

# Public Health Law In Malaysia And The United States: Comparing Current Applications

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**Abstract-Background:** The main objective of public health law is to pursue the highest possible level of physical and mental health in the population, consistent with the values of social justice.

**Aims:** To elaborate on Malaysia's public health laws that share unique commonalities with those of the United States of America, due to both countries' colonial past as part of the British Empire.

**Methods:** Historical review and analysis of current public health law issues in both nations.

**Results:** The United States of America gained full independence from the British Empire on 3 September 1783, while almost three years later, on 11 August 1786, the Union Jack was raised on the island of Pulau Pinang in Malaysia. When the colonies first formed the United States, there was no national public health law; the American colonies adopted the English laws on the control of diseases. This is similar to Pulau Pinang, after the implementation of the Charter of Justice in 1807.

**Conclusion:** Current applications of the law, which include quarantine, sanitation, disease reporting, and vaccination, exhibit interesting similarities as well as differences between the United States and Malaysia.

**Index Terms—** Comparative Law, History, Public Health, Malaysia, United States.

## I. INTRODUCTION

The responsibility for the public's health lies with its government, which is the publicly appointed entity that acts on behalf of the people and is

mechanisms, inter alia, health services, health financing, and public health law [1]. Public health law is defined as the study of the legal powers and duties of the state, interpreted and executed in collaboration with governmental and non-governmental partners to ensure that the people live in utmost salutary conditions, as well as taking into consideration the limitations of state power to constrain for the common good the rights, livelihood, privacy, and other legally protected interests of individuals. Its main objective is the achievement of the highest possible degree of health among the general population while preserving social justice [2]. The recent global COVID-19 pandemic has peeled away layers of presupposition on how far-reaching public health laws can be, revealing the stark reality of ideological clashes between restrictive and liberal state action [3,4].

Malaysia and the United States of America (USA) share a colonial past as part of the British Empire, though they were not part of the empire at the same time. The USA gained full independence with the end of the American Revolutionary War on 3 September 1783. Almost three years later, on 11 August 1786, the Union Jack was raised on the Malaysian island of Pulau Pinang and Captain Sir Francis Light took formal possession of the island "in the name of His Britannic Majesty, King George III and the Honourable East India Company" [5]. When the colonies first formed the United States (US), there was no national public health law [6]; the US adopted the English laws on disease control measures. English statutory and common law recognises as a state right actions including quarantine, isolation, and limiting the movement of individuals deemed to be carriers of infectious disease [7]. This is similar to Pulau Pinang, after the implementation of the Charter of Justice in 1807.

Before independence, the British Americas (i.e., the Thirteen Colonies pre-American enlightenment) suffered greatly from infectious diseases including,

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but not limited to, smallpox and yellow fever [8]. The immediate post-independence United States consisted of state governments that had broad autonomy on matters of communicable disease control. State regulation was quickly hammered out, with input from medical experts, to form extensive disease control and preventive measures. The lack of medical technology was not an obstruction to sound epidemiological principles, which led to the regulation of key areas of public health such as safe food and water supplies, strict sanitation requirements coupled with municipal action, and proper housing conditions. Further laws that affected individual rights but were justified for the common good were mandatory vaccination laws and isolation of infectious disease carriers [8]. The courtroom gradually saw less attendance by individual offenders of public health laws, due to the nature and rationale of the laws' enforcement. Indeed, the courtroom was visited by groups that sought to resist public health regulation and, subsidiary to that, challenge the authority of public health agencies. Although said groups were on the whole unsuccessful, public health gained little by such litigation. With the passage of time, the courtroom was seen by public health authorities as an obstacle, after the hard travails of passing public health laws, to the comprehensive protection of the population's health [9].

In the USA, the greatest change in legal practice since the mid-twentieth century has been the move away from adjudication based on private law between individual parties, to public law. Public law covers the regulation of individual parties, litigants (both of government and non-government origin) challenging public policy, and the authority and actions of agencies themselves [10]. The core of public law is administrative law, which includes legislative roles of the executive branch of government, adjudication, and enforcement of said laws. Public health law is a prime example of administrative law.

