health matters while ensuring data privacy and protection (Section 2(6)). Public Health Officers (PHO) have the additional power during emergencies, can conduct inspections and enquiries, issue notices, formulate guidelines and take legal action (Section 2(7)). 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 (Karpagam,2024).

The Act prioritises emergency preparedness and disease surveillance to ensure early detection and containment of health threats. Moreover, the Act mandates real-time monitoring of infectious diseases, allowing authorities to detect early outbreaks and implement rapid containment measures. When outbreaks occur, the state government is authorized to take preventive measures such as quarantines, health checks at borders, and public health interventions (Section 7(46)). Specific provisions address vulnerable groups such as migrant labourers, ensuring regular health check-ups and access to necessary treatment (Section 7(29)). The Act also prohibits infected individuals from engaging in activities that spread diseases, such as handling food or gathering in public spaces (Section 7(37)). Health institutions are required to report cases of communicable diseases to designated public health authorities, enabling swift identification of trends and potential outbreaks. The legal backing provided by

the Act ensures that such measures can be enforced efficiently and without delay, helping to curb the spread of diseases. Kerala's experience with disease outbreaks, such as the Nipah virus and COVID-19, has highlighted the importance of such surveillance systems, and the Act institutionalizes these efforts.

The key provisions of the KPHA are combating new Viruses, pathogens, infectious diseases, the heightened threat of the spillover of zoonotic diseases, epidemics as part of climate change, and human-animal interactions, making provisions for the welfare of migrant labourers, food safety, blood banks, blood safety, biomedical waste management, tackling anti-microbial resistance, and even ensuring adequate toilet facilities in public spaces. On the other hand, the Act provides the right to state public health authorities to collect data from public and private healthcare establishments regarding any communicable/ notifiable disease. This authority shall lay down the conditions under which a public health emergency can be declared in the state or a district.

The KPHA (2023) recognises the importance of social determinants of health such as clean water, environment, sanitation, and waste management. The legislation sets rigorous standards to protect citizens from health hazards arising from poor sanitation, unsafe water and food, and environmental pollution (Sections 3, 4, and 5). The act focuses on the responsibilities related to sanitation, particularly public latrine facilities, which must be implemented by local authorities in public spaces (Section 4(2)). These latrines should be user-friendly, properly maintained, and accessible to all, including women, differently-abled and transgenders (Section 4(4)). Additionally, the Act prohibits the deposit of filth and rubbish in public areas, imposing fines or imprisonment for violations (Section 4(20)). Public health officers are responsible for conducting regular inspections to ensure sanitation standards are met in institutions, and those failing to comply face penalties.

Moreover, the act deals with the removal of nuisance, including health hazards like poorly maintained buildings, polluted water sources, and improper waste disposal (Section 5). Under the Act, it is the responsibility of water distributors to ensure drinking water quality. Additionally, the Act prohibits the introduction of harmful substances into watercourses, including construction debris, industrial waste, and other pollutants that can harm public health (Section 5(21)). Public Health Officers are empowered to regularly test the water quality and take corrective actions if contamination is detected, such as seeking explanations from the distributors, implementing remedial measures, or even halting the distribution of unsafe water (Section 3(16)). If the water quality fails to meet the required standards, legal actions, including fines, may be imposed (Section 3(15 b)).

Most importantly, the KPHA 2023 enshrines the principles of equity and accessibility, ensuring that every individual, regardless of socioeconomic status, can access quality healthcare. The act gave special care and attention to individuals facing physical, mental, social, and economic challenges, including aged, bedridden, severely ill, and differently-abled (section 10). The public health officer is responsible for ensuring that healthcare activities and services, particularly those related to preventing communicable diseases and protecting public health, are accessible to these vulnerable groups. Furthermore, the act outlines the responsibilities of the public health officers at various levels (state, district, and Local) in improving reproductive, maternal, neonatal, child, and adolescent health (Section 6(27)).

