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Editorial

Lessons from COVID-19: Building Resilient Health Systems[*]

1. 'The COVID-19 pandemic is a tragedy' as recently reminded in the sharp opening of a recent OECD report titled 'Ready for the next pandemic? Investing in Health System Resilience'[1].

As the report highlights, the impact on human health has certainly been serious and not limited to the 772,138,818 confirmed cases, including 6,985,964 deaths, reported to WHO as of November 26, 2023, which also reports a total of 13,595,721,080 vaccine doses administered[2]. Indeed, the excess mortality analysis suggests that as many as 18 million people worldwide may have died from the pandemic by the end of 2021[3]. The health impact was also triggered by the slowdown or discontinuation of prevention and treatment of diseases other than COVID-19 and is a persistent impact in the years following the closure of the pandemic[4].

The health crisis has resulted in the crisis of health care systems around the world, which, partly due to widespread funding cuts, were largely unprepared to cope with the pandemic outbreak, in terms of lack of contingency plans, in particular equipment, personnel and facilities, availability of places in resuscitation rooms, protective equipment, and organization of community medicine[5]. Health workers have thus been exposed to serious risks and tragic choices with the consequent triggering of major litigation aimed at identifying responsibility and repairing damages that states are facing[6].

The inability of health systems (unprepared, understaffed and suffering from underinvestment) to manage the outbreak of the pandemic has exacerbated the impact of the crisis on the economic and social level, because of the COVID-19 response measures that governments have had to adopt to protect especially fragile populations. As comparatively explored in the first volume of this journal, a variety of measures have been adopted, including lockdowns, distractions and restrictions on economic and social activities, education systems and individual freedoms, often with implications for human rights[7], the rule of law and democracy[8].

This has highlighted the existing structural limitations, both at institutional and organisational levels, and the need to strengthen the sustainability and resilience of health systems,

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[*] Elisa Scotti and Matteo Gnes.

[1] OECD, *Ready for the next pandemic? Investing in Health System Resilience* (2023) <https://www.oecd-ilibrary.org/sites/1e53cf80-en/index.html?itemId=/content/publication/1e53cf80-en> accessed 15 November 2023.

[2] WHO Coronavirus (COVID-19) Dashboard <https://covid19.who.int/?mapFilter=deaths> accessed 15 November 2023.

[3] OECD (2022[3]), OECD Health Statistics, <https://doi.org/10.1787/health-data-en> accessed 15 November 2023; H Wang and others, 'Estimating excess mortality due to the COVID-19 pandemic: a systematic analysis of COVID-19-related mortality, 2020–21' (2022) The Lancet, vol 399/10334, 1513-1536 <https://doi.org/10.1016/s0140-6736(21)02796-3> accessed 15 November 2023. It estimates excess mortality from the COVID-19 pandemic in 191 countries and territories, and 252 subnational units for selected countries, from Jan 1, 2020, to Dec 31, 2021.

[4] OECD, *Ready for the next pandemic? Investing in Health System Resilience* (2023); C Arsenault and others, 'COVID-19 and resilience of healthcare systems in ten countries' (2022) Nat Med 28, 1314-1324.

[5] European Parliament, *Special Committee on the COVID-19 pandemic: lessons learned and recommendations for the future* (A9-0217/2023 Rapporteur: Dolors Montserrat, (2023) <https://www.europarl.europa.eu/doceo/document/A-9-2023-0217_EN.pdf> accessed 15 November 2023.

[6] See <https://www.covid19litigation.org/> accessed 15 November 2023.

[7] MA Tigre and others, 'Environmental Protection and Human Rights in the Pandemic' (2021) 1(1) LPPJ; European Parliament resolution of 12 July 2023 on the COVID-19 pandemic: lessons learned and recommendations for the future (2022/2076(INI)) <TA MEF (europa.eu)> accessed 15 November 2023.

[8] See LPPJ, Vol 1, Section I, II, III.

in line with the Sustainable Development Goals, and in particular, Goal 3 on disease prevention and the effectiveness of health systems in ensuring universal and global health coverage, so that 'no one is left behind'[9].

The call for a resilience strategy based on a close interrelationship between environmental and human rights protection and respect for the rule of law is now widespread at the institutional level. WHO[10], OECD[11], World Bank[12], EU[13] just to mention a few entities, first and foremost emphasize the strategic approach essential to building a system that can withstand the threat of future health crises, one that does not repeat the mistakes of COVID-19 but rather draws lessons from the experience that perhaps cannot yet be said to be over.

There has thus been renewed attention to the causes of the pandemic and, in particular, on the link with the ecosystem crisis and, with the predation of biodiversity barriers that, according to one of the main hypotheses supported by the scientific community on the origin of the COVID-19 pandemic[14], facilitated the emergence of the virus as a zoonotic spill over introducing us into an era of continuous spillover and high pandemic risk[15].

The pandemic has thus refocused the attention of institutions on the importance of a holistic approach to the sustainability of socio-ecological systems and the centrality of the One Health strategy, based on the recognition of the interrelationship between human, animal and environmental health, as the most effective and cost-effective way to prevent pandemics of zoonotic origin, to be implemented through public policies, legislation and research, with multi-sectoral involvement and coordination between policies and authorities responsible for the protection of the environment, human and animal health being essential, first and foremost, for prevention[16].

One Health is thus now placed at the heart of the review of pandemic treaties as a fundamental strategy of effective pandemic prevention, preparedness, and response[17].

This goal requires, even within the current framework, strengthening transparency and cooperation and governance at the global scale, that enabling the effective participation of civil society and scientists, with timely sharing of information, data and other elements at all levels, including universal and equitable access to tests, medicines and vaccines in low and middle-income countries[18].

2. 'Ready for the next crisis?' is the provocative challenge posed by the above-mentioned OECD report, which, like many others, suggests 'investing in the resilience of health systems' to prevent the next pandemic from catching us unprepared. With the worsening of the ecological crisis, the risk to which populations are exposed is now evident, and this calls for strengthening health system resilience as an adaptation strategy to the ecological crisis, alongside the broad prevention strategy based primarily on environmental protection.

Finding a reasonable balance between cost containment and quality goals, implementing responsive health services and efficient health care organizations, is the main challenge of all

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[9] See, on SDG no 3 'Protecting Human Health' and related global health policy directions, WHO, *World health statistics 2023: monitoring health for the SDGs, sustainable development goals* <https://www.who.int/publications/i/item/9789240074323> accessed 15 November 2023.

[10] WHO, 'Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond: position paper' (2021) <WHO-UHL-PHC-SP-2021.01-eng.pdf> accessed 15 November 2023.

[11] OECD, *Ready for the next pandemic? Investing in Health System Resilience* (2023).

[12] World Bank, 'Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19', (2022) <http://hdl.handle.net/10986/38233> accessed 15 November 2023.

[13] European Parliament resolution of 12 July 2023 on the COVID-19 pandemic: lessons learned and recommendations for the future (2022/2076(INI)).

[14] JD Sachs and others, 'The Lancet Commission on lessons for the future from the COVID19 pandemic' (2022) The Lancet 400, 12.

[15] NA Robinson, 'Integrating the SDGs through One Health?' in N Kakar, V Popovski and NA Robinson (eds), *Fulfilling the Sustainable Development Goals: On a Quest for a Sustainable World* (Routledge 2021).

[16] See Food and Agriculture Organization (FAO), United Nations Environment Programme (UNEP), World Health Organization (WHO), World Organisation for Animal Health (WOAH), One Health Joint Plan of Action 2022-2026 <https://www.unep.org/resources/publication/one-health-joint-plan-action-2022-2026> accessed 15 November 2023.

[17] M Prieur, MA Mekouar, 'Towards a Global Convention on Pandemics'(2022) LPPJ 2(1).

[18] OECD, *Ready for the next pandemic? Investing in Health System Resilience*.

health systems. However, economic and financial sustainability, linked to austerity measures, are not sufficient conditions to ensure the sustainability of health systems. This must now go hand in hand with the environmental and social dimensions of sustainability and with technological innovation, which is increasingly perceived as an enabling factor[19].

The problem is common to public and private health care systems, given their high costs and the need to ensure access to care as widely as possible, especially in emergency situations.

Along with organizational and resource use efficiency to contain health system costs, there is a need to ensure increasingly broad access to care that is correlated with fundamental human rights and sustainability goals[20].

3. This issue focuses on the multiple aspects of sustainability and resilience of health services.

Cristina Fraenkel-Haeberle analyzes the impact of COVID-19 on German health care reforms aimed at more effective use of resources and reduced hospital spending.

Uday Shankar and Shubham Pandey highlight the constitutional recognition of public health care in India through fundamental rights and guiding principles of state policy. The right to health care has been read as an integral part of the right to life and the responsibility of the legislature and the executive to consider the issue of public health when drafting laws. The judiciary has played a crucial role in elevating public health to a fundamental right, interpreting by including the right to health in the right to life and liberty, which is expressly protected in Article 21 of the Indian Constitution.

4. A group of essays by an interdisciplinary group of scholars from the University of Urbino Carlo Bo coordinated by Matteo Gnes is dedicated to the Italian experience, which represented one of the countries most affected in the first eruption of the pandemic immediately giving rise to a debate on the causes of the high number of victims of the epidemic, among the highest in the world. Among the reasons most often cited are, on the one hand, the high average age of the Italian population, in relation to a virus that affects with worse consequences especially older people; on the other hand, the failure to update a pandemic plan, dating back to 2006. These elements, which are not sufficient to fully explain the unpreparedness for the pandemic and the need to respond to it with extraordinary tools, with very strong restrictions on people's freedoms, have been accompanied by previous problems, which can be summarized in the growing inattention to prevention in the living places, to primary and territorial care, to general medicine, to services with high social integration, to hygiene and occupational medicine, which has been confronted by the trend toward concentration in a few hospital poles of health protection.

The response to the pandemic has indeed highlighted the importance of a solid territorial social-health structure: to prevent the spread of the virus in the hospital setting, general practitioners (GPs), although unprepared and ill-equipped to deal with the epidemic, have been asked to intervene by phone or home visit as a first filter to manage suspected cases; and Special Continuity of Care Units (USCAs) have been established with the specific task of visiting and testing people with symptoms attributable to the infection.

Widespread residential models in Italy for the management of frail and elderly individuals (nursing homes), proved inadequate in the face of the health risk, causing a very high number of deaths among residents and prompting reflection on alternative forms of residential and home care, elaborating performance models, both public and private, capable of ensuring the greatest possible well-being and social inclusion of medically frail people.

The pandemic has then renewed the debate on the social-health system and the different forms of care that has focused, over the past two decades, on the public-private and state-region contraposition in a multilevel system that has generated unresolved problems, territorial inequalities and contributed to the collapse of the system in the emergency phase with prejudice to citizens' fundamental rights to health and life.

The first essay ('Duties in the Postpandemic Era', by Antonio Cantaro) explores the changing conception of rights in the aftermath of the pandemic, which, according to widespread opinion, has profoundly affected the relationship between authority and freedom.

[19] European Parliament resolution of 12 July 2023 on the COVID-19 pandemic: lessons learned and recommendations for the future.

[20] OECD, *Ready for the next pandemic? Investing in Health System Resilience*; "World Bank, *Change Cannot Wait: Building Resilient Health Systems in the Shadow of COVID-19*.

The author offers interesting food for thought, focusing on the increasing attention on duties, almost forgetting about rights. In order to guarantee the health of citizens, an objective ordering of the health and safety of the consociates is established, but whose rights are rewritten and limited.

In the second essay ('Pandemic Emergency and Resilience of the Italian Health Care System', by Matteo Gnes) a quick stocktaking of the pandemic experience is attempted, in order to identify lessons to ensure that we are no longer unprepared for a future new pandemic. First, the management of the pandemic is examined, from both regulatory, organizational and health perspectives. Then, the lessons that can be learned from this, and which pertain to all the profiles examined, are examined.

The third essay ('Italian Reform of Primary Health Care in a multi-level Governance. The National Recovery and Resilience Plan becomes the last opportunity to promote a much-needed new organizational model', by Nicola Giannelli and Andrea Lippi) traces the evolution of the National Health System to the point of noting that, with the National Plan for Recovery and Resilience – PNRR, the necessary resources were allocated for shelter facilities. In particular, with Ministerial Decree (of the Ministry of Health) no 77 of June 23, 2022, models and standards were defined for the development of territorial care in the National Health Service, also based on the experiences of the regions that have tried to build containers in which general practitioners are called upon to work in sharing with medical and especially public nursing staff. To incentivize the development of such a model, the NRP has focused economic incentives on new 'community houses' and 'community hospitals'.

The fourth essay ('The COVID-19, the PNRR and Good Administration in the Health and Social-Health Sector: the Health Budget as a Tool for Taking care of the Whole Person', by Luca Di Giovanni) evaluates the consequences of the COVID-19 experience on territorial welfare systems, which have shown the need to provide adequate health and social-health services especially for patients with chronic diseases. To this end, it was necessary to overcome the rigidities of the current system, using an organizational model focused on the use of the 'health budget', aimed at promoting integrated and coordinated management of interventions for patients.

The fifth essay ('Residential Care Facilities under the Test of the Pandemic Emergency. Values at Stake, Problematic Profiles, Insights for the Future', by Chiara Gabrielli and Federico Losurdo) deals with assisted-living residences, where the restrictions on freedom of movement established to cope with the spread of the virus have been particularly intense and heavy also from a psychological point of view, due to the deprivation or strong limitation of interpersonal and affective relationships of the guests of these facilities. The legitimacy of such restrictions has been examined both in relation to constitutional principles, which would not appear to be violated since they do not involve the restriction of personal freedom, and to supranational norms.

The experience of the restrictions imposed during the pandemic also stimulates reflection on the practical aspects of territorial health care.

The sixth essay ('The structural weaknesses of residential care homes for the elderly at the time of the COVID-19 pandemic: a contextual analysis', by Desirée Teobaldelli) examines, through the use of statistical data, the consequences of the pandemic on residential care for the elderly (on which there are marked territorial differences). After describing its operation during the pandemic, the paper makes proposals for related future policy directions.

The seventh essay ('Support administration and health treatment: The COVID-19 vaccination as a test case for legislation', by Roberta S. Bonini) evaluates a different profile of the protection (from a civil law perspective) of the elderly, through the institution of supportive administration (introduced by Law no 6 of January 9, 2004). This institution, during the pandemic, raised several problems, including in relation to the inherent choice of administering the vaccine to the beneficiary of the support administration.

The eighth contribution ('Solidarity Cohabitation and Senior Cohousing', by Paolo Morozzo della Rocca) concerns cohabitations based on a bond of friendship or solidarity. This is a little-studied phenomenon, but one that, especially with reference to senior cohabitation, may represent an interesting and growing model, regulated by the legislature essentially with reference to cohousing and territorial social and socio-health care.

The last essay ('Technological Development and Legislative Choices: Brief Reflections on the Relationship between Science and the State in the Health Emergency from COVID-19', by Allegra Dominici) concerns the relationship between science and the legislature's discretion, examining how, on the basis of a law,

public administration decisions can be based on scientific-technical evidence. To this end, two particular cases are examined: compulsory health treatment (TSO) and mandatory vaccination against COVID-19.

5. Emanuele Guarna Assanti's paper closes the volume, bringing us back to the centrality of environmental policies. He examines an empirical case of 'glocal' interaction, highlighting the rationale behind the rules of green budgeting and providing some experiences from the municipalities of Venice and Växjö and the French state, showing the centrality of the local public sector to the implementation of green operational tools functional to the pursuit of environmental objectives. Local and national communities have thus helped introduce best practices in the field, stimulating international principles and rules.

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SECTION I
ESSAYS

New Challenges for Germany's Healthcare System in the Wake of COVID-19

Cristina Fraenkel-Haeberle[*]

Abstract. This contribution investigates the impact of COVID-19 on long overdue reforms of German healthcare. The pandemic revealed some major shortcomings in patient care and elicited calls for new legislative solutions, more effective use of resources and a reduction of hospital expenditure. The proposals discussed here clash with the "stability" which is a major feature of the German legal system.

***Keywords**: COVID-19 pandemic, federalism, digitization, hospitalization.*

Introduction

The economic weight of healthcare in Germany is enormous, standing at 654.4 billion euros in 2020, with one in ten workers (4.6 million people) employed in the health sector[1]. Faced with this huge apparatus, Germans are often inclined to grumble about their healthcare system, although it offers a wide range of easily accessible treatments and emergency medicine of high quality.

The COVID-19 pandemic stressed the German healthcare system, highlighting its inefficiencies and shortcomings. Against this backdrop and the proverbial Teutonic 'culture of stability,' it is no small challenge to introduce effective, cost-cutting solutions.

Considering the particular features of the German healthcare system and the challenges directly related to COVID-19, this contribution underlines the urgency of radical reforms. It shows that improvements will have to cope with the federal structure of German healthcare, the persisting low specialization of hospitals, the need to promote a coordinated and integrated response to healthcare and social care problems, and the inertia of the German people to digitization[2].

1. Origins and general features of the German healthcare system

The main feature of the German healthcare system is its long tradition and stability. It dates back to 1883, when pre-existing private insurance was placed under state control. Under Chancellor Otto von Bismarck, a law on healthcare, containing the following principles, was passed:

- compulsory insurance for all workers
- health insurance companies organized as self-governing bodies
- incorporation of the various pre-existing private funds into the public health system
- mandatory contribution to the funds by employers and the employees
- establishment of the principle of benefits in kind (*Sachleistungsprinzip*)[3].

The Bismarckian system, based on social insurance supplied by a multitude of insurance organisations (*Krankenkassen*), and organizationally independent healthcare providers, has so far proved its worth and remains the main feature of the German healthcare system.

In more recent times, the insurance law of 1955, gave associations of affiliated doctors the status of public law bodies. Another important

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[1] Sören Deister and Hauke Jagau, 'Den Vorhang zu und alle Fragen offen – zum neuen Niedersächsischen Krankenhausgesetz' (2023) 2 NdsVBl. 34.

[2] According to the Euro Health Consumer Index of 2018, published in Sweden, on the basis of a comparative analysis Germany is no. 12 in the European ranking (Italy is no. 20 of 35 states). At the top of the ranking are Switzerland, the Netherlands (which have recently implemented a huge health reform) and Norway; <Euro Health Consumer Index 2017 (healthpowerhouse.com)> at p. 26, accessed 5 November 2023.

reform introduced in 2009 was a 'health fund' (*Gesundheitsfonds*) for financing health insurance[4]. The fees of affiliated doctors were also reformed. The health fund is a special public fund. Besides contributions from employees and employers, it also receives federal financial resources (*Bundeszuschuss*) and is intended to be a liquidity reserve to cope with cyclic fluctuations in income. The contributions are not a tax, because they are not paid to the Treasury, but to the special fund itself[5].

Unlike US healthcare, the German system is universal. According to BOOK 5 SC (Social Code – *Sozialgesetzbuch*), healthcare is provided in kind and is generally free of charge. All workers contribute to the health insurance system in proportion to their wages (15.5%)[6]. As a rule, health services are financed by public and private health insurance companies, or by government itself for its civil servants. People who cannot afford to pay insurance are supported by social security under the solidarity principle.

The system is therefore corporative and is not financed by income tax (Beveridge model), unlike the Italian and British systems[7]. Instead, it is provided by public and private insurance funds and covers the whole population, irrespective of individual risk; 90% of the benefits are provided by public insurance funds[8].

2. The huge challenge of the pandemic

Germany has a population of almost 84 million. It is by far the most populous country in the European Union. To date (October 2023) COVID-19 has caused the death of about 176,000 persons, a very large number, though less for example than the numbers of Italy (population about 60 million and 192,000 deaths from COVID-19) and France (67 million persons and 167,000 deaths)[9].

Nevertheless, a huge problem in tackling the pandemic has been Germany's federal structure, which divides the country into 16 states, called to take a front-line role in managing the emergency. The COVID-19 restrictions have not been very popular. Since COVID-19 did not strike the whole country with the same virulence[10], the prime Ministers of the federated states (*Länder*) called for exceptions and less restrictive rules, resulting in a patchwork of measures. Contradictory regulations between different states caused confusion, allowing the virus to spread across the country[11].

The most dramatic period was the beginning of 2021 when infections were high and vaccination very slow. Restrictions were tightened until summer in the hope of preventing hospital collapse. At this time, the number of infections and the death toll increased dramatically, especially in the states of eastern Germany (Saxony, Saxony-Anhalt and Thüringen)[12]. Just before Christmas 2020 and 2021 (in spite of the availability of vaccines), restrictive lockdowns had to be imposed, forcing residents to stay at home and to refrain from close contact with family members and friends, as the virus had pushed the healthcare system to its limits[13].

At the end of 2021, this development was widely due to the change in government after the political elections of September. Negotiations for the formation of the new government overshadowed containment of the pandemic. As soon as the new government took office, it had to take emergency measures to reduce the spread of infection. At this time, the selection and

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[3] Constanze Janda, *Medizinrecht* (4th edn., utb. 2022) 33.

[4] See BOOK 5 SC (Social Code – *Sozialgesetzbuch*), § 271.

[5] <Gesundheitsfonds (bundesgesundheitsministerium.de)> accessed 5 November 2023.

[6] Hans-Joachim Reinhard, 'Challenges for Germany's social security system' in Stamatia Devetzi and Angelos Stergiou (eds), *Social security in times of corona a legal comparison of selected European countries* (Sakkoulas Publicatioons 2021).

[7] Helge Sodan, Handbuch des Krankenversicherungsrechts (3th edn., Beck 2018), § 3, marginal numbers 12-14.

[8] Katharina Dinter, 'Die Bürgerversicherung unter dem Blickwinkel des Verfassungsrechts' (2021) 5 SRa 234.

[9] Cf. <https://de.statista.com/statistik/daten/studie/1100818/umfrage/todesfaelle-aufgrund-des-coronavirus-2019-ncov-nach-laendern/> accessed 5 November 2023.

[10] Reinhard (fn. 6) 8.

[11] Reinhard (fn. 6) 8. See more extensively also Cristina Fraenkel-Haeberle and Elena Buoso, 'COVID-19 and Government Response in Germany. Building Resilience by Comparison of Experiences', 1 GPN 2021, 103 et seq; Herrmann Josef Blanke and Aimee Sander, 'Bewährungsprobe des deutschen Föderalismus in der Pandemie – Zugleich ein Vergleich mit anderen föderalen und präföderalen Staaten', 1 ZG 2023, 15 et seq.

[12] On the challenges connected to federal coordination see *ex multis* Thorsten Kingreen, 'Der demokratische Rechtsstaat in der Corona-Pandemie' (2021) 38 NJW 2766 et seq.

[13] Reinhard (fn. 6) 8.

transfer of patients to other health-centres (or even abroad, also to Italy) has proved necessary at some hospitals, as the intensive care units had been reaching saturation. As mandatory vaccination could not be introduced in Germany, workplace testing was intensified, but it became compulsory for unvaccinated workers only in early December 2021. Germany was very generous, supplying almost unlimited free antigen tests[14].

The German healthcare system was hit particularly hard by the pandemic[15]. Hospitals were able to treat significantly fewer patients because they were repeatedly urged to provide beds for COVID-19 patients by political authorities. Despite additional transfer payments from the federal government, insiders argued that these sums were insufficient to cover all costs of the particularly labour-intensive treatments required by COVID-19 patients[16].

3. The hurdle of widespread vaccination

Germany is the homeland of Biontech-Pfizer, which has its European central office less than 50 kilometres from Frankfurt. This suggests that vaccinations were favored in Germany. The federal vaccination plan was in place by November 2020, and vaccinations began at the end of December 2020, starting with a few tens of thousands of shots and reaching a peak of over 1.6 million shots a day in December 2021[17].

In spite of this large capacity and although the most effective vaccine at that time was mainly developed in Germany, the vaccination rate was not as high as expected. Almost one quarter of the German population is still not vaccinated and only about 60% has received more than one shot[18].

One important reason for this low vaccination rate was failure of the National Parliament to impose mandatory vaccination, not extending this obligation even to the most vulnerable, such as people over 60 years of age.

Only the staff of healthcare or care institutions and organisations was required to provide proof of full vaccination (*Impfnachweis*) against COVID-19 by 15 March 2022 or of recovery from the illness. Persons with a medical certificate of contraindication for vaccination were exempt. If adequate proof was not provided, the management of the institution had to inform the local public health authority (*Gesundheitsamt*)[19]. Pursuant to § 20a (5) third sentence of IfSG (Federal Infection Protection Act), introduced at the end of 2021, the public health authority could issue an order banning the persons concerned from entering the institution or from working there[20]. Non-compliance with a number of rules contained in § 20a IfSG was subject to a fine up to € 2,500[21].

A constitutional complaint against this provision was rejected in April 2022 by the Federal Constitutional Court[22], which stated that the provisions did not violate the complainants' rights under Art. 2(2) of the German Constitution (Basic Law – BL) on the protection of individuals against state measures that result in impairment of physical integrity and the corresponding right to self-determination or Art. 12(1) on professional freedom.

The Court admitted that the provisions interfere with these fundamental rights, but stated that the interference was justified under constitutional law. The legislature remained within its jurisdiction, striking an appropriate balance between the protection of the life and health of vulnerable groups due to COVID-19 infection on one hand, and impairment of fundamental rights on the other. Despite the high intensity of the interference, the fundamental rights of the complainants, who work in the healthcare sector, ultimately had to retrocede, considering also that in the eyes of the Court serious side effects of the vaccination were very rare.

As in other countries, extensive control of 'vaccination proofs' took place and verification proved complex and time-consuming. Some of these non-compliant employees have been fined; almost none had to leave their job. The

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[14] Sönke Oltmanns and Philipp Harländer, 'Pandemiebekämpfung am Arbeitsplatz: 3G und die neue (alte) Homeoffice-Pflicht' (2021) DB 2021, 3093.

[15] See <Coronavirus – Auslastung von Intensivbetten seit Pandemiebeginn | Statista> accessed 5 November 2023.

[16] Rainer Stadler, 'Warum vielen Kliniken in Deutschland die Insolvenz droht', *Süddeutsche Zeitung – SZ online* (Munich, 22 December 2022).

[17] <COVID-19 Impfdashboard> accessed 5 November 2023.

[18] Ibidem.

[19] For more detailed information see <Die einrichtungsbezogene Impfpflicht in medizinischen und pflegerischen Einrichtungen (bundesgesundheitsministerium.de)> accessed 5 November 2023.

[20] *Infektionsschutzgesetz* (IfSG) of 20 July 2000, BGBl. I, 1945.

[21] § 73 (1a) nos. 7e to 7h IfSG. See <Einrichtungsbezogene Impfpflicht: Hohes Bußgeld bei Verstoß (bussgeldkatalog.org)> accessed 5 November 2023.

[22] Order of 25 April 2022, 1 BvR 2649/21.

impression was that government was looking for alternative solutions and playing for time, considering that mandatory vaccination would cease at the end of 2022. Since most institutions could not cope with any loss of precious human resources, the workers were fined but not dismissed[23].

4. The major current challenges

COVID-19 stressed the social and regional divide in Germany: the infection rate and victims were higher in disadvantaged areas (old industrial regions, rural areas) and city areas with a migration background. In rural regions, the deficits are also related to a lack of qualified caregivers (so called '*Pflegeflucht*') and doctors, which particularly threatens vulnerable groups like the elderly[24]. On the other hand, COVID-19 has accelerated the digitalisation of healthcare. Digital tools, like video consultation of doctors and electronic patient records, were progressively introduced.

4.1. Electronic patient records (Electronische Patientenakte – ePa)

Electronic patient records were introduced step by step. Since January 2021, the health insurance companies have been required by law (Patient Data Protection Act)[25] to make an electronic health record available free of charge to insured persons. Against this backdrop, health insurance companies must develop an app or a new health card function that allows patients to save their medical reports, prescriptions and vaccination certificates, one aim being to avoid unnecessary duplication of clinical tests[26]. At the same time, an experimental and introductory phase began with selected medical practices. With this reform the legislature aimed to promote greater 'sovereignty of patients' over their data (*Patientensouveränität*), as well as greater transparency in therapy and reporting[27].

In theory, since 2021 the electronic record should have been available to the 73 million patients insured in the public system and should have become a cornerstone of the digitization of healthcare. The digital revolution, however, has not lived up to expectations. Electronic patient records are used by less than 1% of the population due to the enormous importance attributed by German people to the protection of privacy. This led to introduction of a cumbersome procedure for updating and consulting electronic patient records, which has been a major setback for the expected 'triumphal march' of digital health[28].

This is quite amazing, considering that the protection of personal data is harmonized at EU level by the RGDP 679/2016, and comparative analysis shows various examples of good practice in this field throughout Europe. Austria has its electronic patient record (*elektronische Gesundheitsakte – ELGA*), as have Estonia (Health Information System – HIS) and Spain (*Historia Clinica – HC*)[29].

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[23] The vaccination rate of the employees concerned showed remarkable regional differences: in Schleswig Holstein in the north at the border with Denmark the percentage of affected workers was 3%, in the west (Rhineland-Palatinate) it was 10%, and in the east (Thüringen) it was 30%. These percentages reflect the regional differences in vaccination of the general population. See <Coronavirus: Impfpflicht für das Gesundheitspersonal in Deutschland und Frankreich – Trisan – Trinationales Kompetenzzentrum für Ihre Gesundheitsprojekte> accessed 5 November 2023.

[24] <https://www.aerzteblatt.de/nachrichten/122629/Pflegeberufe-Pflegebeauftragter-warnt-vor-Massenflucht> accessed 5 November 2023.

[25] Gesetz zum Schutz elektronischer Patientendaten in der Telematikinfrastruktur – Patientendatenschutzgesetz of 14 October 2020 (BGBl. I 2020, 2115).

[26] The digitization process showed a turning point in Germany in 2015 with the 'e-Health' law (*Gesetz für eine sichere digitale Kommunikation und Anwendungen im Gesundheitswesen* of 21 January 2015, BGBl. I 2015, 2408), which required upgrading of telematic infrastructure for the transmission of health data and provided incentives for the use of health apps. In 2019 a law regulated their use and above all their certification (*Gesetz für eine bessere Versorgung durch Digitalisierung und Innovation – Digitale-Versorgungs-Gesetz* of 9 December 2019, BGBl. I 2019, 2562). Since then, doctors have been able to hold consultations via video. The law was also supposed to introduce electronic medical records, but this only occurred a year later with the Patient Data Protection Act (*Patientendatenschutzgesetz*).

[27] Christopf Krönke, 'Die elektronische Patientenakte (ePA) im europäischen Datenschutzvergleich' (2021) 24 NZS 949.

[28] Johannes Eichenhofer, 'Die elektronische Patientenakte aus sozial-, datenschutz-, und verfassungsrechtlicher Sicht' (2021) 15 NVwZ 1090, 1091.

[29] Krönke (fn. 27) 950. In Austria, the ELGA system is a decentralized solution, where data is saved by the various service providers. The Estonian HIS works with a centralized database, in which all patient data is stored. It is an Estonian e-government service. The system also allows video consultations and remote diagnostics.

The main difference between these foreign systems and the German ePa is that ELGA, HIS and HC work on an opt-out system. This means that patients must expressly decline electronic data recording (and in most cases they do not), whereas in Germany, under the principle of patient sovereignty, people must consent to digital data recording[30]. As in the case of the ELGA, the law envisages differentiated access to clinical data by the various categories of legitimate subject (pharmacists, medical doctors etc.). Also in this case, the German system requires access authorization (granted for a limited period of time) by the patient concerned, who has a personal identification number (PIN). This creates a cumbersome authorization cascade. By contrast, in Estonia and Spain, all healthcare providers have access to all clinical data[31].

4.2. The crisis of the hospital system at the interface between federal and *Länder* competencesx

In recent times an attempt has also been made to overcome a further weakness of the German healthcare system, namely expensive hospitals with low specialisation, as well as lacking interdisciplinary cooperation and integration with social care. On March 2023, the government commission, convened by Health Minister Karl Lauterbach, proposed that all 1900 German hospitals should be divided into three levels of care and financed accordingly: small hospitals for basic care, specialized hospitals for specific treatments and university clinics. As expected, this rationalization met with massive criticism from various German *Länder* who argue that the federal government is encroaching on their sovereignty and that the classification of hospitals has to be defined jointly[32].

Pursuant to art. 70 BL and to constitutional jurisprudence, the *Länder* have exclusive competence in hospital planning and investments and therefore in hospitalization management, whereas the Federation has legislative competence in hospital financing and the setting of hospital fees[33]. To regulate the economic endowment of hospitals, the Federation issued a law on hospital financing (*Krankenhausgesetz- KHG*)[34] that obliges the *Länder* to plan the financial needs of their hospitals. This apparently simple system has actually led to dual responsibilities and dual financing, since investment expenditure is borne by the *Länder*, while current hospital expenditure (staff, material costs and maintenance) is financed by the proceeds of hospital business[35]. To qualify for funding, hospitals must be included in the hospital plan of their Land (they have to be so-called "*Plankrankenhäuser*"), a status which also entitles them to care for patients of public health insurance funds[36]. For their part, the *Länder* are required to draw up a hospital plan which contains a needs analysis (*Bedarfsanalyse*), a list of available hospitals (*Krankenhausanalyse*) and the distribution of tasks among the different healthcare structures (V*ersorgungsentscheidung*)[37].

4.2.1. Necessary reform of the case-based flat-rate system (*Fallpauschale*)

While hospital fees were traditionally calculated on the basis of days of hospitalization, almost ten years ago a case-based flat-rate system was introduced in German healthcare. This system became binding in 2004 as a basic form of invoicing management costs. Complete recording of diagnoses and procedures according to ICD-10 (International Classification of Diseases) therefore became necessary[38]. An important goal was to conduct qualitative measurement and comparison of hospital services. As a result, flat-rate remuneration triggered fierce competition in hospitals, aimed at making care more efficient, optimizing processes though extreme reduction of the length of hospital stay, often associated with the term 'bloody discharge' (*blutige Entlassung*)[39].

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[30] Mario Martini and Matthias Hohmann 'Der gläserne Patient: Dystopie oder Zukunftsrealität?', 49 NJW 2020, 3573 et seq.

[31] Krönke (fn. 27) 954.

[32] <https://www.zdf.de/nachrichten/politik/krankenhausreform-lauterbach-laumann-100.html> accessed 5 November 2023.

[33] Art. 74 (1) no. 19a BL.

[34] *Krankenhausfinanzierungsgesetz* (KHG), of 29 June 1972 (BGBl. I, 2793).

[35] § 4 *KHG*.

[36] § 8 *KHG*; see Anne Barbara Lungstras, 'Einführung in das Krankenvergütungsrecht' (2021) 1 NZS 1, 2. The plan includes 93% of hospitals and also university clinics authorized to care for patients, as well as private structures having an agreement with the Land (Vertragskrankenhäuser).

[37] § 6 KHG; see Ferdinand Wollenschläger, 'Reformprojekt sektorenübergreifende Versorgung und Bedarfsplanung: verfassungsrechtliche Möglichkeiten und Grenzen', part 1 (2023) 1 NZS 8, 9.

[38] § 17b KHG.

[39] <https://www.bundesgesundheitsministerium.de/presse/pressemitteilungen/regierungskommission-legt-kran> accessed 5 November 2023.

In recent years, also due to the pandemic, these grievances made the case-based flat-rate system unpopular[40]. An enormous increase in surgery was a second disadvantage of this system, since surgery is the main source of funding for hospitals. Without surgery there is no cash flow[41]. Conversely, there have been complaints of underfunding of supplies, staffing and infrastructure. The financial problems of hospitals increased enormously during the pandemic, when hospital beds were occupied for a long time without any operations[42].

To take the pressure off hospitals, new flat rates are planned. Fewer than half the treatments will be billed according to a case-based flat-rate, while the remaining costs will be covered by public contributions (*Vorhaltekosten*)[43]. The following 'structural reviews' are also being discussed. They concern future outpatient treatments.

4.2.2. Necessary enhancement of outpatient services (*Ambulatisierung*)

Compared to other European countries, Germany has a very high hospitalization rate (66% above the OECD average). The rate of outpatient services in hospitals is also low, amounting to only 2.85% of total services[44].

Promotion of outpatient services is currently being touted by Health Minister Karl Lauterbach as the biggest reform of the hospital system in the last 20 years[45]. Considering the current shortage of nursing staff, this reform, to be implemented mainly with day hospital solutions, is of the utmost urgency. A 25% reduction in hospitalizations is expected.

The 'traffic light coalition'[46] currently in government proposes to go beyond the dual system of planning, in which hospitalization is governed by federal law and outpatient care is the exclusive competence of the *Länder*, by introducing an intersectoral model[47]. This reform will necessarily require a rethinking of clinical protocols, as well as infrastructural adaptations and reorganization of human resources. It will be a radical change for the German health system.

5. Conclusions

The pandemic crisis has been an accelerator of many ongoing developments in public administration and society, but has not yet been a big game changer for the health system. Nevertheless, it has brought to the fore some of its major shortcomings.

One of the challenges of the social security system will be to tackle long COVID and its aftermaths (including the side effects of vaccinations). Since many COVID-19 patients take a long time to recover, appropriate treatment facilities and sufficient qualified staff are necessary to provide acceptable rehabilitation services. High treatment costs are another challenge.

The 2021 Global Health Security Index, which measures the capacity of 195 countries to prepare for epidemics and pandemics, shows that all countries remain dangerously unprepared for future epidemic and pandemic threats, including threats potentially more devastating than COVID-19. Germany ranks 8th (Italy 41st)[48].

Moreover, as Germans use to say, 'after the crisis is before the crisis'. In the wake of the global crisis triggered by the invasion of Ukraine, new benefits have been approved by the National Parliament to limit the impact of the war and exploding energy costs. Germany is a notoriously wealthy country, but it is legitimate to wonder if it will be able to meet all these financial commitments in a long-term perspective.

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[40] S2ee more extensively Anne Lungstras and Frank Bockholdt, 'Einführung in das Krankenhausvergütungsrecht' (2021) 1 NZS 2021, 5 et seq.

[41] Alexander Geissler, 'Sind DRG-basierte Fallpauschalen in der Lage, die Kosten von Behandlungen in deutschen Krankenhäusern zu decken?' (2013) 11 IR 325.

[42] <Fallpauschale – Was ist das? Einfache Erklärung inkl. Video (reimbursement.institute)> accessed 5 November 2023.

[43] Peter Udsching, 'Probleme der Verzahnung von ambulanter und stationärer Krankenbehandlung' (2003) 8 NZS 412.

[44] Claus Bartels, 'Ambulantisierung – was ist zu beachten? Statt stationäre Versorgung' (2023) 1 RDG 10.

[45] Ibidem, 11.

[46] "*Ampelkoalition*", formed by the socialdemocratic party (red), the liberal party (yellow) and the ecological party (green).

[47] Ferdinand Wollenschläger (fn. 37) 8. See also Ferdinand Wollenschläger, ‚Reformprojekt sektorenübergreifende Versorgung und Bedarfsplanung: verfassungsrechtliche Möglichkeiten und Grenzen', part 2 (2023) 2 NZS 48-54.

[48] <https://www.ghsindex.org/>, accessed 5 November 2023. The Global Health Security (GHS) Index 2021 is the first comprehensive assessment and benchmarking of health security and related capabilities across the 195 countries party to the International Health Regulations (IHR).

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SECTION I
ESSAYS

Constitutional Recognition of Public Health in India: Examining the Interplay between Fundamental Rights and Directive Principles of State Policy

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Abstract. This article explores the constitutional status of public health in India, examining the nature of rights associated with it. Public health enjoys recognition through Fundamental Rights (FR) and Directive Principles of State Policy (DPSP) in the Constitution. The right to health care has been read as an integral facet of the right to life and the responsibility of the legislature and the executive to consider the matter of public health while making laws. Responsibility for public health is shared by all three tiers of government, including local self-government bodies. The judiciary has played a crucial role in elevating public health to a fundamental right by interpreting Article 21 of the Constitution, which guarantees the right to life and liberty, to include the right to health.
During the COVID-19 pandemic, the constitutional expectations surrounding public health highlighted the government's duty to fulfil healthcare needs. The central government emphasized the state's constitutional responsibility for public health. This article critically examines the duality in approaches to public health: one emphasizing individual rights and the state's responsibility and the other viewing federal government efforts as programs rather than constitutional obligations. The authors have analysed the implications of these approaches for public health governance in India.

Keywords*: COVID-19, pandemic, public health, fundamental rights, cooperative federalism, legislative competence.*

1. Introduction

The COVID-19 pandemic has exposed the vulnerability of health infrastructure and lack of the preparedness of the state towards health care services globally and throughout India. The suffering of the individuals was aggravated during the pandemic and exposed the weak enforcement of the right to health through judicial process across the country. The right to health has been recognised as an integral part of the right to life and an essential attribute to lead a decent life under many constitutional laws. Public health has been stated in the form of 'duty' under Part IV and accorded the status of right through judicial interpretation of Article 21 of the Constitution. In India, the reference to 'health' as a right is a result of explicit and implicit reading of the provisions laid down under the Constitution. The Constitution has also demarcated a jurisdictional responsibility to the provincial government and the third tier government on the matter public health. This Article explores the constitutional recognition of public health, the interplay between the legally enforceable Fundamental Rights (FR) and the guiding principles enshrined in the Directive Principles of State Policy (DPSP), which are unenforceable in the court of law, and the shared responsibility for public health among various tiers of government.

2. Public Health as a Constitutional Imperative in India

In the fabric of India's governance, the realm of public health is not just a matter of policy but a constitutional discourse that has witnessed transformative interventions, especially amid the global pandemic[1]. The amalgamation of judicial activism and government policies has woven a narrative where public health takes

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[1] SU Kumar, DT Kumar, BP Christopher, CGP Doss, 'The rise and impact of COVID-19 in India' (2020) Frontiers in Medicine 7, 250.

centre stage as a revolutionary agenda[2]. Public health is not just a policy objective but a constitutional mandate for the Government of India. The Indian Constitution, the foundational document that embodies the nation's values and aspirations, emphasizes public health through two distinct forms of rights: the enforceable FR and the guiding principles enshrined in the DPSP, which are unenforceable in the court of law.

The realm of public health in India extends far beyond individual rights, encompassing a nuanced interplay of responsibilities shared between the central and state governments. This article navigate the various constitutional dimensions that weave together public health, shedding light on the allocation of responsibilities and the evolving contours of cooperative federalism. Within the constitutional tapestry of public health in India, beyond the purview of individual rights, lies a symphony of responsibilities shared between central and state governments. This harmony, intricately woven, demands an equilibrium that ensures a robust response to the challenges that health crises bring. As the nation and its health priorities evolve, it is in the synergy of shared responsibility and cooperative governance that a resilient future is generated[3]. During the pandemic, the questions on the enforcement of the rights came to the forefront and raised the issue of the preparedness of the state on the matter of public health. The courts artfully harnessed Article 21 of the Constitution, enshrining the right to life and liberty, to encompass the right to health as well[4]. This innovative interpretation resonated with the understanding that the right to life entails various attributes that render it meaningful, dignified, and indeed, healthy.

3. Constitutional Anchoring of Public Health

The Indian Constitution underscores the significance of public health by incorporating it as a fundamental goal of the state. This commitment is echoed through the DPSP, which emphasizes social and economic objectives to ensure the welfare of citizens. Article 38 of the Constitution directs the state to secure a social order for the promotion of the welfare of the people[5]. Further, Articles 39(a) and (e)[6] underscore the state's responsibility to ensure that citizens health and strength are not abused and that children are given opportunities to develop in a healthy manner.

Article 47 specifically mandates the state to improve public health and nutrition standards[7]. It provides that the state shall regard raising the level of nutrition and the standard of living of its people as among its primary duties. This constitutional provision not only reflects the government's commitment to public health but also highlights its recognition of the close relationship between health, nutrition, and the overall well-being of the citizens[8]. There are references of public health and the responsibility of the state to provide health care to the citizens.

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[2] Y Assefa, CF Gilks, S Reid, R van de Pas, DG Gete, W Van Damme, 'Analysis of the COVID-19 pandemic: lessons towards a more effective response to public health emergencies' (2022) Globalization and Health 10, 18(1).

[3] MZM Nomani, R Parveen, 'COVID-19 pandemic and disaster preparedness in the context of public health laws and policies' (2021) Bangladesh Journal of Medical Science, 20.

[4] MZM Nomani, Z Hussain, R Dhawan, 'Judicial Policy for The Covid-19 Pandemic in Comparative Legal Perspective' (2021) International Journal of Pharmaceutical Research, 13(1).

[5] Article 38: (1) The State shall strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of the national life. (2) The State shall, in particular, strive to minimise the inequalities in income, and endeavour to eliminate inequalities in status, facilities and opportunities, not only amongst individuals but also amongst groups of people residing in different areas or engaged in different vocations; Constitution of India, 1950

[6] Article 39 (a): The State shall, in particular, direct its policy towards securing— (a) that the citizens, men and women equally, have the right to an adequate means of livelihood;

Article 39 (e): That the health and strength of workers, men and women, and the tender age of children are not abused and that citizens are not forced by economic necessity to enter avocations unsuited to their age or strength; Constitution of India, 1950.

[7] Article 47: The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health; Constitution of India, 1950.

[8] MZM Nomani, R Parveen, 'Medico-Legal Insights into Covid-19 Pandemic and the Platter of Health Law Reform In India' (2020) International Journal of Pharmaceutical Research, 12(sp1).

As highlighted above, the right to life has been given expansive meaning to include health care by the Supreme Court of India. The idea is to encapsulate health care is to enable individuals to lead a decent life. The enunciation as a right resulted in the constitutional obligation of the governments, the central governments and the governments of the states, to provide health services[9]. The interrelationship between Fundamental Rights and Directive Principles has resulted in the obligation of the judiciary to take cognizance of the violation of the right and the responsibility on the legislature and of the executive to enact law or to make policy catering to the requirement of public health.

4. Shared Responsibility among Government Tiers

The recognition of public health as a constitutional goal is not limited to the central government alone[10]. The responsibility for ensuring public health is allocated among all three tiers of government in India: central, state, and local. This multi-tiered approach is a testament to the comprehensive nature of the state's commitment to public health.

Within India's federal framework lies a complex division of legislative powers between the central and state governments. Considering the recognition of health care as a right, the constitution imposes an obligation on the central and state governments to do the needful for the realisation of the right. Notably, public health rests within the domain of the State List, marking it as an exclusive prerogative of the states[11]. This allocation is a reflection of the intent to craft tailored public health policies that address the distinct nuances and exigencies of diverse locales[12]. This acknowledgment is rooted in the understanding that health challenges are not monolithic but intricately shaped by regional realities. Thus, states are vested with the ability to navigate the contextual tapestry of health issues and deliver solutions attuned to their populace.

While emergencies, such as the recent pandemic, tend to amplify the role of the central government, the constitutional compass resolutely points to public health as an arena primarily under the jurisdiction of state governments. The centre often underscores this constitutional tenet, subtly reminding the states of their paramount role in public health governance[13].

In addition to the central and state governments, the local self-governments, including municipalities[14] and Panchayats[15], also hold a crucial role in the provision of public health services. This decentralized approach acknowledges the diverse health needs of various regions and communities across the country. It also facilitates a more responsive and contextually relevant approach to public health governance.

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[9] State of Punjab v. Mohinder Singh Chawla, AIR 1997 SC 1225.

[10] MZM Nomani, R Parveen, 'Legal dimensions of public health with special reference to COVID-19 pandemic in India' (2020) Systematic Reviews in Pharmacy, 11(7), 131-134.

[11] List II – State List, Entry 6 – Public Health and Sanitation; hospitals and dispensaries; Seventh Schedule, Constitution of India, 1950.

[12] SL Greer, EM Fonseca, M Raj, CE Willison, 'Institutions and the politics of agency in COVID-19 response: Federalism, executive power, and public health policy in Brazil, India, and the US', (2022) Journal of Social Policy, 1-19.

[13] Covid cases on rise, Centre asks eight states to act (Indian Express, 22 Apr 2023) <https://indianexpress.com/article/india/covid-cases-on-rise-centre-asks-eight-states-to-act-8569606/> accessed 15 November 2023.

[14] Article 243W: Subject to the provisions of this Constitution, the Legislature of a State may, by law, endow the Municipalities with such powers and authority as may be necessary to enable them to function as institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats at the appropriate level… (for) the implementation of schemes for economic development and social justice as may be entrusted to them including those in relation to the matters listed in the Twelfth Schedule.

Entry 6 of Twelfth Schedule: Public health, sanitation conservancy and solid waste management; Constitution of India, 1950

[15] Article 243G: Subject to the provisions of this Constitution, the Legislature of a State may, by law, endow the Panchayats with such powers and authority as may be necessary to enable them to function as institutions of self-government and such law may contain provisions for the devolution of powers and responsibilities upon Panchayats at the appropriate level… (for) the implementation of schemes for economic development and social justice as may be entrusted to them including those in relation to the matters listed in the Eleventh Schedule.

Entry 23 of Eleventh Schedule: Health and sanitation, including hospitals, primary health centres and dispensaries; Constitution of India, 1950.

5. Public Health Responsibilities: A Kaleidoscope of Perspectives

The coexistence of Fundamental Rights and Directive Principles in the Indian Constitution has led to a dual approach in addressing public health concerns. In navigating the labyrinth of public health responsibilities, two distinct perspectives emerge, the rights-based lens and programmatic interpretation.

a. Rights-Based Lens

The canvas of public health is painted with the hues of rights, invoking shared responsibility between the centre and states. Under this perspective, the crux lies not in the origin of entitlements – centre or state – but in the tangible accessibility of these rights to individuals.

The Indian Constitution recognizes public health both through the enforceable Fundamental Rights and the aspirational Directive Principles. The Fundamental Right to life and personal liberty under Article 21 of the Constitution has been interpreted by the judiciary to encompass the right to a clean and healthy environment, which is integral to the citizens' well-being[16]. Courts have ruled that the right to health is an essential part of the right to life[17]. This interpretation has led to landmark court decisions that uphold citizens' rights to healthcare and environmental protection. The acknowledgement of the right to health as a fundamental right has imposed an obligation on the centre and the states to undertake all necessary measures to realise the rights of individual.

However, there exists a significant distinction between the enforceable nature of Fundamental Rights and the non-justiciable nature of Directive Principles. While Fundamental Rights can be directly enforced in courts, Directive Principles provide a broader policy framework that guides legislation and governance. This distinction can sometimes lead to a gap between the constitutional commitment to public health and its effective implementation.

b. Programmatic Interpretation

The efforts of the central government are viewed as initiatives or strategic plans rather than constitutionally binding obligations. Failures at the central echelon are not perceived as shortcomings of constitutional aspirations, and they do not impose legal obligations on the federal apparatus.

Pursuant to the Directives, the governments at both the levels have formulated policies to give effect to the constitutional goals. The central government provides a broader framework and direction to programmes related to public health such as small pox and HIV. These programmes are implemented all over the country uniformly. The central government provides funds to the state government for implementation and execution of the programmes. The states also implement all centrally funded programmes like family planning, *Swachh Bharat Abhiyan* (Clean India Mission), universal immunization and *Ayushman Bharat Yojana*. The National Health Policy, 2017, replaced the Policy 2002, aimed at centralize the role of the government in shaping the health systems in all its dimensions[18]. The policy advocates a progressively incremental assurance based approach to realise the right to health care[19]. This idea draws strength from the aspirational goals laid down in the Part IV of the Constitution.

While Fundamental Rights provide legal protection, Directive Principles offer a holistic policy perspective. However, the non-justiciable nature of Directive Principles can hinder their practical implementation. To bridge this gap, there is a need for a harmonized approach that integrates the strengths of both forms of rights. This could involve ensuring that policies and legislation formulated to fulfil Directive Principles are designed in alignment with the spirit of Fundamental Rights. Additionally, enhancing public awareness and advocacy about the significance of Directive Principles in shaping public health policies can generate more public pressure for their effective implementation.