## II. METHODS

For this paper, the authors have employed mostly primary sources and subsequent analysis of public health laws from Malaysia and the United States of America. Issues and recommendations were

obtained from comparison between the two nations' health systems in addition to public perspectives.

## III. RESULTS

### *Law on Infectious Disease Prevention and Control With Regard to Coverage of Offences:*

In Malaysia (the name Malaya having changed to Malaysia in 1963 after the country of Malaya was joined by Singapore (from 1963 to 1965), Sabah and Sarawak), the Prevention and Control of Infectious Diseases Act 1988 (Act 342) is federal law that allows government action to be taken in the event of infectious disease outbreaks [11]. Since the federal government of Malaysia has full jurisdiction over health matters, state governments are not involved in decision-making with regards to controlling or preventing patients or suspected infected individuals from crossing state borders. In comparison with the USA's public health law on infectious diseases, the intention and content of the Prevention and Control of Infectious Diseases Act 1988 resembles a combination of US state laws, such as the Disease Prevention and Control Law 1955 of Pennsylvania (or equivalent laws from other US states) and the US federal Public Health Service Act 1944. Like Malaysia's federal Prevention and Control of Infectious Diseases Act 1988, US state laws cover restrictions on human activity and movement in preventing the spread of infectious diseases, in addition to mandatory health and punitive measures to enforce said restrictions at state level [2,12]. As for the US federal Public Health Service Act 1944, it establishes the powers and duties of the Public Health Service with respect to foreign and interstate quarantine, while leaving intrastate infectious disease control to the laws of each state [13]. In addition, the Public Health Service Act 1944 gives authority to federal public health service agencies including the Centers for Disease Control and Prevention (CDC) and National Institutes of Health (NIH) [14]. In Malaysia, the Disease Control Division and National Institutes of Health are not formed by law, but rather directly under the Ministry of Health Malaysia. During the peak of the COVID-19 pandemic in Malaysia, the Prevention and Control of Infectious Diseases Act 1988 was employed to govern a wide range of human activities, inter alia, closing of non-essential businesses, restricting movement of the public

across state borders, and enforcing the mask mandate [15].

The strength of the Prevention and Control of Infectious Disease Act is its effective legal reach over all manner of human activity, including the opening of businesses, business hours, government services open and accessible to the public, working hours, movement of individuals outside their homes, personal health practices such as wearing of masks, personal hygiene measures, and mandatory activities such as MySejahtera QR code scanning (compulsory scanning of QR codes in all premises for the purposes of tracking and tracing COVID-19 positive patients) [16]. In addition, subsidiary regulations to the parent Act were issued immediately to control outbreaks, such as the Prevention and Control of Infectious Disease Act (Measures within infected local areas) (Movement control) Regulations 2021 [17].

A weakness of the Prevention and Control of Infectious Diseases Act 1988 is that it requires a combination of acts other than itself to build a complete legal framework for infectious disease control. This is explained by an example of areas not covered by the Act, which requires another law for efficacious enforcement, such as the Destruction of Disease Bearing Insects Act (DDBIA) 1975 (Act 154), which covers activities and penalties related to the prevention and control of vector-borne disease [18]. Without the DDBIA, the Prevention and Control of Infectious Diseases Act alone does not cover specific offences related to vector borne disease control, such as the obstruction of thermal fogging activities. Hence, the health enforcement officer is required to have authority, delegated by the Director General of Health, for a combination of public health laws in order to carry out their work effectively. This is evidenced by the necessity for Environmental Health Officers and Assistant Environmental Health Officers, who serve as enforcement officers for the Ministry of Health Malaysia, to have several letters of delegation of authority (*surat penurunan kuasa*), each empowering authority for separate Acts [19].