Community participation constitutes a defining feature of the KPHA. The Act institutionalizes the role of local self-government institutions, community health committees, and civil society actors in public health decision-making. Unlike older laws, the KPHA Act recognizes health as a fundamental right and empowers local self-governments with clear responsibilities in health planning and crisis management. Going beyond conventional methods

of infectious disease control, it incorporates aspects like disease surveillance, digital health data integration, pandemic preparedness, real-time monitoring and preventive measures, making it highly relevant in a post-COVID world (Fernandez et al., 2024).

Although the KPHA 2023 underscores the importance of prevention and strengthening social systems, it has also faced various criticisms. Sylvia Karpagam criticized the KPHA 2023 Act, which has significant potential, but some aspects require careful implementation to ensure it aligns with public health ethics and the human rights framework. She also mentioned that the act neither prioritizes individual choice nor provides any protection or care for infected people. Furthermore, she highlighted that principles like autonomy, privacy and confidentiality, transparency, accountability, rule of law, and least harm were not given minimal consideration in the KPHA Act. However, many scholars, including Bhavya Fernandez, Veetilakath Jithesh, and Anish T, oppose this criticism. The Act does not seek to interfere in an individual's preferred treatment choice, except in the case of a public health emergency. They argued that the government has the right to prevent collective costs arising from countless individual decisions and holds responsibility toward the population as a whole, not just individuals. They stated that 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. KPHA is not a standalone document but a supporting tool to the existing Kerala Public health policy and various other health policies and programs instrumental in improving the health and quality of life of the people of the state.

Global Relevance: Linking Local Action to Global Health Goals

The KPHA 2023 effectively integrates local governance with public health priorities, offering valuable lessons for global health governance. Kerala has significantly contributed to

global health governance by aligning with global health frameworks, robust pandemic preparedness, commitment to health equity, and collaboration with international health bodies. While its scope is localized, its principles of pandemic preparedness, prevention, equity, and community participation resonate with international frameworks such as the International Health Regulations (IHR), Universal Health Coverage (UHC), and Sustainable Development Goals (SDG-3) (Table-3).

Table 3

Comparative Analysis of Public Health Frameworks

Aspect	**Kerala Public Health Act-2023(Government of Kerala)**	**Sustainable Development Goal 3 (United Nations)**	**Universal Health Coverage (WHO/United Nations)**	**International Health Regulation, 2005 (WHO)**
Objective	Protect and promote the public health in Kerala	Health and well-being	Ensure all people's health services without financial hardship	To prevent and Respond to public health emergencies
Focus on Public Health	Provides a legal framework for public health emergency	Reducing mortality, combating disease, and enhancing healthcare systems	To build resilient health systems ensuring Universal access	Focuses on disease outbreak, control, and preparedness

Equity and accessibility	Recognizes the need for equitable health services	Healthcare access to all	To ensure equitable health services irrespective of income	Calls for fair and consistent responses to public health risk across countries.	
Preventive measures	Highlights measure sanitation, safety, vaccination	Like water and	Disease prevention	Stresses prevention to reduce the disease burden	Provide guidelines preventing international health threats
Legal Framework	A state law providing enforceable public health measures	A Policy Vision for Health Development Globally	A policy goal often implemented through national legal systems	A legally binding framework for member states of the WHO	

(Source: prepared by author)

Each framework or regulation complements the others to build robust, equitable, and responsive health systems at local, national, and international levels. The KPHA integrates elements of all three frameworks by combining public health protection, disease surveillance and equity. Although Kerala has a low per capita income, it is enhancing its public health systems and preparing for future pandemics through various legislative initiatives. By aligning with global health initiatives on early detection, containment, strategies, and health infrastructure, Kerala's model contributes to global efforts in pandemic preparedness. Kerala's use of integrated disease surveillance systems (IDSP) and real-time data sharing aids in early detection and response. Such practices strengthen global epidemic intelligence and the implementation of IHR. During COVID-19 and the Nipah outbreaks, Kerala utilized rigorous

contact tracing, digital tools, and isolation strategies, contributing lessons for pandemic containment that resonate with the global health security frameworks (Rahim et al., 2024). The provisions of the KPHA, 2023 institutionalize these measures, creating a legal framework that allows for swift and efficient pandemic management in the future.