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[16] MZM Nomani, Z Hussain, R Dhawan, Judicial Policy for The Covid-19 Pandemic in Comparative Legal Perspective.

[17] See Bandhua Mukti Morcha v. Union of India (1983) The Supreme Court interpreted the right to health under Article 21 which guarantees Right to Life; In State of Punjab vs Mohinder Singh Chawla (1996) the Supreme Court reaffirmed that right to health is fundamental to right to life and directed the government to provide health services as a constitutional obligation; In State of Pubjab vs Ram Lubhaya Bagga (1998) the Supreme court endorsed the view that it is the constitutional responsibility of the State to maintain health services.

[18] National Health Policy (2017) <https://main.mohfw.gov.in/sites/default/files/9147562941489753121.pdf> accessed 15 November 2023.

[19] Ibidem, 27.

6. Towards a Cohesive Paradigm: The Case for the Concurrent List

In pursuit of a unified response during exigencies, a proposition emerges: the migration of public health from the exclusive confines of the State List to the Concurrent List[20]. Such a transition would amplify the accountability of both the centre and states during crises, fostering a collaborative approach rooted in shared legislative competence. As the spotlight on public health intensifies this transition gains currency as a pathway to fortified cooperative governance. As the pandemic redefines norms, it becomes a crucible for testing the cooperative federalism model[21]. It underscores the imperatives of collaborative endeavours between the centre and states, spotlighting the agility and efficacy of a unified approach during tumultuous times.

This paradigm shift aligns with the aspirations of the Constituent Assembly, echoing the Assembly's resounding emphasis on public health's pivotal role in the mosaic of nation-building. Some voiced a call for the central government's exclusive stewardship, envisioning a uniform standard of health and sanitation woven across the nation, dissolving geographical divides. The global COVID-19 pandemic imparts a profound lesson – a recalibration of the distribution of public health responsibilities. This seismic event unfurls the urgency for a seamless, cohesive response, transcending the contours of traditional jurisdictional boundaries[22].

7. The Right to Health as a Pillar of Life's Dignity: Courts Perspectives

The judiciary's role in shaping India's public health narrative has been profound, particularly amid the pandemic. By invoking constitutional tenets, most notably Article 21 encompassing the right to life and liberty, courts have elevated public health to the pedestal of a fundamental right[23]. This innovative interpretation broadened the canvas of rights, recognizing health as an intrinsic component of life's dignity.

The Supreme Court's acknowledgment of the right to health as a facet of life that contributes to its decency and dignity resonates powerfully during the times of pandemic. The Court recognizes that the right to health is a cornerstone of this dignity, an attribute of life that cannot be divorced from its essence. The Supreme Court's stance solidified the notion that the right to health inherently resides within the broader right to life as a fundamental constitutional prerogative. The pandemic generated upheaval not only in strained healthcare systems but also tested the efficacy of institutions in safeguarding public health[24]. In India, the judiciary emerged as an instrumental player, employing innovative strategies to come to the aid of the common man during these dire times[25].

As the nation grappled with lockdowns, the Indian judiciary swiftly transitioned to virtual hearings, ensuring the continuity of the justice delivery system[26]. While only pivotal matters were scheduled for online hearings, the judiciary exhibited its responsiveness by issuing necessary directives to the government. An epochal instance emerged as a batch of petitions were filed praying for the nationalization of health facilities and free Covid testing. The Supreme Court's response, recognizing the limitation of nationalization but advocating for free testing, was pivotal, impacting a nation of over a billion[27]. Amidst the crisis, the courts directed the government to bolster resources, particularly Personal Protective Equipment (PPE) kits. This intervention

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[20] Fifteenth Finance Commission of India, A report of High-Level group on Health Sector (2019): The Commission had recommended that the right to health is a fundamental right and thus a recommendation was made to shift the subject of health from the State List to Concurrent list, 8th Jun 2023 <https://fincomindia.nic.in/writereaddata/html_en_files/fincom15/StudyReports/High%20Level%20group%20of%20Health%20Sector.pdf> accessed 15 November 2023.

[21] PC Jha, 'India's cooperative federalism during Covid-19 pandemic' (2022) Indian Journal of Public Administration, 68(2) 245-256.

[22] P Banerjee, P Banerjee, 'Application of Cooperative Federalism in India during Covid-19 Pandemic' (2021) Int'l JL Mgmt. & Human, 4(5) 1485.

[23] Supra note 16.

[24] BB Singh, M Lowerison, RT Lewinson, IA Vallerand, R Deardon, JP Gill, HW Barkema, 'Public health interventions slowed but did not halt the spread of COVID-19 in India' (2021) Transboundary and Emerging Diseases, 68(4) 2171-2187.

[25] A Arya, 'Role of Indian Judiciary in the Times of Necessity' (2021) 3 Indian JL & Legal Rsch, 1.

[26] J Rattan, V Rattan, 'The COVID-19 crisis-the new challenges before the Indian justice and court administration system' (2021) 12 IJCA 1.

[27] Supra note 16.

catalysed India's transformation into a PPE manufacturing hub, both for domestic use and global export[28]. The judiciary's directive demonstrated its role in driving practical solutions, motivating the government to take essential actions.

The Indian legal framework empowers the Supreme Court and High Courts to consider petitions in the broader public interest. During the pandemic, numerous public interest litigation cases were filed before High Courts, leading to exceptional interventions and far-reaching relief measures. These actions by the judiciary showcased its proactive engagement in matters of immense public concern. A fresh slew of petitions urged the Supreme Court to establish a comprehensive policy for healthcare workers[29]. The Court, while refraining from dictating guidelines, stressed that the responsibility to create such a policy rested with the government. However, the Court underscored its capacity to address any shortcomings through Contempt of Court proceedings. This approach tactfully balanced the separation of powers while ensuring accountability.

8. A Holistic Approach: Public Health Protection Scheme

Beyond the precincts of the judicial corridors, the Government of India embarked on a significant policy endeavour to fortify public health. The *Ayushman Bharat* scheme emerged as a testament to this commitment, carefully designed with taxpayers' contributions[30]. This comprehensive healthcare protection scheme extended a safety net to the economically disadvantaged strata of society[31].The *Ayushman Bharat* scheme stands as a harmonious convergence of constitutional ideals and policy innovation. It underscores the government's commitment to making public health a societal priority. The scheme's inclusive nature transcends the public-private divide, embracing a spectrum of healthcare providers to ensure that quality healthcare reaches the marginalized segments. *Ayushman Bharat* exemplifies the synergy between constitutional mandates and pragmatic policy formulations[32].This holistic approach, harmonizing both public and private sectors, marked a remarkable stride towards ensuring equitable access to healthcare services[33].

9. Conclusion

In conclusion, public health's journey in India transcends mere policy mandates. It embodies a constitutional commitment that resonates in both judicial interventions and innovative policy frameworks. The crucible of the pandemic has propelled public health to the forefront of governance, prompting a collaborative approach involving government initiatives, judicial wisdom, and societal participation. This crisis-driven paradigm shift stands as a testament to India's resilience and adaptability in the face of unprecedented challenges.

The Indian Constitution, by recognizing public health as a constitutional goal, demonstrates its commitment to ensuring the welfare and well-being of its citizens. This commitment is reflected through both the enforceable Fundamental Rights and the guiding principles of Directive Principles. The shared responsibility among the central, state, and local governments emphasizes the comprehensive nature of this commitment. To enhance the impact of this constitutional mandate, it is crucial to harmonize the two forms of rights, ensuring that policy frameworks guided by Directive Principles align with the principles of Fundamental Rights. Through such synergy, India can more effectively realize its constitutional vision of ensuring public health for all its citizens.

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[28] N Sharma, Z Hasan, A Velayudhan, E MA, DK Mangal, SD Gupta, 'Personal protective equipment: challenges and strategies to combat COVID-19 in India: a narrative review' (2020) Journal of Health Management 22(2) 157-168.

[29] A Kumar, KR Nayar, SF Koya, 'COVID-19: Challenges and its consequences for rural health care in India' (2020) 1 Public Health in Practice 100009.

[30] J Joseph, DH Sankar, D Nambiar, 'Empanelment of health care facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India' (2021) PloS one 16(5) e0251814.

[31] S Garg, S Basu, R Rustagi, A Borle, 'Primary health care facility preparedness for outpatient service provision during the COVID-19 pandemic in India: cross-sectional study' (2020) JMIR public health and surveillance 6(2) e19927.

[32] P Agrawal, AS Chauhan, DC Pandey, R Tiwari, 'Ayushman Bharat for Inclusive Health Insurance in India: A Critical Review (2022) YMER 11, 1483-1492.

[33] S Garg, N Bhatnagar, MM Singh, A Borle, SK Raina, R Kumar, S Galwankar, 'Strengthening public healthcare systems in India; Learning lessons in COVID-19 pandemic' (2020) Journal of Family Medicine and Primary Care 9(12) 5853.

As the nation navigates the contours of the post-pandemic landscape, key lessons emerge for policymakers. The intricate interplay between constitutional principles, judiciary, and policy innovations underscores the need for continued collaboration and synergy in addressing public health challenges. Looking forward, a comprehensive and integrative approach will be instrumental in building a resilient healthcare infrastructure that safeguards the well-being of all citizens.

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SECTION I
ESSAYS

Duties in the Post-Pandemic Era

Antonio Cantaro

Abstract. The prevailing belief is that COVID-19 has profoundly altered the balance between *authority and freedom*. This article argues that the post-pandemic era is marked by a *neglect of rights* and an *inflation of duties*. Both these entities, neglect and an inflation, have been fueled by the 'fact' that in a *state of emergency*, confronted with the extreme risk to health and life, passive legal situations (such as responsibilities, burdens, and obligations) gain a significance that is only clear in a state of normality. This belief, which paradoxically combines *philosophies of care* and '*deferential constitutionalism*', takes on epochal traits in the literature for which we have plunged into a *state of exception*, a *destiny* shared by legal systems that have embraced the imperative of safeguarding 'bare life'. This portrayal of the (presumed) *biosafety regime* we live in reveals little about the extent of the changes that have swiftly impacted the consolidated *structure of rights and duties* in the *post-pandemic era*. Specifically, it entails a rewriting of their catalog, the emergence of new forms of balance, the establishment of an *objective system of health and safety for citizens* ('governed' in the most critical phase of the pandemic by a sort of '*commission dictatorship'*, as this article asserts), all instrumental in restoring the state of normality, the neoliberal normality. The fundamental deontic categories of this normality are not *the right* and *the duty* per se, but the 'unlimited power to do' and the equally compelling self-imposed 'obligation to do limitlessly'. These derive from the *principle of performance*, a meta-value and supreme tenet of the *living constitution*. This encapsulates the psycho-anthropology of today's *machine-like man* (permanently performing and resilient every day of the year, at every hour) fostering the illusion of removing the ontological *vulnerability* of human condition, the self-delusion of 'pretending to be healthy' and is a pervasive and misguided 'passion'.

Keywords*: COVID-19, duties, post-pandemic, authority, freedom.*

1. State of Exception: The Return of the Ethics of Care

One day in the year 2020, the World Health Organisation (WHO) declared that the global community had officially entered a state of health emergency due to the COVID-19 pandemic, ushering it into our collective lives. One day in the year 2023, the WHO declared the end of the state of health emergency[1]. Two days, it was said, destined to remain engraved in history[2].

Few people remember exactly which two days marked the beginning and end of the pandemic. And they do not remember because, despite the rivers of ink spilled, the world did not in the end experience the pandemic as a state of exception but 'simply' as an extraordinary state of emergency.

There was, of course, the possibility that different experiences could have existed depending on the technical details of measures adopted at the international, national and regional levels in response to the declaration of the COVID-19 pandemic. This article asserts that the differences in experience are the result of details in the responses. And, as the saying goes, the devil is often in the details. Here, the key to unlocking

[1] On 9 January 2020, the WHO declared the isolation of a new strain of coronavirus never before identified in humans by Chinese health authorities: 2019-nCoV (also known as COVID-2019), later renamed Sars-CoV-2. The virus was associated with an outbreak of pneumonia cases recorded from 31 December 2019 in the city of Wuhan, central China. On 30 January, the WHO declared the COVID-19 outbreak a public health emergency of international concern, and on 12 March defined it as a 'pandemic situation'. On 5 May 2023, the World Health Organisation declared the end of the public health emergency of international relevance.

[2] P Pantalone, *La crisi pandemica dal punto di vista dei doveri. Diagnosi, prognosi e terapia dei problemi intergenerazionali secondo il diritto amministrativo* (Editoriale Scientifica, 2023).

the reason why an event that we initially collectively experienced as a catastrophic event, that would revolutionise our lives and beliefs (a constitutional event[3]), resolved itself into an eternalisation of the state of normality, of the neoliberal state of normality[4].

Among jurists and constitutional law scholars, strong images have circulated, laden with meanings such as 'oblivion of rights', and 'inflation of duties'. The complicit pragmatism of the officials of the constituted powers has, however, always reminded 'revolutionaries', 'disobedient' and 'guarantors' that the epidemiological and social emergency posed nothing but a problem of risk management, of efficient and effective technical-scientific governance of the risks typical of our modern globalised societies.

The broad consensus of the population on the implementation of what this article will call an objective ordering of the health and safety of citizens has, so far, proved these theorists right. This, in turn, contradicts philosophical literature, which also enjoys a certain credence in the social sciences, that has read a further stage in a more general and long-standing process of normalising the state of exception in the governments' response to the health emergency[5]. And indeed, the exception, from a philosophical and legal-dogmatic point of view, evokes, contrary to what this literature claims, the rupture of a given order and the announcement of a possible alternative order. Emergence of responses in the standard legal and philosophical literature, conversely, postulates the confirmation of the given order, its continuation, its reinforcement[6]. Both of these qualifications of the pandemic event have been present in the collective consciousness and at first the instinctive perception of being faced with a state of exception was indeed prevalent at an emotional level if not always at a legal level.

In the early days, indeed, feelings of bewilderment often prevailed, including the feeling of being faced with a catastrophe. The pandemic as apocalypse and, consequently, the search for a way of salvation in the radical subversion of the given 'laws' became a part of the discourse. Subversion of an order through the revelation of what is essential in it, of 'a movement that, by going to the heart of what we are facing, dissolves it and brings to the fore something that is truer than what has dissolved'[7]. These sentiments are apocalyptic, revelatory, and unveiling of many concerns[8]. In the very first phase of the pandemic, we did not, as is often the case when faced with dramatic and unforeseen events, draw on the narrative structure of the hero's journey (emergencies that, once overcome, re-establish the initial equilibrium), but rather on the far more challenging apocalyptic narrative structure. A watershed 'materialised' in the hashtag 'nothing will ever be the same again' and the hashtag 'we will never go back to normal'. Totemic formulas that took on the rhythm of a mantra, the evocation, with at times millenarian tones, of the advent of a new world[9]. From many quarters, the rise of a 'new humanism' respecting the physical and spiritual world was evoked.

The spread of the virus, it was said almost in unison even by the scientific community, was anything but an accident. Its origins were to be found in the state of neglect of our community life prior to the spread of the virus, the renunciation of which is a *conditio sine qua non* for solving the problem[10]. Conversely, in the initial phase of the pandemic, the most circumstantial explanations that put agribusiness, the reduction of the planet to a farm, animal monocultures and deforestation at fault were widely credited.

At the beginning of the lockdown, a sociologist, in a dreamlike and somewhat naïve post, compared the virus to a biblical Dantesque counter-redemption for our mistakes, our weaknesses, and our superstitions. And it is within this humus that we have witnessed a rehabilitation of the discourse of the cure, long the patrimony only of narrow intellectual elites[11].

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[3] JA Camisòn, 'La pandemia del Covid-19 come (des) acontecimiento juridico constitucional' (2021) Eunomia. Revista en Cultura de la Legalidad, 25, 2023.

[4] A Cantaro, Postpandemia. Pensieri (meta)giuridici (Giappichelli, 2021).

[5] G Agamben 'L'arbitrio e la necessità' 12 febbraio 2021 <https://www.quodlibet.it/giorgio-agamben-arbitrio-necessit> accessed 15 November 2023.

[6] M Luciani, 'Il diritto e l'eccezione' (2022) Rivista AIC, 2.

[7] A Brandalise, 'Apocalisse o della fine senza fine' (2014) Tysm Literary Review, vol 11.

[8] In strictly theological terms, the apocalypse is what prepares the 'Kingdom of God', what opens the way to liberation. See F Ciccarelli, *Una vita liberata. Oltre l'apocalisse capitalista* (DeriveApprodi, 2022).

[9] L Giuncato, 'Niente sarà più come prima. Il Covid-19 come narrazione apocalittica di successo' (2020) H-ermes, J. Comm. 16.

[10] NN Taleb, Il cigno nero. *Come l'improbabile governa la nostra vita* (Il Saggiatore, 2007).

[11] E Pulcini, *Cura e giustizia. Le passioni come risorsa sociale* (Bollati Boringhieri, 2020).

German President Frank-Walter Steinmeier, in an appeal to his fellow citizens in the spring of 2020, used poignant words, emphasising that 'precisely at Easter, the feast of the resurrection, when Christians all over the world celebrate the triumph of life over death, we must endure limitations, so that disease and death do not defeat life'. Continuing his speech, he rejected the use of bellicose metaphors.

In the meantime, the Italian government had named one of its first interventions to combat the pandemic decree 'Cura Italia'[12], a name that symbolically alluded to a narrative of the 'fight against the disease' that called for the mobilisation of the people professionally involved in caring (such as doctors, nurses, and virologists) and asked every citizen to also become 'caring' in their daily behaviour. If, it was said, we are at war against a common enemy and a common threat, we are so in the form of 'we are in care'. The metaphor 'we are in care' corresponded, therefore, to the first phase of the pandemic infection, to a common feeling of rulers and ruled.

2. State of Emergency: The Return of Public Duties of Care

Legal science says that in states of emergency, faced with the risk of losing primary goods, the duties of institutions and individual and collective duties acquire a significance that in the state of normality is only latent.

The observation, which is widely shared, is dense with precipitous normative meanings, legitimising a renewed protagonist identity of the security state, the system existentially entrusted in the modern era with the protection of the goods of life and health of the population. Codification of individual and community conduct functional to the pursuit of this supreme purpose, namely sanctioning those that compromise its pursuit.

In the transition from community duties of care to public duties of protection functional to the management of the state of emergency, in view of the objective of restoring the state of normality, something, therefore, remains. But it also acquires another meaning. It is that subtle and decisive difference between care and cure, where care is empathically taking care of the other from oneself and cure is bureaucratically taking care of a body (be it an individual or a community) on the basis of objective, serial 'protocols'. It is the difference between the old family doctor who cares for his patient in the entirety of body and soul and precision medicine and telemedicine that anonymously, remotely, take care of the proper functioning of a user's organs.

Regulating the conduct of citizens is, therefore, a law that is present in all situations of extraordinary necessity and urgency that totally affect the life of the community. But it is the horizon of sense of overcoming the emergency in view of a return to the pre-existing order that has imprinted a markedly functionalist, pragmatic, technocratic imprint on the pandemic regime of the protection of health and life.

A commissar dictatorship, Carl Schmitt would have called it[13]. Deontologically acted upon by the totalitarian logic of the concrete result to be pursued (counteracting the spread of disease) and 'legitimised', according to criteria of expediency, to remove obstacles of a juridical-institutional order to the government of the emergency and to prepare the conditions for a return to normality. A commissar dictatorship, where what counts is not the strident expression 'dictatorship' but the adjectivization of it as commissar. A dictatorship where not everything is permissible, but it is permissible to resort to whatever the commissars deem necessary for the pursuit of the purpose entrusted to them.

As in war, it is no coincidence that the narrative structure of 'we are in care' was soon flanked, to the point of becoming dominant, by a more overtly warlike declination. And the

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Mead replied that the first sign of civilisation in ancient cultures was a broken and then healed femur. He explained that in the animal kingdom, if you break your leg, you die. You cannot run away from danger, go to the river for a drink or look for food. You are meat for predatory beasts that prowl around you. No animal survives a broken leg long enough for the bone to heal. A broken and healed femur is proof that someone took the time to be with the one who fell, bandaged his wound and clamped his fractured limb, took him to a safe place, refreshed him, helped him recover. It is proof, I argued, that humans, not mankind, inhabit the planet (H Arendt, 'La vita della mente' (Italian translation, il Mulino, 2009); A Cantaro, 'Veritas, Auctoritas, Lex nella disciplina europea della concorrenza', in Id. (eds), Economia e diritto dei mercati nello spazio europeo. Dall'età antica all'età globale (Cisalpino, 2018) 239); H Arendt, *La vita della mente* (Italian translation, il Mulino, 2009).

[12] Law Decree no 18 of 17 May 2020.

[13] C Schmitt, *La dittatura. Dalle origini dell'idea moderna di sovranità alla lotta di classe proletaria* (Italian translation, Laterza, 1975).

analogies with the state of war and the wartime economy gradually became more and more prevalent, evoking multiple parallels. Included in these are the overall reduction of national productive activity, the simultaneous strengthening of indispensable supply chains (the agro-food industry), the maintenance of essential public services and activities of strategic importance for the national economy, the acquisition and support of domestic production of goods and instruments necessary to deal with the health emergency.

These parallels that reverberated in the media lexicon: 'The 'trenches' of hospitals, 'battles' in the ward, 'soldiers' on the run, 'fallen' at the 'front', 'heroes', 'martyrs', the daily 'bulletin' of the dead. A sort of sanitary state of siege with its articulated typology of dutiful conduct, starting with the establishment of differentiated regimes linked to the epidemiological trend of the virus. Positive duties to do, negative duties not to do, prohibitions that are sometimes absolute and sometimes relative, obligations and burdens (including the green pass and vaccination), with different degrees of intensity of the prescriptions in space and time, addressed to different audiences and recipients. And distinct legal consequences in the event of non-compliance, such as fines, disqualification measures, prohibition of access to certain territories, and suspension from work[14].

Legal rules in the strict sense (notably those that prohibit, permit, and impose, with accompanying sanctions), medical-scientific recommendations, hygiene measures, expert protocols, and a mix of normative sources (supranational, European, national, regional, and municipal) of different function (legislative and regulatory acts, ordinances, decrees, directives, circulars, guidelines and other atypical administrative measures). These measures all aimed at incentivising the public administration and citizens to engage in conduct functional to restoring public health and favouring recovery.

An order that, in the name of the 'supreme' values of public health and the return to economic and social normality, has felt authorised to proceed to a balancing act between the duties of protection imposed by the extraordinary nature of the emergency situation and the fundamental freedoms in force in ordinary situations. Sometimes even to a suspension of them, which – it was specified – was strictly necessary and proportional to the purpose. A suspension that substantially conformed to the constitution not only insofar as it was a temporary derogation to the guarantees provided by the constitution but also in the sense of a navigation that proceeded, however, without losing the compass of fundamental principles.

3. Constitutionalism of Duties: Freedom of Care and Compulsory Vaccination

But which fundamental principles were prioritized? The principles of the guarantee of the inviolable rights of man or those of the fulfilment of the inalienable duties of political, economic and social solidarity, to stay with the lexicon of the Italian Constitution? Constitutionalism of rights or of duties? Or both? Or something else?[15]

In Italy, the possibility of restricting freedom of care has always moved, before the pandemic, within the framework of the constitutional discipline contained in art 32 of the Constitution. A provision that emphasises, firstly, the social and individual dimension of the right to health (the only one to be expressly qualified as fundamental), recognising each person not only the right to receive adequate care but also the freedom to choose whether to undergo health treatment. And only, secondly, authorises limitations to the freedom of self-determination on condition that these are ordered by the legislature in the interest of the community and that the law does not in any case violate 'the limits imposed by respect for the human person'[16].

For a long time, legislation and case law were oriented in the sense that the freedom of therapeutic self-determination could be limited only in cases where its exercise endangered public health. In the sense that if the choice not to vaccinate was apt to spread contagion, that choice in the presence of a vaccine capable of averting the spread of contagion could be sacrificed.

That is to say, in the long-standing words of the Italian Constitutional Court, health is not limited only to situations of claim and advantage, but 'implies and includes the duty of the individual not to harm or endanger the health of others by his own behaviour, in observance

[14] P Pantalone, *La crisi pandemica dal punto di vista dei doveri*.

[15] A Ruggeri (2021) La vaccinazione contro il Covid-19 tra autodeterminazione e solidarietà <Dirittifondamentali.it> 2.

[16] V Baldini (2023) L'emergenza sanitaria: tra stato di eccezione, trasformazione della costituzione e garanzie del pluralismo democratico. Aspetti problematici (e poco convincenti…) della più recente giurisprudenza costituzionale <Dirittifondamentali.it> 1.

of the general principle that sees the right of each person find a limit in the mutual recognition and equal protection of the coexisting right of others'. Which in the case of compulsory medical treatment justifies 'the compression of that self-determination of man which is inherent in each person's right to health as a fundamental right' (Judgment no 30 of 1995).

In this 'ancient' constitutional jurisprudence, however, there is no question of balancing duties to protect the health of the community with the individual right to health. The limitation of the freedom of self-determination is justified by the protection of the coexisting right of others, 'inherent in everyone's right to health as a fundamental right'. The individual's absolute freedom of care is the rule. Its limitation the exception, justified not by a generic community interest but by the right of other citizens not to see their equally fundamental right compromised.

In the dramatic climate brought about by the spread of contagion and when the availability of vaccines to combat the 'war on the virus' began to be a concrete option, the 'discourse' of the constitutionalism of duties went beyond this threshold, beyond the threshold of the deontology of balancing equally fundamental rights. And it has done so by appealing to the existence of an unbreakable duty of solidarity to protect a general interest of the community to stay healthy, For example, a widening of the parameters of the vaccination obligation that potentially 'elevates' the obligation from exception to general rule and 'degrades' the freedom of care from general rule to exception[17].

The constitutional provision is weakened, in this literature, on the basis of a 'systematic interpretation' that declines the individual right to health also as an imperative duty of solidarity of the citizen as a fellow citizen. Health, it has been said, 'is, at one and the same time, a fundamental right and an unbreakable duty, one of those duties referred to in art 2 of the Charter' and this follows from the structure of art 2, which sanctions 'the recognition of inviolable human rights, including that of self-determination' but also requires the fulfilment of the duty of solidarity 'without which living together and making a 'community' would remain a hollow thing'.

In this perspective, freedom of care should be preserved as long as it is reasonably possible, but not in every case. Certainly not when one is in the presence of particularly diffusive and aggressive diseases: what prevails, in these cases, is the need to put an end to a contagion that calls into question man's primordial need 'to form a 'group' because only in this way can the objective of satisfying man's elementary needs be achieved'[18].

In the midst of the epidemiological emergency, therefore, a demanding constitutionalism of duties has made its way, which has advocated the thesis that the fundamental principle of solidarity postulates adherence to the anthropological conception endorsed by the Italian Constitutional Court in a recent judgment (no 75 of 1992) in which it emphasised 'the original connotation of man *uti socius*'.

On the limitation of fundamental rights, the pandemic constitutional jurisprudence has in truth had a much more articulate and ambivalent position. The Court has absolved the legislature with regard to the most controversial choices contained in the regulatory provisions that provided for various limitations on rights, taking care, however, to safeguard, as a matter of principle, the guaranteeing principle of freedom of care contained in art 32 of the Constitution.

The Court has, in fact, reaffirmed (judgments nos 14, 15 and 16/2023) the strict assumptions under which a legislative framework must move, which, in the name of the interest of the community, limits the freedom of therapeutic self-determination in matters of vaccination[19]. And, that is, that the

[17] This was a daring operation in terms of the interpretation of art 32 of the Italian Constitution and of a jurisprudence (not only constitutional) that had hitherto held firm to the very different interpretation that the derogation to the general rule of the right to absolute freedom of self-determination of care of the individual is justified only by the protection of the coexisting right of others. See C Iannello (2022) Oltre il Covid. Verso l'obbligo di cura per i sani? Il pericoloso tentativo di scardinare ex post la ratio liberal-democratica dell'obbligo vaccinale per 'giustificare' «scelte tragiche» rivelatesi errate per razionalità postuma <Dirittifondamentali.it> 3.

[18] A Ruggeri, *La vaccinazione contro il Covid-19 tra autodeterminazione e solidarietà*. See Constitutional Court 75/1992. M Viroli, M Malvancini, 'Sentirsi responsabili l'uno dell'altro. Ethos repubblicano e doveri costituzionali, argini alla pandemia', in M Malvicini, T Portaluri, A Martinengo (eds) *Le parole della crisi le politiche dopo la pandemia. Guida non emergenziale al post-Covid-19* (Editoriale Scientifica, 2020).

[19] The Court has done so with decisions, which unlike previous decisions on vaccination damage following the spontaneous fulfilment of the obligation, stemmed from judgments in which the le-

prerequisite of any law imposing vaccination lies in the function of protection of third parties and, consequently, it is to be considered, legitimate in principle only a legislation enacted with a view to the prevention of contagion. Otherwise, the Court, it has been observed, would have expressly legitimised a general principle of dutifulness of treatment that, instead, can only be individual, voluntary and reserved to the therapeutic relationship and the discretion of the doctor in the singularity of that relationship[20].

It is not a question, in fact, of the freedom to use the body for the realisation of the most varied purposes (protected by the traditional habeas corpus), but of the freedom to prevent an intrusion into one's own body which, as the Italian Constitutional Court has affirmed in the past, 'goes beyond personal freedom itself' (Constitutional Court no 238/1996). And besides, it is only Article 32 that provides for the protection of freedom of care not only a formal guarantee (the reservation of the law) but also a substantial guarantee, identified in 'respect for the human person'[21].

In its rulings of February 2023, the Italian Court continued to move in this vein, reaffirming its previous jurisprudence on the only rationale that can constitutionally justify the compulsory vaccination. The protection of public health, the fight against contagion that directly affects the health of third parties, the objective aptitude of the vaccine to prevent contagion, excluding the pursuit of other public interests that although abstractly deserving of protection must be pursued by other means. A person who does not vaccinate exercises a fundamental right (paragraph 12.2 of Judgment no 15/2023) and his choice not to vaccinate is 'legitimate' (paragraph 14.5 of Judgment no 15/2023). The obligation is based on the preventive function of the vaccine to prevent contagion, and in the absence of that efficacy, any restriction imposed on the non-vaccinated becomes discrimination, an arbitrary limitation of a freedom because it lacks justification.

4. Deferential Constitutionalism: The Duty to be Healthy

In the debate between constitutionalism of rights and constitutionalism of duties has, therefore, the former prevailed? Yes and no.

On the basis of the aforementioned premises, the Court should have declared the illegitimacy of the legislative provisions prescribing the compulsory nature of the vaccine for certain categories (health personnel), since the factual assumption on which those legislative provisions were based had become problematic at the time of its decision. They are based on the assumption of the vaccine's suitability to achieve the epidemiological objective of preventing contagion[22].

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gitimacy of the refusal to vaccinate was expressly requested. The novelty of the approach to the constitutional judgment is the procedural reflection of a discontinuity in the substantive law of the emergency. A tendency 'valorised' by the dogmatics of the non-derogable duty to be healthy when it actually advocates the thesis that, in the state of necessity determined by an epidemic that undermines the existence of a community, it is reasonable to invert the relationship between the rule (freedom) and the exception (its limitation). And this is what actually happened, for example, with regard to the so-called green certificate: the non-fulfilment of the obligation or burden (the green certificate) prevented the non-vaccinated from working (without pay) and participating in social life (from the age of 12).

[20] Treatment is virtually incompatible with the obligation, requiring, on the contrary, an individualised assessment, and is reserved to the therapeutic relationship (see Constitutional Court, no 282/2002, point 4), whose autonomy represents a limit for the legislator himself. If a treatment, even life-saving, is refusable (it is the exercise of a fundamental constitutional right: art 32 Const), all the more so is a therapy aimed at preventing the risk of a disease, whose (possible) evolution in serious forms is conditioned by age and previous health conditions (C. Iannello (2023) La ratio dell'obbligo vaccinale nella recente giurisprudenza costituzionale, in <Dirittifondamentali.it> 2). Indeed, this is, as a rule, the prevailing orientation in liberal-democratic systems. Freedom of vaccination is a therapeutic practice, possibly recommended, but left to individual choice. It is, rather, the imposition of the obligation that must be rationally justified, insofar as it compresses the freedom to dispose of one's body with regard to medical treatment, a freedom that is more profound than any other freedom.

[21] A Mangia, 'Si caelum digito tetigeris. Osservazioni sulla legittimità costituzionale degli obblighi vaccinali' (2021) Rivista AIC, 3. Human dignity is both the foundation and the limit of the right to self-determination according to F Losurdo's reconstruction, 2018.

[22] The referring judge, on the basis of a supplementary investigation by the technical-scientific panel appointed in the judgment a quo, had come to the conclusion that the vaccine was not capable

The Court, on the other hand, saved the censured legislative provisions by assessing them not in the light of current knowledge, but in the light of the 'scientific findings available on the efficacy and safety of vaccines' at the time when the legislation was enacted (Constitutional Court no 14/2023, paragraph 6). That is, it judged the law to be legitimate insofar as it gave value to the information that the legislature possessed in the spring of 2021, information that made the obligation in question appear at the time to be 'not disproportionate' and 'not unreasonable' to pursue the objective of preventing infection[23].

The questions raised by the logical-argumentative artifice used to absolve the legislation of the time are many[24]. Not only was a choice made that in the light of the data available at the time of the ruling is at the very least questionable[25], but the belief was also surreptitiously induced that compulsory medical treatment could in future be considered, in fact, legitimate in the absence of the sole purpose (the prevention of contagion of the community) that justifies the derogation from the freedom of self-determination of treatment.

A constitutional deference towards the constituted powers can be argued to now exist, especially towards the certifications of the technical authorities on the basis of which the executive and legislative powers have adopted their choices. Certifications that, in homage to the scientific method, should never be taken as incontrovertible truths of faith but as guidelines on which, however authoritative, it is legitimate to harbour doubts[26] and to be subjected to comparison with other scientific guidelines[27].

The 'deference' of Italian constitutional jurisprudence does not stop here. Even more eloquent is an obiter dictum in which the Court, in order to exclude the practicability of the swab as an alternative measure, opens up the possibility to a vaccination that, while not preventing contagion, can in any case 'prevent the disease (especially serious) of the operators themselves' and thus avoid the 'risk of compromising the functioning of the SSN"'.

No one doubts that the proper functioning of the health system is a condition for guaranteeing the health of the population and that this is certainly part of the purposes that the public authorities are called upon to pursue. The obiter dictum opens up, however, the way to something different: to the idea that in order to ensure the proper functioning of the health system it is legitimate to 'oblige' citizens to take a drug, the vaccine, intended for a purpose other than the containment of the spread of contagion[28].

The objective datum on which constitutional control is based, the prevention of third party contagion, would be replaced by the debatable and subjective assessment of the burden bearable, at a given time, by the National Health System. An assessment perhaps supported, by 'science' and 'experts', by mathematical models for evaluating costs and benefits, by algorithms.

A paradigm, because if the decrease in hospitalisations is considered, albeit in an obiter dictum, an objective capable of justifying a health

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of preventing contagion. A scientific fact considered to be established by a part also of the jurisprudence on the merits subsequent to the Court's rulings of February 2023 (Military Criminal Court of Naples, ruling of 10 March 2023 and Court of Florence, ruling of 27 March 2023).

[23] Probably also in view of the fact that the legislative choice was made under the impetus of the emotion aroused by the close contact with patients of the health personnel, who did not consider the use of the swab alone to be adequate.

[24] C Iannello, 'La sentenza n. 14/2023 della Corte Costituzionale: l'obbligo vaccinale è legittimo solo se serve a prevenire il contagio' (2023) Osservatorio costituzionale AIC, 4.

[25] Since the cornerstone of the entire vaccination campaign, according to which vaccinated persons would be in a 'safe' environment and that the vaccine would be a patent of 'immunity' with respect to the possibility of catching the virus and a guarantee of not transmitting it, had disappeared. The Court held that it did not take this into account, resorting to an assessment of the 'putative truth' at the time when the legislature made its decisions and, therefore, assessing the vaccination obligation as legitimate on the grounds that, at the time of the legislation in question, the 'scientific data' available depended on the vaccine being effective in preventing contagion (Eloisa MB Bellucci, A Mariconda, 'L'obbligo vaccinale dinanzi alla Corte costituzionale: riflessioni sul diritto alla salute e sul consenso informato ai trattamenti sanitari' (2023) Diritti umani e diritto internazionale).

[26] A Mangia, *Si caelum digito tetigeris*.

[27] G Cerrina Ferroni (2023) 'Obblighi vaccinali, conseguenze del mancato assolvimento e Costituzione. Una lettura critica delle sentenze della Corte costituzionale n. 14 e 15 del 2023' <Dirittifondamentali.it> 2.

[28] C Del Bò, 'L'obbligo vaccinale durante la pandemia da Covid-19. Profili etici' (2022) Quaderni di diritto e politica ecclesiastica, 2.

obligation, every drug could be imposed as mandatory. Every drug, from those against cholesterol, to hypertension to any other drug could be subject to the same treatment. With all due respect for the formal constitutional principle of freedom of treatment, which would be effectively obliterated[29].

It is a narrative that sees in the forefront companies interested, for market purposes, in incentivising 'healthy' lifestyles, in promoting the beneficial effects of physical activity and a healthy diet, but which increasingly sees government institutions engaged in singing the praises of a broad notion of health as a state of physical, psychic and social well-being. A health narrative, without ifs and buts, with its stainless certainties and socially imperative character.

We are certainly not at the codification of a legal duty of the people to be healthy. But when a value acquires the aura of a supreme interest, the conditions are in place for it to be experienced as a sort of duty of citizenship that deserves to be assisted not only by soft devices (protocols, guidelines) but also, where necessary, by hard rules capable of ensuring its effectiveness (burdens and obligations assisted by sanctions).

A gentle push to take care of good of health, which in the state of pandemic emergency the public authorities have taken advantage of in the form of advice, recommendations, protocols, and guidelines contained in soft law acts. And of hard law at times when the emergency was at its greatest, relying – even when obligations, prohibitions and sanctions were codified – on the self-responsibility of members of society, on the effectiveness of self-monitoring devices[30].

[29] Eloisa MB Bellucci, A Mariconda, *L'obbligo vaccinale dinanzi alla Corte costituzionale*. The recent jurisprudence of the European Court of Human Rights seems, for example, not to exclude a priori that a vaccination obligation may pursue purposes other than the direct protection of collective health and the rights of third parties. This opening could considerably widen the States' room even beyond the power of derogation in emergency situations, which is characteristic of most human rights treaties. See also *OMS, Covid-19 and mandatory vaccination: Ethical considerations* (30 May 2022).

[30] BC Han, *La società senza dolore. Perché abbiamo bandito la sofferenza dalle nostre vite* (Italian translation, Einaudi, 2021); M Ceruti, R Della Seta, 'Pensiero ecologico e antropocentrismo' (2023) il Mulino, 3. About the 'material constitution of the EU', see A Guazzarotti, *Neoliberismo e difesa dello stato di diritto in Europa. Riflessioni critiche sulla costituzione materiale dell'UE* (FrancoAngeli, 2023). The 'Marxian' exhortation to 'change the state of things' (G Azzariti, Diritto o barbarie. Il costituzionalismo moderno al bivio (Laterza2021)) present, each in its own way, growing in cosmopolitan-mondialist constitutionalism (J Habermas, 'La costituzionalizzazione del diritto internazionale ha ancora una possibilità', in Id., *L'Occidente diviso* (Italian translation, Laterza, 2005); L Ferrajoli, Principia iuris. Teoria del diritto e della democrazia, vol. 2, Teoria della democrazia (Laterza, 2007), in the Franciscan constitutionalism that also permeates some passages of the encyclical 'Fratelli tutti' (I Massa Pinto, *Fratelli tutti. Un'enciclica costituzionale?*, 25 December 2020, <https://www.giustiziainsieme.it/it/attualita-2/1447-fratelli-tutti-un-enciclica> accessed 15 November 2023), in the social constitutionalism that has questioned the reasons for the indifference of constitutionalist doctrine towards the theme of inequality (L Ferrajoli, Per una Costituzione della Terra (2020) Teoria politica, 10, 39).

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SECTION I
ESSAYS

The Resilience of the Italian Healthcare System and the COVID-19 Emergency

Matteo Gnes

Abstract. Once the COVID-19 pandemic is over and the legislative measures aimed at containing its spread have been removed, it is time to identify the problems and successes of the struggle against the virus, in order to ensure not to be found unprepared in case of new pandemics.
To this end, the management of the epidemic is first examined, from both a regulatory, organizational and health perspective. Then, the lessons that can be drawn from it are examined, and which relate to the regulatory profile (with the development of tools aimed at limiting the onset of risk situations; and then, in case of need, establishing the methods of limiting the rights of citizens), to the organizational one (with the need to prepare and update national and regional pandemic plans, to maintain adequate stocks of medical devices; to rethink the organizational model of territorial healthcare, etc.), to that of scientific and technical cooperation, at national, European and international level.

Keywords: *COVID-19, resilience, Italian Healthcare System, emergency measures, emergency organisation.*

1. The Italian legal system tested by the COVID-19 pandemic

The publication of the decree-law of 10 August 2023, no 105, which eliminated the requirement of the isolation for people who tested positive for the COVID-19 virus[1], represented the end of the pandemic emergency, which had begun three and a half years earlier on 23 February 2020. The latter date was when the first orders and the first decree-law aimed at counteracting the spread of the virus were issued in Italy[2], just a few hours after the identification of the so-called 'patient one'[3].

[1] Art 9 of Decree-Law of 10 August 2023, no 105, concerning the abolition of obligations regarding isolation and self-surveillance.

[2] Decree-Law of 23 February 2020, no 6, providing urgent measures regarding the containment and management of the COVID-19 epidemiological emergency. On the first phases of managing the pandemic, see Matteo Gnes, 'Le misure nazionali di contenimento dell'epidemia da COVID-19' (2020) Giornale di diritto amministrativo, 282 ff.

[3] According to other opinions, the beginning of the pandemic emergency can be set on 31 January 2020, when the declaration of the state of emergency pursuant to civil protection legislation was issued in Italy, and its conclusion can be set with the end of this state of emergency (31 March 2022). In particular, with a resolution of the Council of Ministers of 31 January 2020, 'the state of emergency on the national territory relating to the health risk connected to the onset of pathologies deriving from transmissible viral agents' was declared for six months, and then was extended by resolution of the Council of Ministers of 29 July 2020 until 15 October 2020. Therefore, by resolution of the Council of Ministers of 7 October 2020 until 31 January 2021, then with a resolution of the Council of Ministers of 13 January 2021 until 30 April 2021, then with a resolution of the Council of Ministers of 21 April 2021 until 31 July 2021. Finally, the extensions were provided by legislative sources, notably with art 1 of the decree-law of 23 July 2021, no 105, the further extension of the state of emergency was postponed until 31 December 2021, and with art 1 of the decree-law of 24 December 2021, no 221, the further extension of the state of emergency until 31 March 2022 was provided for. Indeed, it does not seem that the state of emergency established pursuant to civil protection legislation can delimit the emergency period. On the one hand, the pandemic tsunami exploded later than the declaration of the state of emergency, yet on the other hand, the rules relating to the state of emergency governed by civil protection legislation have also found subsequent application (see art 1 of the decree-law of 24 March 2022, np 24 which establishes the permanence of the operational capacity of the measures issued with civil protection orders during the state of emergency, in addition to the possibility of adopting further orders).

In fact, with the decree-law no 105 of 2023, the COVID-19 virus is no longer considered a health and social emergency, but it is treated in the same way as the viruses that cause the common flu. Thus, only infected people are recommended to follow some precautions, notably those that are useful for preventing the transmission of most respiratory infections[4].

The COVID-19 pandemic was a dramatic event, not only for the thousands of victims in Italy, but also for the devastating effects on health, social and economic relations, and the concept itself of society. This is an event that will probably not remain in people's memories for long and will not constitute an important event in history (except, perhaps, specifically in the history of medicine), due to the comparably limited number of deaths[5], to the short duration of the restrictions and the speed with which vaccines to fight the virus were developed, thus quickly giving the impression of being able to quickly defeat the virus, or at least contain it.

Now that the pandemic emergency seems to be over, lessons can be drawn from the past, both to avoid repeating the mistakes made in any future emergencies, and to use instruments and tools developed to deal with the health emergency in ordinary times as well. Many of these instruments concern work and social relations, such as the development of remote communication systems, remote (or 'smart') working, and distance learning. As such, they do not specifically concern the healthcare system, so they do not fall within the scope of this study.

As regards the healthcare system, the most interesting tools and practices are those that have enabled and guaranteed its resilience and those that can constitute 'best practices' even outside the state of emergency. It must be underlined, however, that emergency tools may not be appropriate outside of an emergency because emergency tools have the purpose, first and foremost, to ensure the resilience of the system. 'Resilience' means the ability to react and resume, after a traumatic event, the original status quo[6]. The resilience of the system is therefore understood as the ability to overcome a critical situation to return to the previous situation. That is, from an economic point of view, a resistance to an economic shock and rapid recovery from it, not as a strategy to contrast innovation, but as a return to the ordinary development process of the system.

To this end, the most relevant aspects of resilience in the face of COVID-19 from a legal perspective will be examined: 1) the regulatory methods used to manage the pandemic; 2) the organizational measures used to counteract the emergency; and 3) public health and hygiene measures.

2. Management of the pandemic

The pandemic emergency required the adoption of regulatory measures aimed at counteracting the spread of a virus whose epidemic potential and danger were not yet well understood.

As has been underlined, the reaction of the Italian legal system was, on the whole, disjointed, disorganized and confused[7]. There has

[4] See Ministry of Health, circular of 11 August 2023, no 25613, relating to the update of measures to prevent transmission of SARS-CoV-2.

[5] Unlike the Spanish flu of 1919-1920, which is still remembered as one of the most dramatic health events in recent history. COVID-19 has caused less than seven million deaths globally, compared to the unknown number, most likely between twenty and one hundred million deaths, caused by the Spanish flu. Cf. GC Kohn (ed) Encyclopedia of plague and pestilence. From ancient times to the present, New York, Facts On File, 2008, 371 ff.

[6] The word 'resilience', according to the Oxford Dictionary of English (2010), means '1. the capacity to recover quickly from difficulties; toughness […]; 2. the ability of a substance or object to spring back into shape; elasticity'. The word takes on different but similar meanings, depending on the disciplines in which it is used. For example, in ecology, it is understood as 'the speed with which a community (or an ecological system) returns to its initial state, after being subjected to a disturbance that removed it from that state; the alterations can be caused both by natural events and by anthropic activities' (Resilienza, translated from the Treccani online encyclopedia).

From being strictly technical and specific, the term has found increasing use, to the point of indicating the strategy for overcoming a crisis, but which can also be useful for preventing it (see MV D'Onghia, 'Resilienza, una parola alla moda', *Magazine* of the *Lingua italiana della Enciclopedia Treccani*, <www.treccani.it> accessed 20 November 2023). In recent years it has also found wide use in the context of political-institutional language, especially following the COVID-19 epidemic, becoming an integral part of the National Recovery and Resilience Plan (NRPP – PNRR in Italian) (see A Cortelazzo, 'Resilienza', *Magazine*).

[7] M Gnes, Le misure nazionali di contenimento dell'epidemia da Covid-19, 283.

been an overlapping of regulatory and administrative provisions of various authorities (including the Ministry of Health, the President of the Council of Ministers, the presidents of the regions, mayors, prefects, and government commissioners), granted on the basis of different regulatory bodies, giving rise to what has been defined as the neo-law of the pandemic emergency[8].

As a partial justification for Italy's unpreparedness, it should be noted that Italy was the first European country, and even the first democratic country in the Western world, to face the COVID-19 pandemic. Italy found itself quickly choosing a response model to the pandemic, preferring the one based on social distancing and the consequent blocking of economic activities. In this situation, priority was thus given to the protection of health and to the solidarity principle of protecting the weakest subjects and those more exposed to the disease (particularly the elderly), compared to that of minimum measures based on cost-benefit calculations, a model initially used by the United Kingdom[9].

Four different bodies of legislation have been used to deal with the pandemic: health legislation, civil protection legislation, legislation that attributes emergency powers to local authorities and the discipline dictated by decree-laws issued specifically to counteract the spread of the pandemic.

First, in health matters, the Health Code of 1934 gives the Minister for the Interior the power to issue special orders[10], and the law establishing the national health service of 1978 attributes to the State jurisdiction over international prophylaxis (according to art 117 of the Constitution, as amended in 2001) and provides that the Minister of Health can issue emergency orders in matters of hygiene and public health extended to the entire national territory or area of it including several regions. The same power is entrusted to the president of the region and to the mayor, with effectiveness extended respectively to the region or part of its territory including several municipalities and to the municipal territory[11].

Second, there is the regulation establishing the national civil protection service, which has the objective of protecting life, physical integrity, property, settlements, animals and the environment from damage or danger of damage resulting from calamitous events of natural origin or resulting from human activity[12]. The civil protection regulation was 'activated' with the declaration of the state of emergency on 31 January 2020[13] which attributed emergency powers to the Head of the Civil Protection Department. Despite not having specific expertise in health matters, the Department is institutionally responsible for managing emergencies in Italy and is the best equipped body to carry out organizational tasks and/or tasks with financial implications (e.g. allocation of funds, collection of donations from citizens to support the national healthcare system and hiring of staff), as well as instrumental tasks. For example, the supply of healthcare devices, a task subsequently entrusted to the Extraordinary Commissioner for the COVID-19 emergency, due to the difficulty of obtaining them on the national territory.

Third, other emergency powers are provided for by Legislative Decree of 31 March 1998, no 112, which attributes to mayors, as representatives of their local community, the power to adopt contingent and urgent orders. Depending on the size of the emergency and the possible involvement of multiple regional territorial areas, it extends jurisdiction to the State or the regions as well. Furthermore, the Consolidated Law on the organization of local authorities (Tuel) gives the mayor the power

[8] See S Cassese, 'Il neodiritto del virus' (2020), Il Foglio (5 May 2020).

[9] See I Massa Pinto, 'La tremendissima lezione del Covid-19 (anche) ai giuristi' (2020) Questione giustizia (18 March 2020).

[10] Art 261, par 1, of the royal decree 27 July 1934, no 1265, concerning the approval of the consolidated text of health laws, attributes to the Minister for the Interior, in the event of the development of an infectious disease of an epidemic nature, the power to 'issue special orders for the visit and disinfection of homes, for the organization of medical services and aid and for the precautionary measures to be adopted against the spread of the disease itself'.

[11] Articles 6 and 32 of law 23 December 1978, no 833, concerning the establishment of the national health service.

[12] The national civil protection service was established with law 24 February 1992, no 225 and is currently regulated by Legislative Decree of 2 January 2018, no 1.

[13] Resolution of the Council of Ministers of 31 January 2020, Declaration of the state of emergency as a consequence of the health risk associated with the onset of pathologies deriving from transmissible viral agents, in the Official Journal of 1 February 2020, no 26.

to issue contingent and urgent orders to deal with health or public hygiene emergencies or to prevent and eliminate serious dangers that threaten public safety[14].

Fourth and finally, through several legislative decrees, the Government has redesigned the emergency management system, typifying the containment measures (consisting of strong limitations on personal freedom, freedom of movement, economic freedoms, freedom of assembly, religion, and so on), as well as regulating the methods of carrying out judicial activity, allocating funds and establishing other measures to support the economy. With the decree-laws, in particular, it was established that the decree of the President of the Council of Ministers (DPCM) would be a tool to govern the containment of the pandemic. The possibility of intervention by the presidents of the regions and the mayors was also coordinated to avoid measures in conflict with the national ones, establishing, depending on the phases of the emergency, that containment measures for the epidemic could be adopted which extended beyond to those established at national level, or could only be more restrictive, and within what limits[15].