Indeed, the existence of subsidiary legislation, especially ad hoc legislation such as the abovementioned Prevention and Control of Infectious Disease Act (Measures within infected local areas) (Movement control) Regulations 2021,

lays an onerous burden on law enforcers in having to cope with added procedural and punitive actions. Such subsidiary legislation led to confusion caused by the overlapping of public health enforcement duties among 13 different agencies, including police, environmental health officers, local authority officers, and even the military in the presence of police [20], during Malaysia's Movement Control Order (MCO) to restrict public movement to control the spread of COVID-19. The different interpretations of the MCO's Standard Operating Protocols (SOPs) resulted in the issuance of unwarranted fines, according to Bukit Aman's (Royal Malaysian Police headquarters) head of internal security and public order, Abd Rahim Jaafar, in an interview reported on 7 February 2021 [21]. Perhaps the creation of subsidiary legislation was an urgent necessity during the COVID-19 global public health emergency, but it would be advisable to consolidate said subsidiary laws into unified and established primary law now that the pandemic has receded, especially in anticipation of any future pandemic. This not only reduces the complexity of already-complicated legal jargon that must be understood by medical professionals and other stakeholders, but would also likely reduce any redundancy in public health laws that may cause confusion among the public and enforcement agencies.

The above is in contrast to, for example, the Disease Prevention and Control Law 1955 of Pennsylvania and its regulations, which cover the range of penalties and legal repercussions for offences. However, although the Disease Prevention and Control Law covers criminal prosecution, it, too, has weaknesses in that it does not define who may request an inspection or issue an investigative warrant, as relevant rules are listed generally in the Pennsylvania Rules of Criminal Procedure in Title 234 of the Pennsylvania Code [22].

A possible improvement is a restructuring of Malaysia's Prevention and Control of Infectious Diseases Act 1988 to combine the various legal actions and offences related to the issue of communicable diseases and to simplify the codification for better understanding by local enforcement officers and authorities. It is noted that enforcement authorities empowered by the Act are not limited to trained Ministry of Health personnel,

but include also police and local authorities appointed by the Director General of Health. Hence, a clearer, more comprehensive Act would ensure greater legal efficacy and successful enforcement in the face of resistance from offenders [23]. Public health law should be straightforward, without the need to complete multiple detailed steps in order to enforce and invoke it, particularly in crucial matters that require swift action. It should not be procedurally and administratively complex.

*Law on Infectious Disease Prevention and Control With Regard to Dissemination of Information:*

There are extensive provisions on the right of the (federal) government, through the Ministry of Health Malaysia, to collect information from the public in accordance with the Prevention and Control of Infectious Diseases Act. As stated in Section 22, (c) a person who refuses to furnish any information required for the purposes of this Act or any regulations made under this Act; and (d) a person who upon being required to furnish any information under this Act or any regulations made under this Act, gives false information, commits an offence; and also Section 31(2)(o) the collection and transmission of epidemiological and health information and the compulsory reporting of infectious diseases. However, there are no provisions in the Act for the government to supply information on outbreaks to the public.

In contrast, regarding the Disease Prevention and Control Law 1955 of Pennsylvania, although the Department of Health, acting within the law, received withering criticism for having excessively wide discretionary powers to decide on the dissemination of infectious diseases information to the public, the law does specifically state that health authorities may disclose reports of diseases “where necessary to carry out the purposes of this act.” [24] However, this particular phrasing leaves much room for interpretation, creating challenges for enforcement bodies, including by the public, as to what circumstances could be deemed “necessary”. When the law lacks clear criteria for determining necessity, situations may result that are possibly ultra vires. The Department of Health itself has sought to allay concerns by releasing a statement indicating its willingness and efforts towards releasing as many records as it can, all the while still

prioritising the protection of individuals’ privacy under the law: “We believe strongly that the public does have the right to know how these decisions are made. But we also need individuals to trust the department, that we will uphold the principles of the Disease Prevention and Control Law and keep their information confidential.” [25]

In Malaysia, the key principle of dissemination of information involving patients is guided by doctors’ legal and ethical duty to maintain patient confidentiality. The Ministry of Health Malaysia held onto that principle when disseminating information on the COVID-19 outbreak through various avenues, inter alia, daily press conferences on key data by the Director General of Health himself together with his team; supply of epidemiological information through GitHub and the Ministry’s own COVIDNOW website; and responsive data on outbreaks and vaccination activities through public hotlines. Hence, despite the lack of such provision on the dissemination of outbreak information in the Prevention and Control of Infectious Diseases Act 1988 of Malaysia, the Ministry of Health Malaysia has done reasonably well in disseminating information on COVID-19 to guide public response and action [26].