On the other hand, Kerala has established itself as a pioneer in advancing health equity. Addressing the health disparities in rural and marginalized communities is another concern of global health governance. To reduce health disparities, KPHA has special provisions for promoting the welfare of the marginalized. Addressing social determinants of health is important for improving health and reducing longstanding disparities in health and healthcare (Artiga & Hinton, 2025). The KPHA focuses on addressing social determinants of health, such as nutrition, sanitation, and education, to reduce health disparities, supporting the global agenda by promoting inclusivity and leaving no one behind

Furthermore, the state actively collaborates with organizations like the WHO, World Bank, and UNICEF, sharing its expertise and learning from global experiences, reinforcing its in global health governance. Kerala has an established long-term technical partnership with the WHO, collaborating on a vaccination drive, and disease surveillance with a focus on strengthening primary healthcare services and tackling the leading causes of morbidity and mortality, particularly NCDs (WHO, 2025). In 2018, during the Kerala floods, WHO assisted the government in enhancing disease surveillance within the private sector. During the COVID-19 pandemic, WHO supported Kerala by providing guidance, expertise, and resources, including information on the virus, treatment protocols, and containment strategies. Kerala's inclusive health model has reaffirmed its role as a crucial partner in creating robust and equitable healthcare systems globally, which also sets a precedent for achieving long-term global health goals.

Policy Implications and Lessons for Developing Countries

The Kerala development model is illustrated as a sustainable model for healthcare and human development (Chathukulam & Tharamangalam, 2021). It offers a robust framework that integrates preventive care to address health inequities, Community participation to enhance the development, implementation, and evaluation of health services, and equitable healthcare delivery that values everyone equally, making it a valuable reference for other states/countries (Persaud et al., 2023; Haldane et al., 2019; Nelson et al., 2020).

However, implementing it globally presents promising opportunities and significant challenges. The KPHA presents a replicable model for other states and countries to improve their health systems. In India, the Epidemic Diseases Act of 1897 is a colonial-era law still used by many states, and it is limited in scope and outdated in approach. Similarly, countries like Nepal and Bangladesh have fragmented health legislation, making Kerala's model a useful template for reform.

KPHA promotes health equity, which is essential for reducing health disparities and addressing the needs of marginalized communities. States like Madhya Pradesh, Uttar Pradesh, Odisha, Chhattisgarh, Jharkhand, and Uttarakhand, with a higher proportion of marginalized groups, could adopt similar provisions to ensure inclusive health services.

It is suitable for developing countries or regions with decentralized health systems, strong community networks, and a focus on equitable healthcare. Kerala's emphasis on community-based health interventions and disease surveillance can be adopted by other regions facing similar health challenges and low-resource setting countries. However, Indian states like Maharashtra and Tamil Nadu have a strong backing of the panchayat raj system but lack a formal legal framework for local public health action.

Developing countries, like Nepal, Bangladesh, Indonesia, and the Philippines, can adopt. Kerala's primary healthcare and community-driven model. Similarly, African countries like Rwanda, Kenya, and Uganda, which are focused on community health programs, can adopt Kerala's preventive approaches to improve outcomes. It is usually argued that decentralized governance of health services bridges the gap between communities and decision-makers, improves equity, accessibility, and accountability of local service providers, and fosters innovation and technical efficiency in healthcare provision (Mahmood et al., 2024).

The major hurdle is physical and financial gaps in low- and middle-income countries. Many countries face shortages of hospitals, clinics, medical equipment, skilled human resources in existing health centres, and proper healthcare facilities. Maintaining financial sustainability in low-resource settings is a significant challenge. In addition, replicating Kerala's model is challenging in countries with political instability and inadequate infrastructure. While Kerala has benefited from a relatively high level of state funding for healthcare, other regions may struggle to secure the necessary resources to implement similar policies. Addressing gaps in healthcare facilities is essential for achieving broader healthcare goals, particularly in resource-constrained regions. Patient-centred health systems need to make sure that sufficient financial and physical resources are available to meet population health needs now and also in the future (Araujo et al., 2022)

Coordination gaps between various inter-departmental sectors also pose a challenge. The government public health agencies cannot work in isolation and must collaborate with various partners to be effective. Collaborative partnerships across sectors are crucial to achieving the social determinants of health, such as education, economic stability, environment, and social conditions. To respond promptly, they must sustain partnerships across public, private, and nonprofit sectors and community-based organizations, which are essential

to bridge resource gaps and improve health system efficiency (National Academy of Medicine, 2016). To adapt Kerala's health model to diverse contexts, strategic planning, sustainable funding models, and multi-sectoral partnerships are needed.