Furthermore, other measures have been adopted with ministerial orders, as well as with ministerial circulars (among which those of the Minister of Health and those of the Minister of the Interior have assumed particular importance). In particular, the orders of the Minister of Health (or that of Infrastructure and Transport) were used to establish restrictive measures, often pending the subsequent adoption of the same measures with DPCMs or as technical decisions in implementation of what was established with DPCM.

The activities implemented during the pandemic emergency followed four essential lines. The first, also in chronological order, consisted of the adoption of regulatory measures to contain the spread of the infection through the imposition of personal distancing (also called 'social distancing') for all people, in order to limit the spread of the virus as well as the quarantine of people suspected of having contracted the disease. The second line of action was that of the development of investigations aimed at identifying infected subjects and those suspected of having been infected, through the reconstruction of the epidemiological chain (so-called *testing, tracking, tracing*) and, subsequently, through the development of rapid tests for the detection of the virus. The third was the strengthening of healthcare facilities (hiring of staff; increase in intensive care places; supply of ventilators; and supply of personal protective equipment) and the assistance of administrative structures (with the supply of personal protective equipment or thermoscanners) and of people in difficulty (such as organizing the return of Italians from abroad). Finally, the fourth line of action had the objective of mitigating the effects of the suspension of administrative and economic activities stemming from the implementation of the containment measures, through economic support measures, suspension of deadlines, legal limitation of the liability of public employees in order to allow the acceleration of procedures, implementation of technological and work measures to allow activities to be carried out from home (remote working, online lessons for schools and universities and so on).

3. The legal problems of the regulatory management of the pandemic emergency

The fight against the spread of the virus required the adoption of measures that were highly restrictive of freedom of movement and other freedoms connected to it, which found its harshest expression in the so-called national *lockdown* (9 March – 18 May 2020), which was preceded and then followed by the establishment of red zones, where people's movements were prohibited except for specific reasons.

With the law-decree of 25 March 2020, no 19, the containment measures already established with law-decree no 6 were better regulated, expressly providing (and, therefore, 'typifying') the possibility of establishing measures to 'limit the movement of people, also providing limitations on the possibility of moving away from one's residence, domicile or abode except for individual movements limited in time and in space or motivated by work needs, situations of necessity or urgency, health reasons or other specific reasons'. Furthermore, the procedure for adopting the measures through Prime Minister Decrees (Decrees of the President of

[14] Articles 50 and 54 of Legislative Decree of 18 August 2000, no 267.

[15] See Law-Decree 23 February 2020, no 6, Urgent measures regarding the containment and management of the epidemiological emergency from COVID-19, later replaced by Law-Decree 25 March 2020, no 19, Urgent measures to deal with the epidemiological emergency from COVID-19.

the Council of Ministers – DPCMs) was better regulated and their maximum duration (thirty days, although they can be repeated) was established. Finally, the powers of the other administrations potentially interested in the adoption of emergency health measures were coordinated. It was foreseen that, pending the adoption of the DPCMs, the Minister of Health, as well as, at a regional or sub-regional level, the president of the regions, could adopt temporary urgent measures in the event of situations of worsening health risk arising without affecting production activities of strategic importance for the national economy. Further, the mayors could not adopt, under penalty of ineffectiveness, contingent and urgent orders aimed at dealing with the emergency in contrast with state measures, nor exceeding the typical measures[16].

The overall regulatory framework as established by decree-law no 6 and 19 of 2020 gave rise to the so-called neo-emergency law, based on the strategy of containing the spread of the virus through the adoption of measures aimed at imposing 'personal distancing', limiting the freedom of movement of people, but also affecting other constitutionally guaranteed rights and freedoms, to be adopted with Prime Ministerial Decree.

The strategy adopted by the Government, despite being, on the basis of constitutional and regulatory principles, of scientific knowledge, and of social and cultural factors, the most adequate to deal with the epidemic, gave the impression of a confused, improvised management, with provisions at least partly unconstitutional.

Simplifying, the most relevant legal problems have been: 1) the constitutional legitimacy of the restrictions adopted to deal with the pandemic with reference both to the constitutional freedom that has been limited and to the reconciliation with the other affected freedoms; 2) the competence to adopt the measures; and 3) the instrument to be used to impose the restrictions.

The issue of the constitutional legitimacy of the adopted restrictions has been the subject of debate by lawyers and media since their adoption. The legal basis on which the emergency regulation was adopted was article 16 of the Constitution, which allows the limitation of freedom of movement and residence only by law and on a 'general basis for health or safety reasons', giving rise to a legal reserve strengthened in content. Restrictions on freedom of movement have had significant consequences on most constitutionally protected freedoms, such as the right of assembly (art 17), some forms of expression of thought (art 21) and freedom of religion (art 19), the right to strike (art 40), the right-duty to work (art 4), private economic initiative (art 41), the right to education (arts. 33 and 34), freedom and secrecy of correspondence (art 15), and the right to vote (art 48)[17].

Some of the restrictive measures adopted have suggested an interference with personal freedom (art 13 of the Constitution), the limitation of which requires the intervention of the judge. In particular, it was discussed whether the latter included the obligation to stay at one's home, from which one could only leave for the reasons indicated by the DPCMs and the various interpretative circulars, or the 'absolute ban on mobility from one's home' for people subjected to quarantine or who tested positive for the virus, or self-isolation for fourteen days for people coming from risk areas.

Even if, in some cases, the ordinary judge considered that the measures adopted entailed an (illegitimate) limitation of personal

[16] Art 3, c 2 and 1, of Law-Decree 25 March 2020, no 19; the rule limiting trade union powers was later repealed by art 18, of Law Decree 16 July 2020, no 76.

[17] For a detailed list of limited rights, see A Algostino, 'Covid-19: primo tracciato per una riflessione nel nome della Costituzione (2020) Rivista AIC, 21 April 2020; A Bartolini, 'Torna il coprifuoco? Alcune riflessioni sul DPCM (Decreto Presidente Consiglio dei Ministri) coronavirus dell'8 febbraio [marzo] 2020' (2020) ridiamm; L Fabiano, 'La catena della normativa emergenziale in risposta alle minacce di diffusione del Covid 19 riflessioni sulla tenuta in termini di legittimità e di opportunità delle scelte normative del governo italiano' (2020) BioDiritto – BioLaw Journal (16 March 2020); L Cuocolo, 'Presentazione', in 'I diritti costituzionali di fronte all'emergenza Covid-19. Una prospettiva comparata (2020) Federalismi; M Carrer, I limiti costituzionali del diritto di circolazione. I casi della pandemia e delle politiche sulla mobilità e circolazione stradale (2023) Ambientediritto. As concerns the limits to the right of education, v. B Barbisan, 'Uguaglianza nell'emergenza? Il Persönlichkeitsrecht della Grundgesetz e la Due Process Clause del XIV Emendamento alla prova dei limiti al diritto all'istruzione in tempo di pandemia da COVID-19' (2023) 'DPCE online 57, no 1; G Trombetta, 'I limiti alla libertà di riunione nella costituzione materiale del Paese, anche a fronte dell'emergenza coronavirus', Federalismi, 19 October 2020.

freedom[18], administrative jurisprudence has consistently expressed itself in the sense of the legitimacy of the measures adopted. Indeed, as subsequently confirmed by the Constitutional Court, art 13 refers to restrictions mediated by the use of physical force, as well as those which involve the 'total subjection of the person to the power of others', with which the 'freedom of moral' of individuals, imposing on them 'a sort of legal degradation'[19].

Therefore, the restrictions established to deal with the pandemic do not fall within the scope of application of the art 13 of the Constitution (personal freedom), but that of art 16 (freedom of movement and residence) read together with art 32 of the Constitution (right to health). Therefore, the measures adopted were to be considered legitimate in relation to the constitutional principles of adequacy and proportionality with respect to the aim of protecting one of the fundamental values of the Italian Republic, namely the health of citizens[20]. Even if the right to health, despite its qualification as a 'fundamental right' (the only right to be defined 'fundamental' by the Constitutional Charter), cannot be considered a primary and prevalent right with respect to which all other rights can be sacrificed[21], it can, in conjunction with other rights, allow a temporary and partial limitation. The management of the health emergency has led to a limitation, sometimes very strong, of other rights, but not a complete sacrifice of them.

The limitation of other rights seems to be tolerated when two fundamental values are at stake: the security of the State and the health of its citizens. The first, because it is 'related to the protection of the *salus rei publicae* and, therefore, such as to involve a pre-eminent interest over any other, because it concerns the very existence of the State'[22], the second because it is inherent to the survival of its associates

[18] See for example Justice of the Peace of Frosinone, judgment 15-29 July 2020, no 516; Court of Reggio Emilia, Sec. GIP-GUP, judgment 27 January 2021, no 54.

[19] Constitutional Court, judgment 26 May 2022, no 127, point 5, in Foro it., 2022, I, cc. 2246, with comment by R Romboli; and in the Criminal and Procedural Directorate, 2022, 1510 ff., with comment by V Zagrebelsky, Quarantena da Covid nella giurisprudenza della Corte costituzionale e della Corte europea dei diritti umani, ivi, 1515 ff. The decision recalls its precedents of 27 March 1962, no 30 and 3 July 1956, no 11. For this thesis, see M Luciani, 'The system of sources of the right to proof of emergency', in Consulta Online, 11 April 2020, 14 ff. On the distinction between personal freedom and freedom of movement, see A Pace, Problems of constitutional freedoms: lessons. Special part, Padua, 1992, 169 ff.; on the different theories, see C Sagone, Freedom of movement and limitations placed for health reasons in the regional system, (2020) AIC magazine, 4.

[20] Furthermore, taking into account the "reserve of science" that exists in the matter: cf. M Nocelli, 'The fight against coronavirus and the solidarity face of the right to health', Federalismi, 11 March 2020, 6.

[21] According to the Constitutional Court, judgment, 9 May 2013, no 85, 'we cannot share the assumption […] according to which the adjective 'fundamental', contained in the art 32 of the Constitution, would reveal a 'pre-eminent character' of the right to health compared to all the rights of the person. Nor does the definition given by this Court of the environment and health as 'primary values' (sentence no. 365 of 1993[…]) imply a 'rigid' hierarchy between fundamental rights. The Italian Constitution, like other contemporary democratic and pluralist Constitutions, requires a continuous and mutual balancing between principles and fundamental rights, without claims of absoluteness for any of them. The qualification of the values of the environment and health as 'primary' therefore means that they cannot be sacrificed to other interests, even if constitutionally protected, not that they are placed at the top of an absolute hierarchical order. The balance point, precisely because it is dynamic and not pre-established in advance, must be evaluated – by the legislator in establishing the rules and by the judge of the laws during control – according to criteria of proportionality and reasonableness, such as not to allow a sacrifice of their essential core'. See L Fabiano, 'La catena della normativa emergenziale in risposta alle minacce di diffusione del Covid 19. Riflessioni sulla tenuta in termini di legittimità e di opportunità delle scelte normative del governo italiano', (2020) BioDiritto – BioLaw Journal, 16 March 2020.

[22] Constitutional Court, judgment 13 February 2014, no 24 (regarding state secrets). On security as a priority value of the State, see G de Vergottini, 'Una rilettura del concetto di sicurezza nell'era digitale e della emergenza normalizzata', (2019) Rivista AIC, 11 November 2019; T Giupponi, 'La sicurezza e le sue "dimensioni" costituzionali, in Diritti umani. Teorie, analisi, applicazioni', in S Vida (ed) Human Rights. Theories, analyses, applications, Bologna, 2008, 275 ff. This is an ancient principle, which can be summarized in the statement in the Conclusions before the Tribunal des Romieu's conflicts in the case of Société immobilière de Saint-Just v. Prefect du Rhône, dated 2 December 1902, Req no 00543, therefore «quand la maison brûle, on ne va pas demander au juge l'autorisation d'y envoyer les pompiers».

(*primum vivere*)[23]. That the primary task of the State is to protect itself and its citizens is an ancient thought, which has been enriched with other values over the centuries, but whose essential core is that '*ollis salus populi suprema lex esto*'[24]. Therefore, the objective of collective safety was achieved with a sacrifice of the rights of individuals, in order to slow down the contagion and thus safeguard the capacity of the healthcare system, avoiding the need to make 'tragic choices' regarding who to treat[25].

The second problem concerns legislative competence, since 'health protection' is a matter of concurrent legislation between the State and the regions and the Italian national health system is managed at a regional level. In order to coordinate the response to the pandemic emergency between all bodies with intervention powers pursuant to current legislation, with legislative decrees no. 6 (and especially no 19) of 2020, the Government defined (and limited) the measures (and related limits) that local authorities could have adopted, in some cases challenging regional orders conflicting with national decisions before administrative courts[26] or eliminating the mayors' orders through a special power of annulment granted to the Minister of the Interior, or challenging regional laws in conflict with state emergency regulations before the Constitutional Court.

The Constitutional Court, first with a preliminary order and then with a judgment, found the exclusive legislative competence of the State in the matter, which is that of 'international prophylaxis', which 'is inclusive of every measure aimed at combating an ongoing health pandemic or to prevent it'[27].

The third problem is that of the source used to establish the measures limiting freedoms. During the Conte Government, which faced the first and most critical phase of the pandemic health emergency, 31 law decrees were issued to combat the epidemic (including those relating to economic support measures) and 23 DPCMs. Subsequently, during the Draghi Government it was preferred to resort to the decree-law, also in order to partially extend the effectiveness of the measures established with the DPCMs.

The legitimacy of the use of the DPCM instrument was discussed, both because it was an 'anomalous' instrument compared to those established by the legislation in force at the time of the outbreak of the pandemic, which attributed intervention powers to the Minister of Health, the presidents of the regions and the mayors, and because it was considered in violation of the constitutional principles regulating legislative activity, as they would have had a normative function.

Given that the DPCM is an increasingly used instrument, which lends itself to multiple functions, including that of innovating the legal system, thus assuming a normative function, it should be specified, on the one hand, that it is not a new instrument also for managing emergency situations and, on the other, that it did not have a regulatory nature[28].

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[23] For this opinion, see M Luciani, 'Il sistema delle fonti del diritto alla prova dell'emergenza', 4 ff.; G Zagrebelski, Giusti i divieti se tutelano il diritto alla vita, in (2020) Repubblica, 21 marzo 2020, 7.

[24] Cicero, De legibus, III, 3, 8-9. See also T Hobbes, De Cive, chap XIII, par II and chap VI, par VI, for the idea that the rule of law must ensure the protection of a single fundamental right, namely the right to life. On the role of the State as intervener or guarantor of last resort, see M Gnes, 'Wars and fights against pandemics: the re-emerging role of the State as guarantor of last resort' (2022) Revue européenne de droit public – European review of public law, vol 34, 57 ff; and, for other ideas of interest, G Amato, Bentornato Stato, ma, il Mulino, 2022.

[25] See S Cassese, 'Stato di necessità. Perché dobbiamo evitare di essere messi di fronte a "scelte tragiche"', Il Foglio, 10 March 2020, 1.

[26] Starting with one of the first orders adopted to combat the pandemic, namely the order of the president of the Marche Region of 25 February 2020, no 1.

[27] Constitutional Court, order 14 January 2021, no 4 and judgment 12 March 2021, no 37, on which see B Caravita, 'La sentenza della Corte sulla Valle d'Aosta: come un bisturi nel burro delle competenze (legislative) regionali', Federalismi, 21 April 2021; D Morana, 'Ma è davvero tutta profilassi internazionale? Brevi note sul contrasto all'emergenza pandemica tra Stato e regioni, a margine della sent. no 37/2021' (2021) Forum di Quaderni costituzionali, 2, 11ff; A Cardone, 'Contrasto alla pandemia, "annichilimento" della potestà legislativa regionale e torsioni della decretazione d'urgenza: è davvero così liberamente derogabile il sistema di protezione civile?, ivi, 312 ff; A Poggi, G Sobrino, 'La Corte, di fronte all'emergenza Covid, espande la profilassi internazionale e restringe la leale collaborazione (ma con quali possibili effetti?)' (2021) Osservatorio costituzionale, no 4, 231ff; L Califano, 'I nodi irrisolti del regionalismo italiano' (2022) Cultura giuridica e diritto vivente, no 10, 1ff.

[28] M Rubechi, I decreti del Presidente. Studio su D.P.C.M., atti normativi del governo e dinamiche

The use of the DPCMs was not the result of an extemporaneous improvisation, but was foreseen in the 'National plan for preparation and response to an influenza pandemic' (so-called Pandemic Plan) of 2006, which, although not expressly applied nor even referred to in the official documents concerning the management of the pandemic, was known to the technicians who supported the Minister of Health. It is also a tool used within the civil protection system.

The Constitutional Court itself recognized that legislative decrees no 6 and no 19 of 2020 did not attribute legislative powers to the Prime Minister in violation of articles 76 and 77 of the Constitution. In fact, the legislative decree no 19 of 2020, typifying the containment measures, providing for their temporary nature, establishing a criterion to guide the exercise of discretion through the 'principles of adequacy and proportionality to the risk actually present on specific parts of the national territory or on its entirety'[29], by establishing a complex preparatory activity, had established its character as an administrative (and not normative) provision. The figure outlined, according to the Constitutional Court, 'is much more consistent with the provision of administrative power, albeit with general effect', and the rule 'far from giving rise to a conferral of legislative power on the President of the Council of Ministers in violation of the articles. 76 and 77 of the Constitution, merely authorizes him to implement the typical measures envisaged'[30].

Therefore, the DPCM and the decree-law are both legitimate instruments[31] although with differences regarding political expediency, where the decree-law leads to the full involvement of the Parliament, and the speed of intervention of the administrative judge, who can immediately review and possibly cancel the Prime Minister decrees (DPCMs), as they are administrative measures.

A problem arose, indeed, in the use of other tools to indicate the scope of the measures, such as circulars (in particular, from the Ministry of the Interior and the Ministry of Health), press releases and *frequently asked questions* (FAQ): these tools, in fact, constituted the instrument for outlining the scope of the restrictions[32].

4. Organizational measures

Alongside the pandemic containment measures, emergency regulations have been issued aimed at implementing, in derogation of current legislation, organisational, contractual, simplification and support measures for the management of healthcare facilities, from the establishment of the phone emergency number, to the creation and administration of swabs, vaccination, or hiring of staff. Even the issuing of these measures demonstrates the improvisation of the emergency management and the lack of an adequate strategy to deal with it.

Yet, although not updated, a *Pandemic Plan* existed, dating back to 2006[33], but it was never applied and was only mentioned once in one of the first meetings of the 'Task force' established by the Ministry of Health. The failure to apply the Plan, subsequently justified by the leaders of the Ministry of Health on the basis of the consideration that the COVID-19 pandemic and the influenza pandemic are different situations[34], has relevance not only from a formal

decisionali, Torino, Giappichelli (2022), 115 ff.; B Sboro, 'Stato d'emergenza, atti necessitati e ordinanze emergenziali. Alcune riflessioni a partire dalla sent. no 198 del 2021', Federalismi, 2022, 9, 70ff; G Tropea, Biopolitica e diritto amministrativo del tempo pandemico (Editoriale scientifica, 2023) 271ff.

[29] In art 1, c 2, of legislative decree 19/2020.

[30] Constitutional Court, judgment 22 October 2021, no 198, in Foro italiano, 2021, I, c 3721.

[31] Constitutional Court, judgment, 12 March 2021, no 37 and above all Cons. State, Sec. I, opinion, 13 May 2021, no 850.

[32] GF Pulizzi, 'Administrative circulars and "internal rules" to the test of the emergency', (2023) Nuove Autonomie, 337ff; S Foà, 'Administrative circulars in the pandemic emergency' (2022) Federalismi, 7, 92ff.

[33] The national plan for preparation and response to an influenza pandemic, approved with the agreement of the State-Regions Conference of 9 February 2006, no 2479 (and published in the Official Journal of 1 April 2006, no 77, SO), drawn up on the basis of the indications issued in 2005 by the World Health Organization, represents the reference on which the regional operational plans as well as the national guidelines must be prepared for further actions by the National Center for Disease Prevention and Control – Ccm) and is divided into six phases, providing for each phase and level the corresponding objectives and actions. On planning on the matter, see M Gnes, Le misure nazionali, cit.

[34] We cannot agree on this point. Despite the incomparably greater virulence, infectivity and mortality of the SARS-CoV-2 coronavirus compared to the virus of the so-called seasonal flu, both have in common the transmission through the spread of the virus by air, through respiratory droplets,

and regulatory point of view but also from that of health preparation. In fact, it was foreseen both the development of protocols for the use of personal protective equipment (PPE) for professional categories at risk, as well as their adequate supply, which did not happen, unless very late.

As a result, not only did Italy lack supplies of PPE, and in particular facial masks, but it had sent a significant quantity to China's as an aid when the pandemic appeared there. Therefore, to remedy the difficulty in supplying PPE, administrative simplification rules were issued. In particular, it was allowed to 'produce, import and market surgical masks and personal protective equipment in derogation of the provisions in force'[35]. This 'simplifying' rule, accompanied by an incorrect interpretation and application by the Italian administrations (such as the Customs Agency and the administrations commissioning the purchase of the masks, primarily the Department of Civil Protection) has led to the distribution, even to healthcare workers, of protective devices that did not comply either formally or substantively with technical standards.

As regards the organization of the regulatory management of the emergency, the considerable number of state authorities involved have already been mentioned. The most relevant bodies were, in addition to the President of the Council of Ministers, the Minister of Health, the Scientific Technical Committee (whose decisions constituted the scientific reference for the adoption of the DPCMs) and the Department of Civil Protection, whose functions were partly assumed by the Extraordinary Commissioner. When the consequences of the *lock-down* on the economy were realized, in April 2020 a committee of 17 experts was established (the so-called Colao Committee, from the name of its President) with the task of giving suggestions regarding the re-openings of selected economic activities to be implemented[36].

This demonstrates the unpreparedness and lack of knowledge of the already existing structures that should have been activated. In 2010, Italy established a crisis management system which, although its primary purpose is essentially to deal with political and economic emergencies, also has health-related responsibilities[37]. It is a body with transversal skills, also with information and national security tasks, which could have offered the political decision-maker a broad-spectrum vision of the consequences of the decisions to be made. The civil defense system should be completely rethought, and while being able to collaborate on operational aspects with the civil protection system, should also have strong planning and integrated crisis management functions.

Planning and typification of tools to deal with emergencies and organization to manage health, along with economic and social crises, should be the pillars on which a solid management organization for future pandemics should be based.

5. Public health and hygiene measures

The pandemic has provided useful lessons for dealing with any future health emergencies; it stimulated good practices and gave indications for a reform of the healthcare system 'in the ordinary'.

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which are emitted by the infected person when breathing or coughing. Furthermore, the seasonal influenza virus can also cause serious consequences, generating myocarditis, so much so that the InfluNet surveillance system was created some time ago. Given the rapidity of the mutation of influenza viruses and the possibility that the mutation leads to the emergence of a new influenza virus capable of passing to humans ('species leap'), potentially giving rise to a pandemic due to the absence of immunity, with serious consequences not only for health systems, but also for the wealth, social life and economic activities around the world, the World Health Organization supports the need for planning and preparedness, which are fundamental tools to mitigate the impact of a pandemic, as well as to manage response and recovery, and to this end has published, since 1999, the Pandemic Preparedness Guidelines (<https://www.who.int/influenza/preparedness/en/>). On the epidemiological aspects, see G Rezza, Epidemie. I perché di una minaccia globale (Carocci, 2020) 108 ff; M La Placa, Virus e batteri – Il nemico invisibile (il Mulino, 2011) 106 ff.

[35] In art 15 of Legislative Decree 17 March 2020, no 18 (so-called 'Cura Italia' Decree).

[36] The committee was established with the Prime Ministerial Decree of 10 April 2020 and presented its first report on the following 24 April.

[37] The system was established with the Prime Ministerial Decree of 5 May 2010, concerning the National Organization for Crisis Management, in the Official Journal of 17 June 2010, no 139, on which see M Gnes, 'La riforma dell'organizzazione nazionale per la "gestione di crisi"' (2011) Giornale di diritto amminstrativo, 19ff.

The health response consisted of the adoption of measures to contain and mitigate the epidemic, which, with their harshness, had made it possible, albeit with very serious costs for the economy, to reduce the epidemic, bringing to a very limited spread of the infection during the summer of 2020. Once the spread of the virus had been reduced and brought under control, while awaiting the development of a vaccine, it would have been necessary to prepare an efficient system for tracking cases. Instead, the development of the Immuni APP, due to its cumbersomeness and poor use, was a failure.

From a strictly healthcare perspective, examples of good emergency practices include the rediscovery of hygiene measures, the use of personal protective equipment, the identification of 'dirty' routes for access to emergency rooms and patient healthcare facilities of Covid patients, the temporary hiring of medical and nursing staff to identify people positive for the virus (with a progressive improvement not only of the diagnostic tools, but also of the organization of the service) and to treat the sick people, both at home (with the so called 'special continuity care units' – USCA) and in dedicated hospital departments. An example of excellent administrative organisation, even if based on the use of the logistical system of the armed forces, was the mass vaccination of the population against COVID-19.

The critical issues concerned the saturation of places in intensive care units, with the consequent risk of having to select the people to be treated[38] and the spread of the virus in nursing homes (RSAs), where it claimed a significant number of victims.

The pandemic has brought to mind hygiene measures that are often neglected, such as washing hands frequently and after contact with potentially contaminated objects. It also drew attention to alternative models of public health management, based on the diffusion of care across the territory, rather than the concentration of patients in a few large hospitals and retirement homes and nursing homes. Something has been done and will remain even once the emergency is over, but the impression is that many of the possible innovations are falling into oblivion. However, there is an important project for the reorganization of territorial assistance, which could constitute an interesting model for the development of public health[39].

6. Lessons for the future

Over three years after the declaration of the COVID-19 pandemic, the lessons from it are emerging in the legal and health areas[40].

First, it is necessary to rethink and reevaluate the relationship between science and technology, on the one hand, and politics and administration, on the other. And, above all, the role of judges, who were repeatedly called upon to resolve the complex conflicts that emerged between the various political decision makers involved, citizens and economic activities during all phases of the pandemic. There is the need to strengthen international[41] and European cooperation[42] and to guarantee the independence of technical bodies, which are too often controlled by politics.

In this direction, at a European level, it may be mentioned the strengthening of the role of the European Medicines Agency[43] and of the European Center for Disease Prevention and Control (ECDC)[44], and the establishment of bodies and procedures to address serious cross-border threats to health. In particular, the establishment of the Committee for Health Security (CSS), composed of representatives of the Member States, the establishment

[38] B Brancati, 'La selezione dei pazienti per l'ammissione alle terapie intensive. Una scelta tragica durante la pandemia di Covid-19', Consulta Online, 27 marzo 2023.

[39] Ministerial Decree (Minister of Health) 23 May 2022, no 77, concerning the regulation on the definition of models and standards for the development of territorial assistance in the National Health Service, in the Official Journal of 22 June 2022, no 144.

[40] M Gnes, 'La risposta italiana all'epidemia da Covid-19', (2021) Giornale di diritto amministrativo, 277ff.

[41] See D Mauri and G Minervini, 'On the implementation of international response and recovery obligations in the face of the Covid-19 pandemic: an Italian perspective', in Osservatorio sulle fonti, 1/2023.

[42] See S Tranquilli, 'Nobody saves himself alone: who decides on health security in the European Union?', Federalismi, 31 May 2023.

[43] Regulation (EU) 2022/123 of 25 January 2022 on an enhanced role of the European Medicines Agency in crisis preparedness and crisis management in relation to medicines and medical devices.

[44] Regulation (EU) 2022/2370 of 23 November 2022, amending Regulation (EC) no 851/2004, which creates a European Center for Disease Prevention and Control.

of a Union health crisis and pandemic plan (the *Union Prevention, Preparedness and Response Plan*) to promote an effective and coordinated response at Union level to cross-border health threats, and the regulation of an Early Warning and Response System (EWRS)[45]. The issue of rights also becomes increasingly relevant in consideration of the technologies that can support healthcare: hence the development of a 'European health data space', to be regulated by a European regulation, proposed by the Commission in May 2022[46].

Second, it is necessary not only to carefully analyze the legal management of the emergency, to evaluate its compatibility with the national and international system of protection of fundamental rights, but it is necessary to prepare rules, plans and bodies that can avoid the use of disproportionate and unnecessary measures. This is also in consideration of the possible different interpretation of the measures that could be provided by supranational judges[47].

Third, attention must be paid to the medical-health management of the emergency, especially with regards to its organizational issues, relating to the tools used to contain and mitigate the epidemic. It is essential for Italy to reflect on how to build a national emergency management system (not just one that addresses health emergencies) and, more generally, a crisis management system, that is closely coordinated with the European one and respectful of democratic principles.

Fourth and finally, with reference to the 'administrative' management of the emergency, attention must be paid to the application of pandemic plans, to (excessive) administrative simplifications and to the procurement of medical devices and equipment, as well as to the tools necessary to carry out the most important activities, such as educational activities. Emergency situations are often an opportunity to introduce exemption regimes and false administrative simplifications. Rather than introducing exceptions and suspensions of the ordinary regime, it would be appropriate to proceed with ordinary 'maintenance' of the rules, to keep the administrative system in a constant and updated state of efficiency, respecting the functions and public interests whose satisfaction was preordained by the legislator. Where necessary, exemptions should be carefully monitored.

[45] Regulation (EU) 2022/2371 of 23 November 2022, relating to serious cross-border threats to health and repealing Decision no 1082/2013/EU.

[46] COM (2022) 197.

[47] See T Pagotto, 'La Corte EDU promuove un approccio "olistico" alla Convenzione e accerta la violazione della libertà di riunione avvenuta durante la pandemia', (2023) Osservatorio costituzionale, 1.

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SECTION I
ESSAYS

Italian Reform of Primary Health Care in a Multi-level Governance. The National Recovery and Resilience Plan Becomes the Last Opportunity to Promote a Much Needed New Organisational Model

Nicola Giannelli and Andrea Lippi

Abstract. Public healthcare was born in Italy underfinanced, allowing doctors to supplement their earnings with freelance work. With the development of the mutual system, the general practitioner remained a freelancer while hospital doctors were allowed to practice freelance. National Health System born in 1978 inherited this professional duality. Therefore the physician who manages access and daily care of users is a private doctor with a loose agreement. The new health district was born with great hopes and few certainties. Yet doctors, experts and politicians agree on the fact that in the face of the inexorable aging of the population and therapeutic progress and the growing demand for treatment can only be supported with a strong capacity for prevention, medicines initiative, home care and therapeutic continuity outside the hospital. As more and more vulnerable people live alone, a social integration of the health care there will be necessary. Health plans and national reforms have not been sufficient to effectively strengthen primary care. Investments in reception facilities have finally arrived with the RRNP. With Decree 77, the Draghi Government has adopted as a model the organizational experiences of some regions that had tried to build containers in which general practitioners are called upon to work together with public medical and especially nursing staff. To convince all the regions to make this collaboration model work, the RRNP has concentrated its capital account economic incentives on the new Community Houses and outpatient care. Through investments in building containers we want to spread a new model of prevention, continuity of care, home care and local social care. Faced with the serious lack of human and organizational resources, however, there is a high risk that the regions that did not believe in this assistance model until yesterday will now limit themselves to a formal compliance, the minimum necessary to avoid losing the funds made available to them.

Keywords: *Health Care, Primary Care, Continuity of Care, Medicines Initiative, Outpatient Care, Community Hospital, Community Houses.*

1. Introduction

The COVID-19 pandemic (pandemic) was seized as an opportunity by the European Union (EU) to create a Community policy of investment in health policies. Within the framework of the Next Generation EU programme, Italy has agreed with the European Union on its plan to invest 191 billion euros. On 23 April 2021, the Draghi government presented the National Recovery and Resilience Plan (PNRR) to Parliament. The stated aim of the plan was to revive Italian productivity, which had been stagnant for many years, and to recover growth after the economic freeze caused by the pandemic. The first mission, transversal to all the others, was digitalisation, the emblem of modernisation of all national apparatuses. The second was ecological transition, the third was sustainable mobility, the fourth was education and research, the fifth was social inclusion and the sixth was the protection of citizens' health. The pandemic crisis has made it clear to everyone that public insurance against health risks is not a burden, but rather an indispensable resource for the smooth functioning of the economic system as a whole. And yet, this protection system risks becoming unsustainable in the face of Italy's long process of demographic aging.

There are two objectives indicated by the PNRR's sixth mission: a) 'strengthening prevention and care on the territory with the integration of health and social services'; and b) 'modernising the technological equipment

of the National Health Service'[1]. Both are called upon to help increase the sustainability of the Italian healthcare system. The first promotes technological efficiency, the second the strengthening of primary health care, considered indispensable to contain the growth of health expenditure in the face of a rapidly ageing population.

Modernisation does not refer to upgrading diagnostic or therapeutic equipment but instead to innovative services, such as digital medical records, telemedicine, and digital skills for staff. The Plan allocates EUR 8.63 billion to healthcare innovation and digitisation, while from 2023 – 2026 EUR 7 billion is dedicated to improving primary and territorial healthcare and telemedicine as a tool to overcome physical space. For the sake of comparison, let us recall that the total annual ordinary expenditure on public health in Italy was EUR 124 billion in 2022[2]. In that year, the annual allocation for the pursuit of national priorities amounted to only 1.5 billion.

In a healthcare system with a strong regionalisation in budget management such as the Italian system[3], tied funding represents one of the main political instruments to induce regions to pursue nationally defined objectives, although these are typically agreed upon between the national government and the regional administrations at the National Permanent Conference for Relations between State, Regions and Autonomous Provinces, a coordinating negotiating body that allows the connection between the central government and the regions. The allocations decided when the PNRR was drafted thus constitute an important chapter in the national-regional co-management of the guidelines for intervention on the health system and were specified by the Ministry of Health in Decree No 77 of 23 June 2022, which was the result of a comparison between the levels of government. Since regions in Italy have both centre-right and centre-left governing coalitions, and since there are significantly different healthcare systems within regions in terms of organisation, each decision is the result of a mediation between different perspectives and composite interests[4].

This article addresses the second innovation because it proposes a new organisational model that enhances the intermediate level between the primary care of family doctors (i.e. General Practitioners), on the one hand, and hospitals, on the other. In Italy, territorial healthcare has always been depressed and its strengthening has been a historical reform objective that has never been realised. In this area, the PNRR opens a window of opportunity never seen before, because it makes possible the relaunch of an idea that is crucial to the fate of Italian healthcare by giving it relevance and financial support. However, as we shall see, at the same time it does not provide all the necessary conditions for this outcome to be achieved. A few months after the approval of the PNRR, the Draghi government passed a decree, no. 77 of 23 July 2022, which specifies the model of territorial care sketched out in the PNRR and which is aimed at bridging the gap between hospitals, on the one hand, and the network of services on the territory, on the other.

This article describes the design of the reform which has as its centre the so-called Community Homes in a network of integrated services within the health administrative unit of reference: the health district. The aim of the contribution is to highlight the aims, strategy and policy tools of the reform promoted by Ministerial Decree No. 77 of 2022 and to highlight the main threats and criticalities of its implementation. The analysis concludes with an interpretation of current trends and a path-dependent implementation process, which is highly localised, full of potential, but extremely uneven.

Since an understanding of the historical pathway is indispensable for understanding the current situation, this article describes the evolution of territorial healthcare in Italy from its origins, with its challenges and the attempt to institutionalise it through a number of failed reforms. It then describes the planning and programmatic instruments of Ministerial Decree No 77 of 2022 and the main criticalities of its implementation. The data in this section are derived from documentary analysis, in addition to the historical background of the initial section, and three interviews with privileged witnesses[5].

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[1] Italian Government National Recovery and Resilience Plan (PNRR), Rome, 2021, par. 2.3, Mission 6, 21.

[2] Camera dei Deputati, Repubblica Italiana, Il livello di finanziamento del Servizio Sanitario Nazionale, Roma 28 September 2022.

[3] V Mapelli, Il sistema sanitario italiano (il Mulino 2012).

[4] F Toth, Politiche sanitarie. Modelli a confronto (Laterza, 2009).

[5] 1) A professor of health economics and former director of the Ministry of Health; 2) A manager of a public health and social care service; and 3) A manager of a Health District.

2. The Evolution of Territorial Primary Care in Italy: A Trajectory of Path Dependence

The historical roots of primary care in Italy

The traditional Italian system of "mutual aid societies" had not experienced, in the inter-war period, the breakthrough of compulsory health insurance that happened in other European countries. This did not happen until the height of the war, on 11 January 1943, with the establishment of the Ente di Mutualità Fascista, which became the Istituto Nazionale per l'Assicurazione contro le Malattie (INAM) in 1947.

The mutualist system, developed in liberal Italy and preserved during the twenty-year fascist period, combined the defence of the free professional activity of doctors with a private insurance model subject to political control, which became absolute during the fascist period[6]. Political control remained separate from fiscal responsibility and, throughout this period, public health expenditure fluctuated between 0.2 and 0.5 per cent of GDP[7]. Thus, the bulk of health care expenditure came out of citizens' pockets. It must be remembered that pharmacology was in the infancy: quinine, produced since 1900 by the state pharmaceuticals company as a drug against malaria, was widely used 'off label', and surgery was also rudimentary.

In the area there was generally the 'medico condotto', a municipal employee who acted as a health officer and only worked as a public doctor for the poor but was authorised to collect fees from patients who could afford it. From that time, therefore, the public role and the private profession coexisted. The public remuneration could be modest because it was supplemented by the private profession. But this second source of income depended on the social context in which the doctor had the good or bad luck to work. The geography of health coverage provided by these doctors was, however, insufficient for the population to be served and therefore, with the development of the clinical capabilities of medicine, the space for the spread of the General Practitioner (then 'mutual aid doctor'), a professional who was tied to the mutual aid societies by a piecework service contract, expanded after the Second World War.

The most important stakeholder in this sector was the Catholic Church, linked to private health institutions, as well as the entrepreneurs who wanted to maintain their discretion as employers in the provision of health cover, the doctors who practised mostly as professionals and the majority party and the Christian Democrats who set out to represent all these categories by combining their interests with those of the workers and their families. The state was the guarantor of the maintenance of the mutualist institutions for the various population groups. The doctors were able to maintain conditions of great freedom and professional autonomy within the conventions stipulated with the mutual societies. The Church managed many clinics indirectly, while entrepreneurs contracted health coverage as part of the workers' compensation, and the latter saw a confirmation of their social position precisely in this recognition. In connection with this, trade unions saw their role in bargaining recognised. In the traditional family model it was considered normal that a person's enjoyment of social protection depended on the social status of his or her breadwinner[8].

The mutual entities were therefore weak organisations in which the corporate and individual interests of the professionals prevailed, as well as pressure from politicians to extend coverage, even in deficit. It was a fragmented, uneven, weak system, with strong territorial differences ranging from the excellence of a few well-established hospital institutions, especially in the North, to the marginal and backward realities of many garrisons in less wealthy and less central areas. Being an insurance system offered by numerous mutuals, the lack of homogeneity also concerned the level of coverage against health risks. The economically richer territories were more attractive to doctors and offered the resources to develop much more complex care institutions.

3. The Italian National Health System in the 1970s

The Italian National Health System was born with a reform in 1978, Law No. 833, which traced the model of the British National Health Service of 1948 that itself was modelled on the universalist principle of equal social rights.

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[6] G Vicarelli, Politica sanitaria e medicina privata in Italia. Stato e mercato, no. 36, December 1992, 457- 471.

[7] D Vincenti, La storia della sanità pubblica dall'Unità ai giorni nostri. Tesi di Laurea Magistrale (LUISS Universiy 2015/16).

[8] G Vicarelli, Politica sanitaria e medicina privata in Italia. Stato e mercato, 460.

Hence its stated purpose, which is to provide all citizens with the same level of care. From the British model, Italy has adopted a second principle, since the National Health System is financed by general taxation instead of payments to mutual societies and therefore everyone pays in proportion to income. Italy has thus moved from a corporatist principle of risk protection to a universalist redistribution.

Previously, in 1968, the Italian hospital reform tried to bring some order to the hospital sector but failed to make up for the deficits that the mutuals were accumulating due to the rising costs of this area of care[9]. As discussed above, the mutual societies already had a general practitioner whose task it was to take charge of first intervention drug prescriptions and provide small-scale treatment while trying to minimise the cost of individual services. The differences in the availability of resources and the fragmentation of the delivery models in the territory remained, which were therefore present at the time of the introduction of the new organisational model.

The new healthcare system did not wipe out the previous organisational models; instead, it was built from the existing professional structures in the healthcare field with the legacy of established interests. In those same years, throughout the developed world, scientific and technological advances were transforming hospitals into establishments with ever greater technological investment and professional specialisation, finally achieving great clinical success. Patients began to see the hospital as the real place of care while the general practitioner was assigned the task of first screening and prescribing drugs. The other access point to public care was the hospital emergency room.

The project to nationalise the health system in Italy saw strong political opposition from the majority of general practitioners and the most sought-after professionals, who did not want to lose their free-professional autonomy. This opposition was overcome through two options: 1) the concession to doctors in public hospitals to be able to practise as freelancers even in relation to the same patients for the same speciality for which they practised in public hospitals, and 2) the maintenance of the freelance status of general practitioners, who were, however, not allowed to carry out specialist activities with the patients assigned to them[10]. These are concessions that weaken the institutional strength of the public organisation of services and confirm the political weight of these professional categories.

4. The Crucial Role of Primary Health Care

The Alma Ata Declaration, also from 1978, in which the World Health Organisation emphasised the importance of primary health care as an indispensable guarantee of people's care, explained that:"It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work and constitutes the first elements of a continuous health process"[11].

Thus, at least on paper, the health district was born. Without the imposition of a single organisational model and left to the political choices of the regions, which in the Italian institutional system had only been operational for a few years, it had a scattered and episodic implementation. These choices may explain the structural weakness at the root of the public organisational system, which left room for individual incentives dictated by the market and not always consistent with the objectives of the public health system.

General practitioners of mutual societies, therefore, remained professionals contracted to the public health system within a system of separation that did not provide for shared governance and remained the only real daily interface with patients. In this case, as in the mutual agreement, they were forbidden from practising their profession in relation to the patients they cared for, which was, however, permitted in other outpatient activities[12]. Quality standards and controls were entrusted to provincial commissions composed of a majority of general practitioners and chaired by the local presidents of the Medical Association. The state thus renounced any real control role, contenting itself with imposing, from time to time, spending limits on the quantity of services.

[9] F Toth, La sanità in Italia (il Mulino, 2014).

[10] G Vicarelli, Professioni e welfare: i medici generici nel Servizio Sanitario Nazionale, Stato e Mercato, no 16 April 1986, 93-122; F Toth, La sanità in Italia.

[11] World Health Organization, Conferenza internazionale sull'assistenza sanitaria, Alma Ata, URSS, 1978, <https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata> accessed 15 November 2023.

[12] G Vicarelli, Professioni e welfare: i medici generici nel Servizio Sanitario Nazionale, 110.

5. The Health District in the Light of the Reforms

As noted above, the law instituting the National Health System of 1978 assigned the district the task of providing primary care, leaving the organisation of its operation to the regions. The district had thus featured different forms and attributions in the various regions. The management of hospitals and districts was entrusted to the Local Health Authorities, on the boards of which sat the members of the municipal councils of the area in which the units operated. In Italy at that time there were many competing parties in a proportional electoral system and, therefore, representatives of many parties in alliance and competition sat on the boards. As a result, governance was fragmented and lacked clear managerial responsibility. The reputation of this party-clinic system among citizens gradually declined and, in most cases, the district suffered from weak management, few resources and represented unattractive career prospects for doctors.

In 1992, the Italian political system was hit by a wave of judicial investigations that showed the public many areas of corruption in the party system. In that same year, the law was passed that introduced the corporatisation of health services in Italy according to the doctrine of New Public Management, separating health management from local politics[13]. The reform required the regions to reshape the geographical area of the districts into a larger one, often at the provincial level, to pursue efficiencies of scale. The internal structures were divided into departments, including prevention and mental health departments, whose operations in the territory overlapped with those of the districts. In this model, the district remained without managerial autonomy and was consequently very weak.

The 1992 law that introduced the corporatisation of public health confirmed the central role of coordinating the health services of prevention and primary care at the district level together with the social services of the municipalities. As such, the district had the task of coordinating social and health care at the same time. The new governance system provided for a general director, who was not appointed by the representative body, and did not provide for any consultation body with the local authorities.

The district still assigned general practitioners (GPs) the task of ensuring continuity of care for residents. The law recognises a right of veto for the doctors' representative bodies, since the regulation of this task is postponed to these agreements, which must "agree, together with the trade unions of the categories of duty doctors and duty doctors, on the tasks and services to be ensured on the basis of a per capita fee per patient, defining the areas referred to in the regional level agreements, which must guarantee continuity of care for the whole day and every day of the week, also by means of gradual forms of medical associationism, as well as providing that the services be ensured with remuneration commensurate with the services themselves'[14]

With respect to this provision of the law, it must be said that the part relating to continuity of care has never been fully implemented, while medical associationism has so far remained voluntary and little practised.

The first turning point towards a new approach in primary care: the 1998-2000 PSN

The National Health Plan (PSN) 1998-2000 confirmed the district as the place of continuity of care, institutionalising territorial care as a place of integration between general practitioners, clinical specialities and social welfare interventions through the creation of the one-stop shop for access care. That PSN reversed, on paper, the tendency to concentrate resources on hospital care and provided for more resources to be allocated to the territory than to the hospital. It prescribed that the district should be about one third of the size of the average ASL, i.e. about 60,000 inhabitants. The objectives of the 1998 Plan included the principles of the subsequent legislative delegation from Parliament to the Government that would give rise to the 1999 reform. District directors, who became de facto directors of complex areas (clinical organisational units), were eventually assigned a budget and objectives[15].

Within the PSN the articulation of the offer of services established the integrated care pathways (PAI), which became the pivot of the continuity of care with a view to a social-health

[13] Legislative decree 30 dicembre 1992, no 502, Riordino della disciplina in materia sanitaria, a norma dell'articolo 1 della legge 23 ottobre 1992, n. 421 art 3 C5 point b).

[14] Ivi, art 8 C1 point e).

[15] AGENAS, La rete dei distretti sanitari in Italia. Monitor (Rome, 2011) 89.

integration that would become indispensable in all those cases in which loneliness, marginality, and the non-self-sufficiency of the patient entail the need for an integrated intervention. Since families in Italy are increasingly smaller and therefore less able to guarantee care for non-self-sufficient persons with disabling chronic conditions, these care paths are becoming increasingly useful. Over the years, a steady growth in PAIs, from 1,378 per 100,000 inhabitants in 2014 to 1,982 in 2021 (less than 2%) in a country that has 22% of the population (more than 12 million) over 65 and more than 7 million over 75 (11.7%) has been witnessed[16]. Thus, these care pathways are still seriously inadequate and often lack continuity. Moreover, the data show a wide statistical variability between regions in the implementation of this service due to different primary care strategies[17]. In addition, the management of PAIs has been extremely difficult where the regions have not created institutions capable of managing the integration between operators in the territory. This shortcoming gave rise to the need to create an effective intermediate level of management.

6. Relations with the General Medical Practitioners (MMGs)

Within this design of territorial services, the role of family doctors becomes indispensable. The law, however, provides for coordination within the district without building the institutional conditions for public guidance. As a result, the only tools to guide the doctors are incentives and trust in goodwill.

Since 1998, many debates and projects have been carried out to achieve this goal. Attempts have been made to induce family doctors to overcome the individual dimension of work and to work in groups or networks. This has been done in two directions. On the one hand, the doctors participate in the provision of care in low-intensity care residences, such as the nursing homes in Italy. There are differing views of the effectiveness of these measures:

'As far as I have been able to ascertain, the cost of using these contracted doctors is equal to, if not even higher than, that of using the doctors hired by the district, and there is too much coincidence in the origin of the in-patients with the reference territory of the general practitioners working in the facilities'[18]. Besides, it is true that for the patient to find his or her family doctor near the residence is a guarantee of continuity of care.

The other option is that of teamwork, typically involving the establishment of shared surgeries between several doctors. In this case, it is necessary to overcome the doctor's sense of 'ownership' over his patients so that they can be shared in order to cover the full need for patient care in the prescribed hours. It should be noted that not all doctors are reluctant to overcome the exclusivity of the relationship with their patients. For example, there is anecdotal evidence that younger doctors are much more likely to share patients than older ones in the service[19].

From the point of view of governance, the 1999 reform also stipulates that the GP participates in the definition of guidelines and objectives and in the evaluation of the quality of services. There is thus an explicit attempt to involve these contracted doctors in the hope of overcoming the individualism typical of the private professions. And yet, this participation does not seem to have borne the hoped-for fruit so far, perhaps because it establishes weak links by maintaining the weakness of the institutions in which it is placed.

7. Social-Health Integration

The 1999 reform takes up the idea, already envisaged in the 1978 law, of socio-healthcare integration, providing: 'Socio-healthcare services are defined as the set of activities aimed at satisfying, by means of integrated care pathways, the health needs of the individual that require unitary health services and social protection actions capable of guaranteeing, even in the long term, continuity of care and rehabilitative interventions'[20].

The law, on the other hand, assigned the burden of social assistance to the municipalities and delegated to the regions the task of establishing criteria and modalities for the integration, 'on a district basis', of health services with social services: 'It is up to the District to perform the important function of guaranteeing continuity of care for the individual

[16] Istat, Annuario 2021.

[17] Ministero della Salute, Annuario statistico del Sistema Sanitario Nazionale (Rome, 2022).

[18] Our interview with a public manager with experience in social work as well as in health care.

[19] Our interview with a health district manager.

[20] Legislative Decree 19 June 1999, no 229, Norme per la razionalizzazione del Servizio sanitario nazionale, a norma dell'articolo 1 della legge 30 novembre 1998, n. 419, art. 3 setti C1.

and to exercise an activity of coordination, verification and control over the implementation of pathways, especially with regard to the many extremely fragile patients, whose condition must be reviewed very often'[21].

The district reform was completed in 2000 by Law No. 328, which promoted the integration of health and social care as a fundamental requirement. This reform also introduced a new level of social welfare governance allowing several smaller municipalities to share their services. The law provides for a correspondence between social ambits and districts, leaving it up to the region to design them, and asks health authorities to allocate budgets according to objectives. To overcome the old Italian scheme of primary care and move closer to the Anglo-Saxon concept of primary care, the law uses the English term 'primary healthcare', which contains the terms prevention, initiative medicine, continuity of care and multidisciplinary approach.

8. There is no Alternative to a New Territorial Primary Care: Community Welfare in the 2003-2005 PNS

The National Health Plan of the Second Berlusconi Government, 2003-2005 notes 'the now imperative need to better organise the territory by shifting to it resources and services that are being absorbed by hospitals in a hospital logic that is no longer sustainable'[22].

The plan not only envisages a 'strong integration of health services with social services'[23] but also calls for a considerable increase in spending on social assistance, '[a]gainst an estimated need of around EUR 15 billion a year, Italy today spends around EUR 6.5 billion on social assistance'[24]. It is true that this increase did not take place, but interestingly the government that published this plan had a centre-right majority, thus opposite to the one that had approved the 1999 reform and the 2000 NDP. The simplest explanation is that this choice was forced in the face of public expenditure drivers that made hospital care a response to the demand for protection from health risks of the elderly. In Italy, the over-65 population is a quarter of the total and will reach 35% in 2050. At the same time, chronic illnesses absorb an estimated 80% of total health expenditure (care + drugs) and require an integration of different prevention and treatment specialities, the continuity of which is indispensable to avoid acute episodes requiring costly hospital care. In Italy, 48.7% of people over 65 have two chronic diseases and this percentage rises to 68% among the over 75s[25].