A possible improvement is the inclusion in the Prevention and Control of Infectious Diseases Act 1988 of provisions on the dissemination of information on infectious diseases. No doubt unchecked and unrestricted dissemination of such information is likely to cause unnecessary public panic with the unintended consequence of harming public health measures. However, the example from Pennsylvania also uncovers harmful public perception associated with a perceived lack of transparency in public health announcements, especially on the spread and severity of infectious diseases. Hence, a balance between transparency and public calm must be achieved in announcing information about infectious diseases. Indeed, public health law provisions on the dissemination of infectious diseases information should not grant blanket permission to agencies to release information on a given public health threat, or even compiled statistics on said threat, but rather provide for decision-making authority among public health professionals in coordination with key stakeholders to release relevant public health information. This is

primarily to enable the public to be better informed of infectious diseases and, in turn, foster greater understanding and compliance with the law and public health tenets.

*Law on Health Service With Regard to Registration of Medical Practitioners:*

For medical practice, the procedures employed by Malaysia and the United States are largely similar, but the philosophical approach to practitioner registration diverges. In the US, the ability to practice medicine after registration is a privilege granted by the state, while in Malaysia, the ability to practice medicine after it has been granted by registration is a right and privilege [27]. Unlike Malaysia, which has a centralised or national oversight of medical practice carried out by the Malaysian Medical Council (MMC) as allowed for in the Medical Act 1971 (Act 50), the US uses a state-based system for medical regulation [28]. The 10th Amendment of the US Constitution authorises the states to establish laws and regulations protecting the health, safety and general welfare of their citizens. Rather than being seen as an inherent right of an individual, the ability to practice of medicine in the US is considered a privilege granted by the government of a state acting through their elected representatives [29], whereas in Malaysia, the Malaysian Medical Council itself describes the intention of registration as follows: “Through registration, the Council ensures that a medical practitioner has the knowledge, skill and competence levels to provide safe and effective treatment to the Malaysian public.”[30] This implies that a medical practitioner with the recognised “knowledge, skill and competence levels to provide safe and effective treatment” (Malaysian Medical Council, 2017) is bestowed the right and privilege to practice. This is affirmed by section 29A of the Medical Act 1971 (Amended 2012), subsection [10], which states, “...the person’s rights and privileges as a registered medical practitioner...” [31]

The use of “...the person’s rights and privileges as a registered medical practitioner...”, as stated in Malaysia’s Medical Act, requires defining. A right is defined as an entitlement, in contrast to a privilege or a licence. In terms of human rights, in the Malaysian Federal Constitution for example, all

Malaysians are entitled to liberty of the person; equality; freedom of movement; freedom of speech, assembly and association; freedom of religion; and other rights. Privileges, on the other hand, are not rights; they can be revoked because they are conditional. Once the intended results have been achieved, privileges can be taken away but rights cannot [32]. Hence, “the person’s rights and privileges as a registered medical practitioner” implies that a person has earned the right to practise medicine after meeting the criteria set out by the Malaysian Medical Council, and this right is inalienable. On the other hand, the meaning of privilege as a medical practitioner in the Medical Act most likely refers to the privileged status of being recognised as a competent professional, and can be revoked. Although practitioners are said (by letter of the law) to have earned the right to practise upon meeting the specified criteria, in truth, the strict regulatory framework imposed by the Malaysian Medical Council suggests that this right is not absolute. This is because the Malaysian Medical Council does not confer the right to every medical graduate, or even those who have completed their housemanship training [33]. Rather, it is subject to approval by the Malaysian Medical Council, at its discretion as a regulatory body. Hence, this conferment is not a right at all, as is legally defined, but actually a privilege in the correct legal sense.