Conclusions

The KPHA, 2023 represents a significant advancement in decentralised health governance, offering a comprehensive and equity-oriented approach to pandemic preparedness, prevention, and community participation. While grounded in Kerala's unique socio-political context, the Act's underlying principles possess broad relevance for global health governance. Soon after the pandemic, Kerala focused on strengthening its core health capacities and enhancing the surveillance and response system. Kerala's dedication to advancing public health governance through progressive, rights-based, and environmentally conscious legislation is exemplified by the KPHA of 2023. This visionary Act has the potential to inspire other regions, especially in developing countries, to reduce health inequalities and strengthen their own health systems. The Act exemplifies how localized efforts can drive progress toward achieving international health goals such as "Health for All." Kerala's proactive measures through the KPHA set a powerful example, demonstrating that even smaller states can effectively prepare for future pandemics. The act makes it a potential blueprint for other regions, positioning Kerala as a role model for global health governance.

References

Adithyan, G. S., Ranjan, A., Muraleedharan, V. R., & Sundararaman, T. (2024). Kerala's progress towards universal health coverage: the road travelled and beyond. *International Journal for Equity in Health*, *23*(1), 152. https://doi.org/10.1186/s12939-024-02231-2

Araujo, E. C., Lobo, M. S. C., & Medici, A. C. (2022). Efficiency and sustainability of public health spending in Brazil. *JBES: Brazilian Journal of Health Economics/Jornal Brasileiro de Economia da Saúde*, *14*. DOI: 10.21115/JBES.v14.n1.

Artiga, S., & Hinton, E. (2018). Beyond health care: the role of social determinants in promoting health and health equity. *Kaiser Family Foundation*, *10*.

Bisht, S. (2025). role of local self-government in strengthening public health services: A comprehensive review. *Lex Localis*, *23*(S5), 1987-1995.

Bossert, T. J., & Mitchell, A. D. (2011). Health sector decentralisation and local decision-making: decision space, institutional capacities and accountability in Pakistan. *Social science & medicine*, *72*(1), 39-48. doi:10.1016/j.socscimed.2010.10.019

Chathukulam, J., & Tharamangalam, J. (2021). The Kerala model in the time of COVID19: Rethinking state, society and democracy. *World development*, *137*, 105207. https://doi.org/10.1016/j.worlddev.2020.105207

Comptroller and Auditor General of India. (n.d.).https://cag.gov.in/uploads/download_audit_report/2024/04.-Chapter-I-0678f47acf14b16.73621091.pdf

Fernandez, B., Jithesh, V., & Anish, T. S. (2024). Reflections on the Kerala Public Health Act 2023: A response to Dr Karpagam's commentary. *Indian journal of medical ethics*, *9*(3), 228-231. doi: 10.20529/IJME.2024.043.

Government of Kerala. (2025, December 23a) Aardram mission. https://arogyakeralam.gov.in/2020/04/01/aardram/.

Government of Kerala. (2023). The Kerala Public Health Act, 2023. https://prsindia.org/files/bills_acts/acts_states/kerala/2023/ActNo.28of2023Kerala.pdf

Government of Kerala (2025b). Health at a glance 2022-2023. https://dhs.kerala.gov.in/wp-content/uploads/2024/08/HEALTH-AT-GLANCE-2022-23_merged.pdf

Haldane, V., Chuah, F. L., Srivastava, A., Singh, S. R., Koh, G. C., Seng, C. K., & Legido-Quigley, H. (2019). Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes. *PloS One*, *14*(5), e0216112 https://doi.org/10.1371/journal.pone.0216112.