To cope with the combination of a growing elderly population and technologies that can keep them alive for longer, but not always in good health, governments have deemed a Copernican revolution necessary in which the focus shifts from the service to the person. Indeed, it has been noted that "[i]n this conception, primary care constitutes a system that integrates, through the Diagnostic Therapeutic Assistance Pathways (PDTA), the actors of primary care and those of specialist outpatient care, both territorial and hospital-based, and, in a broader perspective, also community resources (community welfare)"[26]

From the PTDAs, one can therefore understand why the community model has been perceived as increasingly indispensable by successive governments. This system should focus on home care and a customised and coordinated package of interventions since '[h]ome care is effectively 'integrated' when health and social workers work together to implement unified projects to meet different needs. It requires the enhancement of nursing care and the collaboration of families, bearing in mind that close collaboration between hospital and territory can allow people with complex pathologies to remain at home'[27]. The district, therefore, is called upon to play a bridging role between the hospital and general medicine spheres of care, the adequacy of which is entrusted to the Multidisciplinary Evaluation Units, which should be placed at this organisational level[28].

The PSN 2011-2013 re-proposes the centrality of primary care, the fundamental role of initiative medicine and the need to take care of patients 'in a global and complete way', thanks to 'multi-professional teams that treat health problems in a holistic way'[29].

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[21] AGENAS, La rete dei distretti sanitari in Italia.

[22] AGENAS, La rete dei distretti sanitari in Italia, 94.

[23] Italian Ministry of Health, Piano Sanitario Nazionale 2003-2005 (Romw, 2003) 18.

[24] Ibidem.

[25] Italian Ministry of Health, Piano Nazionale delle cronicità (Roma, 2016).

[26] Ivi, 16.

[27] Ivi, 17.

[28] AGENAS, La rete dei distretti sanitari in Italia, 106.

[29] Italian Ministry of Health, Piano Sanitario Nazionale 2011-13 (Rome, 2011) par 2.7.1, 38.

However, a 2011 report by the National Agency for Regional Health Services (AGENAS) assesses the district experience as substantially disappointing, noting '[t]he district succeeded neither in being the true central hub of public health nor in representing a true organisational and coordinating interlocutor of general medicine, which remained as two interacting but distinct profiles'[30] If the balance is negative, the direction that the report suggests is to bring together with general practitioners some specialists, basic diagnostics, nurses, midwives, small surgery and home care. Therefore, the PSN that came into being in the same year promotes new innovative organisational forms, again within the district, such as the Territorial Functional Aggregations (AFT), the Complex Units of Primary Care (UCCT), the Territorial Units of Primary Care (UTAP) and the House of Health (Case Della Salute, CdS).

9. Further Attempts to Organise Primary Care at Regional Level: The Case of UTAPs and Health Homes

Territorial Primary Care Units (UTAPs) are true multidisciplinary outpatient clinics. Trialed mainly by the Veneto Region in the years 2006-2007, they benefited from substantial economic incentives and services provided by the Region until the costs appeared too high and the experiment was abandoned. Since then, the Veneto Region has fallen back on less costly initiatives to promote group medicine[31].

Since 2012, experiences of local aggregation of primary care have started to flourish in the regions, based on incentives and staff and facilities made available by the competent Region. These are initiatives within districts with a catchment area of approximately 20-40 thousand inhabitants. The problem is that these experiences do not fully reflect the spirit of the reform proposed by the 2012 law, and 'In reality, it is only and only if all the general practitioners of the health district are present in the room, with all the paediatricians of free choice, with all the outpatient specialists of the same district and with the nurses and psychologists and health technicians that there is an aggregative relationship, then there is a true UCCP that is always in a single polyclinic location in the health district, or there is a true AFT (Aggregazione Funzionale Territoriale – Territorial Functional Aggregation) that provides for single-professional associations of individual medical practices sometimes even with several doctors associated in certain locations and grouped together in the same territorial functional aggregation'[32].

Health Homes, on the other hand, are defined by an annex to the ministerial decree of 10 July 2007 as 'a multi-purpose structure capable of providing in the same physical space all the social-health services, favouring, through the spatial contiguity of services and operators, the unity and integration of the essential levels of social-health services, must represent the reference structure for the provision of all primary care'[33]. The decree says that within this ambit 'the main clinical branches and those related to laboratory diagnostics and basic radiology and ultrasound must be activated'[34]. In addition, there must be protocols governing the relationships between outpatient specialists. In practice, the interpretation of what to put in each home is left open and leaves room not only for regional regulations but also for specific company acts. These facilities, however, must be open during the week on a 24-hour basis.

In 2012, the so-called Balduzzi Decree[35] introduced the UCCPs and AFTs that 'were conceived as networks of territorial outpatient clinics equipped with basic equipment, open to the public throughout the day, as well as on pre-holidays and holidays with appropriate shifts, operating in coordination/telematic connection with hospital facilities'[36]. And, as such, UCCPs constitute a fundamental element of the district since, in practice, a district may contain one or more Case di Salute (CdS) and within these it may perform the functions of the Complex Units of

[30] AGENAS, La rete dei distretti sanitari in Italia, 109.

[31] Law 18/2012 ('Conversione in legge, con modificazioni, del decreto-legge 13 settembre 2012, n. 158, recante disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più alto livello di tutela della salute', c.d. Legge Balduzzi), art 1, c 2.

[32] M Calisi, 'Medicina del territorio. Facciamo chiarezza', Quotidiano Sanità, 4 May 2019.'

[33] Italian Ministry of Health, Decreto 10 luglio 2007 ('Progetti attuativi del Piano sanitario nazionale – Linee guida per l'accesso al cofinanziamento alle regioni e alle province autonome di Trento e Bolzano') attachment A, point 1.

[34] Ibidem.

[35] Italian Ministry of Health, Law-decree 13 September 2012, no 58 ('Disposizioni urgenti per promuovere lo sviluppo del Paese mediante un più alto livello di tutela della salute').

[36] Italian Parliament, Case della salute ed Ospedali di comunità: i presidi delle cure intermedie, Ricerche, no. 144, 1 March 2021.

Primary Care[37]. In 2020, 493 Health Homes were active in Italy, located mainly in four regions: Emilia-Romagna, Tuscany, Piedmont and Veneto, which activated a total of 348, while the other 15 regions and the two autonomous provinces activated a total of 145[38].

The CoS is a flexible and multifunctional container, interpreted in a very heterogeneous way. For example, in order to meet the requirement of being open 24 hours a day, it was sometimes sufficient to place only the on-call medical service there. This made it possible to design 'variable geometry' homes. In some regions there have been experiences of health homes that have tried to mark the transition from Primary Medical Care to Primary Health Care. This second approach does not focus on illness but on health, a shift in perspective in which the focus is on relationships with people rather than on care plans. This shift is conceptually defined by an official World Health Organisation document of 2008 in which the concluding document states:

'Wholeness, continuity and person-centredness are fundamental to achieving better health outcomes. They all depend on a stable, long-term personal relationship (a characteristic also called 'longitude') between the population and the professionals who are their point of access to the health care system'[39].

The World Health Organisation calls for a move away from healthcare based on disease and treatment programmes towards healthcare based on the centrality of the patient's health, understood as quality of life, participation in therapeutic decisions, prevention, continuity of care and the ability to live consciously as a sick person. Thus conceived, primary care becomes the heart of health care. And this is not only for fairer and more humane health care, but also for more effective care, as '[t]here is a substantial body of evidence on the comparative advantages, in terms of effectiveness and efficiency, of health care organised as person-centred primary care. […] its characteristic features (person-centredness, comprehensiveness, integration and continuity of care with the participation of patients, families and communities) are well identified'[40].

This report denounces the consequences of the hospital approach that characterised the last century and from which we must learn, explaining '[t]he experience of industrialised countries has shown that a disproportionate focus on specialist and tertiary care offers poor value for money. Centralisation on hospitals comes at a considerable cost in terms of unnecessary medicalisation and iatrogenesis and undermines the human and social dimensions of health. It is a cost that reduces opportunities: Lebanon, for example, has more cardiac surgery units per inhabitant than Germany, but there is a lack of programmes to reduce risk factors for cardiovascular disease'[41].

The combination of the push from the WHO reports and Italian legislation should therefore have contributed to shifting the centre of gravity of the healthcare system more and more towards the intermediate level and the related innovative policy instruments that enable integration between hospitals and general practitioners. Yet there have been factors that have slowed down the shift. In fact, hospital healthcare is much more visible and perceived as fundamental by non-practitioners. Citizen-voters focus their attention on that and consequently politicians are induced to concentrate the most resources on that. In the context of a plan addressed to the European Union, with technically prepared interlocutors who are aware of the costs of protecting an increasingly ageing population, it was instead easy to present the need to strengthen primary healthcare as an investment in the resilience of the welfare system and with it the system of reproduction of the social order as a whole.

10. The Policy Design of Territorial Primary Care in the 2022 Reform

The first substantial orientation to primary care in Italy finally arrived in 2022. After a long wait, the reform was initiated by the Draghi government thanks to funding from the European Union. The policy design contained in Ministerial Decree no. 77 of 23 May 2022, in fact, represents a policy window that aggregates several factors[42].

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[37] Conferenza Permanente per i rapporti tra lo Stato, le Regioni e le Province Autonome. Intesa concernente il nuovo Patto per la salute per gli anni 2014-2016.

[38] Italian Parliament, Case della salute ed Ospedali di comunità.

[39] World Health Organization, The World Health Report 2008 (trad it. 'Assistenza sanitaria di base – Ora più che mai') 51.

[40] Ivi, xvii.

[41] Ivi, 11.

[42] Italian Ministry of Health, decree 23 May 2022, no 77 ('Regolamento recante la definizione di modelli e standard per lo sviluppo dell'assistenza territoriale nel Servizio sanitario nazionale').

The first factor is the availability of a project already sketched out years before, but never realised and waiting to be relaunched. Secondly, the substantial convergence of a large number of political stakeholders, experts, and interest groups around that reform project, which gives the decision-maker the opportunity to support that kind of change. Finally, the possibility of drawing on a financial resource of unprecedented proportions. It must be remembered that Italy has a long tradition of low performance in spending European funds[43]. Both the government and the regions had no choice but to turn to projects that already existed and for which there was a reasonable chance of success. Therefore, even in the area of healthcare, they had to look for ideas and projects that had already been tried and tested. This is why decree no. 77 does not propose an innovative political project, but rather gathers and integrates ideas, tools and strategies already on the Italian agenda, partly anticipated in the 'Balduzzi Decree' of 13 September 2012, and encloses them in a single design.

Ten years after that attempt, the new programme outlines a second-order policy change, because it is mainly aimed at reorganising the healthcare system by strengthening its territorial level. The change is therefore ambitious, because it pushes the health system towards an integrated and multi-level approach by trying to create a filter between general practitioners operating individually on the territory and the hospital system. However, the impact potentially produced goes no further. It is not a third-order change of policy, because the decree does not actually envisage a different idea of the health system, but only envisages its reorganisation through the re-proposal of a widely discussed project and lacks, on paper, any real antagonists. In fact, there are no known successful models of territorial healthcare in Italy other than the one proposed here, but only cases of great strengthening of hospital healthcare to the detriment of territorial healthcare, or cases of the use of non-innovative territorial healthcare tools, such as the on-call doctor, in an attempt to make up for structural deficiencies.

As seen in the preceding paragraphs, the objective of creating territorial primary care was shared by the centre-left and centre-right parties that have alternated in government since 1998, by the main opinion makers, and has also been accepted by a large part of the stakeholders in health policies. Moreover, the political commitment required of the government is relatively low and taken for granted: the government invests in a project that is already discussed and already known, by allocating a major EU grant to make it feasible.

Underneath this there is no new political elaboration but an attempt to make a reform walk the walk. The assumption that led to the decision to adopt a decree was that the previous Balduzzi decree (2012) was technically and politically adequate but had not been implemented due to the scarcity of resources. The use of the copious resources of the NGEU is therefore considered by the Draghi government as the trigger that can finally support the realisation of the project. A distinction must be made here: the resources of the NGEU are only capital and they cannot be spent on current expenditure for the health staff needed to run these facilities. The staff must be provided by the regions. The PNNR can therefore be conceived as a one-off incentive to undertake a new service design. In fact, it must be considered that the regionalisation of the health system in a governance system based on institutionalised consultation between the government and the regions makes it difficult for the national government to make the regions adopt organisational solutions, even if they are shared, in the absence of additional economic resources.

For example, Lombardy, the most populous and productive region in the country, has not implemented either health districts or health homes and is far removed from the new territorial care model of the reform. Lombardy could also be a veto player because in Italian multi-level governance it has a very strong and performing public and private hospital system on its side. It is conceivable that it has abandoned an attitude of resistance to overcoming the hospital model following the pandemic experience that hit Lombardy hard, during which, according to almost all observers, the shortcomings of the primary care system were dramatically highlighted[44]. From the initial evidence it appears that the strategy adopted by Lombardy was not to obstruct the reform but to implement it internally only formally, transferring from the existing organisational containers to the new ones the same healthcare

[43] For example G Chiellino, 'Tutti i ritardi delle regioni e dei ministeri nella spesa dei fondi europei', Il Sole 24 Ore (9 January 2020).

[44] G Busilacchi, F Toth 'Il Servizio sanitario nazionale alla prova della pandemia. Cosa abbiamo appreso?' (2021) Rivista delle Politiche Sociali, 2, 81-97.

staff and in practice the same services[45]. The conditions leading to the reform could be classified in Howlett's categories as highly positive in terms of both consensus and technical effectiveness. The policy design could be interpreted as a case of packaging: supported by a good degree of consensus in the policy sphere and articulated on a degree of technical development at the cutting edge and in line with the healthcare innovations of the most advanced healthcare systems.

Ministerial Decree No. 77 defines the framework of a new organisation of territorial health care, providing regulatory, technological and service standards oriented towards health, environment and climate prevention. It is the general document for territorial planning that is developed through a series of innovative policy instruments that are listed and described. We summarise the main ones.

11. Community Houses

The first highly innovative instrument is the establishment of the Community House (CdC), the easily identifiable administrative unit in the territory that citizens can access for ordinary health and social-health needs. CoCs are the direct heirs of the CdS introduced as a model in 2007 and experimented in some regions. These new units located throughout the territory are designed to provide proximity health services to residents, delegating the management of clinically more challenging cases to more complex structures and constituting the filter that should allow hospitals to concentrate on the acute phases of pathologies. The CoC is based on a system of integrated and multidisciplinary services, which should include a wide range of medical professionals and are divided into two categories, CoC-hubs and CoC-spoke. The house-hub is an integrated service structure that also has planning capabilities, should have 24-hour access and be the node of a network of smaller territorial services. The original plan envisaged one every 40,000-50,000 inhabitants. Instead, case spokes are territorial terminals of the Hub with a reduced service capacity, decentralised peripheral units open 12 hours at a time. The number and minimum threshold of the reference population must be established by the individual regions on the basis of the needs of the districts and the conformation of the territory since there are no national reference standards.

CoC-hubs comprise a predefined and mandatory cluster of services: (i) primary care services provided through multi-professional teams, (ii) a Single Point of Access of services that should be an orientation point for patients and a triage point for providers; (iii) a home care service, (iv) outpatient specialist services for the main widespread diseases; (v) basic nursing services vi) an integrated telephone and digital booking system; vii) integration of health services with Social Services; viii) co-production of services with users; ix) 24-hour presence of doctors and nurses; x) minimum basic diagnostic services; xi) Continuity of Care; and xii) at least one daily blood sampling clinic. These mandatory services can be associated with a list of optional services such as, including those for minors, immunisation and public health services, screening services for the most common diseases, sports medicine, services for dependent patients, mental health and neuropsychiatry. CoC-Spoke share with CoC-Hubs the mandatory services i)-viii) while everything else is considered optional.

An innovative figure in the CoCs is the community nurse. A figure introduced by Decree 77 to complement the previous figure of the family nurse, oriented towards the home care of the chronically ill, notably: 'The Family or Community Nurse is not only the provider of care, but becomes the figure who guarantees the care response to the onset of new expressed and potential health needs that persist latently in the community. He/she is a professional with a strong orientation towards proactive health management. He/she is involved in activities of promotion, prevention and participatory management of individual, family and community health processes within the territorial health care system in the different care settings in which it is articulated'[46].

It is therefore a figure that should integrate the health aspects with the social ones, becoming a promoter of the always desired participation and collaboration of patients and their community of reference in the therapeutic pathway. It would also be a driving force for prevention and so-called initiative healthcare, which are ingredients of quality primary

[45] VM Turri, Le case di comunità a Milano: luci e ombre del processo di (ri)costruzione della salute comunitaria locale (Presentation at the Conference Espanet Italia 2023, Milan 13-15 September 2023).

[46] F Pesaresi, 'L'infermiere di comunità, come sarà' (2022) I Luoghi della cura on line, 4, 3 <www.luoghicura.it> accessed 15 November 2023.

healthcare[47]. However, at a time when Decree 77 envisages a standard of one community nurse for every 5,000 inhabitants, it depreciates the novelty because it counts in the reference standard all nurses involved in territorial services in any capacity.

Even so, however, the required standard is far from being achieved since '[i]n the community hub house, the standard is 7-11 nurses and 5-8 support staff (social, administrative)'[48]. To achieve this goal, the 2022 budget law provides an additional 90 million for personnel, which, in the intentions of the legislature, should grow year by year until it reaches more than a billion in 2026. These are not huge resources, but they would still give a signal that a direction is being taken. All that remains is to read the budget laws of the coming years.

12. The Territorial Operations Centre (CoT)

Decree No. 77 also provides for the creation of a Territorial Operating Centre (COT) in each territorial health district of each region. Each COT performs the function of coordinating the taking charge of the patient, linking the services and professionals involved by integrating the territory, health and social care, the hospital and the emergency and first aid network. The COT is located in the territory every 100,000 inhabitants or in any case must coincide with a district and must have minimum organic standards in terms of doctors, nurses and administrative staff. The COT must also have telemedicine services and technologies for tracking and monitoring diseases, such as ultrasound and radiodiagnostics. The COT is therefore not a counter service for the population, but a coordination of services at district level. However, the territorial operations centre should also be integrated with the 116117 Operations Centre (e.g. European Harmonised Number) for non-urgent medical care: this is the free telephone service to the population for all low-intensity health and social welfare services.

13. Continuity of Care Unit

In addition, the operations centre also envisages the parallel creation at a territorial level of the so-called Continuity of Care Units (UCA), mobile district teams for the management and support of the taking charge of individuals, or families or groups, who are in particularly complex clinical-assistance conditions and which entail a high level of operational difficulty. The UCA guarantees continuity of care on the territory by reaching patients at home.

This is an innovation which, if truly realised, institutionalises an emergency practice invented during the pandemic emergency, the USCA, which assisted patients in their homes by crossing a team of doctors, nurses and anesthetists who offered home care services guaranteeing isolation and protecting the hospital at the same time.

UCAs are therefore one of the main organisational lessons of the Italian territorial system[49]. The UCA represent the highest form of territorial reorganisation of second-order change and they offer home care characterised by a fairly high level of intensity and complexity of care, like hospitalisation, but within the framework of specific pathways and a personalised care plan.

14. Community Hospital

Last, but very important, is the creation of the Community Hospital. This is a facility capable of accommodating patients discharged and stabilised from acute hospitals or of admitting patients requiring reduced complexity interventions. It is a facility with a low number of medical staff – one doctor for 4 hours a day – but a higher presence of nurses – 9 covering 24 hour shifts. As in Anglo-Saxon countries, most of the doctors should be general practitioners, provided they are willing to do so. These are hospitals equipped with simple technology in which patients are admitted when they need care that cannot be organised at home.

In some Anglo-Saxon countries, the Community Hospital is a model of low specialised care that dates back to the middle of the last century, while in Italy it was formally introduced on 20 February 2020 by an agreement between the state and the regions[50]. The agreement formalises already existing experiences because about a hundred facilities had been set up in the

[47] AF El Assaf, M Sheikh, Quality Improvement in Primary Health Care. A Practical Guide (World Health Organization, Cairo, 2004).

[48] DL Vetrano, La mappa della fragilità in Italia e determinanti socio-demografici, Indagine 2022, (Ministero della Salute, Rome, 2022).

[49] N Giannelli, A Lippi, 'The relevance of non-institutional practice in health care steering at local level in Italy. What has been learnt in pandemic times?', Working Papers in Economics Mathematics and Statistics, WP-EMS 2022.

[50] G Fattore, F Meda and M Meregaglia, Gli ospedali di comunità in Italia: passato, presente e futuro (Cergas, Bocconi University, Milan, 2021).

previous twenty years, mainly in the Veneto, Marche and Molise regions, and especially in areas with medium-low population density, presumably replacing pre-existing small hospitals. Twenty-three per cent are private facilities affiliated with the regions, the others are public facilities in which general practitioners, privately affiliated, operate[51]. The Community Hospital is part of the Territorial Assistance supply network and performs an intermediate function between home and hospitalisation, with the aim of avoiding improper hospitalisations or favouring protected discharges in places more in keeping with the prevailing social-health needs, clinical stabilisation, functional recovery, and autonomy, and closer to home. The Community Hospital is expected to be at least one per 100,000 inhabitants and equipped with no less than twenty beds. The DM 70/2015 envisages a standard of 0.7 beds per one thousand inhabitants (thus 70 per one hundred thousand) for long-term care and rehabilitation, for low-intensity care admissions with the 3.5 per thousand of acute care hospitals. This is a very low standard if one considers that since the costs of acute hospitals are very high, it is in the health system's interest to entrust a lower-intensity facility with personnel and technology when a patient no longer needs it. The acute hospital, however, can afford to discharge the patient when he or she is stabilised but not yet self-sufficient if there is a caring context in which there are healthcare personnel, mainly nurses, capable of assisting him or her 24 hours a day until complete discharge. This phase can be long, especially for elderly patients, and in fact admission to a community hospital is expected to last up to 30 days, against an average of 7.5 days for acute hospital admissions[52]. Since the proportion of the elderly population in Italy has been growing for many decades and the families that are supposed to provide care for the elderly are becoming increasingly small and even many elderly people live alone[53], it is easy to imagine that the standard of expected low intensity of care would turn out to be lower than necessary. Such a standard would, however, be compatible with a district sanctity that would be able to follow the patient at home also through non-strictly health care services. The socio-health integration that was at the birth of the district is therefore indispensable and we shall see that it is included in the organisational model of the community home.

15. Integrative territorial services

Alongside the aforementioned facilities there are also two supplementary territorial services, palliative care and counselling centres for minors and women, couples and families. The palliative care network is made up of services and facilities capable of guaranteeing comprehensive care for the patient and his or her family, in the hospital setting, with counselling and psychological support when there are invalidating and serious illnesses. Palliative care is aimed at patients in the terminal phase of life, but also includes active care from the early stages of chronic and degenerative disease, preventing or mitigating the effects of functional decline. This innovation, too, should respond to the changing needs of the population that is undergoing a strong ageing trend and therefore more afflicted by chronic and degenerative diseases whose hospital care is much more costly and intermittent than continuous home care. Therefore, investing in these services and financing them adequately could prevent the collapse of public hospital care.

The Family Advice Bureau is the free activity aimed at minors, for the protection, prevention and promotion of health; it advises women in their life cycle (including pregnancy), couples and entire families. This is a front office service already present in the territories but unevenly from region to region and even within each region, which should be systematised and planned throughout the country.

The set of tools listed can be described as a complex, multi-level governance system where independent units make up an integrated system of independently operating units that are called upon to network (see table 1).

Table 1. The governance of the care system.

INFERMIERE DI FAMIGLIA O DI COMUNITA'	UNITA' DI CONTINUITA' ASSISTENZIALE	OSPEDALE DI COMUNITA'	RETE DELLE CURE PALLIATIVE	
CENTRALE OPERATIVA 116117	ASSISTENZA DOCIMICILIARE	CENTRALE OPERATIVA TERRITORIALE	HUB CdC	SPOKE CdC
CONSULTORI PER MINORI, COPPIE E FAMIGLIE	SISTEMA INFORMATIVO E QUALITY MANAGEMENT	TELEME-DICINA	PREVENZIONE	

Source: F Pesaresi, *Il DM 77/2022 sull'assistenza sanitaria territoriale. La norma, gli approfondimenti, le valutazioni. Ebook sul benessere*, 2022, 7, 11.

[51] Ibidem.

[52] Istituto Superiore di Sanità, Ricoveri Ospedalieri in Italia, rapporto SDO 2020 (Roma, 2022).

[53] Istat, Il futuro della popolazione: meno residenti, più anziani e famiglie più piccole. Report, (Roma 22 September 2022).

The declared objective of Decree 77 is to overcome the fragmentation of services and to make it clear that the whole only becomes coherent and effective if the individual units are linked together by a common idea, by convergent objectives. Obviously, the centre of this network are the CoC-Hubs. They have been imagined as a solution to current shortcomings and as the new centre of gravity of the 'new territory', which can be an alternative to the hospital in order to respond to the currently unmet needs discovered and because of which citizens inappropriately turn to the hospital.

In this system, the CoCs thus have two main tasks: on the one hand to relieve hospitals of the responsibility for providing care that can be provided outside the hospital, and on the other hand to integrate general practitioners, who operate in the territory in an excessively individual manner, into an integrated network of services. The CoC-Hubs are therefore imagined as organs of the health districts. The CoCs are places of care in the territory, while the districts continue to be the administrative units of reference in the health geography of the regions that have decided to implement them. The district continues to be in the Italian health system the 'solid' administrative container of all services, pursuing the idea that it must continue to play a key role in the new architecture of territorial care.

This type of system faces certain challenges and relies on certain resources. Firstly, the district continues to be a strong idea on paper, but the design of the reform does not spend much energy on explaining how strong and how it should be, because its strength remains implicit and is deduced from the type of tools and governance derived from this model. This raises a question about the implementation and whether it is sufficiently clear to the regions in what way the districts can really take the lead in directing this governance. Secondly, the planning and standards adopted by the ministerial decree have a binding value, but do not oblige the regions to follow a single national model, also because from a legal point of view they are indicated by a ministerial decree, so there remains a margin of ambiguity on limits, objectives and constraints. The decree outlines this reform, but those who must implement it are left with margins of discretion because the text is a regulation, not a law. Thirdly, the policy design is grafted onto a geography of deeply inhomogeneous regional systems with very different degrees of adherence to the new national purpose: some regions already possess intermediate structures of the territorial type and have already set up primary care territories, which other regions exist only on paper, or in a very reduced way. Still other regions possess a dichotomy between MMGs on the territory and hospitals without any intermediate structure. The implementation of this design is confronted with widely varying resources and difficulties: while for some regions the change may even be of the first order, because it is an incremental change to a situation that already exists, for other regions the reorganisation entails almost a general overhaul of the overall healthcare logic, almost a third-order change.

Alongside these difficulties, there are some strengths that made this decree particularly relevant. The first is that an attempt at national planning after a long time seeks to offer a national model of territorial care. This model also imposes, albeit with the weaknesses mentioned above, common standards and objectives. Moreover, it entrusts AGENAS, an agency that is not autonomous but shared between the state and the regions, with a monitoring role.

All these aspects favour integration and attempt to contain the fragmentation of the system. In fact, it must be remembered that the policy instruments listed were already present, but were distributed unevenly throughout the territory in a dispersed and inconsistent manner: the fact of having included them all in a single design has clarified the meaning, policy mix and objectives of these instruments and their integration. Following this reform, the Italian healthcare system at least knows what integration of the territorial care service is and what it consists of, regardless of the ability to implement it.

16. Critical Aspects of Implementation: Scarcity of Resources, Path Dependence and Weak Institutionalisation

The implementation of Decree 77 is still in progress, the process is developing in local contexts according to multi-level governance for which the individual regions adapt the design taking into account the needs, resources and constraints of each context.

It is therefore a complex implementation that highlights the overlapping of several critical factors, which can be summarised as the scarcity of resources, the weak institutionalisation of the territorial level of the Italian health system already described in the previous paragraph and the influence of past choices and events that influence the current dynamic.

In the meantime, it is possible to highlight some critical elements.

a) The shortage of medical personnel in Italy

Based on OECD statistics, the overall number of doctors in Italy is within the average of countries with a comparable income and health system[54]. However, too few of them work as employees of the SSN. The number of nurses is much lower than in similar countries[55]. Returning to doctors, very often in Italy there are reports of public competitions for the recruitment of public doctors that have been deserted in part or in full[56]. This may be due to the migration of doctors from the public to the private profession, an exodus incentivised precisely by the shortage that makes the work of those who remain in the public health system more tiring. Then it is true that some specific professional profiles are missing, such as those related to emergencies, which appear less attractive on the healthcare market in the cost-benefit ratio of a professional career. The Meloni government in October 2023 tried to remedy this by increasing the overtime pay of emergency doctors to 100 Euro. Interestingly, the Emilia Romagna region moved in this direction as early as April 2023, a few months before the government did.

In order to make up for the shortages, the prevailing option now followed by healthcare companies is to buy professional medical hours directly from private providers. These 'rented doctors' are paid much more than those employed as civil servants, even 4 or 5 times more[57]. This imbalance further fuels the haemorrhaging of staff and seriously undermines the possibility of strengthening the intermediate level at the CoC-Hubs which, without staff employed in the public health system, are seriously at risk. For this reason, the re-hiring of doctors who have resigned from the NHS has been prohibited.

A further reason for the staff shortage is organisational backwardness. Nurses have always been given less responsibility and autonomy in patient management than in other European countries. This deficit has been responded to over the last 20 years with a change in the role of the nurse in organisational models. It is a long process that requires a cultural, as well as organisational, evolution of both doctors and nurses themselves. At the same time, however, there has not yet been a real increase in the number of nurses trained each year. On the contrary, the OECD data available for 2020 see Italy at the bottom of the league table in terms of the number of trained nurses per capita[58]. To reach the European average number of nurses per inhabitant in 2020 we would have to recruit 148 thousand more than the current 279 thousand[59]. And many thousands would be needed to implement the reform of territorial services. Yet many calls for applications for nursing degree courses are not sufficiently taken up by young people coming out of schools. Thus, the profession, both in terms of remuneration and prestige, does not yet seem to be attractive enough.

Finally, the shortage of medical personnel is also caused by its aging demographic, which is very high in some specialities and especially among general practitioners[60]. This is not only a problem of staff turnover, but also the fact that elderly doctors are exempt from the heaviest shifts and are generally more reluctant to organisational innovations, and this is particularly evident among GPs. A whole large age group is about to retire and the replacements who are now in the training phase will not be numerically sufficient.

b) The first crack in implementation: hubs without spokes

The Meloni government, faced with the difficulty of concluding the work within the planned timeframe, taking into account the increase in implementation costs, decided to reduce the number of hubs from 1350 to 960 for community homes, from 600 to 524 for territorial operating centres, and from 400 to 305 for community hospitals[61]. The revision prioritises investments in existing facilities

[54] <https://data.oecd.org/healthres/doctors.htm#indicator-chart> accessed 15 November 2023.

[55] Ibidem.

[56] For example P Todesco, 'Guardia medica in Trentino. Niente candidati per gli 85 posti necessari all'Azienda sanitaria', L'Adige (2 August 2023).

[57] S Ravizza, GI Viafora, 'I medici a gettone arruolali in chat senza controlli guadagnano anche 3600 euro in 48 ore', Il Corriere della Sera on line (1 October 2022).

[58] <https://data.oecd.org/healthres/nursing-graduates.htm#indicator-chart> accessed 15 November 2023.

[59] AGENAS, Il personale del Servizio Sanitario Nazionale, (Roma, March 2023).

[60] Italian Ministry of Health, Annuario statistico del Sistema Sanitario Nazionale 2021.

[61] Ministro per gli Affari Europei, il Sud, le Politiche di Coesione e il PNRR. Proposte per la revi-

for which the time and cost of intervention is more certain. The document also promises to finance the other centres from other sources, but of course the risk that in some contexts the implementation of the NRP will not lead to an organisational change but only to a restructuring of the existing one grows. The first to jump are the case-spoke projects that are considered less of a priority than the case-hubs. A pivot, however, performs its function when it is connected to the spokes.

c) The coexistence of the public and private systems

The coexistence between the organisational logic of public healthcare and that of private activity in Italy has historical roots (path-dependency) and is so ingrained that no reform has succeeded in eradicating it. The paradoxical consequence is that many public physicians receive in their private practice, inside or outside the walls of the public service, patients who come to their facility for services related to the speciality they practise there. This would not be allowed in a private organisation, due to an obvious conflict of interest. If the granting of this possibility has allowed the state to reduce the salaries of professionals in comparison with similar jobs in private clinics or in foreign countries, in most of which it is not allowed, this competition in the same person between public and private professions distorts the mechanisms of allocation of economic and career incentives that should perfect organisational outcomes. This can also affect trainees who find themselves working on the territory.

As far as the GPs are concerned, they are very sensitive to economic incentives, and have, on the contrary, rejected the hypothesis of being absorbed into the public system and, to date, have rejected any organisational system that would oblige them to obey logics superordinate to their profession. Young doctors, on the other hand, seem to be more in favour of teamwork.

d) The weak leadership of the Ministry of Health

The health sector is a high-technology and highly professionalised sector. Established interests in treatment facilities, diagnostic and pharmaceutical supplies are very relevant in the implementation of policies. In addition, formal hierarchies are very much influenced by professional relationship networks. This was a positive fact during the pandemic, when spontaneous networks with exchange of expertise between practitioners were activated[62].

The professional community of doctors in Italy is characterised by the importance of reputation and individual value. Scientific authority and professional recognition are indispensable for building credible policy communities. In this respect, the authoritativeness of the Ministry of Health in the national policy community has been weakened by the establishment, at the regional level, of networks between research centres and places of clinical experience that in the most important regions link universities to hospitals, adding know-how to the networks of self-government, with configurations that vary from region to region.

The leadership of the Ministry of Health is therefore not uniform across the country and this negatively influences the orientation of the policy community with respect to the objectives of the ministerial policy design and could produce an even very important curvature with respect to the expected outcomes of the proposed reforms. This happens in particular when the national policy design is at odds with the policy orientations that have shaped the health system of a particular region over time.

e) Low learning capacity of the system

The learning capacity of the system as a whole seems low. For example, during the COVID-19 pandemic emergency, the government was very quick to put the regions in a position to create small intervention units in the territory to make up for the lack of response by proximity medicine[63]. It was a flexible instrument, because the regions could develop it with doctors and nurses, public or private, using significant economic incentives. Where USCAs were implemented and proved to be effective, their experience was soon terminated without producing real institutional learning. They were discontinued. Toth and Busilacchi observe that 'in general and net of these territorial

sione del PNRR e capitolo REpowerEU, 27 July 2023 <www.italiandomani.gov.it> accessed 15 November 2023.

[62] N Giannelli, A Lippi The relevance of non-institutional practice in health care steering at local level in Italy. What has been learnt in pandemic times? Working Papers in Economics Mathematics and Statistics, WP-EMS 2022.

[63] Law decree no 14 of 9 March 2020 (the day before the Italian national lockdown started).

differences, the new instrument of territorial medicine introduced during the pandemic, the USCAs, does not appear to have been fully effective; or at any rate, it does not appear to be the decisive solution on which to design the territorial healthcare of the future, if the current shortcomings are not addressed first, including in the integration between professionals'[64].

f) The problem of recruitment

The problems of the shortage of doctors and nurses are also due to planning errors in their training and recruitment, which is troubling because the statistics on the demography of these professional categories had been known for decades and were even the subject of scientific reports and conferences.

The universities, the Medical Association and the Ministry of Health have failed to cooperate on this point. What is certain is that the decision makers involved in all three areas – medical faculty, Ministry and professional association – are predominantly doctors. The medical constituency has always had a great political influence on every decision. It is difficult to think that the medical professional constituency can shift the responsibility onto the political class.

More likely, it is a matter of lobbying logics, in which it is possible that the coexistence of market logic and public interest have played a not insignificant role and have prevailed over the necessary maintenance of the healthcare system as a whole. This does not bode well for the logic that will emerge in the future if the shortage of professional supply dominates over all other needs[65].

g) Too much haste in issuing Decree 77/2022

The draft of decree 77/2022 was drawn up by the Draghi government in just two months, under pressure to be able to submit a valid and credible document to the European Commission, Parliament and public opinion. In other words, there was no time for an in-depth phase of study and discussion with stakeholders. There has not even been time for a real discussion between the state-regions and between the state and the medical professional order aimed at prefiguring more advanced solutions. As mentioned, the design packages already known tools and existing strategies into a new formula that is more integrated, more responsible, and above all, better financed. The regional pragmatism took the form of a request to amend decree 77 which, as we have said, by watering down the standard of the number of community nurses in relation to the population, allows the formal objective to be achieved but reduces the effort for the pursuit of the substantial one.

On the other hand, those who wrote the PNRR in 2021 and Decree 77 in July 2022 chose to bet on the successful experiences of a few regions, in particular Emilia-Romagna, Veneto, Tuscany and Piedmont, with the idea of transferring them to the others. The risk is that most of the other regions will find this solution inconsistent with the available resources and their past choices and will therefore prefer formal compliance to substantial implementation by adapting the new to the pre-existing situation, without real innovation, and resorting to modest incremental behaviour. It is also possible that some regions distort the content because they do not find the model suitable for the solutions they perceive as best suited to their context.

In short, the model is congenial for only some regions, and this may not be conducive to a general improvement, leading to more formal than substantial changes. However, these considerations apply for now only as hypotheses to be tested empirically.

17. (Partial) Conclusions

The healthcare reform contained in the PNRR is the last stage in a design for the creation of a territorial healthcare system that in the long evolution of the Italian healthcare system has been much invoked and little pursued. The analysis of the prospects is shared by the policy makers of the various parties, but in practice the narrowness of resources and the need to support the current conformation of hospital healthcare have prevailed over the implementation of the declared intentions. Historical reconstruction has allowed us to highlight the very slow progress towards the integration of services through the creation of the districts and the quite innovative policy instruments later promoted in Decree No. 77.

[64] G Busilacchi, F Toth, 'Il Servizio sanitario nazionale alla prova della pandemia. Cosa abbiamo appreso?' (2021) Rivista delle Politiche Sociali / Italian Journal of Social Policy, 2, 81-97.

[65] Ibidem.

In the health sphere, experts and policy makers seem to share the view that, in the face of the demographic ageing under way, only a strengthening of continuous care through proximity healthcare will make it possible to maintain the sustainability of public healthcare. However, this awareness had produced more wishes than operational results. The PNRR gave the government the opportunity to promote an organisational model developed in some regions with economic incentives to all regions.

However, the high regional fragmentation and weak institutionalisation of territorial care highlight the path dependence of the reform process, which struggles to make systemic reforms. The structure of interests and choices in other directions made in the past still condition the ability to implement a truly innovative reform. Similarly, the risk of replicating another case of dispersed, highly localised and piecemeal implementation, as in other cases of administrative reforms in the country, is still high[66].

So while the PNRR espouses a specific organisational model, specified by Decree 77, the lack of resources and the legacy of existing organisational models produces hybrid and fragmented implementation paths. On the other hand, as a positive element, one must consider that the process still has much potential and that the policy design has not been substantially opposed by anyone, a fact that reinforces the consideration that success or failure will result above all from the capacity for coordination and consistency of implementation between state and regions.

[66] A Lippi, Valutazione del programma di decentramento "quasi federalista" in Italia a partire dagli anni '90: un approccio con effetti collaterali, Studi sugli enti locali (2011) vol 37, 5, 495–516.

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SECTION I
ESSAYS

COVID-19, the National Plan for Recovery and Resilience (NRRP) and Good Administration in the Health and Social-Health Sector: The Health Budget as a Tool for Taking Care of the Whole Person

Luca Di Giovanni

Abstract. The COVID-19 pandemic has produced an increase of conditions of fragility, disability and non-self-sufficiency of patients with chronic diseases, imposing a rethinking of the organizational structure of territorial welfare systems, too inflexible to intercept the needs of the sick. This paper intends to focus the attention precisely on overcoming this form of rigidity in the provision of health and social-health services, achieved through the application of an organizational model based on the Health's Budget, that is a tool aimed at promoting an integrated and coordinated management of services for patients and to the strengthening of those objectives of social cohesion and efficiency in carrying out administrative action which COVID-19 has, however, substantially weakened.

Keywords: *COVID-19, NRRP, Good Administration, Health Budget.*

1. Introduction

The COVID-19 pandemic has significantly increased the conditions of fragility, disability and non-self-sufficiency of patients with chronic illnesses and has made their relative care needs even more complex compared to those existing in the period prior to this emergency situation, imposing a rethinking of the organisational structure of the territorial welfare systems. The social inclusion of this category of patients has been significantly compromised due to a lack of care by the national social and health system, characterised by gaps in management, a decrease in services dedicated to the person and the inability to convert them into home-based services[1].

On the other hand, the outbreaks that developed during that period in the Residenze Sanitarie Assistenziali (RSAs) – non-hospital facilities for non-self-sufficient persons – as well as the causes that gave rise to them, are well known[2]. The failure of RSA managers to comply with the Health and Safety Protocols, and also

[1] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato (FrancoAngeli, 2022) 56ff and, in particular, 57 with footnote no 86, according to which 'the pandemic has disproportionately affected people with disabilities, compromising their social inclusion: think of the invisibility of people with disabilities in the civil protection system, the medical triage that discriminated against them, the lockdown of dedicated services and the partial inability to convert them into home-based services, the deaths in residences for elderly people and people with disabilities, the limited protection of workers with intellectual and relational disabilities who could almost always not take advantage of smart working, the absence of support interventions for the right to study in distance mode for students with disabilities'; see also G Griffo, 'Il nuovo welfare di inclusione e i progetti personalizzati' (2021) Prospettive Sociali e Sanitarie, 1, 5.

[2] RSAs find their regulatory reference in Law no 67 of 11 March 1988 and in the Ministry of Health Guidelines of 22 December 1989 and 1 January 1994. They are non-hospital facilities, but nonetheless with a healthcare imprint, which house for a variable period (from a few weeks to an indefinite period) non-self-sufficient persons, who cannot be cared for at home and who require specific medical care by several specialists and articulated healthcare assistance. They differ from rehabilitation facilities in that the intensity of health care is less and the length of stay of the patients is longer, and in relation to their psycho-physical state they may in some cases be permanently housed there. See C Scarcella, Manuale di igiene e organizzazione sanitaria delle residenze sanitarie assistenziali (Maggioli editore, 2014) 89ff, according to which the Operational Plan for the Elderly (POA), approved by Parliament in January 1992, revolutionised the care and assistance of the elderly with disability prob-

the simultaneous decision by many regions to send patients with COVID-19 to these facilities despite their having insufficient capacity and inadequate space in order to end the quarantine and thus free up scarce hospital beds[3], turned out to be decisions that contributed to the spread of the pandemic, causing a high number of deaths among the frail[4].

The events that followed have demonstrated, on the one hand, the failure or inaccurate transposition of the indications contained in the current regional social-health plans and, on the other hand, the consequent inappropriateness of the territorial welfare system to deal with emergency situations. They have made it necessary, therefore, to rethink the methods of providing health and welfare services, which must be conducted starting from a full application of the contents of the aforementioned Plans and a different interpretation of the concept of 'taking charge' of patients[5]. This rethinking should be based on better integration of social and health services and implemented in the home, also to lighten the burden of public health and ensure the economic and financial sustainability of the related health expenditure[6].

In actual fact, this would be the strengthening of a transformation that was already underway but never completed, which began with the enactment of Legislative Decree no. 158 of 13 September 2012 (the so-called Balduzzi Decree), converted with amendments into Law no. 189 of 8 November 2012, through which, in addition to reducing the number of beds, an attempt was made to overcome the distance that characterised the hospital and territorial networks in order to arrive at a single and unified

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lems, outlining the Geriatric Assistance network and indicating the RSAs as 'out-of-hospital facilities for the elderly with disabilities, mainly non-self-sufficient, who cannot be cared for at home, and who need continuous and persistent treatment, and are aimed at providing accommodation and healthcare, assistance, and functional and social recovery services'. During the COVID-19 pandemic in Italy, they ended up at the centre of judicial enquiries for not respecting safety protocols and, consequently, causing large outbreaks of contagion and the consequent deaths of a large number of elderly people.

[3] Due to the serious international economic-financial crisis and the obligations imposed by the European Union regarding the balance of public budgets, the hospital care model was consequently modified with the reduction of beds and with the start of 'a season of experimentation with new models of care, in particular aimed at favouring integration between hospital and non-hospital facilities' (A Santuari, Il Budget di Salute e la presa in carico delle persone fragili, 64). To confirm this, see Art 15, par 13, let c) of legislative decree no 95 of 6 July 2012, converted with amendments into law no 135 of 7 August 2012 (Urgent provisions for the revision of public spending with unchanged services to citizens), which establishes that hospital facilities may not contain more than 3.7 beds per thousand inhabitants, with a view to containing national healthcare spending.

[4] See Istituto Superiore di Sanità (ISS), National survey on COVID-19 infection in residential and socio-medical facilities. FINAL REPORT (5 May 2020) <www.epicentro.iss.it> accessed 15 November 2023. The survey started on 24 March 2020 and involved 3292 RSAs (96% of the total) distributed in a representative manner throughout the country. The aim of the survey is to monitor the situation and adopt possible strategies to strengthen programmes and basic principles for the prevention and control of care-associated infections.

[5] The concept of 'taking charge' delineates a set of curative, continuous and preventive actions, the management and provision of which is entrusted mainly to the general practitioner, as well as 'to other actors in the care setting', F Foglietta, 'Introduzione: la presa in carico del cittadino da parte del SSR', in C Bottari, M Gola (eds), La presa in carico del cittadino da parte del servizio sanitario regionale (Maggioli editore, 2020) 22ff.

[6] The integration of health and social services represents the only form of full protection of the patient's health, 'in the awareness of the insufficiency of only one of the two [services] to offer an adequate response to protect the person's rights in relation to specific needs' E Rossi, 'Il "sociosanitario": una scommessa incompiuta?' (2018) Rivista AIC, 2, 3. On the necessary and dutiful sustainability of public healthcare spending, see the document of the Ministry of the Economy and Finance, Department of the State Accounting Department, The Monitoring of Healthcare Spending, Report No. 9, August 2022, 2ff, where it is pointed out that 'in order to cope with the effects of the pandemic, it was necessary to introduce significant changes in the organisation of the National Health Service, which will have to be consolidated in order to allow a timely response in the event of the repetition of further emergencies', guaranteeing a 'maintenance of the quality standards achieved' compatible with 'the issue of the sustainability of the costs of the public health system in the presence of funding levels conditioned by the financial constraints necessary for the respect of the commitments undertaken by Italy in the EU'.

network, consisting of the integration of health and social-health services[7]. In this renewed context, the general practitioners were to associate 'in organisational forms through which they could provide services to citizens-patients in a continuous, coordinated and integrated manner […], realising proximity and home care, with greater appropriateness than in the previous system, with a view to improving the integrated social and health offer'[8].

The concrete application of this organisational design resulted in the adoption of a management model based on the partial de-hospitalisation of patients and the development of some forms of territorial care. The result was the creation of special intermediate structures whose purpose was, on the one hand, to lighten the workload of hospitals and, on the other hand, to guarantee the provision of health and social-health services that could not be provided at home[9].

Health Homes, which make it possible to provide integrated proximity care within the same place through the participation of general practitioners and outpatient specialists, as well as with the active involvement of citizens, and Community Hospitals, which take care of patients who do not have a home suitable for the required health interventions, represent organisational branches of a territorial welfare system that must be strengthened as subsidiary structures functional to satisfying the performance deficiencies existing in hospitals. In this way, the patient can enjoy facilitated access to those territorial services that he could not otherwise receive at home.

The refinement and completion of such a welfare system could take place with the use of the Health Budget (so-called BdS), a tool oriented towards the integration of health services and welfare interventions. These BdS are to be implemented with the involvement of a plurality of public bodies and with the direct participation of the patients themselves, who can contribute to the creation of flexible services that can be modified according to their personal needs, moving away from the standardised scheme of health protection and social assistance that has always characterised our system[10].

This contribution intends to focus attention precisely on overcoming this form of rigidity in the provision of health and socio-medical services. This is to be achieved through the application of an organisational model centred on the use of the BdS and aimed at promoting an integrated and coordinated management of interventions in favour of patients, reinforcing those objectives of social cohesion and efficiency in the performance of administrative action that the COVID-19 pandemic has, instead, substantially weakened.

2. Social Cohesion and Administrative Efficiency in Health and Social Care Services: Indications from the National Recovery and Resilience Plan

As already mentioned, the COVID-19 pandemic has shown the organisational and managerial inefficiencies of the health and welfare system, significantly decreasing the level of social

[7] On the Balduzzi decree, see E Jorio, D Servetti, 'La difficile riforma dell'assistenza primaria, tra legge statale, accordi collettivi e programmazione regionale' (2019) Corti supreme e salute, 2, 259ff; D Morana, 'I decreti del 2012 tra le riforme della Riforma sanitaria' (2018) Corti supreme e salute, 3, 596ff.

[8] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 65-66 and, in particular, footnotes 118, 119, 120 and 121. The author also mentions Ministerial Decree no 70/2015, which reiterates the relevance of the integrative phenomenon between hospital and territorial structures, in order to guarantee 'continuity of care'.

[9] According to A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 67, these intermediate structures (Case della Salute and Ospedali di comunità) 'were, therefore, designed to favour hospital-territory integration, continuity of care in a dimension close to the habitual places of life of the persons themselves, as well as collaboration and coordination between health and social services'. For an up-to-date picture of the presence of these intermediate facilities on the national territory, please refer to the analysis carried out in the document of the Chamber of Deputies, entitled 'Case della salute ed Ospedali di comunità: i presidi delle cure intermediie. Mapping on the territory and national and regional regulations', 1 March 2021, no 144. See E Rossi, 'Le "Case della comunità" del PNRR: alcune considerazioni su un'innovazione che merita di essere valorizzata' (2021) Corti supreme e salute, 2, 9ff.

[10] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato. In this regard, please see also L Di Giovanni, 'Budget di salute e L.E.P.: rapporti reciproci e conseguenze organizzative' (2016) Rassegna di diritto farmaceutico e della salute, 2, 204ff.

cohesion that, in general, was found in Italy[11]. It has significantly affected the an quantum and quomode of the services provided to citizens-patients, increasing the existing disparities and producing strong territorial imbalances in the various regions. This has resulted in the inevitable consequence of the partial non-application of the principle of solidarity and of those mandatory duties placed by Article 2 of the Constitution on the various public and private entities[12].

In order to remedy this situation and, therefore, repair the economic and social damage caused by the pandemic, the National Recovery and Resilience Plan (PNRR) has intervened. Missions no. 5 and no. 6 aim to promote the development of social inclusion and cohesion and a better protection of health through a unitary and coherent planning-programme[13]. The measures developed by this Plan, in fact, aim at eliminating or at least reducing the factors of social and territorial inequality that have been accentuated by COVID-19 through policies of a transversal nature, aimed at overcoming the logic of the sectorialisation of the interventions prepared in favour of a global and integrated vision of action.