Hence, a possible improvement is a change in legal provision to consider the ability to practice medicine in Malaysia as a privilege granted by the government, rather than a right and privilege (as worded in the Medical Act) once the practitioner is found to be competent. Although the concept of registration with the Malaysian Medical Council has similarities to licensing with US state medical boards, a firm philosophy conferring privilege and licence would foster greater respect for medical practice regulation among practitioners.

*Law on Health Service With Regard to Regulation of Medical Practice:*

In all 50 US states and the District of Columbia, and in all the United States territories, laws and regulations have been enacted that govern the practice of medicine and outline the responsibility of state medical boards to regulate such practice within their borders. The state statute is usually called a

Medical Practice Act. State medical boards adopt policies and guidelines related to the practice of medicine, designed to improve the overall quality of health care in the state. Overall, state medical boards regulate the activities of licensed physicians in the United States [28].

State medical boards have three main functions: licensing, discipline, and regulation, and are often identified with their function of licensing medical practitioners before the practitioners are allowed to practice in areas under the boards' jurisdictions. These boards investigate complaints against licensees, in addition to conducting licensee evaluations and facilitating rehabilitation of licensees when appropriate [27]. In the course of the practitioners' practice, conduct that occasions disciplinary proceedings entails extensive investigations and discussions by the state medical board that are necessarily time- and resource-intensive to determine all the facts for every case [29]. In Malaysia, this function of disciplinary action on medical practitioners is carried out by the Malaysian Medical Council. Pursuant to Section 29(1) Medical Act 1971, the Council has disciplinary jurisdiction over registered medical practitioners. However, in-depth investigation of complaints to obtain findings for use during proceedings is usually carried out by the Ministry of Health Malaysia's Medical Practice Division. As an example, the Medico Legal Section manages medico legal cases by coordinating the investigation of any medico legal complaint [34]. In this sense, the resources for managing complaints (relevant to the Ministry of Health) are shared by the Ministry of Health Malaysia and the Malaysian Medical Council. In the US, the state medical boards also share staff — such as investigators and attorneys — with other state regulatory agencies; however, in the aspect of funding, they are supported through licensing fees and/or state budget appropriations provided independently. This ensures that the boards are financially independent in the interest of unbiased licensing and judgment on complaints. In Malaysia, the Malaysian Medical Council is working towards complete financial independence for the same reason [35].

To ensure unbiased disciplinary proceedings, as well as the perception thereof, against errant medical practitioners, the Malaysian Medical Council should

be financially independent, whereby even if government budget appropriations are provided, there is a higher degree of independence in the use of such funds by the Council [36]. However, such financial independence may have positive as well as negative consequences. As a positive, greater funding independence strengthens the Malaysian Medical Council's hand and provides greater decision-making autonomy without undue influence from external stakeholders. On the other hand, full self-funding may render the Council less accountable in the eyes of the public, especially if its accounts are not mandatorily subject to scrutiny. These issues can be addressed in a legally binding framework that supports good governance and ensures reporting transparency by the Council, both in its core duties of registration and discipline and in its financial dealings.

#### IV. CONCLUSION

From this comparison of public health law between Malaya (Malaysia after 1963) and the United States of America, several conclusions arise. First, there are commonalities in the history of public health law in both countries, owing to their history of colonial rule by the British Empire, notwithstanding American independence predating the first colony of Penang (known by the British as Prince of Wales Island) in Malaya. The USA's approach to the independence of state law from federal jurisdiction, with the federal government supporting state legislative authority, has meant that infectious disease prevention and control laws were formulated by individual states. Initially, this was similar in Malaya, as each state was taken over by British rule at different points in time. When the country became a federation, however, public health law was centralised under the federal government. The United States is a developed nation compared with Malaysia, an upper-middle income country. However, common elements in their public health law heritage uniquely allow both countries to learn from one another in managing public health law issues.

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