Israelsen, S., & Malji, A. (2021). COVID-19 in India: A comparative analysis of the Kerala and Gujarat development models' initial responses. *Progress in Development Studies*, *21*(4), 397-418. https://doi.org/10.1177/14649934211030462

Karpagam, S. (2024). Commentary: Public health ethics and the Kerala Public Health Act, 2023. *Indian Journal of Medical Ethics*, *9*(2), 154-158. https://doi.org/10.20529/IJME.2024.007

Kartha. C.C. (2020). The ascent of the 'Kerala model' of public health. KIMS, Trivandrum, Kerala. https://www.ias.ac.in/public/Resources/Articles_Repository/20200511_01.pdf

Kaur, M., Prinja, S., Singh, P. K., & Kumar, R. (2012). Decentralisation of health services in India: barriers and facilitating factors. *WHO South-East Asia Journal of Public Health*, *1*(1), 94-104. https://doi.org/10.4103/2224-3151.206920

Kerala Health Portal (2025). Kerala's health journey; Insights and horizons. https://health.kerala.gov.in/index.php/healthscapedetail/Keralas_Health_Journey_Insights_and_Horizons/eyJpdiI6ImZDc0tNRDBrTG45VjVucFl4SHBLQ0E9PSIsInZhbHVlIjoiS1B0V3VxV09zZzhlamljaEhJTi90UT09IiwibWFjIjoiMjNjMGJmNWYyMTljMDk4MjVmNWY0MTQ1OWRiNTVmM2YyZTNhMWE2MzQzZjgwZjU3NmQ0M2Q2MGM0NjJlYjMyYiIsInRhZyI6IiJ9.

Radeena, D. N., & Velluva, S. (2022). Kerala's healthcare journey: Navigating development, challenges, and synergies. *International Journal of Food and Nutritional Sciences, 11*(2), 1724–1731.

Kutty, V. R. (2000). Historical analysis of the development of health care facilities in Kerala State, India. *Health Policy and Planning*, *15*(1), 103-109. https://doi.org/10.1093/heapol/15.1.103

Mahmood, S., Sequeira, R., Siddiqui, M. M. U., Herkenhoff, M. B. A., Ferreira, P. P., Fernandes, A. C., & Sousa, P. (2024). Decentralization of the health system: Experiences from Pakistan, Portugal and Brazil. *Health Research Policy and Systems*, *22*(1), 61. https://doi.org/10.1186/s12961-024-01145-3.

Manor, J. (1999). *The political economy of democratic decentralization* (pp. x+-133).

Mubeena, O., & Akram, M. (2016). Role of third sector in promoting health outcomes in Kerala: A sociological study. *International Journal of Community Medicine and Public Health*, *3*, 30-6.DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20151476

Muraleedharan, M., & Chandak, A. O. (2022). Emerging challenges in the health systems of Kerala, India: Qualitative analysis of literature reviews. *Journal of Health Research*, *36*(2), 242-254.https://doi.org/10.1108/JHR-04-2020-0091

Nabae, K. (2003). The health care system in Kerala: Its past accomplishments and new challenges. *Journal of the National Institute of Public Health*, *52*(2), 140-5.

National Academy of Medicine, Secretariat, & Commission on a Global Health Risk Framework for the Future. (2016). The neglected dimension of global security: A framework to counter infectious disease crises. *National Academies Press*. https://nam.edu/wp-content/uploads/2016/01/Neglected-Dimension-of-Global-Security.pdf.

National Health Profile (2025 March 14). National Health profile 2021, 2022, 2023. https://cbhidghs.mohfw.gov.in/publications/national-health-profile

Nelson, H. D., Cantor, A., Wagner, J., Jungbauer, R., Quiñones, A., Stillman, L., & Kondo, K. (2020). Achieving health equity in preventive services: A systematic review for a national institutes of health pathways to prevention workshop. *Annals of internal medicine*, *172*(4), 258-271 https://doi.org/10.7326/M19-319

Oliveira, R., Santinha, G., & Sá Marques, T. (2023). The Impacts of health decentralization on equity, efficiency, and effectiveness: A scoping review. *Sustainability*, *16*(1), 386. https://doi.org/10.3390/su16010386.