In particular, the fifth mission focuses attention on the social aspects of the issue, intending to resolve it through the preparation of specific measures aimed at assigning families, communities and third-sector associations a key role in increasing the inclusion and cohesion of the individual components of civil society. These measures address the problematic issue of support for frail persons, forcing the adoption of a regulatory framework on disability that is concerned with making organisational and managerial interventions more rapid and effective. They are also concerned with the identification of clear essential levels of services referring to the conditions of the non-self-sufficient elderly[14].

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[11] Cohesion is a purely European principle and was only later introduced into our legal system. Initially envisaged by the Single European Act of 1986 exclusively for political purposes, it then took on an economic and social dimension with the Maastricht Treaty of 1992, Article 130 of which, contained in Title XIV, entitled 'Economic and Social Cohesion of the Maastricht Treaty', expressly provided that 'in order to promote its overall harmonious development, the Community shall develop and pursue its actions leading to the strengthening of its economic and social cohesion. In particular, the Community shall aim at reducing disparities between the levels of development of the various regions and the backwardness of the least favoured regions, including rural areas'. This principle finally acquired a purely territorial dimension with the Lisbon Treaty, whose Articles 174-178, contained in Title XVIII, state that 'in order to promote its overall harmonious development, the Union shall develop and pursue its actions leading to the strengthening of its economic, social and territorial cohesion'. Moreover, it is necessary to take into account the fact that cohesion, understood as a process aimed at promoting cooperation between the territories of the different Member States of the European Union through the implementation of joint actions aimed at achieving the economic, social and territorial development of the Union as a whole, has moved into a second programming phase (2021-2027), after the previous 2014-2020 programming period has ended. See G De Giorgi Cezzi, P Portaluri (eds), La coesione politico-territoriale, in L Ferrara, D Sorace (ed.) A 150 anni dall'unificazione amministrativa italiana (Florence University Press, 2016) 9 ff. See also <www.agenziacoesione.gov.it> accessed 15 November 2023.

[12] The constitutional basis of the principle of cohesion is well highlighted by the contribution by L Mezzetti, 'Principi costituzionali e forma dell'Unione', in P Costanzo, L Mezzetti, A Ruggieri (eds), Lineamenti di diritto costituzionale e dell'Unione europea (Giappichelli, 2014) 85.

[13] The National Recovery and Resilience Plan (NRRP) was approved on 29 April 2021 by the Council of Ministers and represents the investment programme that Italy submitted to the European Commission in the context of the Next Generation EU, the instrument to respond to the pandemic crisis caused by COVID-19. For more details on the characteristics of this type of planning, please refer to <www.governo.it and www.politicheeuropee.gov.it> accessed 15 November 2023.

[14] For a description of the measures contained in the PNRR regarding the third sector, see G Marocchi, 'Il Terzo settore e il PNRR' 22 June 2021 <www.welforum.it> accessed 15 November 2023, and V Falabella, 'The urgency of inclusive policies on disability. Gli scenari e le attese alla luce del PNRR', 28 October 2021 <www.welforum.it> accessed 15 November 2023. See also A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 91, according to which mission no 5 of the NRRP envisages, on the one hand, 'the adoption of an organic discipline (Code) of disability, aimed at redesigning the protection of disability in the various spheres and, at the same time, at providing for more efficient processes in the organisation and delivery of interventions and services, through the approval of a delegated law by March 2023 and subsequent legislative decrees by June 2024', while, on the other

These measures, which are to be implemented by municipalities, other local authorities and non-profit organisations, are mainly aimed at enhancing services relating to home care and social housing. They take concrete form in the transformation of RSAs and nursing homes for the elderly into autonomous living places, equivalent to those belonging to the institutionalised context[15]. The aim is, therefore, to guarantee an independent life to the vulnerable patient through 'the creation of care networks that serve groups of flats in semi-autonomy, ensuring the services necessary for the elderly person to remain safely in their own territory'[16]. From this point of view, therefore, the fifth mission of the NRP requires the appropriate subjects to promote specific public policies that favour the provision of home care or, at least, ensure the effective care of frail patients through the use of subsidiary intermediate structures[17].

If these constitute the objectives of the fifth Mission, others are the aims of the sixth Mission, which mainly concern the theme of health protection. In this case, the NRP intends to strengthen territorial health care through the creation of new local structures, the promotion of the use of telemedicine and the development of more integrated social and health services[18].

The direction taken coincides with the move towards a healthcare system of an integrated and multidisciplinary nature, which guarantees the profitable management and provision of essential levels of services and which prefers, where possible, the implementation of home-based interventions, especially in view of the 'shortcomings and dysfunctions recorded in hospital care following the pandemic'[19].

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hand, it establishes that it will be necessary 'to introduce an organic system of interventions in favour of the non-self-sufficient elderly that also envisages the identification of essential levels of services for the same elderly to be realised through the outline of the enabling act-legislative decrees, to be completed by the natural end of the current legislature (spring 2023)'. The delegated law on disability was enacted in December 2021 (Delegated Law no. 227 of 22 December 2021), while for the non-self-sufficient elderly the draft law on policies for these types of patients was approved on 19 January 2023 by the Meloni government.

[15] According to MA Sandulli, 'Introduction', in MA Sandulli (ed), L'assistenza domiciliare integrata. Esperienze, problemi e prospettive (Editoriale Scientifica, 2021) 19, 'home care must however be valued in more general terms, in its capacity, that is, to meet the needs of all frail patients […]'. The strengthening, therefore, of social and socio-medical services is a consequence of the effects of the COVID-19 pandemic, which has made it necessary to expand the services relating to 'territorial medical care' and also 'social and welfare support for those with fragility, health difficulties or previous multi-problems' (thus G Gazzi, 'A professional community and the emergency', in M Sanfelici, L Gui, S Mordeglia (eds), Il servizio sociale nell'emergenza Covid-19 (Fondazione Nazionale Assistenti Sociali, 2021) 16.

[16] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 92. The author also emphasises that 'the objective in question, therefore, seems to want to fill a gap, which is often easy to detect on Italian territory, namely the lack of alternative structures to residential centres for those who can live at home with adequate support'.

[17] See MA Sandulli, 'Sanità, misure abilitanti generali sulla semplificazione e giustizia nel PNRR' (2021) Federalismi, 10ff, on the necessary effectiveness of health and social-health services, offered by public and private facilities.

[18] Component no 1 of Mission no 6 of the NRRP is, in fact, entitled 'Proximity networks, structures and telemedicine for territorial healthcare'. It prefigures a reform aimed at determining a new institutional and organisational set-up, both in the health and welfare fields, aimed at ensuring greater integration of health and social-health services. Concrete examples of this new organisation are the Case della comunità (community homes) and community hospitals: the former represent specific places in which a plurality of professionals (general practitioners, specialist doctors, nurses, social workers, etc.) will operate, through which an attempt will be made to coordinate all the social-health services provided in the territory; the latter, on the other hand, are territorial health facilities intended for patients who require short admissions and hospital stays and medium/low-intensity clinical health interventions. For more details on the peculiarities of these instruments, see V Mapelli, 'La grande incompiuta: l'assistenza primaria', 20 September 2021, <www.welforum.it> accessed 15 November 2023; D Donetti, A Proietti, S Giacomini, 'Ospedale di comunità – Rafforzare l'assistenza intermedia e le sue strutture', (2021) Monitor, Piano Nazionale di Ripresa e Resilienza. Missione salute, 45, 37ff.

[19] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 95. In this regard, the author observes that 'the

However, some scholars have stressed the existence of certain critical points in the management and organisational design envisaged by Missions No. 5 and No. 6 of the PNRR[20]. Specifically, it has been pointed out that the short time frames for the implementation of the interventions imposed by the European Union (the deadline for which is set for the year 2026), the necessary constructive contribution of non-profit and mutualist organisations (which has been lacking to date) and the excessive focus on healthcare services (and not on more properly social services) all represent obstacles that contribute to the emergence of doubts and perplexities as to the positive outcome of this macro-restructuring of the health and social-health system.

A solution to the aforementioned problems could derive from the application of the Health Budget, which, as discussed below, possesses characteristics that permit an effective integration of the health and socio-health services, allowing the overcoming of that 'chronic incommunicability' characteristic of the relations between these types of services[21].

3. The Legal Regime and the Special Features of the Health Budget

The Health Budget represents a suitable and adequate means to translate the personalistic principle of the Constitution into structural and not just operational indications[22]. The realisation of personalised therapeutic projects, which can be modelled on the treatment and care needs of each patient, makes it possible to implement the true essence of social rights, which can be identified in the full development of the human person. This considers man's needs and no longer just his pathology as the object of social and health protection and enhancement measures[23].

The BdS can be understood in two different senses. Firstly, it constitutes a set of economic, professional and technical resources, which are capable of facilitating a process of

pandemic has highlighted a non-optimal integration between hospital, territorial and social services, showing the problematic nature of a system that requires renewal and innovation, even profound in certain regional contexts, of the relations between the various levels'. On the same subject, see also S Lorusso, S Sassone, V Vena, F Di Pasquale, G De Santis, EP Coletto, 'Le riforme quali condizioni abilitanti per gli investimenti in sanità' (2021) Monitor, 45, 15ff. As regards, on the other hand, the characteristics of integration and multidisciplinarity of the new healthcare system, see D Mantoan, A Borghini, 'Potenziamento dell'assistenza sanitaria e della rete sanitaria territoriale' (2021) Monitor, 45, 10ff.

[20] Indeed, according to A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 95-96, 'it is impossible not to notice certain critical points in the provisions contained in the Plan. Firstly, the timeframe for the implementation of the measures envisaged therein, identified as 2026, is taken into consideration. Also in the light of the assessments that have emerged in the light of the health emergency, it is necessary to associate the timeframe for the implementation of the interventions, given the urgency of ensuring, as of now, answers, solutions and interventions capable of responding in a timely manner to the complexity of the problems and expectations that, also due to the pandemic, have manifested themselves in all their harshness. Secondly, community homes and hospitals require institutional arrangements and organisational models of intervention at regional level that cannot be separated from effective integration between hospital and territorial services and an equally effective contribution by non-profit and mutualist organisations. In this perspective, therefore, the Regions are called upon to propose, develop and implement intervention models which, however, will have to find appropriate forms of coordination and synthesis in the competent Ministries so that uniform levels of assistance can be ensured throughout the national territory. Thirdly, as already mentioned above, the Plan favours the development of home care, which is excessively focused on health-related responses to the detriment of more markedly social ones'.

[21] D Donati, 'Dopo il contagio. Quattro tracce per la riprogettazione dell'assistenza domiciliare', in MA Sandulli (ed), L'assistenza domiciliare integrata. Experiences, problems and prospects, 90.

[22] On the personalistic principle in the Italian Constitution, please refer to E Casetta, Manuale di diritto amministrativo (Giuffrè, 2011) 63ff; A Barbera, Corso di diritto pubblico (il Mulino, 2008) 127 ff; G De Vergottini, Diritto costituzionale (Cedam, 2006) 381ff.

[23] See L Di Giovanni, Budget di salute e L.E.P.: rapporti reciproci e conseguenze organizzative, 204 and to Id., 'Un nuovo strumento per l'integrazione socio-sanitaria: il budget di salute' (2016) Sanità pubblica e privata, 2. For more analysis on the characteristics of the BdS, see A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, cit.

autonomy aimed at restoring an acceptable social functioning to the person, in accordance with the principles set out in Articles 2 and 3 of the Constitution. From this point of view, it is considered as a material and economic means made available by the public administration to all those patients suffering from physical and mental disorders, so that they can follow therapeutic paths, customisable on the basis of their own care and assistance needs and under the supervision of third parties, such as, for example, co-managers and their families.

Secondly, in its legal meaning, the BdS can be analogised to a shop, similar in structure and content to the public-private partnership contract[24]. The contracting parties are identified by the local authority (especially the municipality), the local health authority, the co-managing body and, lastly, the patient himself, which together must provide for the regulation of the medical-care relationship with the patient and their operational responsibilities. Through the contract, a direct link is established between the private partner, represented by the co-manager, and the public partners, generally consisting of the municipalities and the ASLs[25], under which the former provides a service to the patient, but always under the control of the latter.

In practice, a variant of this contractual scheme has also emerged, called a mixed management form (the so-called 'welfare mix'), where the public partner, in addition to constantly supervising the work of the co-manager in relation to the expected results, may directly take part in the provision of social and health services. This creates a co-managed system with the private subject, with the aim of implementing individual therapeutic-rehabilitative actions in both the health and social sectors.

The economic or legal classification of the BoD, however, is irrelevant for the purposes of applying the principle of loyal cooperation between the parties to the relationship. In fact, whether the BdS is intended as a mere budget or whether this instrument is considered as a legal transaction, its promotion, management and monitoring represent activities to be performed in a coordinated and integrated manner among all the operators in the case with the aim of addressing the patient's needs and requirements in a customised manner.

In particular, 'the aim of individual therapeutic-rehabilitative actions through BdS is to provide the patient with care appropriate to his or her needs'[26] in order to guarantee an increase of the patient's faculties and bargaining power[27]. This also allows for the effective usability for the same patient of the areas-rights related to specific sectors, such as, for example, those concerning the home or the social habitat, training and work, sociality and the area of affectivity[28].

The recipients of these interventions, organised through a network system[29], are citizens with social disabilities concomitant or consequent to psychic or physical illnesses with a protracted and potentially worsening course

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[24] On the characteristics of public-private partnerships, both contractual and institutional, see G Cerrina Feroni (ed), 'Il Partenariato pubblico-privato. Modelli e strumenti', in Quaderni Cesifin (Giappichelli, 2011); B Raganelli, 'Principi, disposizioni e giurisprudenza comunitaria in materia di partenariato pubblico-privato: un quadro generale' (2010) Giustamm; MP Chiti, Il partenariato pubblico-privato (concessioni, finanza di progetto, società miste, fondazioni), (Editoriale Scientifica, 2009); MP Chiti, 'Partenariato pubblico-privato', in M Clarich, G Fonderico (ed), Dizionario di diritto amministrativo (Il Sole 24 ore, 2007) 495ff; R Dipace, Partenariato pubblico-privato e contratti atipici (Giuffrè, 2006) 93ff.

[25] 'Azienda Sanitaria Locale' (Local Health Utility).

[26] L Di Giovanni, Budget di salute e L.E.P.: rapporti reciproci e conseguenze organizzative, cit., p. 205.

[27] In doctrine, there is the theory according to which there would exist a 'consumer welfare', within which the individual would be the holder of a contractual power and, consequently, would be able to make use of social and health services: in this regard, see the works of J Habermas, La nuova oscurità. Crisi dello stato sociale ed esaurimento delle utopie (Edizioni Lavoro, 1998) 1ff; Z Bauman, L'etica in un mondo di consumatori (Editori Laterza, 2010) 1ff. On contractualisation in social and health policies, see R Monteleone, 'La contrattualizzazione nelle politiche socio-sanitarie: il caso dei voucher e dei budget di cura', in L Bifulco (ed), Le politiche sociali. Temi e prospettive emergenti (Carrocci, 2005) 1ff.

[28] According to A Righetti, I budget di salute e il welfare di comunità (Editori Laterza, 2013) 48, these sectors represent the so-called social determinants of health, i.e. precise parameters pertaining to constitutionally guaranteed citizenship rights.

[29] The use of the BdS implies the necessary activation of a networked system of specialist knowledge, ranging from medical skills to social and welfare ones. On this topic, see L Fazzi, 'L'attivazione di una cultura di rete nei servizi sociali', in M Croce (ed), L'intervento di rete. Concetti e linee d'azione (EGA, 1995) 1ff.

or in a state of serious risk and vulnerability due to the prognosis. In short, the recipients coincide with all those in conditions that require individual assistance characterised by the inseparability of health and social interventions, starting with needs with health prevalence and social relevance. Consequently, the interventions envisaged by the BdS are aimed at persons requiring social-health services with a high degree of therapeutic integration, carried out in particular social contexts. These are areas characterised by the presence of the elderly, persons addicted to drugs, alcohol and pharmaceuticals, persons with psychiatric pathologies, HIV infections or in a terminal phase, persons incapacitated or disabled due to chronic-degenerative diseases.

With regard to the methodology applied for the proper implementation of the aforementioned interventions, it seems evident that there is recourse to criteria of co-planning, co-management and co-financing, as well as to an assessment of the processes and programmes to be implemented in an agreed manner between public bodies and private subjects. This seeks to substantially achieve three results on the one hand, to avoid the establishment of delegation mechanisms between the parties to the performance relationship, to focus attention on the outcomes of health and social-health actions and not on the accreditation methods of the operating structures, and to promote associationism and widespread cooperation in the social-health sector as a guarantee against the monopolistic and productive centralisation of private actors.

From the reflections formulated, an organic and systematic framework seems to emerge, within which the BdS is identified as the most suitable instrument to represent and implement the constitutional principles of solidarity, subsidiarity and differentiation[30]. Firstly, this is because it guarantees patients the concrete application of their inviolable rights, recalled by art. 2 of the Constitution, and makes the organisations of the third sector, as well as his family members, fulfil those duties of social welfare solidarity. Secondly, this is because the BdS involves private co-managers at an equal level with the public administrations in the provision of social and health services, favouring relations of cooperation and collaboration between these actors. Lastly, this is because it makes it possible to implement a customised therapeutic programme modulated on the specific and real needs of the patient and not based exclusively on general and collective needs, previously defined by the competent public bodies.

The BdS, therefore, would make it possible to address the issue of determining the essential levels of services (and also of the related essential levels of care) from a different perspective, which takes into due consideration both the need for the legislature to circumscribe and delimit the discretion of the administration through specific standards and the desire to leave the public body and the patient margins of manoeuvre in defining part of the content of these levels[31].

4. Organisational models and regional experiences of the BdS

The perimeter of the State's intervention in the area of health protection was reduced with the reform of the Constitution by Constitutional Law No. 3 of 18 October 2001, which amended

[30] For a general overview of the principle of subsidiarity and its corollaries of differentiation and adequacy, see A Barbera, Corso di diritto pubblico, 325; V Cerulli Irelli, Lineamenti di diritto amministrativo, 56; E Casetta, Manuale di diritto amministrativo, 60ff; L Melica, 'Sussidiarietà', in S Cassese (ed), Dizionario di diritto pubblico (Giuffrè, 2006) 5836ff.

[31] Standards have a highly technical content, taking the form of actual prescriptions, i.e. quantitative and qualitative technical parameters in relation to which the essential levels of services are to be determined (in this regard, see C Bottari, Tutela salute ed organizzazione sanitaria (Giappichelli, 2009) 86ff. C Bottari, Tutela della salute ed organizzazione sanitaria (Giappichelli, 2009) 86ff; C Tubertini, Pubblica amministrazione e garanzia dei livelli essenziali delle prestazioni (Bonomia University Press, 2008) 39 ff). The Constitutional Court has held that standards constitute integrations and specifications of the essential levels of assistance, capable of affecting the discretionary power of the public administration in order to relate the supply of services to the demand for services (Constitutional Court, 31 March 2006, no 134, Constitutional Court, 23 November 2007, no 387, Constitutional Court, 27 February 2008, no 50, available at <www.cortecostituzionale.it> accessed 15 November 2023). In the past, however, the Constitutional Court had adhered to an orientation that tended to exclude standards from the scope of the essential levels of services (Constitutional Court, 26 June 2002, no. 282, Constitutional Court, 23 December 2003, no 370, Constitutional Court, 25 March 2005, no 120, available at <www.cortecostituzionale.it> accessed 15 November 2023).

the content of Article 117, paragraph 3, of the Constitution, attributing legislative power in this area also to the Regions. The Regions, therefore, have the task of dictating the precise discipline of the social-health sector with respect to the fundamental principles laid down by the State[32].

In this framework, the Regions have taken steps to regulate certain organisational, managerial and delivery aspects of healthcare and social-health services, such as, for example, 'the role of the GP, the Health Homes, Community Hospitals and, more generally, the care of citizen-patients, as well as the definition of the levels of social-health integration and the levels of collaboration with third sector entities'[33].

In particular, the direction taken by the regional systems coincides with a taking charge of the patient that can guarantee functional coordination between health and care services. For example, in Emilia-Romagna the 2017-2019 social-health plan, whose validity has been extended until the end of 2021, has proposed the implementation of a series of public policies of a transversal nature, in the sense that the effects of operational measures do not only affect a specific health or social area, but also produce consequences in other areas.

The same considerations, moreover, can be made for the Veneto Region, where the relevant Social and Health Plan 2019-2023, approved by Regional Law 28 December 2018, no 48 of 28 December 2018, confirms the objectives set out in the previous Plan, establishing that integration must also take place with reference to the operating locations and means used[34]. For the Lombardy Region, within which integration is implemented through a 'care pact', stipulated between the patient and the co-managing body, with the aim of providing the services requested in compliance with the contents of the Individual Care Plan, the so-called PAI[35].

Socio-healthcare integration therefore takes place through specific interventions implemented by the Regions within the framework of the regional socio-healthcare Plans. The latter provide the guidelines for the protection of the health of frail persons and for the performance of primary care, so as to guarantee the necessary assistance in all phases of the process of taking charge of the sick[36]. The measures prepared are therefore intended to ensure that the

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[32] See L Dimasi, 'Il sistema sanitario della Regione Veneto', in C Bottari, M Gola (eds), La presa in carico del cittadino da parte del servizio sanitario regionale, 85ff. See also D Mone, 'Autonomia differenziata come mezzo di unità statale: la lettura dell'art. 116, comma 3, Cost., conforme a Costituzione' (2019) Rivista AIC, 1, 349, who observes that the differentiated regionalism referred to in Article 116 of the Constitution is not an element to be interpreted negatively, as an instrument of 'disintegration of the unitary State', but rather as a factor for the growth of the poorest areas of the country, provided it is applied correctly.

[33] A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 72. Moreover, it is possible to find in these interventions carried out by the Regions a particular attention to the theme of socio-healthcare integration, understood as a phenomenon of functional coordination between health services and socio-welfare services, to be implemented within the District, that is in an organisational articulation of the local health authorities. For example, with reference to the territory of the Emilia-Romagna Region, we would like to highlight the provisions of the Regional Health Plan 2017-2019, which considers the District as a 'strategic junction and focal point of health, social and socio-sanitary integration', and of the Area Plan for Health and Social Wellbeing 2018-2020 of the metropolitan city of Bologna, which establishes that the District is assigned management and control tasks in the social and socio-sanitary sphere (in this regard, in doctrine, see S Nuti, S Barsanti, 'L'integrazione sociosanitaria: strumenti per la programmazione e la valutazione delle zone-distretto del sistema sanitario toscano', in AD Barretta (ed), L'integrazione sociosanitaria- Ricerca scientifica ed esperienze operative a confronto, (il Mulino, 2009) 44ff.

[34] Integration between operating sites must take place with regard to hospitals and territorial bodies; as far as instruments are concerned, on the other hand, Integrated Group Medicine, the Territorial Operating Centre and intermediate hospitalisation facilities are worthy of mention.

[35] In this regard, see F Laus, 'La presa in carico nel sistema sanitario lombardo', in C Bottari, M Gola (eds), La presa in carico del cittadino da parte del servizio sanitario regionale, 81ff.

[36] For example, as models of regional social-health plans, the following can be mentioned: Veneto PSSR 2019-2023; Emilia-Romagna PSSR 2017-2019; Lombardy PSSR 2019-2023; Tuscany PSSR 2018-2020. On this topic, see M Spagnolo, 'Il sistema sociosanitario veneto', in C Bottari, M Gola (eds), La presa in carico del cittadino da parte del servizio sanitario regionale, 52; M Caiolfa (eds), Elementi di programmazione sanitaria e sociale in Toscana (Regione Toscana, ANCI Toscana, 2020) 23ff.

person is taken care of as a whole, as a founding element of the health and social-health system of the Region concerned[37].

This assumption of responsibility is satisfied through regional organisational models capable of guaranteeing a coordinated management of the interventions and an effective integration of their health and social-health components. These models intend to overcome the fragmentation of health and social care in the territory, abandoning the vision of the hospital as the centre of the system and recognising the importance of the District and the home dimension of care, as well as enhancing the services provided by intermediate structures through groups of medical experts in various disciplines[38]. In this respect, the use of the BdS would make it possible to strengthen the coordination and integration of services through the application of a multi-sectoral approach, in order to bring the outcome of the activities carried out closer to the needs and requirements of the patient.

Examples of this are the models adopted in Lombardy, Veneto, Tuscany and Emilia-Romagna. In the first case, it is important to draw up a 'care pact', an agreement of one year's duration signed by the patient and the manager, through which the latter undertakes to provide the former with the social-health services envisaged in the PAI, with the aim of satisfying the needs of the patient. In the second case, on the other hand, the regional integrated health protection system deserves attention. It is concerned with satisfying the patient's health needs starting from their specific identification, through the activities carried out by a number of subjects present on the territory (Integrated Group Medicine, Territorial Operations Centre and Intermediate Care Facilities). As far as Tuscany is concerned, it is sufficient to recall what is provided for by the resolution of the Council of 11 October 2021, implementing the previous resolution no. 1449/2017, which imposes the use of the BdS methodology for the preparation of the so-called 'Life Projects of persons with disabilities'. Lastly, with reference to Emilia-Romagna, the indications on how to implement social-health integration on the territory are contained in the PSSR 2017-2019, which identifies areas of intervention of a transversal nature on the basis of citizens' assistance needs[39].

In addition to the aforementioned regional experiences, the organisational model adopted by the Marche Region, which demonstrates that it incorporates the indications coming from the reference legislation, should be noted. These models are represented, on the one hand, by art. 1, paragraph 4-bis of Decree-Law no. 34/2020, converted into Law no. 77 on the subject of the experimentation of "Proximity structures for health promotion and prevention", intended as additional structures for taking charge of and rehabilitating the categories of the most fragile persons. On the other hand, they are represented by the discipline contained in Law No. 227 of 22 December 2021 on the subject of disability, which establishes that the customised life project shall indicate the set of human, professional, technological, instrumental and economic resources (public and private) that can also be activated within the territorial community and the system of informal supports.

Moreover, the 2020-2022 Social and Health Plan, approved by Regional Council Resolution No. 107/2020, moves precisely along the track of integration between the health and social systems in order to fully guarantee the new essential levels of care, in a logic of development of individualised care plans consistent with citizens' demand for health, based on their needs, with particular attention to vulnerable persons.

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[37] See, for example, Lombardy Regional Law no 22 of 14 December 2021, which, by amending Art 2 of Regional Law no. 33/2009, reiterates the concept that the regional health system must take into consideration the principle of taking charge of the person as a whole.

[38] According to G Galera, 'Verso un sistema sanitario di comunità. Il contributo del Terzo settore' (2020) Impresa sociale, 2, 105, following the COVID-19 pandemic and the lockdown that ensued, the hospital 'while being a fundamental and indispensable facility, should be rethought as one of the components, no longer the totemic component of healthcare policies and investments. The hospital-centric model should be contrasted with a capillary system of territorial medicine, which relies on monitoring, information and socio-healthcare networks. A system that would act as a shield and antenna against situations such as the one we are currently experiencing and help to promote a culture of health as a common good'.

[39] For more details on the organisational models adopted by the Regions mentioned above, which employ the BdS methodology, see the observations made by A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 76ff.

In this respect, the Plan attempts to develop the key concepts of integration, accessibility and sustainability, making them conform to the notions established by the Health 2020 model, agreed upon by the Member States of the European Region of the World Health Organisation. In particular, the priority objectives consist in strengthening the role of the Districts and in reinforcing the structures of territorial medicine, in the implementation of home care and in the development of all those health and socio-medical tools useful to offer the appropriate support to the various categories of fragile persons (temporarily or permanently), starting from newborn babies up to the elderly.

It is therefore a restructuring of the system for the management and provision of health and socio-health services, which intends to renew the provision of territorial care by focusing on less hospitalisation, through the adoption of home, residential and semi-residential care models (Home, Intermediate Care, Health and Protected Residences). Within these systems the patient, who is a chronic disease sufferer, actively participates in the definition of his or her treatment pathway, also thanks to the help of family members and professionals[40].

Finally, it is worth noting that the personalisation of treatment and care pathways is also taking place, albeit slowly, in the regions of Southern Italy. In Calabria, for example, with the decree of the Commissioner ad acta no. 158 of 14 November 2022, the agreement ratified in the Unified Conference on 6 July 2022, bearing the 'Agreement, pursuant to Article 8, paragraph 6, of Law no. 131 of 5 June 2003', between the Government, the Regions and the Local Authorities on the document bearing the 'Programme Lines: designing the health budget with the person-proposal of the qualifying elements' was implemented.

With this act, the Region of Calabria, in the face of evident territorial urgencies, intended to contribute to the achievement of the objectives of the United Nations' Agenda 2030, which defines a combined approach to the economic, social and environmental aspects that impact on the wellbeing of persons and the development of societies, addressing, therefore, the fight against health inequalities as a transversal priority to all health and social-health objectives. The methods of intervention for taking charge of and rehabilitating the most fragile persons, which are part of the measures prepared by the 2020-2025 Regional Prevention Plan, aim, consequently, at overcoming the fragmentation of the system, favouring home care and enabling the assessment of the results obtained also through the use of innovative tools, such as the Health Budget[41].

5. Concluding remarks

The COVID-19 pandemic has produced negative effects on our health and social-health care system, increasing the structural conditions of weakness, inadequacy and inefficiency in which it already existed. This situation, which has produced strong territorial imbalances in the various Regions, has resulted in a rethinking of the organisation and welfare services provided in the territory, aimed at fully implementing

[40] According to the aforementioned Plan, there is a need to move citizens away from hospitals 'where hospitalisation must be considered a rare event to be reserved only for times when an adequate and appropriate level of care must be provided in hospital. This model will make it possible to avoid overcrowding of hospitals, guaranteeing better quality of care for citizens, reducing the risk of hospital infections which, in fragile and/or chronic patients, often lead to a prolongation of hospitalisations and a massive use of antibiotics, which in turn lead to the growth of antibiotic resistance' (PSSR Marche 2020-2022, p. 26 ff., available at <www.regione.marche.it> accessed 15 November 2023).

[41] The Regional Prevention Plan 2020-2025 was adopted with the Decree of the Commissioner ad acta 31 December 2021, no 137. The plan shows the awareness of the need to identify policies and instruments that are capable of offering particular and specific responses to the problem of chronicity, which the COVID-19 pandemic has greatly exacerbated by further fragmenting the territory-hospital care pathway (Regional Prevention Plan 2020-2025, <www.regione.calabria.it> accessed 15 November 2023). In addition, the Plan also highlights the lack of health and socio-health services from which the regional care system suffers: in this regard, it is pointed out that the starting point is represented by 'a delay in the development of home care with a rate of patients over 65 treated at home that is well below the national average. The reported data show, moreover, that the Calabria Region does not succeed in guaranteeing an adequate level of taking charge of the population in residential and semi-residential care, since the number of persons assisted is below the national average. Finally, the situation is strongly differentiated between the different regional territories for reasons related to the organisation of territorial assistance and to the orographic and cultural conditions of the different territories' (485ff).

the principles of social cohesion and inclusion envisaged by the European Union, in order to achieve a different type of patient care, based on an effective integration of services and carried out mainly in the home environment[42].

The PNRR, with its missions no 5 and no 6, has attempted to eliminate or, at least, reduce the causes of social and territorial inequality accentuated by the pandemic, through the implementation of policies of a transversal nature, aimed at overcoming the logic of the sectorialisation of the interventions provided in favour of a global and integrated vision of action. In particular, the guidelines of the first mission focus attention on the social issues, addressing the problematic topic of support for fragile persons, while the indications coming from the second mission focus mainly on the health protection sector, suggesting the strengthening of health care provision through new instruments and local structures.

Despite the fact that there has been no lack of criticism regarding the implementation of this organisational and managerial framework[43], it nevertheless appears that the direction taken can produce positive effects in terms of the transformation of the places of care and the services provided. This enables the strengthening of a system with an integrated and multidisciplinary character that can effectively implement the essential levels of services and, consequently, also the essential levels of care.

It is likely that aid in concretising this change could derive from the use of the BdS, whose constituent elements appear to conform to the logic of integration and coordination of care and assistance services. As described in this article, the BdS constitutes an instrument suitable for placing patients and their needs at the centre of the system, preparing specific customised therapeutic treatments, modelled on the needs of each patient and aimed at guaranteeing effective use of the so-called 'social determinants of health'[44].

The BdS would also make it possible to strengthen the home care system by making available a set of economic and professional resources for the autonomous management of services, reducing, where possible, the workload in hospitals and avoiding the overcrowding of the intermediate structures already present in the territory. This is the same form of overcrowding which, at the height of the COVID-19 pandemic, contributed to the spread of the virus and to aggravate the management of the health emergency.

The use of the BdS, moreover, would be compatible with that model of taking charge of patients promoted at the regional level through the adoption of the socio-health plans, most of which were issued prior to the approval of the PNRR. The PSSRs of the various Regions, in fact, aim at establishing a functional coordination between health and social-health services within policies oriented to develop the theme of proximity and domicile of care[45]. The organisational structure adopted by the Marche Region, for example, shows that it acknowledges the indications concerning the appropriate integration between the health and social systems, as well as the activation of rehabilitative forms addressed to the most fragile persons, to be performed in their own homes through customised life projects[46].

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[42] A solution already indicated years earlier by the so-called Balduzzi Decree (law decree 158/2012), which attempted to activate a management model based on the de-hospitalisation of patients and the development of certain forms of territorial care, with the creation of special intermediate structures, which had the task of reducing the workload in hospitals and making up for the shortcomings of the home level, taking the place of specific types of services (in particular, the Case della Salute and the Ospedali di comunità).

[43] See the critical approach showed by A Santuari, Il Budget di Salute e la presa in carico delle persone fragili. Profili giuridici di uno strumento innovativo di partenariato pubblico-privato, 95-96, according to which the short time frames for the implementation of the actions (according to the rigid chronoprogramme imposed by the European Union), the necessary collaboration of the non-profit organisations of the third sector (which has been lacking up to now) and, finally, the excessive focus on the problems of the health sphere (to the detriment of social assistance issues) would act as obstacles to the full implementation of the contents of the PNRR.

[44] Thus A Righetti, I budget di salute e il welfare di comunità, 48. As pointed out in paragraph no 3 of this contribution, the BdS represents a suitable instrument for fully applying the personalistic principle of the Constitution.

[45] See the contents of the RDPs of Emilia-Romagna 2017-2019, Veneto 2019-2023, Lombardy 2019-2023 and Tuscany 2018-2020.

[46] See the PSSR Marche 2020-2022, approved by resolution of the Regional Council no. 107/2020 and aimed at guaranteeing new essential levels of care through the formation of individualised care plans consistent with patients' health requirements.

This, in essence, seems to be the right direction to follow, where the public administration acts on the basis of the indications coming from the patients themselves, in a perspective of loyal collaboration and confrontation, which also takes into account the unavoidable economic-financial parameter for the purposes of public debt sustainability. Sustainable administrative action and, therefore, good administration can only be considered that which, 'based on the criteria of fairness, efficiency and cost-effectiveness, intervenes to take care of the public interest, respecting prudential rules of conduct, in order to avoid undermining the integrity of that interest and, therefore, the possibility of its full implementation'[47].

This means that a good administration is such only if it is characterised by precautionary conduct aimed at the prior identification of the danger of damage and the choice of the methods of exercising administrative power with respect to the level of protection to be accorded to the predetermined public interest[48]. It follows that, in the field of health protection, the concept of good administration cannot but coincide with a preliminary assessment of the risks run by the patient and with his overall care. This means a global management of all the patient's care and assistance needs, which is guaranteed by the cooperation established between the public body and private subjects and which takes into account the economic and professional resources available at the time of the provision of services[49].

In conclusion, from a model of administration that observes only the parameter of legality, it is necessary to shift our attention towards a health and social-health system that also rests its foundations on the different criterion of 'functionality', understood as a measure of the degree of satisfaction of the patient[50]. Only in this perspective will it be possible to activate virtuous health protection mechanisms that are truly oriented towards the reduction of territorial inequalities and the promotion of social inclusion and cohesion.

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[47] L Di Giovanni, 'Una rilettura dell'azione procedimentale amministrativa nell'ottica della sostenibilità: il contemperamento tra esigenze di equità e di efficienza del potere pubblico' (2022) Federalismi, 14, 63.

[48] The principle of good administration is contained in Article 41 of the Charter of Fundamental Rights of the European Union. This principle is considered as an obligation imposed on public bodies to guarantee citizens a complete assessment of the interests involved, with the economic and professional resources available. See DU Galetta, 'Il diritto ad una buona amministrazione nei procedimenti amministrativi oggi' (2019) Riv it dir pubbl com, 2, 165 ff; P Piva, 'Art. 41. Right to good administration', in R Mastroianni, O Pollicino, S Allegrezza, F Pappalardo, O Razzolini (eds), Charter of Fundamental Rights of the European Union (Giuffrè, 2017) 756ff.; L De Lucia, B Marchetti (ed), L'amministrazione europea e le sue regole (il Mulino, 2015) 124 ff; G Della Cananea, C Franchini, I principi dell'amministrazione europea (Giappichelli, 2010) 101ff; F Trimarchi Banfi, 'Il diritto ad una buona amministrazione', in MP Chiti, G Greco (eds), Trattato di diritto amministrativo europeo (Tomo I, 2007) 49ff.

[49] Also in the NRP the concept of good administration has declined in terms of efficiency and cost-effectiveness of performance. In this sense, we refer to the reflections of B Ponti, 'Le diverse declinazioni della "Buona amministrazione" nel PNRR' (2022) Istituzioni del Federalismo, 2, 401ff, according to whom the meaning of 'Good Administration' proposed by the PNRR, therefore, appears strongly shifted towards the dimension of efficiency. Of course, the final recipient of such progress is the citizen (and the business), but the idea is to simplify steps, cut red tape, reduce time. In other words, it is not a question of protecting the citizen in his relationship with the public administration, but rather of investing in making the same machine more efficient, streamlined, uniform, and digital' (404).

[50] G Della Cananea, C Franchini, I principi dell'amministrazione europea, 102.

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SECTION I
ESSAYS

Residential Care Facilities under the Test of the Pandemic Emergency. Values at Stake, Critical Profiles, Hints for the Future

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Abstract. The pandemic emergency represented a 'stress test' for Italian 'Residential Care Facilities', where restrictions on freedom of movement, aimed at safeguarding health, were particularly intense. This was due to the deprivation of an important relational and emotional dimension crucial for the psycho-physical well-being experienced by the residents of these facilities. The article aims to analyse the legitimacy of restrictions on fundamental rights in relation to the principles of the Italian Constitution and supranational norms. The authors' thesis is that there were no restrictions on personal freedom, as hypothesised by the National Guarantor for Persons Detained or Deprived of Liberty and the European Committee for the Prevention of Torture, in the Italian responses to COVID-19 in Residential Care Facilities. Rather, the article asserts that it is appropriate to question the methods adopted to avoid a disproportionate sacrifice of the elderly person's right to self-determination and, at the same time, reconsider, in light of the tragic 'lesson' of the pandemic, some practical aspects of territorial healthcare assistance, taking into account also the insights provided by the case-law of the European Court of Human Rights.

Keywords: *Residential care facilities, COVID-19, fundamental rights, restrictions, ECHR.*

1. The Containment Measures of the Pandemic Emergency and the Impact on Fundamental Freedoms in the Particular Context of the RSAs

The state of public health emergency due to the spread of the COVID-19 pandemic, declared by the Italian Government pursuant to Articles 7 and 24 of the Civil Protection Code (Legislative Decree No. 1 of 2 January 2018), constituted the legal basis for the adoption of a conspicuous series of normative acts of primary and secondary rank and administrative acts. These measures included the controversial Decrees of the President of the Council of Ministers (D.p.c.m.), measures that raised constitutional legitimacy doubts[1] and imposed strict social distancing obligations and containment measures and, in the second pandemic phase, vaccination obligations[2].

The introduction of such bans on moving from one's home, protected by an apparatus of sanctions of an administrative and sometimes criminal nature, appears to be the outcome of a balancing act between values of a constitutional rank that assigns pre-eminent importance to the right to health (Article 32 of the Constitution), recognised by the Fundamental Charter in its twofold capacity as an individual good ('fundamental right of the individual') and as a public good ('interest of the community'). This is a logical precondition for the exercise of any other right, the protection of which, as well as the duties of social solidarity enshrined in Article 2 of the Constitution, justifies restrictions on the other fundamental

[*] C Gabrielli wrote §§ 1-3; F Losurdo wrote §§ 4-6.

[1] It is critically noted how 'the President of the Council of Ministers found himself the holder of a de facto indefinite emergency ordinance power', at the basis of which 'was placed an act, Decree Law no 6/2020, decided by the government he himself presided over', and on which there was 'precipitous and reduced-rank ratification' (F Pallante, 'Pandemia, sicurezza, democrazia' (2021) Questione giustizia, 10).

[2] The Italian Constitutional Court has called the D.p.c.m. 'sufficiently typified administrative acts', recognizing the legitimacy of the overall regulatory chain of the emergency (Const. Court, 23 September 2021, no 198).

[3] Although health does not escape the balancing act either, not placing itself on a hierarchically superordinate plane to that on which other constitutional rights lie (M Luciani 'Avvisi ai naviganti del Mar pandemico' (2020) Questione giustizia, 2, 8).

rights[3] provided that the measures adopted to create a 'cordon sanitaire aimed at protecting health in the interest of the community' from the 'spread of contagious diseases of high gravity' are 'proportionate and limited in time'[4].

Another implicated Constitutional right is the freedom to 'move and reside […] in any part of the national territory' enshrined in Article 16 of the Constitution. This was a freedom that was immediately, albeit not exclusively, affected by the containment measures launched in the pandemic emergency[5]. In fact, the super-ordinate norm assigns to freedom of movement a recessive character with respect to the need to protect health in that it authorises 'the limitations that the law establishes in a general way for reasons of health or safety', entrusting 'the point of maximum tolerance' in identifying those balances 'to criteria of reasonableness'[6].

It follows from the constitutional dictate that there is a reserve of the law that is considered relative[7], whereby the law or the act of equivalent rank can limit itself to providing the general parameters, entrusting the detailed indications to secondary laws and norms[8]. In this instance, the limitations must be justified by 'reasons of health or safety' and provided for 'in a general way', therefore not addressed to individuals but rather to categories of subjects. Such were the restrictive measures introduced on the basis first of Decree-Law no. 6 of 2020 and then of the Decree-Law no. 19 of 2020, which empowered the President of the Council of Ministers to adopt by means of a Prime Ministerial Decree one or more of the measures listed in Art. 1. This involved a large catalogue, which included, for the purposes of this article, both the restriction on the freedom of movement imposed on the person housed in a nursing home (RSA)[9], in the same way as any other citizen, and the closure to the outside of the same structure, by means of 'prohibition or limitation of access by relatives and visitors', in an attempt to prevent the spread of the virus among the patients.

For the residents of the so-called health and social care institutions, most of whom are elderly and suffer from medical vulnerabilities that make it unlikely that they will ever be able to return to an autonomous life, the combination of these competing limitations undoubtedly resulted in isolation, compromising the possibility of cultivating the right to emotional relations and social relations. The latter was a right that had been continuously available since such facilities had to be open seven days a week. This extended the possibility of receiving visits from relatives and caregivers in order

[4] Const. Court, 27 January 2022, no 22. 'Limitations on constitutional rights may not be extended beyond what is strictly necessary, with immediate and direct reference to the situation that in fact imposed the health security measures', also notes G Azzariti, 'I limiti costituzionali della situazione d'emergenza provocata dal Covid-19' (2020) Questione giustizia.

[5] Indeed, the limitations have reflexively affected freedom of assembly, the right to education, work and enterprise, and the right to defense in its traditional fullness. Intuitively, a regime of severe limitation on freedom of movement can exert wide repercussions on the entire system of rights, considering that this freedom that allows people to meet and relate to other people is an instrumental condition for the concrete exercise of almost all other freedoms. On the ability of the measures adopted, 'moving within the horizon of balancing with the right to health, as well as the operation of constitutional principles', to meet criteria of 'proportionality and […] reasonableness', see A Algostino, 'Costituzionalismo e distopia nella pandemia di Covid-19 tra fonti dell'emergenza e (s) bilanciamento dei diritti' (2021) 1, 39 ff <Costituzionalismo.it> accessed 15 November 2023.

[6] Giuliano Amato, 'Commento all'art. 16', in G Branca (ed) Commentario alla Costituzione (Zanichelli-Il Foro Italiano, 1977) 119.

[7] See U De Siervo, 'Soggiorno, circolazione, emigrazione (libertà di)', in Noviss Dig Ital (Torino, 1970) vol XVII, 820; M Mazziotti Di Celso, 'Circolazione (libertà di)', in Enc dir (Roma, Istituto della Enciclopedia italiana, 1960) vol VII, 22.

[8] In this particular case, 'the primary-ranking source complies with the reservation of law under Article 16 Const. by providing for the 'limitations' consequent to the emergency, and the secondary-ranking source 'administratively' implements it' (R Di Maria, 'Il binomio "riserva di legge-tutela delle libertà fondamentali" in tempo di Covid-19: una questione non soltanto "di principio"', 30 March 2020, 506ff, part 511 <www.dirittiregionali.it> accessed 15 November 2023).

[9] It is, according to the guidelines disseminated by the Ministry of Health in January 1994, a socio-medical residential facility, which provides out-of-hospital services designed to meet the demand for rehabilitation and long-term care expressed by the elderly, disabled, and otherwise non-self-sufficient individuals who cannot be cared for at home. The assisted living residence is distinguished from the assisted living residence (RA), which is defined by the same guidelines as a social welfare residential facility.

to be able to guarantee effective, care and assistance support on a daily basis as well. These are contributions that presuppose physical contact, difficult to replace with remote communication, which appears complex and less significant for a user unfamiliar with technology.

It is difficult to deny that the restrictive effects of measures taken in Italy to address the COVID-19 pandemic on individual freedoms have a different intensity and impact on individual well-being depending on the characteristics of the recipient and the location. Thus, rigid confinement such as the one experienced in the acute phase of the pandemic was heavier when faced in a place other than one's home, outside one's home and family dimension, by those who were medically frail and isolated, often with limited cognitive and relational capacities. The widespread impression is that ensuring health prevention that could be somewhat effective has imposed a particularly high price on the vulnerable. To be content with an essentially only biological protection of life meant, according to the national guarantor of the rights of persons deprived of their liberty, living 'an experience of time without measure and place without meaning', in which the protracted lack 'of treatment activities and socio-affective relations with the outside world' exacerbated 'disproportionately the suffering of people who are already extremely vulnerable' and determined 'serious outcomes of cognitive regression'[10].

2. The Relationship with Personal Freedom: The Relevance of Consent

It is therefore not surprising, in the light of these considerations, that on another occasion[11], during the COVID-19 state of emergency, the national authority itself noted the 'transformation of […] residency into a de facto form of segregation' and prefigured within the so-called semi-closed communities[12]. It was also, as a result, impossible for non-medical support figures to access the facilities – the 'risk of a de facto deprivation of personal liberty'.

Assuming that the reservation of the law was fulfilled, it would obviously have been a restriction of personal liberty carried out outside the reservation of jurisdiction, lacking the reasoned act of the judicial authority referred to in Article 13 paragraph 2 of the Constitution.

In the present case, however, this eventuality seems to be ruled out, whereas it would occur, for example, where the difficult pandemic conditions were not accompanied by adequate health care resulted in the use of instruments of restraint, undermining the core of the guarantee of habeas corpus[13].

In order to deny that the restriction of the *status libertatis* may have occurred, one could first invoke the argument, drawn from the jurisprudence of the Constitutional Court, according to which 'Article 13, in declaring personal liberty inviolable, refers to the liberty of the person in the strict sense, as is apparent from the exemplifications of the second paragraph: detention, inspection, search' personal[14]. A freedom that is "at stake in every case of coercion that has as its object the body of the person,"[15] protracted for a duration that is not entirely negligible and momentary. When the freedom of movement is affected, and this was certainly the case with the restrictive measures adopted in the pandemic phase, "a certain index for assigning" such measures "to the

[10] Report to Parliament, year 2022.

[11] Report to Parliament, year 2020.

[12] This is how the Higher Institute of Health defines them in the National Survey on COVID Contagion in Residential and Social-Health Facilities, May 5, 2020.

[13] The explicit qualification of mechanical restraint as a mode of restriction of personal freedom, devoid of any therapeutic or curative purpose, endowed with a merely 'precautionary' function, being aimed at safeguarding the physical safety of the subject or those who come into contact with him/her has been affirmed by the Court of Cassation (Cass, sec V, June 20, 2018, no 50497, Mastrogiovanni, in C.e.d. Cass., no 274435), according to which it can never be equated with a therapeutic act and, in the logic of the extrema ratio, can be ordered only in extraordinary situations and for the strictly necessary time, with strict observance of the prerequisites required by Article 54 of the Criminal Code. For a critical commentary on the Supreme Court's not strict enough approaches see D Piccione, 'La Costituzione contro la contenzione biomeccanica' (2020) Dir pen uomo, 3, 31, according to which the only form of lawful coercion is 'that which is instantaneous and punctiform, serving a medical act and immediately interrupted once the latter is accomplished', while 'in the remaining circumstances […] any coercion carried out by the medical power without typification by law falls under the effects of the formula recited by art. 13, paragraph 4, Const.'.

[14] Const. Court, 30 June 1960, no 45.

[15] Const. Court, 27 January 2022, no 22. See also A Barbera, 'Un moderno habeas corpus?', 27 June 2013 <Forumcostituzionale.it> accessed 15 November 2023.

field of application of Article 13 of the Constitution (and not Article 16 of the Constitution) is that they are not only obligatory (i.e. such as to entail a sanction for those who evade them) but also such as to require physical coercion", which did not exist in this case.

If, in fact, on that first occasion the Constitutional Court held that the protection ensured by Article 13 of the Constitution focused on the person in the physical sense (the body of the prisoner) and in another decision defined it as aimed at protecting "the autonomy and availability of one's person"[16]. In another circumstance[17], the Court addressed the hypothesis that 'legal degradation' occurs when a measure of public authority puts 'moral freedom (or freedom of self-determination) at stake, but to such a pervasive extent as to amount, on the whole, to a coercive situation'[18]. Degrading restrictive prescriptions for the person, "insofar as they are provided for by law and necessary to pursue the constitutionally traced end that justifies them", would in any case deserve, observes the Constitutional Court called upon to pronounce on the legitimacy of the police warning, to be assisted by the reservation of jurisdiction, inasmuch as, "by separating the individual or a circumscribed group of individuals from the rest of the community, and reserving to them a deterrent treatment, they bring with them a high rate of potential arbitrariness, to which the rule of law opposes the filter of control of the judge, as an organ called upon to objectively apply the law in conditions of independence and impartiality"[19].

In the case in point, the limitation placed on relational and affective prerogatives, which is devoid of any stigmatising connotation at a social level, derives from the combined effect of the consensual entry into the residential care structure. This presupposes that the guest accepts its procedures and prescriptions[20], and the occurrence, as happened in the exceptional contingency of the pandemic, of restrictive regulations to satisfy the health reasons referred to in Article 16 of the Constitution. The Constitutional Court specified that the phrase 'generally' used by the superordinate norm not only alludes to the assumption of 'situations of a general nature, such as epidemics, public calamities and the like', but also to the circumstance of being 'applicable to the generality of citizens, not to individual categories'[21]. The limitation in question is therefore not the result of an *ad personam* measure that determines a judgement of disvalue on the personality of the individual, degrading his social dignity. Instead, the measures 'concern the community as a whole', and are justified by the 'need to protect the health of the citizens'[22]. They operate against "a vast and indeterminate number of persons", a circumstance which, as the Constitutional Court itself has observed with reference to the so-called compulsory quarantine, makes this limitation of freedom of movement "entirely neutral in terms of moral personality and equal social dignity"[23].

The existence of consent to hospitalisation, moreover, is one of the elements on which the European Court of Human Rights has also based its examination of psychiatric patients in healthcare facilities in order to establish whether they are deprived of their personal liberty in a condition that falls under the protection of Article 5 ECHR. According to the Strasbourg judges, in addition to the objective requirement of the indefinite restriction of liberty[24] – for which it was not necessary that the facility be closed, because constant control over treatment, care, residence and freedom of movement is enough[25] – the subjective requirement of manifested dissent to the

[16] Const Court, 23 March 1960, no 12.

[17] Const Court, 22 March 1962, no 30; Const Court, 19 June 1956, no 11.

[18] A Pace, Problematica delle libertà costituzionali. Parte speciale I (Padova, Cedam,1985), 21.

[19] Const. Court, 7 April 2022, no 127.

[20] For example, the rhythms of daily life are dictated in most cases, i.e., the time of waking up, eating meals, their duration, and the time of rest. 'The person immersed in the absorbing life of the institution that contains him benefits. But because of the manner in which the therapeutic or rehabilitative activity of the person under conditions of inpatient or coercive hospitalization is carried out, the spaces of choice available to the individual contract', observes D Piccione, 'Deistituzionalizzazione, libertà personale e diritto alla salute' (2022) Biolaw Journal – Rivista di biodiritto, 4, 84ff.

[21] Const. Court, 23 June 1956, no 2.

[22] C Caruso, 'La pandemia aggredisce anche il diritto?', in Giustizia insieme, 4 aprile 2020.

[23] Again, Const Court 7 April 2022, no 127.

[24] «Confinement in a particular restricted space for a not negligible lenght of time», as defined by the ECHR, 16 June 2005, Storck v Germania.

[25] In the case addressed by the ECHR, Jan 22, 2013, Mihailovs v Latvia, the person concerned was not allowed to leave the facility without the management's permission, which in any case in-

hospitalisation needed to be met, even when the person in question lacked legal capacity but was nevertheless capable of understanding his situation.

The circumstance that "the placement in a residential facility is in voluntary principle" did not prevent the European Committee for the Prevention of Torture and Inhuman and Degrading Treatment and Punishment (CPT) from hypothesising that "the prolonged and indefinite restrictions in force" during the pandemic "could be considered de facto a deprivation of liberty (within the meaning of Art. 3 ECHR)', particularly in light of the 'isolation and high level of segregation from the community during the Covid-19 pandemic and the lack of viable alternatives for living in the community'[26].

However, the interpretative factors described appear difficult to follow. In order to qualify the restrictions imposed on freedom of movement and sociability, must demonstrate their indispensability to prevent the spread of the contagion. that there were other equally effective ways to achieve that result. In this context, measures capable of alleviating the objective contraction of social and emotional relations were not implemented, for example by increasing access to alternative means of communication, such as the telephone.

If anything, as discussed below, this was all the more so if there were any restrictive changes in the rules characterising admission to the facility, even if they were the result of measures of general application. Any dissent that the person concerned may express at a stage subsequent to admission should always be taken into account as a decisive factor. An express indication to this effect is also to be found in the case-law of the Strasbourg Court, where, reconstructing consent as reversible, it agreed that the right to the protection of personal liberty was not lost when a person has initially agreed to be confined and that this eventuality does not eliminate the duty of state bodies to control the legitimacy of the deprivation of liberty suffered by the victim[27]. A restriction that, on the other hand, seems to be imposed in relation to Article 32 of the Constitution, which, reconstructed 'as an envelope of the trinomial dignity-self-determination-physical and psychic health', 'finds, among its social determinants, a panorama of institutions with less capacious containment, the residual application of high-intensity measures, the valorisation of the individual's will as a factor of safeguard and restitution of the autonomy of choice regarding health treatments'[28].

Consent to admission to the facility, in other words, must always be current, lasting throughout the stay, and intentional. That is, it must be based on full awareness and acceptance of the rules and conditions that characterise the experience, so as not to fatally restrict the independence and autonomy of the person concerned. Otherwise, there would be a paradigm distortion, whereby the protective action of social legislation would take on a prescriptive character, contrary to Article 19 of the United Nations Convention on the Rights of Persons with Disabilities. Disconnected from the valorisation 'of that limited, even apparently residual, margin of self-determination which, however, constitutes the seed of the recognition of the right of every person", on closer inspection, permanence in a condition of protected residency would assume "de facto a dimension of deprivation of personal liberty'[29].

3. Compulsory Hospitalisation

Issues concerning personal liberty arise from the outset in the event that admission to the healthcare facility takes place against the will of the person concerned, beyond the requirements for the execution of compulsory healthcare treatment, the regulation of which is contained in Law No 180 of 1978. The situation

volved the accompaniment of the operators or other patients; specifically, he had never been escorted out by his guardian, was under the constant supervision of the operators, and was drastically restricted in his ability to receive visitors.

[26] In particular, the CPT found that the restrictions imposed continuously since February 2020 in the two institutions visited had had an increasing negative effect on the residents' mental and somatic health.

[27] ECHR, 16 June 2005, Storck v Germania.

[28] D Piccione, Deistituzionalizzazione, 85.

[29] See statements by E De Robert, in 'Quando la Rsa diventa una prigione', garantedeidetenutilazio.it, 26 settembre 2023. During the monitoring activity carried out by the National Guarantor of Persons Deprived of their Liberty during the pandemic phase, many Rsa guests consciously and credibly expressed their desire not to remain in the residence that housed them and highlighted that the choice of placement in it had not been taken as an extreme measure after other possibilities of social welfare and support intervention had been unsuccessfully tried (Guarantor of Persons Deprived of their Liberty Report, year 2022).

of greater delicacy and complexity is encountered in the case of persons subject to support administration, suffering from pathologies that do not result in the loss of their capacity to make decisions, and therefore in a position to express a valid dissent to placement in a nursing home.

The fact that this is a measure restricting ordinary faculties taken against the will of the person concerned leads us to consider compliance with the guarantees of Article 13, paragraph 2, of the Italian Constitution and therefore to exclude. First of all, the will expressed by the support administrator is sufficient for this purpose, even if, on the basis of the decree of appointment, he holds the power of exclusive representation in the health care sphere, on the assumption that, because of his pathological condition, the person concerned does not retain a residual capacity for conscious self-determination. To hold otherwise would be a blatant violation of the constitutional precept that places at the basis of any restriction of personal liberty a reasoned order of the judicial authority and, on the other hand, precluded the role that the tutelary judge is called upon to exercise as 'Judge of the Person'[30] in terms of control of frailty and health, a role that cannot be delegated to the support administrator.

It is more delicate to establish whether the so-called forced hospitalisation can be authorised by the tutelary judge, at the request of the support administrator. Unlike the hypothesis previously described, this solution satisfies the reservation of jurisdiction[31]; it is much less certain, however, that it respects the reservation of law. We are faced with a qualified limitation, which is also produced at the expense of personal freedom and as such does not tolerate being based on generic formulations unsuitable for integrating those 'cases and ways' that the constitutional dictate requires to be exhaustively identified. In a different context – that of the forcible taking of biological samples for the purpose of a DNA expert's report – the Constitutional Court censured Article 224 paragraph 2 second part of the Code of Criminal Procedure for violation of Article 13 paragraph 2 of the Constitution in the part in which it allowed such non-consensual removal capable of restricting the personal liberty of the person concerned by including it in the indefinite category of "all other measures that are necessary for the performance of expert operations".

The legal basis of the power in question is identified in case law in the combined provisions of Article 411 of the Civil Code and Article 358 of the Civil Code and Article 371 of the Civil Code. In practice, the applicability of Article 371 of the Civil Code to the support administration has sometimes been sustained on the basis of a systemic observation, the 'primary purpose' of the institution 'is the protection of the person', explaining the lack of mention of it in Article 411(1) of the Civil Code by the 'circumstance that the precept is intended to be applied only in cases considered by the magistrate, unlike those expressly named in the rule (Articles 349 to 353 and 374 to 376)'[32]. On other occasions, it has been held that Art. 358 Civil Code is applicable in the present case on the basis of the general provision contained in the last paragraph of Art. 411 Civil Code, according to which 'certain effects, limitations or disqualifications, provided for by provisions of the law for the interdict or the incapacitated, are extended to the beneficiary of the support administrator, having regard to the latter's interest and the interest protected by the aforesaid provisions', there being no 'literal reasons to the contrary'[33].

These arguments are questionable. Meanwhile, both articles of the Civil Code were invoked as a basis for the legitimacy of forced

[30] The expression is used by S Celentano (2018) 'L'amministrazione di sostegno tra personalismo, solidarismo e sussidiarietà ed il ruolo del Giudice della Persona', in Questione giustizia, 3, 66 ff, to define a subject that has seen its 'function and role' greatly enhanced in light of 'a new legal-cultural approach to the world of protection of the weak', which identifies it as 'an essential figure of coordination, but also of propulsion, direction and control for the implementation of solidaristic projects of overcoming autonomy limitations that may make it too burdensome, if not impossible, for a person with physical or mental infirmity or impairment to independently carry out everyday acts, realize his or her 'interests,' value and give meaning to his or her directions, satisfy his or her needs and aspirations, and consciously make his or her own choices while striving to achieve the result'.

[31] It expressly excludes its practicability the Procedural Protocol on Support Administration stipulated between the Court of Chieti and the Chieti Bar Association Council, according to which 'under no circumstances may the support administrator be given the power to order the forced placement of the beneficiary in care and assistance facilities'.

[32] Trib. Modena, 26 November 2008, <personaedanno.it>.

[33] Trib. Vercelli, 28 March 2018.

hospitalisation in a health care facility and refer to the place of living and not to the pharmacological treatment to which the beneficiary of the support administration may potentially be subjected. On the health care side, the intervention of the tutelary judge must be considered "limited to the decision in particular contingencies about the need to carry out a single health care treatment". Instead, he is not authorised by any provision of Law No. 219 of 2017 to "intervene by forcing a prolonged hospitalisation of the person in a health care facility'. Therefore, the authorisation measure of the tutelary judge imposing the beneficiary's admission to one of his care and assistance facilities against his will would be 'in contrast with the existing rules and in particular with the inspiring rationale of Law No. 180/1978, which abolished the so-called forced hospitalisations, allowing them exclusively within the framework of compulsory health treatment and in any case limiting them within a particularly short time window predetermined by law (seven days)'[34].

4. The Right to Self-Determination and its Limitations in Residential care facilities

It has emerged from the above observations that personal freedom, guaranteed by Article 13 of the Constitution, in the event of physical coercion or legal degradation, is a legal good that cannot be confused with the freedom of the person. In this regard, it has been observed that the 'moral' freedom of the person, i.e. the right to self-determination, is a good that cannot be called into question even in situations of the most intense deprivation of personal freedom, in which the expression and 'blossoming' of the individual personality must always be permitted[35]. Otherwise, the person would be reduced to a thing and it would no longer make sense to speak of either dignity or freedom[36]. This is immediately evident in the case of prison, where the Italian Constitutional Court has repeatedly emphasised that the detained person, restricted in his personal freedom, must have even a reduced capacity for self-determination[37].

Albeit a somewhat forced analogy, it is possible to question the right of self-determination of the elderly person "imprisoned" within the RSA by his express will or by virtue of a judicial decision. On the one hand, it is necessary to understand the constitutional and European relevance of the right to self-determination, and on the other, to assess the reasonable restrictions that this right may suffer, with a retrospective look to the time of the health emergency, in the belief that the 'lesson' of the pandemic may provide an opportunity to rethink the places and forms of territorial health care[38].

With respect to the first point, although part of the doctrine tends to deny a properly constitutional foundation to the right to self-determination[39], the dominant doctrine today considers a constitutional right to self-determination configurable on the basis of the systematic

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[34] Thus D Genovese, MG D'Ettore, 'La "cura" e le "cure" della persona sottoposta ad amministrazione di sostegno', in Questione giustizia, December 15, 2020, who also note how in fact 'in some cases hospitalization in a care and/or assistance facility is proposed not only where there is a need to ensure full adherence to therapy by the subject but also in cases where those services (e.g, of the home type) that would allow the person to remain in an autonomous living context, with the presence of adequate care and assistance support'. On the possible conflicts with the European Convention on Human Rights see M Pelazza, Incapacità legale e ricoveri coatti: giurisprudenza europea e situazione italiana, in Diritto penale contemporaneo, 25 marzo 2013, pp. 12 ss.

[35] M Ruotolo, Editoriale. Per una cultura costituzionale della pena, in Federalismi, 4 October 2023.

[36] According to the teaching of C Beccaria (1764), Dei delitti e delle pene (ed by F Venturi, Torino, Einaudi, 1965) 50.

[37] A Longo, 'Est modus in rebus. Modalità e contesto nella compressione dei diritti fondamentali, a partire dalla sentenza della Corte costituzionale n. 122 del 2017' (2017) Nomos, 3, 1-22. Regarding the detention regime of Article 41-bis, the Constitutional Court. (Judgment No. 18 of 2022) declared the unconstitutionality of the provision that subjected the correspondence maintained with lawyers to censure, as a form of communication strengthened by the inviolable right of defense (Article 24 Const.).

[38] See § 6.

[39] For S Mangiameli, 'Autodeterminazione: diritto di spessore costituzionale?', in Forumcostituzionale.it, 2009, 'the Constitution, which expresses itself in terms of rights and freedoms, does not express a notion of self-determination, but if anything it can qualify certain choices and decisions of the individual in a punctual way'. In the same sense see L Antonini, 'Autodeterminazione nel sistema dei diritti costituzionali', in F D'Agostino (ed), Autodeterminazione. Un diritto di spessore costituzionale? (Giuffrè, 2012) 4-47 and L Violini, 'Bioetica e laicità'.

connection between art. 2 and art. 32, paragraph 2, of the Constitution[40]. The principle of freedom of care[41] (which presupposes consent to health treatment as a rule) can only be derogated from under two conditions: the obligation of health treatment must be made explicit by law and there must be a general interest of the community[42]. The last clause of Article 32 of the Constitution adds a final safeguard in that compulsory treatment must respect the person. Thus, in the Italian legal system, self-determination means that each person is free to identify what he considers to be 'the full development of the human person' in his internal sphere, but he is not permitted to ascribe legal effects to this identification[43]. Self-determination, in other words, is not configured in a 'proprietary' sense, as a full sovereignty over every aspect of one's being, an 'insular' sovereignty that rejects any commitment to reciprocity and responsibility for one's actions[44].

This 'mild' approach is supported by the most recent constitutional jurisprudence concerning the case of assisted suicide (passive euthanasia)[45]. The judge of laws has excluded the constitutionality of a 'right to die', stressing how human dignity can constitute 'a limit to the right to self-determination of the weakest and most vulnerable persons, […] also in order to avert the danger that those who decide to carry out the extreme and irreversible gesture of suicide suffer interference of any kind'. At the same time, the Court identified certain situations of extreme psycho-physical suffering of the person in relation to which the indiscriminate criminal repression of assisted suicide ends up coming into conflict with the right to refuse medical treatment[46].

The jurisprudence of the Constitutional Court thus seems to suggest that human dignity has a 'double face'[47]. While it gives foundation to the right of self-determination understood

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Relazione al Convegno annuale AIC, 2007 I problemi pratici della laicità agli inizi del secolo XXI, in Rivista Aic, 2, 2007.

[40] See GU Rescigno, 'Dal diritto di rifiutare un determinato trattamento sanitario, secondo l'art. 32, comma 2 Cost, al principio di autodeterminazione intorno alla propria vita' (2008) Diritto pubblico, 1, 85-105.

[41] The consensualistic principle marks the shift in the biomedical paradigm from the 'Hippocratic Oath' to the 'Nuremberg Code'. After the horror of Nazi doctors' experimentation conducted on people who were still alive, voluntary consent (in the sense made its own by the Nuremberg Tribunal of free, informed, revocable consent provided by a capable subject) is portrayed as the primary foundation of medical activity, to the point that without it health treatment is illegitimate.

[42] In the words of the Constitutional Court, health is not exhausted in situations of claim and advantage, but 'implies and includes the duty of the individual not to injure or endanger the health of others by his own behavior, in observance of the general principle that sees the right of each person find a limit in the mutual recognition and equal protection of the coexisting right of others' (Judgment No 30 of 1995).

[43] The point is lucidly developed by C Pinelli, 'Il diritto ad essere sé stessi e il pieno sviluppo della persona umana'. Relazione al Convegno AIC 2021, in Rivista Aic, 4, 2021. Before, see N Bobbio, Libertà, in Enciclopedia del Novecento (Istituto dell'Enciclopedia italiana, vol III, 1978) 994-1005, argued that self-determination as freedom of the will constitutes the essence of positive freedom: 'the possibility of directing one's will toward a purpose, of making decisions, without being determined by the will of others'.

[44] Those who emphasize the absolute value of consent see in the latter a true 'transfer of sovereignty from the state to the person' in these terms Rodotà, Il diritto di avere diritti (Bari, Laterza, 2013) 297. The doctrine that tends to absolutize the right to self-determination pivots on Constitutional Court ruling no 438 of 2008. In this pronouncement the Constitutional Court has, indeed, stated that the principle of informed consent must be understood as a 'point of synthesis' between the right to health and the 'right to self-determination on the basis of a joint interpretation of Articles 2, 13 and 32 of the Const' (in the same direction rulings No. 471 of 1990 and No. 332 of 2000). For further discussion G Marini, 'Il consenso', in S Rodotà, P Zatti (eds) Trattato di biodiritto – Ambito e fonti del biodiritto, Milano, 361-400. For a very critical perspective on the 'sovereignty over bios' thesis see A Morrone, 'Sovranità', report to the XXXI Annual Conference of the AIC, in Rivista Aic, 1, 2017.

[45] This is the well-known Antoniani-Cappato case that was first the subject of the order of referral to Parliament Constitutional Court No. 207 of 2018 and then Constitutional Court no 242 of 2019.

[46] And, specifically, that the person is: '(a) suffering from an irreversible pathology and (b) a source of physical or psychological suffering, which he or she finds absolutely intolerable, who is (c) kept alive by means of life-support treatment, but remains (d) capable of making free and conscious decisions' (Judgment No. 242 of 2019).

[47] For a more detailed discussion on this point please refer to F Losurdo, 'L'Ultima scelta. Dogmat-

as the free expression of one's personality, human dignity also represents a heteronomous limit. It is a limit that derives from the inescapable mediation of parliamentary law, subject to the possible review of the Constitutional Court.

The thesis of the double face of human dignity, as a foundation and as a limit, is also confirmed by an analysis of the jurisprudence of the European Court of Justice and the European Court of Human Rights. Both supreme jurisdictions, while recognising the centrality of the right to self-determination within the framework of European values, have not failed to point out its potential heteronomous limits, especially when its exercise produces arbitrary outcomes that disregard the relational dimension of human existence. The Omega case-law is famous in this regard. In this case, the Court of Justice declared a game that simulated the commission of murders in a hyper-realistic manner to be contrary to human dignity[48].

This theoretical approach can also be transposed to the specific case of residential care facilities. Dignity in the subjective sense gives a strong foundation to the right of self-determination of the residents, who must be guaranteed adequate forms of social relations to be reconciled with the need for the orderly conduct of activities within the facility and the safety of the patient and other residents. Dignity in the objective sense requires the commitment of public institutions to protect fragile subjects, sometimes even against their will, when an ascertained mental infirmity would condition this, provided that this duty of protection is not understood in a paternalistic light, but instead is aimed at the full emancipation of the person, in the light of the principle of substantive equality under art. 3, paragraph 2, of the Constitution.

During the pandemic emergency, the balancing between the right to self-determination and the protection of health as a fundamental right of the individual and as an interest of the community took on the contours of a 'tragic choice'. The need to contain the spread of the viral contagion required severe limitations on the freedom of movement of the elderly in residential care facilities, 'confined' to their rooms and with reduced opportunities to spend time outdoors, and an equally severe restriction on ordinary family and social relations.

5. Respect for Private Life in the Case Law of the European Court of Human Rights

The approach outlined here, centred on the conceptual distinction between personal freedom and the right to self-determination, finds authoritative support in the case law of the European Court of Human Rights and, an Italian case concerning the "compulsory hospitalisation" in a residential care facility. It is opportune to summarise the essential aspects of the case of life to appreciate the decision adopted[49].

The 'Kafkaesque' case revolves around Mr. Carlo Girardi, a former teacher and an Italian citizen aged over 90 to whom a support administrator had been appointed, pursuant to Article 404 et seq. of the Italian Civil Code, for the circumscribed purpose of exercising decision-making functions for Mr. Girardi. However, when Mr. Girardi's closest relatives turned to the tutelary judge to request the termination of the protection measure, the latter, on the basis of a report by the social services, proceeded in the opposite direction, extending the powers of the support administrator to all aspects of care for him. After a succession of contradictory 'technical' opinions, the support administrator obtained an order of compulsory hospitalisation in a residential care facility from the tutelary judge, even though, according to the reports, the applicant was capable of understanding, although prone to 'excessive prodigality'[50]. The admission was carried out with the use of public force and deception, making Mr. Girardi believe that admission to

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iche dell'autodeterminazione e fine vita' (2018) Koreuropa, 12, 1-39.

[48] Court of Justice, October 14, 2004, C-36/02, Omega, on which see ME Gennusa, 'La dignità umana vista da Lussemburgo' (2005) Quaderni costituzionali, 1, 174ff. The Court of Justice declared that 'Community law does not preclude an economic activity consisting in the commercial exploitation of games simulating murder from being prohibited by a national measure adopted for reasons of safeguarding public order, because that activity violates human dignity'. Also famous is the case decided by the Conseil d'Etat, Assemblée Oct 27, 1995, which banned the practice of 'dwarf throwing', because it was contrary to human dignity, no matter how much they had themselves thrown by their express will.

[49] ECHR, 6 July 2023, Calvi and C.G. v Italia.

[50] We read in the first measure of the tutelary judge that the person would follow 'Franciscan' precepts, living simply and donating his money to those in need, but would be unable to handle the limits of this practice, which would place him in a vulnerable situation.

the RSA was only temporary, immediately preventing any possible contact with the outside world.

The case, which made the headlines through a well-known Italian television programme, was also the subject of an intervention by the national guarantor for the rights of persons deprived of their liberty, who severely condemned the forced hospitalisation of the patient, describing it as a 'segregation measure'. The condemnation was not only for the failure to offer an alternative to the resident, but also for the deprivation of all emotional contact, since all communication with relatives and friends was filtered by the facility managers[51].

As a preliminary point, the ECHR found the appeal inadmissible on the basis of Article 5 ECHR, considering that the right to personal liberty was not at stake in this case[52], but rather admissible on the basis of Art. 8 ECHR, which recognises everyone's 'right to respect for his private and family life' and prohibits any 'interference by a public authority with the exercise of that right unless such interference is provided for by law and constitutes a measure which, in a democratic society, is necessary' to safeguard overriding public interests such as 'the protection of health and morals, or the protection of the rights and freedoms of others'[53].

After a careful reconstruction of international, European and Italian law, the European Court of Human Rights came to the conclusion that both the judicial decision appointing the support administrator and the consequent decision authorising him to order hospitalisation with the assistance of the police violated Article 8 ECHR[54]. The Court attached particular importance to the fact that the applicant was not declared incapable of understanding and was not subject to any disqualification, since the expert opinions indicated that he had a good capacity to socialise, with the only 'negative' finding being his excessive prodigality. It was, therefore, unreasonable that, despite the failure to establish a mental illness, the applicant found himself completely dependent on his support administrator in almost all areas of private life and, moreover, without any time limit.

Ultimately, the European Court of Human Rights held, 'the Italian public authorities abused the flexibility of the legislation underlying the institution of the support administrator in order to pursue purposes that Italian law attributes, instead with very strict limits, to the different figure of the TSO'[55]. The violation

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[51] According to the National Guarantor (Report to Parliament of June 2023), 'the overall picture that is emerging with the continuation of hospitalization leads one to believe that the pivotal principles that must underlie the identification of protection measures are being obliterated and, among these, in particular those of 'self-determination and freedom to make choices', 'respect for inherent dignity', proportionality of the measure and the time of the same, to be applied in any case for the shortest possible time' (<https://www.garantenazionaleprivatiliberta.it/gnpl/resources/cms/documents/e62a3c20058f1655a7e6e2e18e642b16.pdf.> accessed 15 November 2023).

[52] Article 5(1) ECHR recognizes the power of the state to deprive 'alienated persons' of their liberty, an expression that by settled case law encompasses mental illness of such a character as to justify compulsory hospitalization. But since the Court does not consider this condition of infirmity to exist in the case, it logically excludes the application of Article 5 ECHR. See for all ECHR, December 4, 2018, Ilnseher v Germany.

[53] The ECHR has proposed a gradually broadening interpretation of the 'right to respect for private and family life' clause in order to give legal coverage to the right to self-determination in the field of biolaw. In a series of pronouncements the European Court has, in fact, brought within the scope of 'respect for private and family life', the right to therapeutic abortion (ECHR, March 20, 2007, Tysiac v Poland), the right to choose one's sexual orientation (ECTHR, October 22, 1981, Dudgeon v United Kingdom), the right to have access to medically assisted procreation techniques (ECHR, April 10, 2007, Evans v United Kingdom), the right to procreate a child who is not affected by genetic diseases from which the parents carry (ECHR, Aug 28, 2012, Costa and Pavan v Italy).

[54] It should be remembered that the support administrator is not entitled to replace the will of the assisted person entirely, but must provide support for that will, enabling it to achieve the desired effects on the legal-technical level as well.

[55] On the issue of 'compulsory health treatments', see F Modugno, 'Trattamenti sanitari non obbligatori e Costituzione (A proposito del rifiuto delle trasfusioni di sangue)' (1982) Dir soc, 313-333; V Crisafulli, 'In tema di emotrasfusioni obbligatorie' (1982) Dir soc, 564-578. More recently D Genovese, MG D'Ettore, 'La "cura" e le "cure" della persona sottoposta ad amministrazione di sostegno, who point out that TSO presupposes psychic alterations of the subject such as to require urgent therapeutic interventions.

of Article 8 ECHR to the applicant's detriment is considered all the more serious in that no provision was made for the person concerned to return to his home during the three years spent in the residential facility, although the placement had initially been decided on a provisional basis. It follows from all the foregoing that the margin of appreciation afforded by Article 8 ECHR to the national authorities has been greatly exceeded and on that basis, the applicant must be granted the right to fair compensation under Article 41 ECHR.

6. The 'Lesson' of the Pandemic

Among the many negative effects, the health emergency has at least had the 'positive' effect of bringing to light a fact that is generally overlooked, namely that the residential facilities contain the characteristic of 'totality' proper to closed institutions in which the personnel in charge provide for the integral management of time, space, movements, and the entire daily life of the elderly person. A resident of a residential facility finds himself 'confined' in these structures for indefinite periods that also go beyond the initial forecasts and, in any case, beyond the will expressed at the beginning or against that expressed later.

From this point of view, the public authorities at every territorial level should encourage forms of home care, so as to preserve the irrepressible dimension of relationality, the set of social and family ties that give full meaning to human existence. At the same time, they should reduce the cases of institutionalisation in health care facilities to cases where there is a proven mental illness or such a degree of non-self-sufficiency of the elderly person that the public authorities are called upon to perform an overriding, non-paternalistic duty to protect the vulnerable.

Secondly, whenever the factual and legal circumstances that justified consensual or compulsory admission to the residential facility change, the elderly person's situation must be reassessed as a whole, in order to prevent a hospitalisation conceived as a temporary measure from becoming a permanent solution. This is the situation that occurred in the case decided by the European Court of Human Rights, in which the guardianship judge unduly superimposed the civil law discipline of the support administration on that of compulsory medical treatment, which is only justified in the case of an established mental infirmity and not on the basis of generic prodigality.

Thirdly, the treatment of the elderly person within the RSA should be inspired by the concept of the 'therapeutic alliance' that constitutes the symbolic and normative cornerstone of the law on advance treatment provisions (Law No 219 of 2017). Recognising, as far as possible, an adequate space for the patient's will of self-determination and, at the same time, support this will and, when necessary, integrate it with the indispensable will of healthcare personnel and the patient's closest relatives and affections. For this reason, the support administrator is called upon to act in support of, not in substitution for, the person to be protected, making decisions that take no account whatsoever of that person's will.

Ultimately, the treatment of the vulnerable elderly person requires a plurality of outlooks that must necessarily intersect, including those of the doctor providing care, the personal one of the closest affections, and the legal one dedicated to guaranteeing the rights of particularly vulnerable persons. This is the only way to give due value to the relational dimension of human existence, which cannot be reduced to the preservation of mere biological life, forgetting that the latter only makes sense if it is not separated from the biography of the person. This is the ultimate meaning of the right to self-determination, aware that the dignity of the person is removed from any balancing, since it is itself the 'balance' on which conflicting rights and interests are weighed[56].

[56] According to the well-known metaphor by G. Silvestri, 'La dignità umana come criterio di bilanciamento dei valori costituzionali', in Studi in onore di Pierfrancesco Grossi (Giuffrè, 2012) 1181-1194.

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SECTION I
ESSAYS

Structural Weaknesses in Residential Care Homes for the Elderly at the Time of the COVID-19 Pandemic: A Contextual Analysis

Desirèe Teobaldelli

Abstract. The COVID-19 pandemic represented a focusing event capable of accelerating the debate on Italian welfare system and the effectiveness of the national health system in guaranteeing universal and global health protection, more in line with the European social democratic model. The dramatic consequences of the pandemic highlighted existing structural limits both at the institutional and the organizational level. The effects of the epidemic were particularly tragic in the nursing home setting, revealing the fragility of a fundamental sector of the Italian welfare system. This article discusses the data available at a national level on nursing homes, describes the context in which they operated in the first wave of the pandemic and draws some policy implications.

Keywords: *COVID-19, residential care homes, elderly, context.*

1. Introduction

The emergency linked to the COVID-19 contagion represented a focusing event capable of accelerating the debate on Italian Welfare and on the effectiveness of the National Health System (NHS) in guaranteeing universalist and global health protection, more in line with the European democratic social model[1]. The dramatic consequences of the pandemic have highlighted pre-existing structural, institutional and organisational shortcomings[2]. On the one hand, the complex subdivision of powers between the State and the Regions, which provides for a decisive State intervention in emergency situations but which in fact gives the Regional Health Systems (SSR) the main responsibility for health protection, has contributed to creating important differences in the guarantee of essential levels of care based on location. On the other hand, the macroeconomic situation of the last twenty years has called for policies of resource rationing and cost containment, leading to the progressive defunding of the NHS and de facto undermining its universalistic imprint[3].

The consequences have proved particularly dramatic when considering residential care for the elderly, as the territorial differences are even more significant and their responses highlight the failure to respect basic parameters[4]. The fact that the final report of the *Istituto Superiore di Sanità* finds that in the first four months of the pandemic 40% of deaths in RSAs[5] were attributable to COVID-19 is, arguably, the clearest manifestation of the structural importance of the Italian welfare system as well as its faults[6].

In the light of these critical issues, this article analyses the available data on residential facilities for the elderly at the national level in order to provide a picture of the context in which these facilities found themselves operating during the critical phase of the first wave of the pandemic. The aim of drawing possible points of reflection in view of the definition of

[1] G Giarelli, G Vicarelli, 'Politiche e sistemi sanitari al tempo della pandemia da Covid-19: una lettura sociologica' (2020) Sociologia Italiana.

[2] F Razetti, 'Il Coronavirus e i nervi scoperti del welfare italiano' (2020) <www.secondowelfare.it> accessed 15 November 2023; M Nocelli, 'La lotta contro il coronavirus e il volto solidaristico del diritto alla salute' (2020) Federalismi.

[3] G Vicarelli, E Spina, 'Disuguaglianze e Servizio Sanitario Nazionale: una contraddizione irrisolvibile', (2020) Politiche Sociali/Social Policies, 1, 77-102.

[4] M Arlotti, C Ranci, 'Report: The Impact of Covid-19 on nursing homes in Italy' (2021) Journal of Aging & Social Policy, 431-443.

[5] 'Residenza Sanitaria Assistenziale'.

[6] ISS (2020) 'National survey on Covid-19 infection in residential and social care facilities', Various Reports <https://www.epicentro.iss.it> accessed 15 November 2023.

future policy indications concerning this delicate sector of the Italian welfare system.

2. Structural characteristics of residences for the elderly in Italy

There are no comprehensive data on COVID-19-related mortality in residential facilities for the elderly in Italy[7]. As Pesaresi points out[8], the only national survey on COVID-19 infection is a survey conducted by the Istituto Superiore della Sanità (ISS) whose report at the end of the first wave of the pandemic is dated 5 May 2020[9]. This survey was carried out by submitting an email questionnaire to the contact persons of 3,292 out of 3,417 facilities distributed in a representative manner in all Italian regions and in the two autonomous provinces[10]. The questionnaire was based on 29 questions concerning the situation from 1 February 2020 to 5 May 2020 and the measures adopted to reduce the risk of COVID-19 infection. The contact persons of the facilities were also interviewed by telephone following receipt of the questionnaire in order to receive support in completing it[11].

The questionnaire was answered by 1,356 facilities, 41.3% of the contacted facilities, for a total of 97,521 observations in terms of elderly people accommodated, constituting 33.7% of the facilities' 289,164 beds. Among the questions, the facilities were asked to indicate the number of overall deaths of the elderly, the number of deaths of the elderly with ascertained positivity by COVID-19 and the number of deaths of the elderly with flu-like symptoms, but without ascertained positivity, during the period considered.

As can be seen from Table 1, the majority of the questionnaires filled in came from Lombardy, Piedmont, Tuscany, Veneto and Emilia-Romagna, while the response rate was 41%, with a high variability at the regional level, with no response received from Valle D'Aosta and Basilicata to more than 50% from Marche, Molise, Sicily, Apulia and Friuli-Venezia Giulia. Table 1 and Figure 1 also show the number of public/concessional facilities broken down by region.

Relevant information emerges from the survey both on the structural characteristics of residences for the elderly in Italy and on the COVID-19 related mortality rate of residents in the period under consideration.

The data indicate that, on average, in residential facilities for the elderly the health and care workers present, as reported by the respondents, were as follows: 2.5 doctors, 8.5 nurses and 31.7 social care workers (OSS) per facility (see Figures 2, 3 and 4). It should be noted that 11% of the facilities stated that they did not have any active doctors among the professional figures involved in care. Overall, considering the three professional figures, there were on average 42.4 operators per facility[12].

With regard to the beds available in the facilities, an average of 74.8 beds per facility were reported, with a variability ranging from a minimum of 8 to a maximum of 667 beds (see Figure 5). Looking at the average number of beds per healthcare worker present in the facility, between doctors nurses and OSS, the ratio was 2 beds per worker on average, with a variability between 0.5 and 16.6. Looking only at doctors and nurses, the average is 8 beds per professional figure, in the range 0.6-42.

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[7] In literature the acronym RSA is used to refer to residential facilities for the elderly in an extensive sense. In reality there are different types of facilities that accommodate the elderly, such as rest homes, sheltered residences, service centers, sheltered houses, RSAs, etc.

[8] F Pesaresi, 'Il Covid-19 nelle strutture residenziali per anziani' (2020) I luoghi della cura, <https://www.luoghicura.it/dati-e-tendenze/2020/05/il-covid-19-nelle-strutture-residenziali-per-anziani/> accessed 15 November 2023.

[9] ISS-ISTAT (2020) 'Impatto dell'epidemia Covid-19 sulla mortalità: cause di morte nei deceduti positivi a Sars-Cov' <https://www.istat.it/it/archivio/245415> accessed 15 November 2023.

[10] The ISS reports that according to the database created by the National Guarantor for the geolocation of social and health care facilities on Italian territory, there are 4,629 residential facilities for the elderly in our country and they include both public and private facilities.

[11] ISS (2020), 'Survey nazionale sul contagio COVID-19 nelle strutture residenziali e sociosanitarie', Vari Report <https://www.epicentro.iss.it/> accessed 15 November 2023.

[12] In addition to these operators, it is necessary to consider the presence in the facility of other types of professional figures, such as physiotherapists, therapists, rehabilitation technicians, educators, entertainers, psychologists and social workers, socio-assistance auxiliaries, care managers, basic care workers, as well as, of course, cleaners and kitchen helpers, maintenance workers, and administrative staff.

Table 1. Number of public/concessional facilities present and contacted out of the total; number of responses obtained.

	Public nursing homes	% of the total	Answers obtained as of April 27th	Answers obtained as of May 5th	% of the total of contacts
Piedmont	608	17,8	608	249	41,0
Aosta Valley	2	0,1	2	0	0,0
Lombardy	678	19,8	677	292	43,1
Bozen	37	1,1	37	4	10,8
Trent	54	1,6	51	15	29,4
Veneto	520	15,2	520	148	28,4
Friuli Venezia Giulia	70	2,0	70	39	55,7
Liguria	120	3,5	116	20	17,2
Emilia Romagna	348	10,2	278	128	46,0
Tuscany	319	9,3	319	200	62,7
Umbria	50	1,5	42	16	38,1
Marche	51	1,5	40	36	90,8
Lazio	207	6,1	192	79	41,1
Abruzzo	16	0,5	16	8	49,0
Molise	6	0,2	6	4	66,7
Campania	121	3,5	121	16	13,2
Puglia	61	1,8	61	35	57,4
Basilicata	1	0,0	1	0	0,0
Calabria	80	2,3	80	36	45,0
Sicily	52	1,5	39	24	61,5
Sardinia	16	0,5	16	7	43,8
Total	3417	100,0	3292	1356	41,2

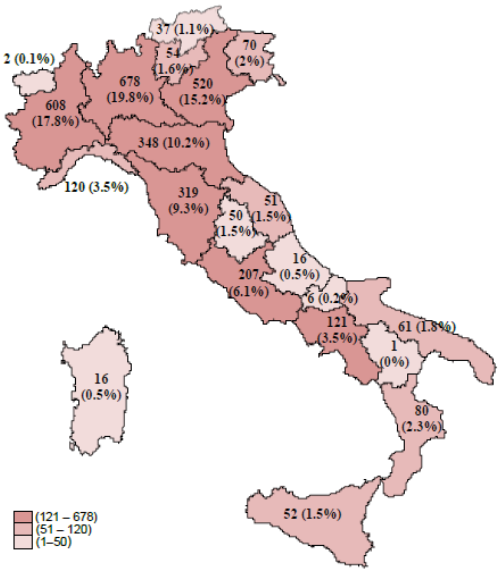
Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

In a survey conducted by Dataroom in collaboration with the Liuc Business School's RSA sectoral observatory, taking into consideration ISTAT data, Ministry of Health data and the Statistical Yearbook, it emerges that Italy has 18.6 beds for every 1,000 elderly people, compared to an average of 43.8 in the rest of Europe (Figure 6). Only Latvia, Poland and Greece perform worse.

Based on the current population of Italy and the number of those over 80 years old, it is estimated that the country should have approximately 600,000 beds. The supply, on the other hand, is about 200,000 accredited beds, while a further 50 thousand places are available in private facilities, where the cost is borne entirely by the guest (Figure 7). Italy, in fact, is the oldest and longest-living country in Europe. Currently, there are 4.4 million people over the age of 80, 2.2 million of whom are over 84 years old (see Figure 8) while 3.5 of the population is over the age of 85, which is far higher than in other European countries. It is estimated that in ten years the number of people over 80 in Italy will increase by 800,000 to almost eight million in 2050 (see Fig. 8). Thus, the ageing of the population has become a structural issue, linked to the shrinking population in the younger age groups.

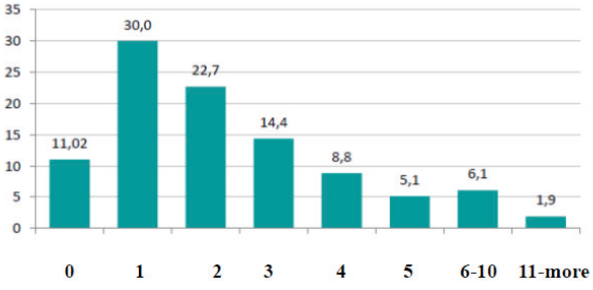
This means that what should be one of the founding pillars of our welfare system lacks the foundations and this can have extensive consequences considering the fact that public interest is so limited in this regard that there is currently not even a homogeneous picture of the actual situation[13].

Figure 1. Residential facilities for the elderly by region.



Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

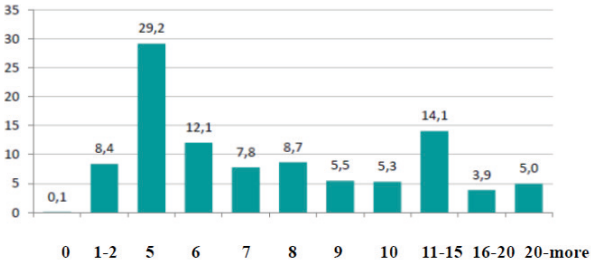
Figure 2. Frequency of residential facilities for the elderly by number of doctors.



Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

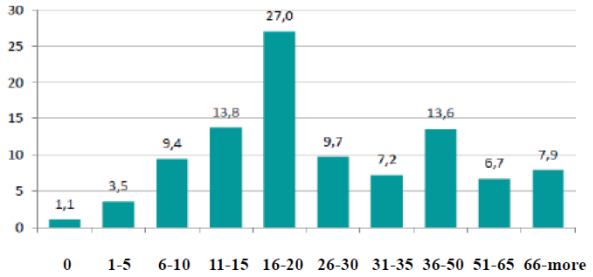
[13] M Gabianelli, M Gerevini, S Ravizza (2020) 'Anziani e Covid, perché le Rsa sono un affare solo per i privati, Dataroom' <https://www.corriere.it/dataroom-milena-gabanelli/rsa-covid-perche-case-riposo-sono-diventate-focolai-virus/c79559d4-1c5c-11eb-a718-cfe9e36fab58-va.shtml> accessed 15 November 2023.

Figure 3. Frequency of residential facilities for the elderly by number of nurses.



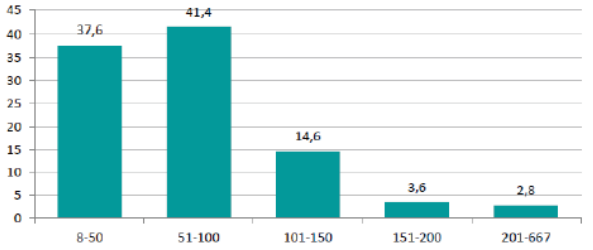
Source: ISS (2020), *National Survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

Figure 4. Frequency of residential facilities for the elderly by number of OSSs.



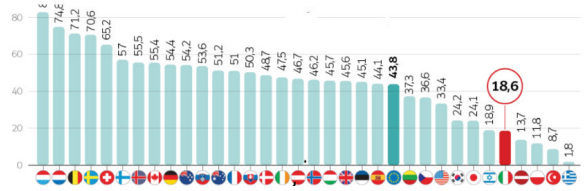
Source: ISS (2020), *National Survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

Figure 5. Frequency of residential facilities for the elderly by number of beds.



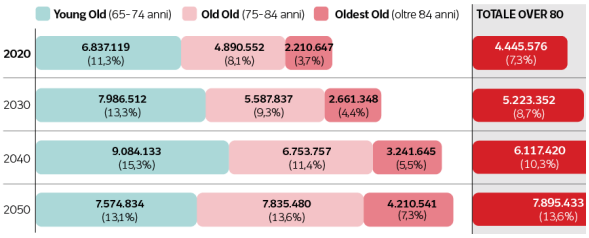
Source: ISS (2020), *National Survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

Figure 6. Number of beds per 1,000 elderly people in Europe.



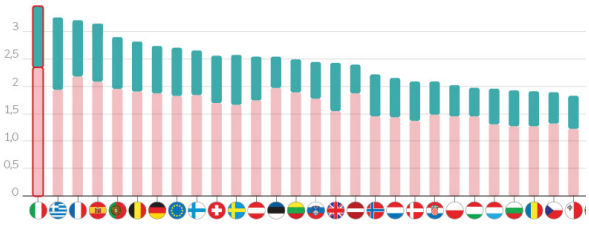
Source: Liuc Business School RSA sectoral observatory on ISTAT data[14].

Figure 7. Estimated elderly population in Italy by age group and incidence on total population



Source: Liuc Business School RSA sectoral observatory on ISTAT data[13].

Figure 8. Population over eighty-five in Europe.



Source: Eurostat[15].

3. COVID-19 mortality in residential facilities for the elderly in Italy and abroad

The ISS report shows that the number of residents in the 1,356 facilities surveyed was 97,521 as at 1 February 2020, with an average of 72 residents per facility (ranging from a minimum

[14] Osservatorio Settoriale sulle RSA, Liuc Business School, <http://www.liucbs.it/ricerca-applicata-e-advisory/centro-sulleconomia-e-il-management-nella-sanita-e-nel-sociale/osservatori-e-club/osservatorio-settoriale-sulle-rsa/> accessed 15 November 2023.

[15] EUROSTAT, 'Health and Long-term care', <https://ec.europa.eu/eurostat/web/employment-and-social-inclusion-indicators/social-protection-and-inclusion/health-long-term-care> accessed 15 November 2023.

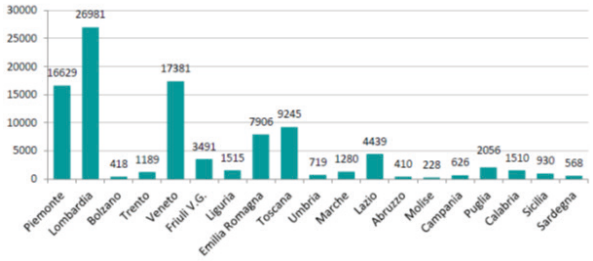
of 7 to a maximum of 632). Data by region are shown in Figure 9. Out of the total number of residents, 9,154 elderly persons died from 1 February to the last date of the questionnaire, corresponding to a mortality rate of 9.1%. Lombardy is the region with the highest number of deaths out of the total (41.4%), followed by Piedmont (18.1%) and Veneto (12.4%). Data on the total number of deaths are shown in Figure 10.

With regard to the COVID-19-related mortality rate in residential facilities for the elderly, the survey shows that of the total of 9,154 persons who died, 680 had tested positive COVID-19 and 3,092 had reported flu-like symptoms. In practice, elderly persons who died from COVID-19 confirmed by the swab-test were 7.4% of all those who died during the period, while residents who died with flu-like symptoms were 33.8% (see Figure 12). In the hypothesis put forward by the ISS survey, the mortality rate of the elderly related to SARS-CoV-2 infection in residential facilities is 0.7%, a figure that rises to 2.7% in the autonomous province of Trento, while the mortality rate related to deaths of residents with flu-like symptoms is 3.1%, a figure that rises to 6.5% in Lombardy (see Figure 11).

Pesaresi points out, in this regard, that these findings do not coincide with the data, albeit limited, provided by the regions, which, however, refer to the total number of facilities. In particular, the total number of deaths due to COVID-19 in residential facilities for the elderly reported by the regions would be lower than that indicated by the ISS surveys[16].

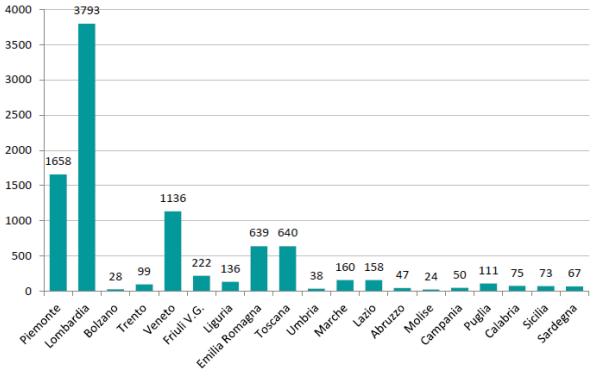
The author attempts an international comparison in this regard, although it is particularly complicated to make such a comparison, both because of the divergences in the measurement methodologies and the timing of these. Internationally, the approaches to measuring deaths related to COVID-19 are of three types: deaths of persons who tested positive through the swab-test before or after death, deaths of persons suspected of being infected on the basis of reported symptoms, and finally, deaths in excess, meaning inferred by comparing the total number of deaths recorded as the difference of deaths occurring in the same period in previous years. Pesaresi highlights the data collected by Comas-Herrera et al. (2020) summarising data from various official sources, shown in Table 2.

Figure 9. Number of residents in facilities as of 1 February 2020 by region.



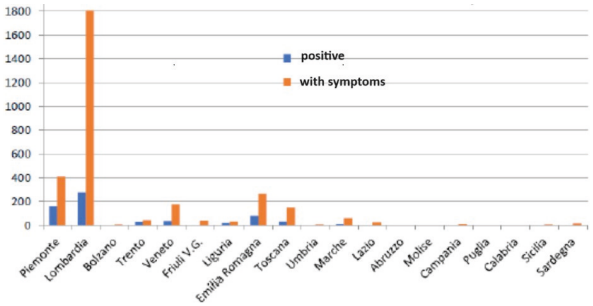
Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

Figure 10. Number of deaths in residential facilities for the elderly since 1 February 2020 by region.



Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

Figure 11. Number of COVID-19 positive residents with flu-like symptoms, by region.



Source: ISS (2020), *National survey on COVID-19 infection in residential and social care facilities, Final Report May 2020*, <https://www.epicentro.iss.it/>.

[16] F Pesaresi, Il Covid-19 nelle strutture residenziali per anziani.

As can be seen from the Table, the number of deaths related to COVID-19 in residential care facilities for the elderly abroad is particularly high with a minimum of 25% to a maximum of 67% of the total number of deaths. In France, Belgium, Ireland, Norway and Spain, the elderly who died of COVID-19 in residential facilities account for the majority of all deaths, with mortality rates reported by the authors ranging from 0.4% in Germany, 3.7% in Belgium, 2.4% in France, 3.4% in England and 2% in Sweden[17].

4. Possible causes of the spread of the pandemic within homes for the elderly

In Italy, the average age of COVID-19 positive citizens who died was 80 years. In particular, 95.4% of them were over 60 years of age and 85.3 per cent over 70, while the lethality rate was among the over-80s where it reached the ratio of about one death for every three positives[17]. It is an established fact that this virus particularly affected the elderly and frail population with concomitant diseases. It is logical, therefore, that the pandemic manifested in a dramatic lethality in residences for the elderly, where the concentration of the medically frail population is endemically more concentrated – three quarters of the elderly accommodated in residential facilities are over eighty years old and not self-sufficient.

Table 2. Number of deaths related to COVID-19 in elderly care facilities abroad.