Oommen, S. E. (2018). Growth of primary health care system in Kerala: A comparison with India. *International Journal of Interdisciplinary Research and Innovations*, *6*(2), 481-90.

Panda, B., & Thakur, H. P. (2016). Decentralization and health system performance: A focused review of dimensions, difficulties, and derivatives in India. *BMC Health Services Research*, *16*(Suppl 6), 561.): https://doi.org/10.1186/s12913-016-1784-9.

Patrick, M. (2017). Public and private healthcare institutions: Preference and expenditure pattern (No. 1). Working Paper.

Persaud, N., Sabir, A., Woods, H., Sayani, A., Agarwal, A., Chowdhury, M., Leon-Demare, K.,[2], Ibezi,S.,[2], Jan, S.H.,[2], Katz, A., LaFortune, F.D., Lewis,M., McFarlane,T., Oberai, A., Oladele, Y., Onyekwelu,O., Peters,L., Wong, P., & Lofters, A. (2023) Preventive care recommendations to promote health equity. *Cmaj*, *195*(37), E1250-E1273. https://doi.org/10.1503/cmaj.230237.

PHCPI. (2022). Decentralized governance and community engagement to strengthen primary care. https://www.improvingphc.org/kerala-india governancereview/ER2017/web_e/foreword.php.

Rahim, A. A., Chandran, P., Bindu, V., Radhakrishnan, C., Moorkoth, A. P., & Ramakrishnan, L. V. (2024). Recurrent Nipah outbreaks in Kerala: Implications for health policy and preparedness. *Frontiers in Public Health*, *12*, 1356515. https://doi.org/10.3389/fpubh.2024.1356515.

Rao Seshadri, S., & Kothai, K. (2019). Decentralization in India's health sector: Insights from a capacity building intervention in Karnataka. *Health Policy and Planning*, *34*(8), 595-604. https://doi.org/10.1093/heapol/czz081

Saltman, R., Busse, R., & Figueras, J. (2006). Decentralization in health care: strategies and outcomes. *McGraw-hill education* (UK).

Singh, S. P., & Singh, S. K. (2024). Strengthening the fabric: Federalism, decentralisation, and India's healthcare imperative. *Liberal Stud.*, *9*, 27.

State Planning Board (2018, January 16). Economic Review 2017. Government of Kerala.https://spb.kerala.gov.in/economic-review/ER2017/web_e/index.php.

The Hindu (2025, February 24). KARE initiative to prevent, manage rare diseases a decisive step by Kerala. https://www.thehindu.com/news/national/kerala/kare-initiative-to-prevent-manage-rare-diseases-a-decisive-step-by-kerala-says-cm-pinarayi-vijayan/article67854685.ece.

Thekkumakara Surendran, A., Gaitonde, R., & Nambiar, D. (2025). Health in Kerala: Exploring achievements and remaining challenges of health systems reform using an equity lens. *International Journal for Equity in Health*, *24*(1), 89. https://doi.org/10.1186/s12939-025-02414-5

UIA. (2022 November 09) Decentralizing government health services. https://encyclopedia.uia.org/strategy/decentralizing-government-health-services .

Varughese, G. M. (2024). Role of women in the development path of Kerala. *Shanlax International Journal Of Economics 12*(4), 5-10. https://doi.org/10.34293/economics.v12i4.7930.

Véron, R. (2001). The “new” Kerala model: Lessons for sustainable development. *World Development*, *29*(4), 601-617. https://doi.org/10.1016/S0305-750X(00)00119-4.

World Health Organisation. (2025, February 24). Technical collaboration between WHO India and Kerala on Universal Health coverage. https://www.who.int/india/news/detail/12-07-2017-technical-collaboration-between-who-india-and-kerala-on-universal-health-coverage.

World Health Organisation. (2008, January 1). International Health Regulations. 2005. Second Edition. Geneva: WHO. https://www.who.int/publications/i/item/9789241580410.