Country	Date	Approach to measuring deaths	Total number deaths linked to COVID-19	Number of deaths of care home residents linked to COVID-19	Number of deaths in care homes	Number of care home resident deaths as % of all COVID-19 deaths	Number of deaths in care homes as % of all COVID-19 deaths
Austria	06/05/2020	Confirmed	510	220		41%	
Australia	18/05/2020	Confirmed	99	29		29%	
Belgium	18/05/2020	Confirmed + Probable	9,080		4,646		51%
Canada	08/05/2020	Confirmed + Probable	4,740	3,890		82%	
Denmark	07/05/2020	Confirmed	506	170		34%	
France	18/05/2020	Confirmed + Probable	28,239	14,363	10,650	51%	38%
Germany[67]	20/05/2020	Confirmed	8,090	3,049		37%	
Hong Kong	20/05/2020	Confirmed	4	0	0	0%	0%
Hungary	11/05/2020	Confirmed	421	100		24%	
Ireland	06/05/2020	Confirmed + Probable	1,375		857	62%	
Israel	29/04/2020	Confirmed	202	65		32%	
Norway	18/05/2020	Confirmed	233		135		58%
Portugal	09/05/2020		1,125	450		40%	
Singapore	03/05/2020	Confirmed	18	2	0	11%	
South Korea	30/04/2020	Confirmed	247	84	0	34%	0%
Spain	10/05/2020	Confirmed + Probable	31,889 (confirmed)		9,642 (confirmed) 16,678 (confirmed + probable)		30% (confirmed)
Sweden	14/05/2020	Confirmed	3,395	1,661		49%	
England & Wales (United Kingdom)	08/05/2020	Probable + Excess deaths	37,375 (probable) 49,470 (excess deaths)	12,526[68] (probable) 25,591 (excess deaths)	9,980 (probable) 21,753 (excess deaths	38% (probable) 52% (excess deaths)	27% (probable) 44% (excess deaths)
Scotland (United Kingdom)	17/05/2020	Probable + Excess deaths	3,546 (probable) 3,946 (excess deaths)		1,623 (probable) 2,006 (excess deaths)		46% (probable) 51% (excess deaths)
United States[69]	20/05/2020	Confirmed	93,163	30,130		41%	

Source: Comas-Herrera et al. 2020 <https://ltccovid.org/wp-content/uploads/2020/06/Mortality-associated-with-COVID-21-May-1.pdf>[18].

There has been controversy in Italy about the existence of factors linked to the structural characteristics of residences that have contributed to the spread of the disease so severely. Certainly, these facilities were unprepared to handle a situation of pandemic proportions. Several factors, however, may have exacerbated the way the virus spread[19].

The ISS survey identified the following among the main difficulties that the structures may have encountered during the period of the spread and management of COVID-19:

a. Poor information received on the procedures to be carried out to contain the infection;
b. Lack of medications;
c. Lack of Personal Protective Equipment (PPE);
d. Absence of health care personnel;
e. Difficulties in transferring residents with

[17] F Pesaresi (2020), 'Il Covid-19 nelle strutture residenziali per anziani'.

[18] A Comas-Herrera and others (2020) 'Mortality associated with COVID-19 outbreaks in care homes: early international evidence, in LTC covid.org, International LongTerm Care Policy Network', CPEC-LSE, <https://ltccovid.org/wp-content/uploads/2020/06/Mortality-associated-with-COVID-21-May-1.pdf> accessed 15 November 2023.

[19] Panorama della sanità, Servizi di prevenzione, situazione disomogenea tra le regioni (24 April 2020).

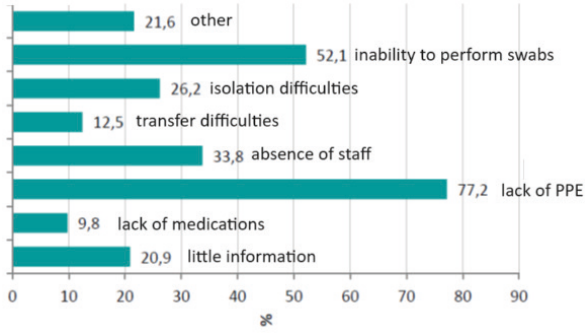
COVID-19 to hospital facilities;
f. Difficulties in isolating residents with COVID-19;
g. Impossibility in having swabs performed; and
h. Other.

In 77.2% of cases, the facilities reported a lack of Personal Protective Equipment, and in 20.9% a lack of information about the procedures to be carried out to contain the infection.

In addition, 9.8% of the facilities reported a lack of drugs, 33.8% a lack of healthcare personnel and 12.5% difficulties in transferring COVID-19 residents to hospital facilities. Finally, 26.2% reported difficulties in isolating COVID-19 residents and 22% indicated an inability to perform swab-tests (21.6% indicated 'other', see Figure 13). Overall, 21.1% of the facilities indicated that the facility's staff had tested positive for SARS-CoV-2 infection, although this variable was affected by the policies adopted by each region or ASL or health district on whether or not to perform swab-tests.

Of all the difficulties encountered, the one concerning the transfer of COVID-19 infected residents to hospital facilities deserves particular attention. In the period considered by the survey, 5,292 residents were hospitalised in the facilities, with an average of approximately 4 hospitalisations per facility. Of the hospitalised residents, 18.2% were positive for COVID-19, while 38.2% presented flu-like symptoms or pneumonia (see Figure 13).

Figure 13. Difficulties encountered when spreading COVID-19.



Lombardy had the lowest number of hospitalisations of residents after Umbria. The case of Lombardy is particularly relevant in the literature because the residences for the elderly in Lombardy represent the flagship of Lombardy's welfare, an example of residency in Italy[20].

In fact, ISTAT (2020)[21] indicates in 2016 that about a quarter of the elderly in facilities and beds are located in Lombardy. Over the years, this sector has been characterised by increasing sanitisation, so much so that the latest ISTAT report shows that 90 per cent of the beds in RSAs in Lombardy are medium/high healthcare intensity.

And yet, the outbreak of the pandemic quickly sent this system into crisis. Arlotti and Ranci (2021) state that, among structural and economic factors that may have contributed to the Lombardy system's entry into crisis, relationship between hospitals and residences for the elderly should be noted[22].

According to the authors, in fact, it is precisely in this delicate situation that 'the consequences deriving from the fragmentation of the intervention system, from the discontinuity of the hospital-territory pathways to the excessive unbalance towards the hospital component' clearly emerged. According to the authors, both the approval of Resolution XI/2906 on 8 March 2020, through which the transfer of patients from hospitals to RSAs was made possible to relieve the pressure on hospitals, and Resolution XI/3018 of March 2020, which established, in the most critical phase of the crisis the blocking of access to hospitals for elderly people admitted to RSAs with flu-like symptoms or Covid positive, have contributed to the dramatic consequences in terms of abandonment of the elderly and COVID-19-related mortality that has been described.

4. Concluding remarks

The emergency linked to the COVID-19 contagion has had dramatic consequences, in terms of contagions and victims, such as to bring out in a striking manner the structural deficiencies of an institutional and organisational nature, of the Italian health system, questioning its effectiveness in guaranteeing universal and global

[20] S Modina, Organizzazione e controllo nelle RSA: Residenze Sanitarie Assistenziali (FrancoAngeli, 2020).

[21] ISS-ISTAT, Impatto dell'epidemia Covid-19 sulla mortalità: cause di morte nei deceduti positivi a Sars-Cov-2 (2020), <https://www.istat.it/it/archivio/245415> accessed 15 November 2023.

[22] M Arlotti, C Ranci, Report: 'The Impact of COVID-19 on nursing homes in Italy' (2021) Journal of Aging & Social Policy, 431-443.

health protection.

These critical issues have been even more tragic in the area of residential care for the elderly, a sector that presents significant and worrying structural deficits and territorial gaps. In a socio-demographic situation of structural ageing of the population in which the need for such services is destined to grow exponentially, the fragility of this sector of our welfare system highlights the fact that it does not have the foundations for a more efficient development on a broader scale, as will be necessary in the future. This article has taken into consideration the available data on residential facilities for the elderly in Italy in order to assess their characteristics, the regional differences and the operational difficulties they faced during the first wave of the pandemic and to understand whether certain specific features had a significant impact on the mortality rate of the elderly occurring in residential facilities. The existing data are not complete and reliable enough to draw conclusions of statistical significance. They are useful, however, to outline a first dimension of the phenomenon. Considering that COVID-19 particularly affected the elderly and medically frail population with concomitant pathologies, and that in residences for the elderly three quarters of the residents are on average over 80 years of age and non-self-sufficient, it is to be expected that the pandemic manifested in a dramatic lethality. Abroad, the mortality rate of elderly residents in facilities is similarly high. However, it can be deduced from the data that some regions were more affected than others, in particular Lombardy, and that the outcome of the spread of the pandemic may also have been determined by the strategies adopted and processes implemented, which differed from region to region and resulted from the regional articulation of the political and healthcare system. In particular, the blocking of transfers to hospitals and the isolation of the sick transferred from hospitals to residences without the possibility of effective distancing between residents in Lombardy, for example, may have amplified a drama that could have had lower proportions.

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SECTION I
ESSAYS

Support Administration and Medical Treatment: COVID-19 Vaccination as a Test Case for Legislation

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Abstract. The civil protection of vulnerable people and in particular the elderly is in most cases entrusted to the institution of support administration, introduced into the Italian legal system with law no. 6 of 2004. The contribution analyzes the problems that arose during the COVID-19 pandemic with reference to the choice relating to the administration of the vaccine to the beneficiary of the support administration, considering law no. 219 of 2017 with which informed consent to medical treatments was regulated.

Keywords: *COVID-19, support administration, medical treatment.*

1. The support administration: premise

In the Italian legal system, the civil protection of vulnerable people and, in particular of the elderly, is in most cases entrusted to the institution of the support administration. For many years, the support administration has come to nearly replace the original protections provided for in the civil code, to the point that part of the doctrine has repeatedly argued the advisability of repealing interdiction and incapacitation[1].

The support administration, introduced by Law No 6 of 2004, is characterised by greater flexibility and adaptability to the concrete case[2], and better protection of the person's dignity especially in times of medical incapacity[3], limiting his or her capacity to act only to the strict minimum necessary.

The beneficiary remains capable of acting, except for the acts included in the decree of the tutelary judge, and, pursuant to Article 409(2) of the Civil Code, is always and in any case recognised as having the capacity to perform 'the acts necessary to meet the needs of his or her daily life'[4].

This was a historical reform compared to the original protections of 1942, capable of

[1] Cfr. CM Bianca, 'Premessa', in Patti (ed), L'amministrazione di sostegno, (Milano, 2005), 2; Id., Diritto civile, I (Milano, 2002) 250; S Patti, 'La nuova misura di protezione', in Ferrando (ed), L'amministrazione di sostegno (Milano, 2005) 108; Id., 'Amministrazione di sostegno e interdizione: interviene la Corte di Cassazione', in Famiglia, Persone e Successioni (2006), 811. About the differences between the various hypotesis, cfr. AA.VV., Amministrazione di sostegno. Interdizione, inabilitazione, incapacità naturale, directed by G Ferrando (Bologna, 2012); MN Bugetti, 'Le incerte frontiere tra amministrazione di sostegno e interdizione' (2006) Fam e dir, 56; M Paladini, 'Amministrazione di sostegno e interdizione giudiziale: profili sistematici e funzionalità della protezione alle caratteristiche relazioni del soggetto con il mondo esterno' (2005) Riv dir civ (2005) 585ff; A Tamborrino, La tutela giuridica delle persone con disabilità. Diritti e libertà fondamentali delle persone diversabili (Milano, 2019).

[2] In the aftermath of the introduction of the legislation, people spoke of a suit made to measure for the beneficiary.

[3] About the issue of fragility, see P Cendon, 'Persone fragili, diritti civili' (2021) Nuova giur civ comm, II, 167ff.

[4] Ex multis, cfr. G Ferrando, L Lenti, Soggetti deboli e misure di protezione. Amministrazione di sostegno e interdizione (Torino, 2006); G Ferrando, Amministrazione di sostegno: interdizione, inabilitazione, incapacità naturale (Bologna, 2012); Id., L'amministrazione di sostegno: una nuova forma di protezione dei soggetti deboli (Milano, 2005); G Bonilini, F Tommaseo, 'Dell'amministrazione di sostegno. Artt. 404-413', in Il Codice civile commentato, fonded by P Schlensiger, directed by D Busnelli (Milano, 2008); G Bonilini,A Chizzini, L'amministrazione di sostegno, II ed. (Padova, 2007); E Calò, Amministrazione di sostegno: Legge 9 gennaio 2004, n. 6 (Milano, 2004); P Cendon, R Rossi, Amministrazione di sostegno: motivi ispiratori e applicazioni pratiche (Torino, 2009); A Farolfi, Amministrazione di sostegno: casistica e formule, Milano, 2013; F Garlisi, L'amministrazione di sostegno: risposte giurisprudenziali ai quesiti della pratica,

overturning the reference principles of the protection of persons deprived in whole or in part of their autonomy. Over the years, a massive use of the support administration, perhaps not even foreseeable at the time, has occurred with considerable repercussions also on the system of the organisation of the Courts' offices[5].

The principles of solidarity, proportionality, necessity and flexibility that had the ambition of creating a new institution tailored to the beneficiary have, however, had to come to terms with a reality that it is perhaps not yet mature. Thus, amidst critical issues and junctures to be resolved, almost twenty years after the introduction of Law No 6, many discussions are ongoing regarding a reform of the effective implementation of the regulatory model, reforming it and making it an instrument for the promotion of dignity and freedom in accordance with the original ratio legis.

2. The informed consent of the beneficiary of the support administration

Among the many critical issues that have arisen in recent years, those of a non-pecuniary nature are certainly of importance, including those relating to the beneficiary's right to health and the regulation of informed consent to health treatments[6]. In particular, as far as the present study is concerned, during the COVID-19 pandemic, issues were raised by the choice inherent in the administration of the vaccine to the beneficiary of the support administration.

It is therefore essential to start from the analysis of informed consent, regulated by Law No 219 of 2017, 'Norme in materia di consenso informato e di disposizioni anticipate di trattamento'[7]. Article 3 of this Law is dedicated to the informed consent of incapacitated

Milano, 2012; R Masoni, Amministrazione di sostegno: orientamenti giurisprudenziali e nuove applicazioni, (Santarcangelo di Romagna, 2009); E V Napoli, L'amministrazione di sostegno (Padova, 2009); P Borsellino, D Feola and L Forni (eds), Scelte sulle cure e incapacità: dall'amministrazione di sostegno alle direttive anticipate (Varese, 2007); A Bortoluzzi, L'amministrazione di sostegno. Applicazioni pratiche e giurisprudenza (Torino, 2005).

[5] The Italian Statistical Yearbook 2023, published by ISTAT, notes that there were 48639 proceedings for support administration in 2020 compared to 2225 for interdiction and incapacitation.

[6] See D Carusi, 'Legge 219/2017, Amministrazione di sostegno e rifiuto di cure: problemi di legittimità di una legge mal scritta' (2020) Corr giur 20ff; G Ferrando, 'Diritto di rifiutare le cure, amministratore di sostegno e direttive anticipate' (2008) Fam e dir, 924; P Borsellino, D Feola and L Forni, (eds), Scelte sulle cure e incapacità: dall'amministrazione di sostegno alle direttive anticipate; MA Piccinni, Relazione terapeutica e consenso dell'adulto «incapace»: dalla sostituzione al sostegno, in Trattato di Biodiritto, directed by Rodotà e Zatti, I diritti in medicina, ed by Lenti, Palermo Fabris, Zatti, Giuffrè, 2011, III, 391ff; Id., 'Il problema della sostituzione nelle decisioni di fine vita (nota a Trib. Reggio Emilia, 24.7.2012)' (2013) Nuova giur civ comm, I, 221.

[7] For a comment on law no 219/2017 see D Carusi, La legge «sul biotestamento». Una pagina di storia italiana, (Torino, 2020). About informed consent see M Franzoni, 'Dal consenso all'esercizio dell'attività medica all'autodeterminazione del paziente' (2012) Resp civ, 2012, 85ff; A Ruggeri, 'Auto-determinazione', in Digesto, Disc. pubbl., Agg. (Utet, 2021) 1ff; V Calderai, 'Consenso informato', in Enc. dir., Annali, VIII (Milano, 2015) 25ff; D Farace, 'La forma del consenso ai trattamenti sanitari', in Foro it, 2015, I, 3665ff; R Omodei Salé, 'La responsabilità civile del medico per trattamento sanitario arbitrario' (2015) Jus Civile, 798; G Pellegrino, Il consenso informato all'attività del medico. Fondamenti, struttura e responsabilità (Frosinone, 2015); A Borretta, 'Responsabilità medica da omesso o insufficiente consenso informato e onere della prova' (2014) Resp civ, 2014, 897; F Salerno, 'Consenso informato in medicina e qualità soggettive del paziente' (2014) Giur it., 277; G Pellegrino, 'Consenso informato e distorsioni cognitive' (2012) Riv crit dir priv, 637; S Rossi, 'Consenso informato', in Dig disc priv, sez civ, Agg VIII (Torino, 2012), 177ff; N Callipari, Il consenso informato nel contratto di assistenza sanitaria (Milano, 2012); M Graziadei, 'Il consenso informato e i suoi limiti, in I diritti in medicina', L Lenti, E Palermo Fabris, P Zatti (eds), in S Rodotà and P Zatti (eds), Trattato di biodiritto (Milano, 2011) 191ff; P Piccialli, 'Il "consenso informato" e la responsabilità del medico' (2009) Corr mer, 303; P Viganò, Limiti e prospettive del consenso informato, (Milano, 2008); G Facci, 'Brevi osservazioni in tema di funzione riparatoria della responsabilità civile e violazione del sanitario del dovere di informazione' (2008) Riv civ, 408; L Eusebi, 'Criteriologie dell'intervento medico e consenso' (2008) Riv it med leg, 1227; S Cacace, 'Consenso informato: novità sul fronte giurisprudenziale – Rappresentazione in tre atti' (2008) Danno e resp, 889; G Montanari Vergallo, Il rapporto medico-paziente – Consenso e informazione tra libertà e responsabilità (Milano, 2008); R De Matteis, Responsabilità e servizi sanitari – Modelli e funzioni, in Trattato di diritto commerciale e di diritto pubblico dell'economia, directed by F Galgano (Padova, 2007) 330; E Turillazzi, G

persons, including beneficiaries of support administration[8].

As has been argued, perhaps it would have been better if law avoided addressing the issue of the treatment to be given to legally incapacitated persons 'not because it is an unimportant issue, but on the contrary in view of its extreme difficulty and delicacy'[9]. The entire provision, not just the part devoted to the support administration, is contradictory and ambiguous at several points 'and the tenor of its words leaves it uncertain whether the principles in force up to now are to be considered disproved or confirmed'[10]. Thus, while the first paragraph of Article 3 proclaims the right of incapacitated persons, including those subject to support administration, to the enhancement of their comprehension and decision-making capacities, subsequent paragraphs provide that consent to medical treatment shall be expressed or refused by the persons exercising parental responsibility, by the guardian, or by the support administrator ('also or only'). This is without prejudice, however, in the event of dissent by the doctor, to the possibility of applying to the tutelary judge who shall make the final determination.

In short, the legislature beguiles the reader with the idea of enhancing the incapacitated person's capacity to make decisions, but then in fact provides for consent expressed or refused by others and not by the incapacitated person himself. Thus, the Law fails to resolve the real question already raised before the legislative amendment – whether the legally incapacitated person can be recognised, given the highly personal nature of the right to health, as having any de facto capacity to refuse the treatments indicated by doctors as necessary[11].

Leaving aside the part of the rule dedicated to minors and incapacitated persons, Paragraph IV of Article 3 states that 'in the event that a support administrator has been appointed whose appointment provides for the necessary assistance or exclusive representation in health matters, informed consent shall also be expressed or refused by the support administrator or only by the latter, taking into account the beneficiary's

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Guerra, 'Consenso informato: l'obbligo risarcitorio' (2007) Riv it med leg 865; G Facci, 'Il dovere di informazione del sanitario' (2006) Nuova giur civ comm, II, 558; Id., 'Il dovere di informazione del sanitario (parte seconda)', ibid, 617; Id., 'Il consenso informato all'atto medico: esercizio di un diritto costituzionalmente garantito per il paziente o una "trappola" per il sanitario?' (2006) Resp civ, 2006, 486; P Zatti, 'Il diritto a scegliere la propria salute, (in margine al caso S. Raffaele)' (2000) Nuova giur civ comm, II, 1ff; G Ferrando, 'Consenso informato del paziente e responsabilità del medico, principi, problemi e linee di tendenza', (1998) Riv crit dir priv, 37; C Castronovo, 'Profili della responsabilità medica' (1997) Vita not, 1222.

[8] According to art. 3 Law no. 219/2017: '1. A person who is a minor or incapacitated has the right to the enhancement of his or her understanding and decision-making capacities, while respecting the rights set out in Article 1(1). 2. Informed consent to the minor's health treatment shall be given or refused by the persons exercising parental responsibility or by the guardian, taking into account the minor's wishes, in relation to his or her age and degree of maturity, and having as its aim the protection of the minor's psychophysical health and life with full respect for his or her dignity. 3. The informed consent of the disqualified person within the meaning of Article 414 of the Civil Code shall be given or refused by the guardian, after hearing the disqualified person where possible, having as its aim the protection of the person's psychological and physical health and life with full respect for his or her dignity. 4. The incapacitated person's informed consent shall be given by the incapacitated person himself. In cases where a support administrator whose appointment provides for the necessary assistance or exclusive representation in health matters has been appointed, the informed consent shall be expressed or refused also by the support administrator, or only by the latter, taking into account the will of the beneficiary, in relation to his or her degree of capacity.

5. In the event that the legal representative of the interdicted or incapacitated person or the support administrator, in the absence of the advance treatment instructions (DAT) referred to in Article 4, or the legal representative of the minor person refuses the proposed treatment and the doctor instead deems it appropriate and necessary, the decision is referred to the guardianship judge on the appeal of the legal representative of the person concerned or of the persons referred to in Article 406 et seq. of the Civil Code or of the doctor or the legal representative of the healthcare facility". On Article 3 of Law No. 219/2017 see D Carusi, *La legge "sul biotestamento". Una pagina di storia italiana*, 48ff; G Ferrando, 'Articolo 3', in *Forum: La legge n. 219 del 2017, Norme in materia di consenso informato e di disposizioni anticipate di trattamento* (2018) BioLaw Journal – Riv. BioDiritto, 1, 46ff.

[9] See D Carusi, La legge «sul biotestamento». Una pagina di storia italiana, 48.

[10] Ibidem.

[11] Ibidem, 50.

will, in relation to his or her degree of capacity to understand and to want'. According to the letter of the law, the support administrator, depending on the powers attributed to him/her by the decree of the tutelary judge[12], could be asked to supplement the declaration of the person concerned (necessary assistance) or even to substitute the person concerned in the choice (exclusive representation).

The legislative solution raises some confusion and does not appear to be in line with the case law that was established, in accordance with the Constitution, prior to Law no 219. Under this case law precedent, in relation to medical treatment, because the expression of consent or refusal to treatment is a very personal act, the person who intervenes to protect the incapacitated person (guardian or support administrator) cannot decide in his place, but can only act as spokesperson for the will of the person concerned, which he is unable to express[13].

Jurisprudence, thus, has affirmed that the support administrator does not have the power to express his own will on behalf of the beneficiary, but on the contrary has the role of investigator and qualified witness of orientations previously manifested by the incapacitated person[14]. The non-pecuniary nature of the interests at stake in fact precludes the application of the rules of representation of property transactions. Paragraph IV of Article 3, is therefore not convincing, even though the statement that it is necessary to 'take into account the wishes of the beneficiary' may ictu oculi seem reassuring and reconnaissance of the aforementioned jurisprudential orientations.

Indeed, according to this provision, a double manifestation of consent (of the beneficiary and 'also' of the support administration) would be required in the same way for both necessary assistance and acts of extraordinary administration of emancipated and incapacitated persons which is ill-suited to the matter of therapeutic treatment. To opt otherwise would be tantamount to arguing that the support administrator's failure to give his consent, for example in the face of a life-support treatment, could prevent the doctor from administering the treatment to the beneficiary who wants it and has given his consent. It is clear that when the person concerned has the capacity for self-determination he alone and no one else will have the choice.

It is likely that with reference to this hypothesis the legislature, from a terminological point of view, has misunderstood previous case law, has affirmed that the guardian or administrator who is entrusted with representing the incapacitated person must decide not 'in place of' the incapacitated person nor 'for' the incapacitated person, but 'with' the incapacitated person, referring in truth to the duty to reconstruct the presumed will of the unconscious or incapacitated patient[15].

With reference then to the hypothesis of 'exclusive representation in healthcare' where it would be 'only' up to the administrator to express consent or refusal with respect to healthcare treatment, it is clear that this is a poorly written provision, the result of the erroneous idea that the instruments of representation proper to patrimonial rights can also be applied to the subject of medical treatment, destined to be constitutionally interpreted by legal operators[16] if not actually abrogated by the Constitutional Court itself[17].

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[12] It is obvious that for one to be able to speak of 'some power' of the support administrator, it is a necessary and indispensable requirement that it be granted by decree by the judge.

[13] Consider that case law has even gone so far as to declare the loss of parental responsibility for those parents who had opposed 'objectively' indicated and useful treatment for the patient.

[14] In the words by D Carusi, La legge «sul biotestamento». Una pagina di storia italiana, 49. In case law see Trib Reggio Emilia, 24 July 2012, in Giur. it., 2013, 347, with a commentary by D Carusi, on the 'refusal' of artificial ventilation in view of a definitive respiratory arrest. See also Trib Roma, 19 March 2004, in Notariato, 2004, 249; Trib Modena, 15 September 2004, in Fam dir, 2005, 85; Trib Vibo Valentia, 30 November 2005, in Riv it med leg, 2006, 117; Trib Sassari, 16 July 2007, in Foro it, 2007, I, co 3025, with a commentary by G Casaburi. In the legal doctrine see also G Ferrando, 'Diritto di rifiutare le cure, amministratore di sostegno e direttive anticipate (2008) Famiglia e dir, 924.

[15] D Carusi, Legge 219/2017, Amministrazione di sostegno e rifiuto di cure: problemi di legittimità di una legge mal scritta, 23.

[16] Ivi, 25: 'the crux of the matter to be dealt with in the immediate future will perhaps be this: to take note that the words 'represents', 'representation', 'assistance', are used in the text of Law 219 with doubtful awareness and without any technical consistency; to recognise that the entire article 3 of the law, in order to be compatible with the constitutional framework, can only be read as a clumsy summary of the previous state of the system on the point of the care of the legally incapacitated'.

[17] The ambiguity of the text, on the other hand, even prompted a tutelary judge (Trib Pavia, 24

In short, the support administrator cannot be attributed the power in the technical sense to represent the person concerned by expressing his or her own will, since the right to health is a very personal right. On the contrary, he or she can only be attributed the function of manifesting the beneficiary's will, reconstructing the presumed will of the incapacitated patient, already an adult before falling into that state, taking into account the wishes expressed by him or her beforehand, or inferring that will from his or her personality, lifestyle, inclinations, reference values and ethical, religious, cultural and philosophical convictions[18].

It is evident that starting with the Englaro case and until Law no 219 came into force, the principle of reconstructing the presumed will of the incapacitated patient was the only way to deal with these issues within a regulatory framework that lacked legislative regulation of advance treatment provisions. Today, with the introduction of the DAT[19], it will be necessary to ascertain whether the subject, before becoming incapacitated, had drawn up dispositions also concerning the specific treatment for which the verification of informed consent is required[20]. Where, then, the patient has not included the treatment in question among his or her advance dispositions, they may still be a valid tool – though not the only one – for reconstructing his or her presumed will.

When it is then in no way possible to ascertain what the beneficiary's will would have been – a case that is alas not improbable – it seems correct to agree with the jurisprudence that, again before the law, seemed oriented to favour the beneficiary of the medical treatment envisaged, the judge always having to inspire his decision in the so-called best interests of the legally incapacitated person in the event of disagreements[21].

3. Supporting administrations and the COVID-19 vaccine

The ambiguity of the text and the practical uncertainties it caused emerged forcefully – as anticipated – during the last pandemic when it came to the choice regarding the administration of the COVID-19 vaccination

March 2018, in Nuova giur civ comm, 2018, I, 1128ff, with comment by Piccinni, Deciding for the patient: representation and care of the person after l no 219/2017) to raise, with reference to Articles 2, 3, 13 and 32 Const., question of the legitimacy of the provision in the part in which it attributes to the support administrator the power to express 'alone' consent or refusal of treatment without the intervention of a third and impartial party such as the judge. The Constitutional Court, however, declared the issues unfounded and rendered a judgment that was described as 'evasive, to be considered hopefully interlocutory'. See Constitutional Court, 13 June 2019, no 144, in Corr giur, 2020, 17ff, with commentary by D Carusi, 'Legge 210/2017, amministrazione di sostegno e rifiuto di cure: problemi di legittimità di una legge mal scritta' (2019) Foro it, I, co 3024. The referring judge in truth, considering that the legal representative of the minor and that 'of the interdicted or incapacitated person' may also find themselves in the same situation, asked to extend correlatively, by way of consequence (art 27, Law no 87 of 1953), the possible pronouncement of unconstitutionality also to the corresponding part of the law. See also A Gorgoni, 'L'autodeterminazione nelle scelte di fine vita tra capacità e incapacità, disposizioni anticipate di trattamento e aiuto al suicidio' (2020) Pers e Mercato, 7, 77ff.

[18] The Court of Cassation expressed itself in these terms in the well-known judgment no 21748 of 2007, published, among many reviews, in Foro it, 2007, I, co 1711 as well as c. 3025, with a note by G Casaburi, in Corr Giur, 2007, 12, 1676, with note by Calò. The principles of the Court of Cassation have been applied by the Court of Rome, which, after reconstructing the previously expressed will regarding the refusal of end-of-life medical treatments, decided to authorise the support administrator to suspend life-saving treatments, as they did not conform to the will, personality, lifestyle and convictions of the person administered. See Trib Rome, decr. 22 January 2021, in Nuova giur civ com., 2021, 834, with note by V Durante, Volontà presunta e best interests del paziente in stato vegetativo permanente. Cfr. anche A Gorassini, 'Cambio vita…con morte', ivi, 2021, 902ff.

[19] 'Disposizioni Anticipate di Trattamento'.

[20] Before the introduction of Law 219, the regulation of DAT could only be found in the code of medical ethics and the Oviedo Convention, where it is expressly stated that the doctor must take into account the provisions contained in these documents. Despite the fact that these were provisions that did not impose a duty on the doctor to comply with them, case law, in the judgment of the reconstruction of the will of the incapacitated person, tended in fact to value them.

[21] See Trib min Bologna, 19 September 2013, in Fam e dir, 2014, 371; App Brescia, 13 February 1999 and Trib min Brescia, 22 May 1999, in Nuova giur civ comm, 2000, I, 204; App Ancona, 28 March 1999, ivi, 2000, 218; TAR Lazio, 8 July 1985, in Dir fam pers, 1996, 998.

to beneficiaries of the administration. Some courts[22], after moments of difficulty and urged by the numerous petitions submitted by the support administrators themselves, drew up guidelines on the expression of informed consent by this category.

Given that the exercise of a person's self-determination in these cases requires first of all a precise distinction between the cases in which the patient has only a residual capacity to consciously self-determine his or her own health (competent patient) and the cases in which this capacity is totally absent (incompetent patient)[23], the guidelines immediately specify that in the presence of a competent administrator, after adequate information, the choice will be his or her alone and cannot be vicariously decided by others (cf. art. 1 paragraphs 3 and 5 l. 219/2017).

In this first part, the guidelines correctly transpose what has been affirmed in case law by enshrining the principle of self-determination in the therapeutic choices of the person subjected to support administration, where the same is capable of understanding and willing, without interference by the administrator. By having to take into account the possibility that the measure appointing the support administrator provides for the necessary assistance in the matter of informed consent, the guidelines, while reaffirming that in this hypothesis the informed consent is expressed or refused, even by the support administrator, take care to specify that in any case the administrator's will cannot prevail over the will expressed by the person administered.

Some perplexity is, however, immediately prompted by the next clause where it reads 'unless the patient himself indicates the family members or a person he trusts to express consent on his behalf (Art. 1, paragraph 3 l. 219/2017). Among the persons the patient may indicate is obviously also the support administrator if already appointed'. Here, the guidelines, through the reference to law no. 219, seem to consider admissible a blank delegation to a third party (relative, trustee or support administrator) and therefore an exclusive representation in matters of treatment. This article asserts that on the basis of the very personal nature of the right at stake, does not seem constitutionally admissible.

The guidelines then deal with the delicate case in which the beneficiary is not able to express his or her own, valid will and the judge's decree has granted the support administrator exclusive power of representation in healthcare matters[24]. On this point, departing from the literal interpretation of Article 3, it is specified that the attribution of the administrator's power of exclusive representation presupposes that the reconstruction of the will that the person administered would have expressed had he been capable of doing so. This is so since it is not possible in this matter to hypothesise an unconditional power of the administrator to dispose of the health of others. This is a choice that is appropriate because only in this way can the support administrator truly achieve the protection of the beneficiary's psychophysical health and life in full respect of his dignity and in compliance with the constitutional principles and values that uniform the entire legal system.

As discussed above, the guidelines, although suffering from the ambiguities and inaccuracies of the law, have given a satisfactory reconstruction of the problem that arose during the COVID-19 pandemic and conformed to the constitutional principles and the jurisprudential orientations of the Supreme Courts.

Looking to the future, without forgetting the lessons of the past, the jurist cannot fail to read the difficulties faced as an opportunity to reflect on the advisability of reviewing and remodelling such a delicate regulation as that of the protection of vulnerable persons, and more specifically of the existential profiles of the lives of incapacitated persons, which are not suited to being regulated by the classic instruments of private law designed, on the contrary, for patrimonial rights.

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[22] Among the various guidelines issued by the Courts, those drafted by the Courts of Genoa and Milan will be analysed in this paper.

[23] The guidelines, which were created precisely to guide the legal practitioner, also distinguish the hypothesis in which the person already has a support administrator from the hypothesis in which there is no support administrator. For our purposes, it will be sufficient to deal only with the former.

[24] The guidelines take care to reiterate that in the event that the appointment order says nothing about health treatments, the support administrator is not authorised to express consent on behalf of the administered person since this power can only be attributed by the tutelary judge in the context of that power/duty 'to model, also in the health field, the administrator's powers on the concrete needs of the beneficiary, establishing from time to time their extension in the sole interest of the disabled person'. In these hypotheses, therefore, the administrator must refer to the judge. See Constitutional Court, 13 June 2019, no 144.

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SECTION I
ESSAYS

Solidarity Cohabitation and Senior Cohousing

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Abstract. The author reviews the various legal effects of cohabitation in solidarity, with particular but not exclusive regard to the cohabitation of the elderly, for which the legislator is preparing a still meagre, but certainly growing, network of regulations particularly focused on the themes of co-housing and social and socio-health territorial assistance

Keywords*: Solidarity Cohabitation, Senior Cohousing, Community Welfare, Elderly, Socio-health territorial assistance.*

1. What are Solidarity Cohabitations as a Matter of Law?

Among the social effects of demographic aging and the increased fragility and insecurity of family relationships, there is an increase in the number of elderly people living alone. An exponentially increasing number of commercial residential responses exist to address these new realities. However, these present challenges as well as alternatives to formalized, institutional housing for the elderly. Examples of these housing experiments include amicable cohabitation or at least among peers, for whom shared housing can be a viable option in which the elderly can continue to enjoy their fundamental legal rights as well as preventing the risks of their violation in the institutional settings.

This article uses the prism of Article 2 of the Italian Constitution[1] to address the ways in which solidarity cohabitation and senior cohousing can be used to respect family rights as well as fundamental personal rights for the elderly[2]. As the article concludes, it is up jurists to suggest the criteria of discernment and the rules capable of tracing the different constitutional disciplines necessary to create a balance between these needs and the commercialization of entrepreneurship involved in many of these cohabitation systems.

2. Solidary Cohabitation and Affective Relationships

Scholars tend to distinguish *de facto* cohabitations belonging to relationships based on friendship, solidarity, mutual aid or sexual intimacy[3]. The former are subject to contrasting but strong regulation. The latter elements still lack an adequate legal framework, so much so as to lead some to create forms of cohabitation *more uxorio* that in reality disguise friendship or solidarity relationships[4].

Solidary cohabitation, unlike other types of cohabitation (i.e. guest houses for workers, military accommodation, and student halls of residence), can also give rise to stable and intense bonds, such as to constitute genuine homes[5].

[1] See E Del Prato, 'Patti di convivenza' (2002) Familia, 960.

[2] Consolidated with the legal literature of the 1980s, including F Gazzoni, Dal concubinato alla famiglia di fatto (Giuffrè, 1983) 146ff; U Majello, Della filiazione naturale e della legittimazione (Zanichelli, 1982) 10; V Franceschelli, La famiglia di fatto da "deviant phenomen" a istituzione sociale (1980) Dir fam Pers, 1257ff.

[3] See F Caggia, 'La convivenza', in S Patti, MG Cubeddu (eds), Diritto della famiglia (Giuffrè, 2011) 23ff; Contra, see P Vercellone, 'Oltre le obbligazioni naturali: le unioni di fatto come rapporto contrattuale' (2018) The Cardozo Electronic Law Bulletin, vol 2.

[4] See F Luiso, 'La convivenza di fatto dopo la L. 76/2016' (2016) Dir fam pers 1083 ss. <https://www.altoadige.it/cronaca/bolzano/ci-siamo-sposate-per-assisterci-in-vecchiaia-1.1636822> ('We 'married' to assist each other in old age'. The choice of two women from Bolzano, both widows: 'Ours is mutual help') accessed 15 November 2023.

[5] The differentiating element seems to be that of cohabitation in the legal sense, as opposed to the mere fact of cohabitation. See Roma, Convivenza e coabitazione (Cedam, 2005) 1ff.

Indeed, as has been written, it is sometimes possible 'to find greater solidarity, affection, a sense of belonging, in a community of choice than in the institutional family', thinking in particular of 'cohabitation between elderly people left alone and young people who share expenses and exchange companionship and care'.

It is therefore necessary to ask why 'it should not be possible to broaden the range of affective communities worthy of public recognition, beyond the family as it is now institutionally defined and regulated'[6]. The fact is that, while emotional cohabitation constitutes an area of primary affective relationship endowed with social typicality and is increasingly widespread (which makes it easier to enforce within the sphere of private autonomy, as well as certain effects of legal sources), less explored is the terrain of 'other' cohabitations which, by reason of their being less widespread and greater originality compared to the socially more practised models, risk being forgotten by jurists and courts. The reproach made by some to the legislature is precisely that of not giving adequate relevance to this relational intensity – ascribable to the social formations referred to in Article 2 of the Italian Constitution – by failing to differentiate it from the many practices of mere cohabitation occasioned for the most diverse reasons[7].

In the absence of a wise intervention by the legislature – which indeed took an interest in it, albeit ambiguously, both in 2006 and 2013[8] – it seems first of all useful to configure the social type, which from now on we shall call 'solidarity cohabitation' for the sake of brevity, whose minimum common denominator is the intention to establish, through stable cohabitation, interpersonal relations different from cohabitation based on sexual understanding, enabling cohabitees to face life's challenges together with greater resources.

Hence the need for a minimum, differentiated statute with respect to family models, including the model, albeit minimalist, ambiguously realised with the 'de facto cohabitations' referred to in the Cirinnà law. This statute, however, must also be differentiated with respect to other cohabitations that are differently motivated and often unwanted (as in the case of hospitals or prisons), or participated in by means of a reception contract between user and manager (as in the case of a home-hotel or rest home) or, finally, so extemporaneous as not to give rise to the establishment of a shared residence[9].

The reconstructive itinerary must start from certain identifying elements and requirements, among which, a recent article indicated the ascertainment of the will to live together by setting up a joint residence project pursuant to Article 43 of the civil code[10]. Indicating residence among the identifying elements in itself

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[6] Saraceno, 'Introduzione', in Nussbaum, Giustizia sociale e dignità umana, il Mulino, 2012, 21; MR Marella, 'Il diritto di famiglia fra status e contratto: il caso delle convivenze non fondate sul matrimonio', in Moscati, A Zoppini (eds) I contratti di convivenza, (Giappichelli, 2002) 94ff; Dogliotti, 'Dal concubinato alle unioni civili' (2017) Pol Dir, 1, 20; Ferrando, 'Gli accordi di convivenza: esperienze a confronto' (2000) Riv crit dir priv, 163ff; Proto, 'Sulle attribuzioni patrimoniali nella convivenza extraconiugale' (2005) Giust civ, 343ff; Parente, 'La convivenza di fatto: un nuovo modello legale di organizzazione familiare' (2018) Dir Succ Fam, 801; Muritano, Pischetola, Accordi patrimoniali tra conviventi e attività notarile, (Giuffrè, 2009) 10ff; Benedetti, 'Le proposte di legge italiane in materia di convivenza', in Brunetta d'Usseaux, D'Angelo, Matrimonio, matrimonii, 212; Autorino Stanzione, Stanzione, 'Unioni di fatto e patti civili di solidarietà. Prospettive de iure condendo', in Autorino Stanzione (ed) Il diritto di famiglia nella dottrina e nella giurisprudenza (Giappichelli, 2011) 226.

[7] The exception to date is the Catalan normative. See Zambrano, 'Parejas no casadas: l'esperienza spagnola e la lei catalana del 10/1998', in Matrimonio Matrimonii, (Giuffrè, 2000) 430; Saracino, 'Le unioni civili in Europa: modelli a confronto' (2011) Dir fam pers, 1471ff.

[8] Ddl Senato, no 1208/2013 and ddl Senato no 909/2013, which provided for a spurious figure of non-more uxorio cohabitation limited, illogically, to only two partners, as noted by Rossi, 'La Costituzione e i Dico, ovvero della difficoltà di una disciplina legislativa delle convivenze' (2008) Pol Dir, 1, 130.

[9] Without such differentiation, there would be no regulatory possibility, as implied by, among others, Balestra, 'Unioni civili e convivenze di fatto: brevi osservazioni in ordine sparso' (2016) <Giustiziaciv-ile.com> accessed 15 November 2023. The heterogeneity of the phenomenon is analyzed by D'Adamo, 'Le convivenze senza matrimonio: diversità di modelli e presupposti di tutela' (2001) Vita not, 1652ff.

[10] I disagree with the admittedly widespread view that the notion of cohabitation (solidary or characterized by sexual understanding) would not require cohabitation, the purpose and practice of mutual dedication or help being sufficient. See Del Prato, Patti di convivenza; Forder, 'Riconoscimento e regime giuridico delle coppie omosessuali in Europa' (2000) Riv crit dir priv, 107ff.

implies a narrowing of the case with respect to the broader phenomenon of cohabitation and cohabitation motivated by friendship or solidarity. A restriction that excludes from the case in point is temporary or secondary cohabitation, which is not necessarily brief but concerns persons who maintain a habitual place of abode elsewhere, in respect of which cohabitation is, precisely, temporary or secondary. In fact, since there is only one residence for each person[11], this implies that the cohabitee has not maintained a different residence, even in the registry office sense, as in the case of a young person, student or worker, who, despite having rented a different dwelling, has maintained his residence at the family home.

Secondly, supportive cohabitation is characterised by the equal dignity and therefore reciprocity of the relationships between its members. No one is at the sole service of the others, but all are mutually supportive, albeit with positions that are in fact sometimes very different, owing, for example, to their state of health or other personal circumstances.

There can therefore be no joint and several cohabitation between one or more subjects and a worker assigned to their care[12]. This is, moreover, the reason why positive law – and in particular registry law – does not consider domestic workers cohabiting with their employers as part of the family unit, even though they register one and the other at the same residence address.

Nor does cohabitation carried out in implementation of an improper life annuity correspond to the legal concept of joint and several cohabitation, since cohabitation therein constitutes the performance of a contractual obligation, albeit subject to certain essential limits of enforceability and substitutability[13]. However, this does not contradict the stipulation of life annuity contracts between cohabitees, provided that the life annuitant is not obliged to provide care in the home and the cohabitation obligation.

Thirdly, cohabitation in solidarity requires its spontaneity, which implies an intangible freedom of repentance to which questions of belonging and enjoyment rights that have arisen in the meantime over the property used for cohabitation must be connected. 'Cohabitation covenant' is an expression often used in intentionally ambiguous terms, so as not to rush into writing a contract, just as the expression repentance is placed before 'withdrawal' to tone down the reference to the contractual relationship. And yet contractual relations are involved, although not always immediately and fully formalised. Relationships perhaps initiated by means of an agreement in principle or even confined, at their inception, to the meagre scheme of a precarious accommodation or hospitality, but subsequently destined for more articulate negotiation.

The reduction to the contractual figure, however, raises the question of the incapacitated person's participation in joint and several cohabitation. In fact, the exclusion from participation in joint and several cohabitation of the person subjected to limitations on his or her capacity to act does not seem justified[14], since in the current discipline of judicial incapacitation the right to be heard is safeguarded. And, within the limit of objective possibilities and need for protection the right to self-determination of existential choices, among which the incapacitated person's choice of dwelling place and of any cohabitants is of primary importance, albeit subject to the scrutiny of the support administrator, if he has been granted the power by the judge, or of the guardian[15].

In this regard, the directive of the legal system is defined differently in the two institutions of protection of the incapacitated person and the support administration, while maintaining the objective of respecting the will and inclinations of the protected person, insofar as this is compatible in practice with his protection[16].

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[11] See I Riva, Domicilio e residenza, in Commentario al codice civile Schlesinger-Busnelli (Giuffré, 2015) 58ff.

[12] See FD Busnelli, 'Sui criteri di determinazione della disciplina normativa della famiglia di fatto', in Famiglia di fatto (Atti del Convegno nazionale di Pontremoli, 27-30 maggio 1976) (Montereggio-Parma, 1977) 133.

[13] See E Del Prato, Patti, 961, footnote 67; Fusaro, 'I contratti di convivenza' (2017) Pol Dir, 123, footnote 8.

[14] Here are the relevant gaps and contradictions sometimes found in support administration decrees, on which, among others, Gordiano, 'L'esercizio delle situazioni esistenziali del beneficiario dell'amministrazione di sostegno' (2011) Dir fam pers, 1911ff.

[15] Art 19-octies, lett d), ddl no 909/2013, excluded the interdict instead.

[16] P Cendon, Rossi, Amministrazione di sostegno (Utet, 2009) II, esp 956ff; Farolfi, Amministrazione di sostegno (Giuffrè, 2014) esp 149ff and 201ff; Bonilini, 'Designazione dell'amministratore di sostegno e direttive da seguire nello svolgimento dell'ufficio' (2007) Fam pers succ, 102ff; Masoni, 'Odi et amo. Consenso, dissenso e rispetto della dignità del bene-

Unfortunately, this cardinal directive of the legal system struggles to impose itself, as evidenced by a recent condemnation of Italy by the European Court of Human Rights, given that the plaintiff was an elderly man who was perhaps too hastily subjected to a support administration and then placed by the administrator, against his will, in an assisted healthcare residence[17].

This has been pointed out for some time by the most alert operators complaining about how recourse to residential care institutions produces a damage that materialises in an 'estranging condition of total separateness from one's own world', imprisoning the elderly person in another world, 'extraneous and incomprehensible, with distorting consequences on the perception of oneself and one's own future'[18].

Therefore, having ascertained the correspondence of participation in a cohabitation in solidarity with the aspirations of the subject to limitation of his capacity to act, his legal representative may negotiate the proper contractual profiles of his participation in the cohabitation with or in place of his representative. And it is on the basis of the concrete content of these negotiations that the fact of cohabitation will be qualified as a joint and several cohabitation or will have to be traced back to a service of a commercial nature or, in any case, to a business activity, deserving of its different legal regulation.

3. Family Relationships within Solidarity Cohabitation

A hybridisation to be accounted for between the articulated discipline of family relationships and the legal effects referable to joint and several cohabitations is constituted by cohabitation realised between relatives to whom positive law attributes autonomous relevance.

Article 4 of Presidential Decree no 223 of 1989 provides that a group of persons bound by ties of kinship or affinity must be registered as a family (and not as a mere cohabitation at the same address).

In this regard, if on the one hand, it does not seem convincing to transpose into civil law the differentiation that the registry law makes of cohabitation between relatives as a 'family', on the other hand it does not seem correct to deny the possibility that between siblings or between relatives in other degrees of relationship a friendly cohabitation may be established, and therefore a joint cohabitation sufficient to substantiate legal effects.

This is a consideration that has been taken up by the Catalan legislature, with the aforementioned law 'sobre situaciones convivenciales de ayuda mutua' (now amended and inserted into the Catalan Civil Code) where the possible participants in such cohabitations include collateral relatives, excluding, on the other hand, those in the direct line, whose reciprocal duties and rights are otherwise regulated. In the same sense, moreover, the Italian legislature had also addressed these issues in bills from 2006 and 2013.

In particular, the legal obligation of alimony, incumbent under Article 433 of the Italian Civil Code on sons-in-law, daughters-in-law, in-laws and siblings, raises the question of the boundaries of competence with different or even partly overlapping obligations that may result from the creditor and debtor of alimony cohabiting with each other, insofar as other duties derive from such cohabitation. This applies whether for the legal or negotiated source, such as that of mutual assistance or contribution.

Moreover, with regard to the enforcement of the legal obligation of maintenance, it is necessary first of all to avoid interpretations that have a negative impact on the freedom of residence of the feeder, requiring the interpreter to defend it against illiberal interpretations that allow the debtor to decide at his mere discretion whether to support the needy relative-creditor by the payment of a periodical allowance or by means of housing (in his own home or elsewhere). It can be argued that the creditor must be protected in his freedom of choice as to where to live, without this affecting his right to maintenance and particularly in regard to elderly creditors, such as usually the parents-creditors of the child-debtor.

That being said, the possibility and the very utility of including persons of the same family among the possible members of a mutual aid cohabitation does not seem to be excluded in

ficiario di A.d.S' (2021) Dir fam pers, 813ff; Buffone, 'La protezione giuridica dell'adulto incapace: l'anziano e l'amministrazione di sostegno' (2011) Giur merito, 2912ff.

[17] ECHR, III, 4 July 2023, no 46412.

[18] See G Lazzari, F Succu and R Zanon, 'Una riflessione ''dal basso'': il ruolo delle associazioni nella prospettiva della centralità della persona beneficiaria di amministrazione di sostegno' (2021) Nuova giur civ comm, II, 739.

these statutory provisions[19]. Indeed, this presents a potentially worrying disharmony, if not incompatibility, regarding the effects deriving on the one hand from marital solidarity (or couple-based solidarity), and on the other hand from the fact (and the relative agreements) of cohabitation. Between the participants in cohabitation the confluence of these effects can be managed, in compliance with the law and any judicial determinations, by means of the negotiating instrument. However, as regards the effects on third parties and the various administrations involved, the concept of cohabitation would appear to maintain its unity even in the case where two or more members form a couple.

Also, with regard to other family relationships, the arising of obligations that originate from the constitution of a solidary cohabitation may overlap without, however, being incompatible with the possible obligation of maintenance.

For example, the case of a contract between two brothers living with the elderly parent who agree on their respective duties of support for the cohabitation has been hypothesised, providing for compensation in favour of the brother who is more involved in care, so that he has to give up part of his outside economic activities[20]. This is different, of course, from remuneration for services performed in the home[21].

4. Solidarity Cohabitation and Residential Care Facilities

In solidarity cohabitees, there is a wide range of possibilities as to the title to the residential property claimed by each of the cohabitees. Notably, one of the cohabitees may be the owner-host, the property may have been rented by all the cohabitees or only by some of them, or a third party may have granted a loan to some or all of the cohabitees. This removes from cohabitation the risk of death or even afterthought of the cohabitee owning the dwelling property.

Nor can it be ruled out that some of the cohabitees are paying tenants in respect of the cohabitee who owns the residential property, or under an agreement providing for a contribution to the maintenance of the property owned by the cohabitee-host.

On the other hand, there is a clear incompatibility between the existence of a supportive cohabitation and the hosting of the person, for reasons of care or simply housing assistance, in a public or private institution. The latter, unlike supportive cohabitation, requires administrative authorisations governed by state and regional law, and is subject to various externally imposed limits, such as in the case of condominium contractual regulations, as will be discussed later[22].

It is not always evident, at least with regard to small structures made up of one or two flats, the difference between a supportive cohabitation (which could also be supported from the outside by a social actor active in the area) and a hotel activity (perhaps accompanied by welfare or care services) exercised in a small structure made up of one or two flats. Indeed, today both these practices are widespread, and in some cases it is obligatory to resort to the model of the house-housing[23], within which, however, the guest's sphere of self-management is significantly limited by the reception contract.

Unlike an institutional residential service, solidarity cohabitation is based on the fundamental principle of self-management of needs by subjects who may be particularly fragile and therefore in need of support, but who are also sufficiently dynamic, at least at the outset, to decide to self-provide a residential service. Therefore, they are not subject to any of the authorisation disciplines that concern institutional residential services.

It is true that the distinction just sketched out sometimes becomes blurred precisely because of the dynamism of the formulas implemented by the direct protagonists, especially if supported by certain social facilitators, such as the «third sector» and voluntary social assistance bodies.

In such cases, above all, the legal interpreter must pay attention to how the wills of the participants have been translated into the contractual clauses, as well as their execution in the course of the cohabitation. In fact, the concrete cause of a contract qualified by the parties as a lease could well turn out to be a hotel contract mixed with care services. This is what the

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[19] See P Morozzo della Rocca, 'Tracce di rilevanza giuridica delle convivenze solidali nel secolo europeo della vecchiaia' (2023) Nuova giur civ comm, II, 162.

[20] Cfr. P Vercellone, 13ff.

[21] Clause also practiced in the context of domestic partnerships. For a paradigmatic case see Cass. 22 January 2014, no 1277.

[22] See Cass, 6 December 2021, no 38639; Cass 14 May 2018, no 11609.

[23] The sad reality of residential care practiced by the great institutions of the past has been studied, among others, by M Foucault, Sorvegliare e punire (Torino, 2005); see also V Paglia, Storia dei poveri in occidente, (Milano, 1994).

administrative judge ascertained on the basis of the imbalance between the market price of a lease and the much larger consideration paid overall by the guests of a rest home informally established in a large flat in the Roman hinterland[24].

The decision concerned a group of elderly people 'all suffering from various pathologies and only partially self-sufficient' with whom the president of a cooperative had entered into a lease agreement. The agreement allowed each person the use of a single room and the common parts of the building (hall, kitchen, garden), for the consideration of the sum of €1,200.00 per month, including the costs of food and continuous assistance. Following the closure of the facility because it was classified by the municipality as an unauthorised rest home, a leaseholder lodged an appeal claiming that it was solidarity cohousing.

The decisive argument for the rejection of the appeal was the evident disproportion between the amount paid by the woman for renting the flat (€10,800 per year) and the monthly fees of €1,200.00 charged to each of the five guests of the facility. Disproportion, the judges noted, 'dictated precisely by the circumstance that the payment of the price by the guests of the residence corresponds […] not only to the mere division of the general rental costs among them, but also to the provision (or disbursement when necessary) of welfare services typical of the qualifications of the stipulating party'.

Having grasped the essence of the case, the judges, however, advanced obiter dicta that are not entirely accurate, including the statement according to which the true hypothesis of co-housing would be typified 'by the full voluntariness of shared housing, in a condition of full self-sufficiency and without the intermediation of third parties external to said experience'. As has already been observed, in fact, not even the capacity to act constitutes an indefatigable element of participation in co-housing where the decision taken in this regard by the legal representative does not conflict with his genuine aspirations and wellbeing. This therefore also applies in the case of the non-self-sufficient person, although this category does not overlap with that of the incapacitated person.

The exclusion of the possibility of any 'intermediation by third parties' is also ambiguous. This exclusion seems to be shared only if the intermediation realises an economic interest of third parties within the overall legal-economic transaction. Arguably, this exclusion, vice versa, should not concern the economically disinterested contribution of a third party supporter or facilitator, who in this way implements a policy of support for co-housing also by helping in the daily management of shared living. The judges observe that there is no 'cohousing' 'when the residence of the elderly is intended in whole or in part to allow the provision of assistance and support services (falling within personal services and as such subject to the requirements specifically provided for the protection of users, in the case in point, by L.R. Lazio no. 41 of 2003) by third parties, on whom the organisation of the environment depends (even partially)'.

However, it may be observed that a hospitality contract accompanied by such services is one thing, while it is quite another if the cohabitees require (from the outset or subsequently) services that can be abstractly ascribed to those also provided in residential social and health care facilities, but also provided as part of public home care. The latter can be supplemented with private law contracts by the individual participants in a cohabitation, just as they would be by any other private individual residing in their own home.

Finally, it is interesting to note the argument with which the judges agree with the appellant that the order for immediate eviction of the flat is unlawful. However, it is possible to doubt that the latter benefited from it. Indeed, the court observes that the elderly, freed from the contractual conditions of the disguised hotel accommodation, remain holders of the right of personal enjoyment of the property on the basis of 'adequate negotiated title'. This, however, could only result in the same rental relationship brought under the law.

It is therefore necessary to distinguish the activity of supporting free choices of private residential living from the commercial or institutional offer of residential assistance, repressing possible abuses but also encouraging empowerment processes wisely accompanied and supported by the social actors operating in the area.

Being able to choose supportive cohabitation instead of residential care in a hetero-managed facility means not only opting for two undoubtedly very different solutions, but also giving oneself a real possibility of choice when the next step in dependence on others will no longer make it feasible for those who find themselves alone to continue living independently in their own homes.

[24] TAR Lazio, II, 3 February 2022, no 1286.

It is well known that very often the elderly person enters a residential care facility without having planned or wanted such a solution at all. For example, after hospitalisation, when a patient has to be discharged and his condition does not allow him to be returned to his home without assistance or company. In such cases, where home care is inadequate, only the pre-existence of a situation of cohabitation can prevent the otherwise obligatory and often irreversible 'non-choice' of institutionalisation[25].

5. Whether Joint Residence Must be Declared in A.N.P.R.

If the fact taken into consideration by the jurist is that of a common life, the cohabitation effect in terms of civil registration law can only be that of the obligation of the civil registration of residence at the address of the shared home. The question arises, however, as to whether the cohabitees must be recorded in the registry office of the resident population (A.N.P.R.) as members of a single registered family or whether they must form several registered families at the same address, thus reflecting the marital status of each.

It is necessary in this regard to consider the different technicalisation of the term 'cohabitation' in registry law compared to private law in Italy. For private law, cohabitees are undoubtedly persons living together on the basis of an affective or family relationship. On the other hand, under Articles 4 and 5 of the Registry Regulations, the cohabitation of persons bound by affective ties (both before and after the Cirinnà law) is considered a 'registry family', but so are cohabitations between relatives of any degree and line, while several persons cohabiting at the same address without affective or family ties form a cohabitation of several households.

According to a first line of interpretation, which undoubtedly conforms to the letter of the aforementioned Article 4, Presidential Decree No 223/1989, cohabitation in solidarity, characterised by the bond of friendship and affection that binds its members, would seem to constitute a 'registry family' on par with cohabitation between spouses, couples and relatives.

However, a different interpretation seems more plausible, one that is also compatible with the letter of the law, according to which Article 4 would have applied to two different sets of persons: spouses and relatives on the one hand and de facto couples on the other. The former united by family ties, while the latter united by the affectio that characterises unmarried couples.

If the first interpretation were to prevail, registration as members of a single family would become the *condicio sine qua non* to be able to recognise the external legal effects of cohabitation, excluding cohabitations (or cohabitants) who have not declared such affective ties as qualifying as mere cohabitants (i.e. as cohabitants of distinct unipersonal registered families).

There would then be a further problem concerning cohabiting households consisting of only two members. In fact, if they declare at the registry office that they are bound by emotional ties, they would automatically be considered there as de facto cohabitations under the Cirinnà law, even if they did not want to be, although they may contradict this in writings that this.

If, on the other hand, the second interpretation were to prevail, the emergence of cohabitation in solidarity for the purposes of its legal relevance (i.e. its distinction from the registry cohabitation of several unipersonal families) would be left entirely to the further ability of the interested parties to prove it[26].

6. Spontaneity of Cohabitation and Private Autonomy

Until Law No 76 of 2016, the subject of cohabitations not characterised by sexual integration between the two partners was frequently associated with claims for the recognition of de facto families. At times they were included in the debate on the becoming of the family archipelago in order to juxtapose them and thus make them functional to the promotion of sexual relationships exorbitant with respect to the couple relationship, making them a single but polyhedral pantheon together with religious communities, siblings and polyamorous relationships[27].

[25] It seems significant that there were 255,000 elderly people in residential care facilities in Italy (over 65 years old); of which 202,174 were non-self-sufficient, accounting for 14/1000 of the total elderly.

[26] But the requirement to reside at the same address remains firm.

[27] MR Marella, 'Il diritto di famiglia fra status e contratto: il caso delle convivenze non fondate sul matrimonio', in Stare insieme (Jovene, 2001) 3ff; L D'Adamo, 1649ff. On polyamorous families see MR Marella, 'Poligamia. Un problema per il diritto occidentale', in S Marchetti, J Mascat and V

Following the Cirinnà Law, the theme of cohabitations not characterised by sexual integration seems to be more easily detached from the reflections on family law, to which it would be erroneous to refer them and from which, however, it is inevitable to borrow certain acquisitions, such as that relating to cohabitation contracts.

Over a long period of time, doctrine and jurisprudence have progressively focused on atypical cohabitation contracts, which were then typified by Law No 76 of 2016. Interpreters have then had occasion to clarify that said typification has not cancelled the right to enter into atypical contracts in the presence of unregistered cohabitations, insofar as they are valid under Article 1322, paragraph 2, of the Italian Civil Code[28]. But it seems that the same requirement of merits characterises contracts stipulated to regulate relations between the members of solidarity cohabitations. Moreover, the realisation of that form of implementation of the right to life that today is programmatically promoted under the name of housing or social co-housing[29].

Far from being mere motives, which have no impact as such on the level of legal regulation, these perspectives, precisely because they are shared, must instead be adequately reflected in the contractual disciplines, conforming their content. They should be prudently taken into consideration, if they express shared needs and therefore characterise the social category to which they belong, also at the legislative level, that is, at the level of the legal effects of public law of the case in point 'cohabitation'.

By way of example, three young students may simply remain co-owners of a lease agreement for study purposes, or rather give rise to partial subletting, without conferring any significance in itself on their temporary and very provisional cohabitation. And this is in fact what normally happens, keeping one's residence elsewhere and thus without giving form to any joint cohabitation.

On the other hand, an elderly person who does not want to end his days in an institution will have to pay far greater attention to the terms of cohabitation, in particular in making his home available to the people with whom he decides to cohabit, and so will his guest cohabitees. This explains, in this case, the usefulness of effectively and formally emphasising the cause of cohabitation by recognising a single contract all or most of the regulatory needs arising from such cohabitation instead of artificially separating them from each other by accommodating them in different types of contract and thus opacifying their overall balance or imbalance with respect to the purpose jointly pursued by the cohabitees.

The vastness of the instruments that can be combined in the exercise of private autonomy and the variety of particular situations do not permit an analytical approach to the clauses serving the individual cohabitation, even if limited to mutual aid cohabitation.

The contract may not commit the parties to establishing and maintaining a cohabitation relationship between them, but may, on the assumption of such a relationship, give rise to a series of legally relevant commitments, including possible end-of-contract allocations and possibly the brief unfolding of a solidarity immediately following the cessation of cohabitation[30].

The two different spheres of family and solidarity cohabitation, however, are by no means assimilable to each other. The former, in fact, bases the private autonomy concerning it on the by now solid lawfulness and merits of the family cause, while the fact that the agreements between cohabitees in solidarity cannot be traced back to the family cause has made its configuration, and therefore its enforcement, more awkward since the solidarity of the cohabitees is much less obvious and necessary than family solidarity.

Hence the even greater usefulness for solidarity cohabitations of the parameter of the

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Perilli, Femministe a parole. Grovigli da districare (Ediesse, 2012) 215ff; E Grande, 'Il poliamore, i diritti e il diritto', (2018) The cardozo Electronic Law Bulletin, 1ff; M Di Masi, 'Sull'istituzionalizzazione del poliamore' (2019) Riv crit dir priv, 145ff.

[28] See G Villa, 'Il contratto di convivenza nella legge sulle unioni civili' (2016) Riv dir civ, 1319ff.

[29] See L Balestra, 'Contratto di convivenza', in Enc. Dir., (Annali, X, Giuffrè, 2017) 299; G Villa 'Il contratto di convivenza nella legge sulle unioni civili' (2016) Riv dir civ, 1335 ss. Contra, R Senigaglia, 'Convivenza more uxorio e contratto' (2015) Nuova giur civ comm, II, 682, secondo il quale al di fuori della convivenza more uxorio non si può parlare di contratto di convivenza ma di singoli profili patrimoniali regolabili con gli opportuni strumenti contrattuali di diritto privato comune.

[30] FD Busnelli, 'Sui criteri di determinazione della disciplina normativa della famiglia di fatto', in La famiglia di fatto, Atti del Convegno di Pontremoli (Luigi Tarantola Editore, 1977) 135.

adequacy of the planned effects with respect to the cohabitation established and the function it is called upon to perform in responding to the interests of its members[31]. In this sense, it would be difficult to justify a clause constituting a communal patrimonial regime of purchases, albeit with effect only between the parties, or a regime of joint and several liability for debts contracted separately, even with regard to goods intended for the cohabitation, unless within the confines of daily expenses. Whether two sisters or four friends, there is no reason to apply rules and logic outside the family that have been created exclusively for it.

Moreover, the criterion of proportionality is also used by interpreters to assess the attributions made during cohabitation, leading to their qualification as the fulfilment of natural obligations based on a qualified solidaristic reason or as liberal attributions, valid or invalid depending on their concrete character and the form used[32]. Similarly, it is still by exercising a control of proportionality that in the sphere of cohabitations in solidarity the possibility of the non-repetition of the attribution made to the cohabitee on the figure of liberality of use is played out[33]. It is, however, essential that the agreement between the cohabitees clearly states the services to which each is bound, even though they may not include the entirety of the services and conduct reasonably expected in the course of cohabitation on the part of each.

The deduction in the agreement of civil obligations will, however, 'also be relevant from the point of view of the seriousness of the commitment, i.e. for the purpose of recognising a legal intent'[34]. This does not preclude the fact that a large space remains free and thus available for attributions not envisaged in the agreement and often deformalised, such as the donation of modest value and sometimes gifts of use, or to sources of obligation other than contracts, which end up playing an inevitably inadequate substitute function with respect to a legal or negotiated regulation of the relationship that has proved to be unforeseeable. The reference is, in particular, to unjust enrichment and performance of the natural obligation[35].

The adequacy of the contract, in this regard, should not be assessed in the abstract but in relation to the situation in concrete terms that arose by establishing cohabitation. Consider, for example, the recognition of the value of domestic work or care work that one of the cohabitees might find himself performing to a greater extent than the other members of the cohabitation. In such a case, contractual provision for compensation, obviously outside an employment relationship, would seem appropriate, in order to avoid the uncertainties and time-consuming action for unjust enrichment.

From the point of view of the daily conduct and non-pecuniary interests of the cohabitees, the contract could not in any way restrict their freedom, obviously without this implying that the normal conduct of life in common could be compromised.

This is a typological trait that certainly distinguishes cohabitation from hospitality in a shelter, which is necessarily regulated, for example, with regard to entry and exit times and visiting hours. If on the one hand the lifestyle cannot but remain free and spontaneous, on the other hand it will still be the subject of daily negotiation, which in itself is legally irrelevant but which may lead to the decision to withdraw ad nutum, and thus silently motivated by the failure of that same negotiation in the daily life of cohabitation.

7. Possible Contents of a Light Private Autonomy

There is no doubt as to the appropriateness of providing, in connection with joint cohabitation, clauses concerning the right to enjoyment of the shared dwelling. There are many possible scenarios, from hospitality in the home owned by one of the cohabitees to the conclusion of a lease in which all or only some of the cohabitees are listed as tenants. Consequently, there are also many possible agreements on the maintenance of the property and its possible future abandonment or release.

Also in this regard, as for the other common expenses, the preferable option seems to be that of a well delimited participation in the expenses

[31] R Senigaglia, Convivenza, 673ff.

[32] See AM Bernardini De Pace, 'Convivenza e famiglia di fatto. Ricognizione del tema nella dottrina e nella giurisprudenza', in E Moscati, A Zoppini (eds) I contratti, 311.

[33] See F Carimini, 'Contratti gratuiti e liberalità non donative' (2021) Dir succ fam, 27ff.

[34] E Del Prato, 978.

[35] See G Oberto, 'I rapporti patrimoniali nelle unioni civili e nelle convivenze di fatto', in La nuova regolamentazione delle unioni civili e delle convivenze. Legge 20 maggio 2016, n. 76 (Giappichelli, 2016) 11ff; P Vercellone, 17. Significantly, Cass. 25 January 2016, no 1266.

and consisting of a fixed periodical contribution, not necessarily equal for each of the cohabitees and naturally subject to a rebus sic stantibus clause, albeit on the basis of objective contingencies[36]. The differentiation of contribution quotas can be broadly justified by respect for the principle of solidarity within the social formation, implying the need to maintain a criterion relating to the contribution capacities of each party[37].

The question of the duration – and hence the certainty – of the right to enjoy the common dwelling in the event of a break in cohabitation, as a result of which the exiting cohabitee, if a partial borrower of the property, would only be entitled, to the time of a reasonable notice according to the rules of good faith regarding the date of actual release of the property[38].

Any lease of real estate is undoubtedly configured with a term, which would coincide with the breaking of the cohabitation relationship[39]. However, even if the lease were prior to the cohabitation or in any case external to the cohabitation contract, the formation or changing of the personal relationships between subjects who may already have been cohabiting would give new meaning to the lease itself. This would be the case even if it was originally configured as precarious and without a term, pursuant to art. 1810 of the Civil Code (which provides for the possibility of a new term for the cohabitation contract), would be considered a 'lease'.

The termination of the cohabitation could in theory also be construed as a termination condition of the lease with a different term, a condition formally imposed on the leasee or even the usufructuary and more appropriate where this termination event is configured in strictly objective terms[40].

Clauses of this kind protect the person or persons who own the property or who continue to enjoy it in common with others, but may instead put the person leaving or who is subject to another person's decision to end cohabitation in serious difficulty. An albeit partial solution to the possible difficulties of those who leave the cohabitation could be constituted by the provision in the cohabitation contract of an economic contribution that ends within a period suitably proportionate to the duration of the individual beneficiary's participation in the cohabitation.

Such a provision can certainly be justified if it binds the parties with whom the creditor has entered into the cohabitation agreement at the time, while it is perplexing with regard to the cohabitees who have entered into the cohabitation agreement after that agreement, who will then have entered into an independent and subsequent cohabitation agreement. The risk to be avoided is in fact that of burdening newly-arrived cohabitees with a reasonable obligation only in respect of those who have cohabited with the departing party, either as joint debtors or in proportion to the period of their actual cohabitation with the departing party.

Without prejudice to the right of idiosyncratic reconsideration and therefore abandonment of cohabitation, with consequent withdrawal *ad nutum* also from the cohabitation contract[41], the only obligation that could be contractually imposed on the former cohabitee, without resulting in the prohibition of restricting his personal freedom, could derive from the need to protect the essential needs of the former cohabitees, whose protection certainly cannot be analogous to that of one of the family members referred to in Article 433. This is true, not even, *tout court,* where identical to that of the partner in the *de facto* family, but is delimited by the possible emergence of obligations of good faith and duties of protection, which could take on a particular depth at certain junctures owing to the possible fragility of the members of the cohabiting couple from whom one intends to leave.

In the aforementioned draft laws a term of three months is indicated to be granted to the cohabitee leaving the cohabitation. However, it

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[36] As noted by R Amagliani, 'I contratti di convivenza nella l. 20 maggio 2016, n. 76 (c.d. legge Cirinnà)' (2018) I contratti, 317.

[37] In analogy to cohabitation. See A Torroni, 'La convivenza di fatto ed il contratto di convivenza: disciplina legislativa e ricorso all'autonomia privata' (2020) Riv not, 666 and 673ff.

[38] Cass 27 April 2017 no 10377. G Oberto, 'La famiglia di fatto. Introduzione alla "riforma Cirinnà"' (2019) Dir fam pers, 739ff.

[39] Similarly to what would apply in the case of a de facto cohabitation within the family. See Cass 30 October 2018, no 27437; Cass 10 February 2017, no 3553, in Nuova giur civ comm, 2017, I, 911ff., with a note by A Salomoni, 'La clausola "fino al reperimento di altra abitazione" apposta in un comodato di immobile ad uso familiare'.

[40] On the use of the condition in order to give causal significance to cohabitation see E Del Prato, 976 ff and G Villa, 1332 ff.

[41] A Fusaro, 126; M Franzoni, 'Le convenzioni patrimoniali tra conviventi more uxorio', in G Bonilini, G Cattaneo (eds) Il diritto di famiglia, II (1997) 470ff.

does not seem that this clause ensures the best possible balance. On the one hand, the immediate removal of the cohabitee is inexcusable, since the return of a dwelling is quite different from the return of any other object that is useful but not indispensable and not difficult to obtain, as is the dwelling[42]. This is the case so that the same effect of a statutory clause or even of a negotiation clause providing for a short term (e.g. three months) for the release of the portion of the property could also tend to be obtained by invoking the principle of good faith that renders inexcusable a truly immediate restitution with respect to the bailor's request, at the expiry of an uncertain term, or at the reversal of the termination condition. On the other hand, the granting of a grace period of three months, whether of legal or conventional origin, would expose cohabitees wishing to continue living together under the same roof to the non-trivial risks and burdens arising from the continuation of a cohabitation that may have broken down even for serious reasons or in any case with serious consequences at the interpersonal level. This problem is very possible in cases of partial lease.

It would then be much more useful, relying on the principle of good faith to determine the time limits of the 'immediate release', to provide in the cohabitation contract that, in the event of the actual release of the accommodation at the time of the request, the former cohabitee shall be entitled, to housing assistance appropriate to his/her basic needs (in pecuniary form or in a specific form) for at least three months.

8. Interference in the Execution of the Contract by the Third-Party Supporters of Cohabitation

The contractual dimension of joint and several cohabitation leads the interpreter to imagine the contracting parties all placed on the same level of equal autonomy and capacity to act. This abstract representation, which is not infrequently already contradicted from the very beginning of cohabitation, is however destined to progressively change with the aging of the cohabitees and/or the worsening of their disabilities.

It happens in fact that the cohabitees' physical and psychological frailty finds support in the intervention of third-party facilitators, who are sometimes the actual promoters of cohabitation. The hypothesis that underlies this article is, in particular, that of the actual promotion of cohabitation by a body operating in the territory, whose capacity to influence it could in fact be decisive on the fate of the cohabitation itself.

The organisation could, for example, be the owner of the common dwelling, granted in qualified custody to the cohabitees; the latter could, on the other hand, have come to know each other on the initiative of the organization or the latter could be the manager, on the order of the settlor, of a family patrimony destined for the needs of one of the cohabitees and have an interest in the cohabitation functioning in the best way possible in the interests of the other cohabitees, as well as of the person in whose interests the patrimony has been destined[43].

There may also be no trace in the cohabitation contract of the role actually played by the sponsoring organisation. The institution in fact supports the individual wills but neither annuls nor replaces them, and they are the only remaining source of legal effects. Rather, the third-party patron will possibly appear in related contracts, such as one having as its object the possession of residential property or, in certain circumstances, assistance to individual cohabitees.

It will be the scrutiny of the legal-economic transaction as a whole that will tell us whether the agency is not in fact the manager of a residential facility with certain social welfare features. But the gratuitousness of the intermediation carried out by the agency between the cohabitees and the providers used from time to time, as well as the gratuitousness of the services provided directly to the cohabitees, excludes this possibility.

Lastly, account must be taken of the hypothesis that has emerged in the doctrine of the participation of cohabitees in forms of association such as to put in place a distinct but connected legal subjectivity, useful for a multiplicity of purposes, one of which is identified in the need to ensure, through the associative screen, the objective of common ownership of the goods acquired during cohabitation[44].

If this alone were the objective, the legal person created for this purpose would undoubtedly be overabundant and, in some respects,

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[42] See D Farace, 'Durata del comodato ed esigibilità dell'obbligazione restitutoria' (2021) Giust civ, 883.

[43] Hints regarding the use of art 2645-ter c.c. in G Oberto, 'I contratti di convivenza', in M Sesta (ed) Codice dell'unione civile e delle convivenze (Giuffrè, 2017, 1398ff.

[44] E Del Prato, 963.

abused. Rather, the question is whether the non-profit association model can find a place in the support activities of several interconnected cohabitations, since the same cohabitants can be included among the members. The breadth of services that the association thus created could provide to the cohabitee(s) of the elderly associated with it could be the most varied, even including specialised nursing care or whatever else could ensure that each member of the cohabitee could remain there in the fullness of years.

The mutual-solidarity purpose of the association could well justify both free and paid services. But in the case of free or subsidised services, funding from third parties, public or private, would also be justifiable. Therefore, it is not the solidarity cohabitation established at a specific private address on a negotiated basis that will be financially supported, but a project of the association in favour of the elderly population that organises itself to live at home instead of in a residential care facility.

With regard to the relations of the cohabitation with the generality of its suppliers, the 'light' negotiating link between the various members of the cohabitation and between them and the association that supports them or of which they are members makes it possible, according to the different needs and circumstances, to refer the services provided by the individual supplier to the individual guest (or guests in agreement with each other) or to the association, charging the former or the latter with the relative relationship and the consequent costs.

9. The Right to Inhabit and the External Effects of the Cohabitation Relationship

From the fact in itself that two or more persons enter into a stable bond of moral and material support, there follows a series of effects that we can define as 'external' since they determine the recognition of the relationship by subjects that, with respect to it, can be qualified as third parties[45]. The occurrence of all of these effects is fragmented in the different areas of the legal system and has therefore been investigated not only in civil law, but also under criminal[46] and administrative profiles, as well as in the law of public welfare and assistance[47].

Although solidary cohabitation constitutes a domestic home shared intimately by its members, this article asserts that it would nevertheless be unfeasible, even in the sphere of housing rights, as a general assimilation to the de facto family of solidary cohabitation.

As is well known, Paragraph 42 of Law no 76/2016 provides, in the event of the 'death of the owner of the house of common residence', that the surviving de facto cohabitee has the right to continue living there for two years or for a period equal to the cohabitation if longer than two years and in any case not longer than five years. Moreover, 'if the surviving cohabitee has minor children or disabled children, the surviving cohabitee is entitled to continue living in the house of common residence for a period of not less than three years'[48].

The rule is not suited to an analogical application to cohabitations in solidarity, but it could serve as a comparison for a not too distant discipline that would apply to cohabitations other than those of a couple, introducing a minimum term for the duration of the right to remain in the dwelling of the surviving cohabitees of the owner of the property; a period that could be fixed in proportion to the duration of the cohabitation and in any case not longer than twelve months, unless otherwise agreed with the new owner of the property[49].

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[45] P Vercellone, 8.

[46] D Falcinelli, 'Elogio dell'inesigibilità. Le scusanti come metodo di scrittura costituzionale dell'illecito penale' (2021) Riv it dir proc pen, 2021, 895ff regarding the need for criminal law to consider more the subject's membership in non-parental or couple forms of cohabitation.

[47] Useful insights in M Aimo, M Consito, S Gianoncelli, J Long, 'Essere famiglia per il diritto: riflessioni interdisciplinari' (2018) Lav Dir, 697. About Const Court 23 September 2016, no 213, see A Cordiano, 'Una nuova pronuncia di incostituzionalilità della l. n. 104/1992: i confini evanescenti della convivenza di fatto non registrata' (2017) Riv it dir lav, II, 152; G Zampini, 'Conviventi e diritto al permesso mensile retribuito' (2017) Lav Giur, 30.

[48] See P Scalettaris, 'Le previsioni dei commi 42 e 43 della L. n. 76 del 2016 in tema di convivenza di fatto ed i loro rapporti con la disciplina del condominio' (2017) Riv giur edilizia, 43ff; M Venuti, 'I diritti successori della persona unita civilmente e del convivente di fatto: un confronto con il sistema tedesco' (2017) Eur dir priv, 1241.

[49] In this regard, the Petraglia ddl, no 909/2013, provided in art 19-terdecies, par 2, that, unless otherwise agreed, in the event of the death of the party owning the house referred to in paragraph 1, the other parties to the mutual aid union shall be

Instead, within the framework of the law in force, the acquisitions of the living law may be applied, at least in part, whereby the partner in the de facto couple is a qualified holder and not simply a guest in the dwelling shared by the couple, with relevant useful effects in terms of possessory protection and also, in the case of the death of the cohabitee, with regard to the application of the principle of good faith in the execution of the obligation to release the property by the occupant former holder who has become untitled[50].

10. The Intangibility of Joint Cohabitation by the Condominium

A brief mention has already been made as to the possibility that condominium by-laws may place limitations on the enjoyment of the exclusive property by the owner/shareholder, obviously involving such limitation also for any tenants. In particular, a clause prohibiting, or subjecting to condominium authorisation, the exercise of 'industries, professions, workshops, trades, arts and crafts' is commonplace in such by-laws. In this regard, the Supreme Collegium has repeatedly confirmed that the scope of trade and commerce also includes the business activity of accommodating the elderly in one or more flats, regardless of the fact that nursing homes for the elderly must meet the same requirements as civil dwellings[51].

In this regard, it may be observed that the use of a dwelling by several persons bound to each other by bonds of friendship and wishing to lead a life in common is not configurable as the exercise of a residential care activity, that is, as a rest home. Consequently, cohabitation in solidarity constitutes neither a commercial nor an industrial activity, which can therefore be included among the prohibitions of the abovementioned customary use clause in the contractual condominium regulations.

Above all, however, since it pertains to the sphere of the existential freedom and domicile of the cohabitees, it is not among the activities that the condominium rules may prevent, with the consequent nullity of the condominium clause providing for it. If it is in fact common ground that such regulations may produce limitations of the individual right of ownership[52], it is also true that this may take place within the counter limit of respect for the fundamental rights of the individual[53]. In fact, such a prohibition would contrast with the principle of solidarity and the principle of self-determination, both of which are coessential to the need for the development of the personality, since cohabitation itself is one of the social formations referred to in Article 2 of the Constitution.

The Civil Code itself, moreover, seems to suggest an unavoidable counterbalance to the breadth of the legal scheme of the voluntary servitude[54], so wide as to give rise to a figure of real right that is typical on a procedural level but actually atypical as to its possible contents. This counterbalance consists in the requirement of utility for the dominant fund, required by Article 1027 of the Civil Code as a legal condition for the affixing of the real bond on the servient fund[55]. And it is in fact difficult to consider that, in the case of a possible prohibition to use a flat as a dwelling for the cohabitees, an objective utility, or even a deserving non-pecuniary interest, can be recognised on the part of the servient estate[56].

Finally, if we consider the intended use of the residential property as an objective characteristic of the property and put this in relation to the owner's concrete possibility of using it according to his aptitudes and capacities it could be doubted that such a clause is respectful

granted a period of not less than six months from the death of the owner, to abandon the same house.

[50] Cass. 27 April 2017, no 10377, in Resp civ e prev, 2017, 1854ff, with comment by S Pardini, 'Il diritto del convivente superstite a continuare ad abitare nella casa familiare dopo il decesso del partner proprietario: un diritto in cerca di identità'; Trib. Roma, V civ., 9 April 2018, no 7292.

[51] Cass., 6 December 2021, no 38639; Cass. 14 May 2018, no 11609.

[52] See Cass 15 April 1999, no 3749.

[53] On the intangibility of fundamental rights by the condominium see FG Viterbo, 'Bisogni primari della persona e disciplina condominiale dopo la l. n. 220 del 2012' (2014) Rass dir civ, 1260ff.

[54] G Branca, 'Comunione. Condominio negli edifici', in Commentario Scialoja-Branca (Zanichelli-Foro it, 1982) 681.

[55] On the requirement of utility in condominium easements, see GW Romagno, 'Osservazioni riguardo all'efficacia delle disposizioni dei regolamenti condominiali. Il decoro dell'edificio come condizione di esplicazione della dignità umana' (2019) Giust civ 796.

[56] A Trotta, 'Interpretazione del regolamento condomi-niale: sul vincolo di destinazione' (2015) Giur it, 809ff; M Dogliotti, 'Comunione e condominio', in R Sacco, Trattato di diritto civile, I (Utet, 2006) 440.

of the essential content of the individual property right, as it merely places limits on his free enjoyment[57].

11. Solidary Cohabitation and Covenant Contrary to Subletting Even a Part of the Property

Article 2, Law No. 392 of 1978, in its current wording, provides that the tenant, unless otherwise agreed, 'shall be entitled to sublet the property in part, subject to prior notice to the landlord', whereas total subletting, which would in effect distort the type of tenancy agreement for residential use, is certainly prohibited. It is well known that it has become a general practice among landlords to include a covenant to the contrary in the contract, sometimes unlawfully extending it to prohibiting the tenant's own family members from permanently lodging in the tenant's home[58]. It is therefore necessary to question the lawfulness of a covenant to the contrary prohibiting not only partial subletting but also partial loan to third parties in the dwelling rented by the host and in fact inhabited by the latter.

This is clearly a different hypothesis from the one in respect of which the law authorises the conclusion of agreements to the contrary, since the aforementioned art. 2, referring to subletting, covers only the assignment, in return for a fee, of rights of use of a portion of the property. The jurisprudence according to which a clause prohibiting the 'non-temporary hospitality of persons not belonging to the registered family unit' is to be considered null and void insofar as it contrasts 'with the fulfilment of the duties of solidarity that may be manifested through hospitality offered to meet the difficulties of others, as well as with the protection of relations both within the family founded on marriage and of a de facto cohabitation protected as a social formation, or with the expression of friendly relations'[59].

The burden of proof in this regard, however, is governed by Article 21, Law No. 253 of 1950, according to which the existence of subletting is presumed when the property is occupied by persons who are not in the tenant's service or who are not related to the tenant by ties of kinship or affinity up to the fourth degree, unless they are guests of a transitory nature[60].

It is therefore up to the tenant to prove that there is no prohibited subletting in this case; this proof may be provided by producing the cohabitation contract of certain date.

12. The Subrogation of the Rights of the Solidarity Cohabitee to the Dwelling

To what extent are the rights of subrogation of de facto family members extended to joint partners? Excluding a general equivalence between the two communities of life, however, it would appear that certain institutions are reasonably extensible to joint and several cohabitees. Among these is the succession of cohabitees in the lease contract in the event of the tenant's death or withdrawal[61], now provided for by Paragraph 44 of Law no 76/2016[62]. The rationale underlying both Paragraph 44 of Law no76/2016 and Article 6(1) of Law no 392/1978 was indicated by two judgments of the Italian Constitutional Court which, with regard to the second of the aforementioned provisions, emphasised its function in the reversal of the 'collective duty to prevent people from being deprived of their homes'[63]. In particular, the judge of laws noted how the legislature, by widening the categories of successors, had not intended to protect the nuclear family (de jure or de facto) nor the parental one, 'but the cohabitation of an aggregate extended to include strangers, relatives without limits of degree and even kindred'. The purpose of the rule is – according to the Consulta – 'to prevent anyone being left homeless'; a purpose specified in the protection of the right to remain in the home of a potentially large number of persons habitually cohabiting. Considering the considerations made at the time by the Giudice delle leggi in relation to the changed legal and social framework of today, it would

[57] M De Tilla, 'Sulle limitazioni del regolamento contrattuale di condominio: servitù prediali ed oneri reali' (2000) Giust civ, I, 171; G Musolino, 'Natura e vincolatività del regolamento di condominio' (2000) Riv notar, 939.

[58] App Firenze, II, 3 May 2012.

[59] Cass,18 June 2012, no 9931, in Arch locazioni 2012, 6, 681; Cass, 19 June 2009, no 14343.

[60] Cass, 10 May 2018, no 11242; Trib. Latina, II, 4 February 2020, no 260.

[61] C Coppola, 'La successione del convivente more uxorio', in Bonilini (ed) Il diritto delle successioni, (Utet, 2004) 385ff; FD Busnelli, M Santilli, 'La famiglia di fatto', in G Cian, G Oppo and A Trabucchi (eds) Commentario al diritto italiano della famiglia, VI, (Cedam, 1992) 789ff.

[62] F Mastroberardino, 'Il diritto di godimento, della casa di comune abitazione locata dall'altro convivente, alla luce della l. n. 76/2016' (2017) Fam dir, 396ff.

[63] Const Court, 7 April 1988, no 404.

seem that the application of Article 6 of Law no 392/1978 to cohabitees in solidarity, especially if they have entered into a cohabitation contract with a certain date and have established their legal residence in the common dwelling, thus certifying the habitual nature of cohabitation, is part of the duty of a constitutionally oriented interpretation.

On the other hand, the opposite solution should be reached where the equating of cohabitations in solidarity with cohabitations between family members would lead to the definitive or very long-term acquisition or assignment of the dwelling property already belonging to the cohabitee, as in the case of the succession of the *more uxorio* cohabitee in the position of the assignee of a housing cooperative or social housing estate. In these cases, the disciplines of the sector stipulate that succession in the event of death is possible in favour of the spouse, children, cohabitee *more uxorio*, relatives-in-law and other members of the family nucleus made up of members who have been registered in the registry family for a certain period. But hindering the extension of succession to cohabitees in solidarity is, in the face of the particular depth of the benefit, the need to preserve the public logic of the allocation of housing property on the basis of the needs of the resident population[64].

13. Solidarity Cohabitation and Senior Cohousing in the Legislation (Hoping for Legislative Decrees as per Law no. 33 of 23 March 2023)

The legislature's recognition of supportive co-housing is essentially expressed in a series of support measures, with particular regard to the availability of housing in which to implement supportive co-housing, either through the mutual aid initiative or with the support of public or private welfare actors.

In this regard, great expectations were aroused by the recent enabling act, 23 March 2023, no. 33, on policies in favour of the elderly, which in Article 2, paragraph 2, sets as one of the general principles and guidelines to be followed by the government in implementing the enabling act the 'promotion of community living services and home co-housing (cohousing), prescribing then in the subsequent Article 3, paragraph 2, no. 6, the objective of 'promoting, also through mechanisms of urban regeneration and reuse of the built heritage, implemented on the basis of regional or municipal planning or programming acts and of adequate design, new forms of solidarity-based home living and co-housing for the elderly (senior cohousing) and intergenerational co-housing, in particular with young people in disadvantaged conditions (intergenerational cohousing), to be implemented, according to criteria of sustainable mobility and accessibility, in the context of houses, family-homes, family groups, flat groups and solidarity condominiums, open to family members, volunteers and external providers of supplementary health, social and sociomedical services'.

Clearly, this is an ambitious programme, aimed both at the creativity of supportive civil society and the beneficiaries of these policies themselves, and at the welfare and social-health entrepreneurship. The latter, in fact, should reconvert their offer of assistance by making residential care effectively temporary instead developing territorial networks of home rehabilitation and social-health assistance through the human and professional resources at their disposal.

It should be noted how, until now, although lacking a discipline dedicated to it in Italy, supportive cohabitation has nevertheless emerged as a figure, albeit laterally and fleetingly considered by the regulations in force, precisely by positioning itself in disciplinary areas such as social housing and assistance, as in the case of Article 4, Law no. 112 of 22 June 2016, which provides for the establishment of a fund for interventions in favour of residency 'supporting forms of mutual aid between persons with disabilities'.

At the regional level, the new Article 12-*bis* of Lazio Regional Law no. 12 of 6 August 1999 (on public residential housing) aims to remedy the underutilisation of the housing units under assignment, which are often characterised by a larger surface area than necessary. The rule provides that the managing body may authorise the assignee of the e.r.p. accommodation to share it with a non-assignee if he/she can prove: a) that he/she is in a 'proven situation of socio-economic fragility or non-self-sufficiency', or b) that he/she is in a situation of 'need of material and moral assistance' as a person suffering from 'psychophysical handicaps or psychiatric disorders' or as an elderly person in a particular socio-economic situation or 'at risk of social isolation'[65].

[64] Cass, 13 October 2016, no 20634.

[65] The rule was added by art 7, par 73, of Regional Law December 27, 2019, no 28.

Without prejudice to the right of the members of the assignee's family unit to take over the housing assignment, the law provides that 'in the event of the death or forfeiture of the assignee during the course of the cohabitation, the person or persons cohabiting with him/her for at least four years, after verifying the existence of the subjective requirements and the criteria established for the assignment of housing e. r.p.', may take the place of the cohabitee already assigned if, within thirty days of the latter's death or disqualification, they submit 'a request for authorisation of a new supportive cohabitation in accordance with this article, failing which the competent managing body shall initiate the procedures for the release of the accommodation'.

This rule was shortly preceded by a legislative innovation ordered to the same end, through the addition in 2018 of a homologous Art. 12-*bis* to the Lazio regional law of 3 September 2002, no. 30 on public residential housing, which to date provides that 'ATER shall provide for the voluntary mobility of those households living in underutilised housing units by offering alternative solutions, in particular for the elderly alone, also in cohousing'. And to this end, in terms of management, the following paragraph 2 provides that 'a special cohousing office shall be set up using internal financial resources, composed of personnel with a degree in subjects in the socio-psychological area qualified in the professions of psychological and social assistance, with the task of promoting the mobility of the households referred to in paragraph 1, as established by the annual programme of activities adopted by the board of directors pursuant to Article 6, paragraph 3, letter f.

It seems that the undeniable difficulties encountered by the above-mentioned provisions, although worthy of support, can be explained by the extremely difficult situation of administrative efficiency characterising both the corporatised management of social housing and the regional administration itself, whose leadership was responsible for making the necessary changes to the regional regulation for the management of e.r.p. housing.

The paradox of a particular regional legislative farsightedness on the subject of this contribution, combined however with a situation of dramatic ungovernability of public housing[66], is confirmed by the subsequent intervention of the Lazio regional legislator, with art. 11 of law no. 10 of 17 June 2022 (on the subject of disability) aimed at promoting experimental interventions in housing policies, also resorting to solidarity cohabitation, thus proposing to privilege 'life projects that guarantee, also from the housing point of view, inclusive rather than segregating models, in all cases where the type of disability allows it'[67].

The Lazio legislation has therefore recognized solidarity-based cohabitation, enhancing two important related social needs in terms of legislation: a) that of better exploiting the public housing stock, which is currently totally unsuitable for the housing needs of single persons; and b) that of supporting the permanence of the elderly who are assigned to it (avoiding the need for care homes) through the establishment of elective cohabitation in the framework of a social cohousing that is not imposed. In fact, the assignee's freedom of choice deserves to be emphasised, as he or she is the promoter of a free cohabitation with one or more subjects indicated by him or herself and welcomed into the home, albeit only among those on the waiting lists for e.r.p. accommodation.

These subjects, in turn, agree to be placed in an e.r.p. accommodation and to be able to take over in anticipation of the ranking, but only on condition that they immediately repeat the experience of living in solidarity with others and accepting the external monitoring of this cohabitation by the local authorities or specifically accredited welfare bodies. This is undoubtedly an eloquent (and unfortunately rare) epiphany of that virtuously shared administration in the management of public goods referred to in Article 118, paragraph 3, of the Constitution[68].

A different, but also significant, legislative initiative has taken shape in Bolzano with a series of legislative interventions, including the current text of Provincial Law no. 13 of 11 August 1997 on town planning. In Article 37, it

[66] Of which is a very serious expression, the unstoppable (at least apparently) phenomenon of squatting in e.r.p. housing, on which see the recent attempts at regularization by the Municipality of Rome. More in P Morozzo della Rocca 'L'anagrafe, il Sindaco e l'occupazione abusiva delle case della povera gente' (2023) Lo stato civile italiano, 2, 53ff.

[67] Similarly, art 5, Lazio Regional Law November 17, 2021, no 16: 'The Region, in order to combat loneliness […] supports housing policies by resorting to forms of cohousing, protected houses and supportive cohabitation'.

[68] P Saggiani, 'Il social Housing e la tutela del diritto all'abitazione' (2021) Rass dir civ, 167ff.

provides that in the implementation plans for urban expansion areas, a privileged quota may be reserved for certain particularly deserving destinations, including residential housing managed by non-profit organisations that promote solidarity between young and elderly people. The same Article 37 also states that if an expansion area includes areas owned by the municipality or other public body or by building cooperatives benefiting from subsidised loans, 'the respective volume must be reserved entirely for subsidised housing and/or secondary urbanisation works, or for housing managed by non-profit organisations that promote solidarity between young and elderly people'.

Again, Provincial Law no 9 (Territory and Landscape) of 10 July 2018, after having established the minimum necessary level of building density for mixed areas, provides in Article 4 that, in the event that the construction serves the purposes of multigenerational cohabitation, the implementation planning may provide that the prescribed cubage be built in several stages.

Lastly, Article 39 provides that dwellings reserved for residents in the province of Bolzano may also be used as […] dwellings built by non-profit organisations that promote solidarity between young and elderly people.

The material basis for the development of a social housing policy, especially intergenerational social housing, which is in fact already spontaneously practised in not a few urban areas of the peninsula, is thus generally strengthened. It is in fact appropriate for local authorities, in agreement with voluntary associations, to promote, support and monitor the initiative of those elderly people, owners of houses, often large but empty over the years, who decide to offer a partial loan for use in order to receive company, sometimes on a rotating basis but preferably stable, so as to ensure greater security, tranquility and sociability in the horizon of life still to come[69].

[69] Ivi, 201ff.

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SECTION I
ESSAYS

Technological Development and Legislative Choices: Brief Reflections on the Relationship between Science and State in the COVID-19 Health Emergency

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Abstract. The inescapability of the empirical knowledge in which legislative choice is embedded has meant that technique has also been accorded a space to intervene in the legislative process. However, the respect for the balance of powers outlined by the constitutional system requires that Parliament be left with an inescapable margin of discretion aimed at ensuring that the balancing of opposing rights or interests is carried out by the very subjects chosen directly by the people, in deference to the principle of popular sovereignty. This inescapable guarantee hinders a full incorporation of the indications provided by the Committees of Sectoral Technicians since these must always fit into contexts of balancing opposing yet equally protected needs. As evidence of the peculiarity of this legislative process there is also an equally peculiar review of legitimacy that the Constitutional Court operates on laws defined as science based.
However, the recent pandemic experience has shown us how, technical-scientific indications, can find full transposition in acts of the Public Administration, which enjoys a pacifically recognized technical discretion; it is still necessary for such a decision to find an express delegation in a regulatory act of primary rank always to ensure compliance with the balances outlined by the Constitution.

Keywords: *COVID-19, technological development, science, state.*

1. Introductory Considerations: The Value of Scientific Data

Empirical knowledge of the reality in which a legislative act is to be applied is the necessary and indispensable condition for it to be able to fully perform its role. This is a condition whose, observance becomes even more stringent in the hypothesis of legislations aimed at regulating aspects and spheres characterised by a high degree of technicality, such as the medical-health sector. In these contexts, legislative activity is increasingly connected to the need for technical experts, who provide the legislature with the necessary scientific data.

The peculiarities of legislation in technical-scientific fields do not end in the purely procedural sphere, they also permeate the outcome since the content of the provisions of science-based laws must also meet certain requirements, which are provided directly by the provisions of the Italian Constitution[1] and also by the development of constitutional and administrative case law. It therefore appears that science and technology provide the indications based on which Parliament's subsequent legislative intervention can be articulated, and it is precisely from the importance of the technical-scientific profile within the legislative activity that the critical aspects of these procedures arise.

In the first place, it seems useful to establish that legislative discretion has a space of constitutional importance aimed at ensuring the protection of interests and rights that may find themselves in conflict in certain situations. In Italy, the legal system recognises the state legislature, elected by the sovereign people, as the exclusive holder of the power to perform balancing operations to ensure a full guarantee of all interests that may be in conflict[2]. Where the legislative decision is inevitably conditioned on technical findings and scientific data, the issue arises was to the effectiveness of Parliament's decision-making power and, consequently, the problem of respecting the balance of power outlined in the constitutional text[3].

[1] See G Branca, Commentario alla Costituzione, Artt 70-74 (Zanichelli Editore, 1986).

[2] See V Crisafulli, Lezioni di Diritto Costituzionale (CEDAM, 1984) 65ff.

[3] See A Iannuzzi, 'Leggi scientifiche science-driven e Covid-19. Il rapporto tra politica e scienza nello Stato di emergenza sanitaria' (2020) BioLaw Journal rivista di BioDiritto, 1. According to him, the roots

In order to reconcile these opposing requirements – the necessary integration of technical knowledge and the centrality of the legislature's decision-making role – in cases where legislative choice concerns specific sectoral areas requiring prior technical knowledge, legislative discretion is necessarily limited, but not eliminated. Moreover, even the product of this particular legislative procedure, often referred to as science-based law, must necessarily meet certain requirements to be considered legitimate, and this also allows for the review of legitimacy by the Constitutional Court[4].

A new framework appears to be emerging in which, on the one hand, it is necessary to ensure respect for the balances outlined by the Constitution, but, on the other hand, also to provide for the necessary integration of knowledge and skills that is required in order to have legislation that can fit into the technical-scientific sphere in a complete and efficient manner.

This integration of competences, which at legislative level is hindered by the need for a space of discretion ensured to the legislature, can exist at administrative level, especially by virtue of laws that delegate to the Public Administration the technical integration to make the discipline established by the primary source complete.

2. Science as a Limit to the Legislator's Discretion?

Beginning with an analysis of the role played by technology in the legislative process, it must be asserted that in order to ensure Parliament is left with a margin of maneuverability that allows it to perform its natural task as decision-maker, the intervention of science in science-based legislative procedures has a significant role.

To this end, provisions have been made for the intervention of Scientific Technical Committees (STCs), composed of highly qualified experts in the field, whose opinion is necessary for the adoption of certain political decisions[5].

The provision for the intervention of the STC responds to the need to guarantee both an appropriate integration of the legislature's knowledge and a threshold of discretion within which the legislature can move to ensure a correct balancing of the interests at stake[6].

The provision of committees of sector experts – despite appearing to be an appropriate solution to ensure the necessary integration of legislative knowledge while still guaranteeing a margin of discretion – opens the way to two different problems, which will only be mentioned here. First, the question of the legislature's reduced responsibility in favour of the technicians' knowledge[7], and second, the question of the advisability of providing for permanent technical-scientific committees in order to ensure the impartiality and independence of the technicians that constitute them.

The intervention of the committees in the legislature's decision-making activity does not entail the automatic presumption of legitimacy of the discipline, as constitutional and administrative jurisprudence has identified requirements that the law itself must necessarily possess in order to be considered legitimate[8].

The first requirement is in fact the plausibility of the legislative choice – it must in fact

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of the problem are in fact based on the ultimate purpose that drives science, i.e. the search for the scientific truth of phenomena through the use of objective evidence, and the different purpose of law and politics, i.e. to govern different situations by attempting to maintain the social consensus on which its very power is based.

[4] See L Del Corona, 'The Public Administration and technical evaluations within the framework of Constitutional principles' (2023) PA Persona e Amministrazione, 207ff.

[5] See L Violini, 'La tutela della salute e I limiti al potere di legiferare: sull'incostituzionalità di una legge regionale che vieta specifici interventi terapeutici senza adeguata istruttoria tecnico scientifica' (2002) Le Regioni, 1450ff.

[6] During the pandemic phase, the Scientific Technical Committee played a fundamental role in the decision-making processes aimed at adopting legislation to contain the emergency. Scientific evaluations conditioned every decision and, in particular, they were exhibited as a justifying basis for the decisions taken by the government. For a detailed reconstruction of the regulations adopted in the pandemic-emergency phase see D Donati, 'La legittimità dell'obbligo vaccinale per gli operatori sanitari' (2022) Giornale di diritto amministrativo, 1.

[7] For a more detailed examination of the issue of legislative de-responsibility see A Patroni Griffi 'Scienza e diritto ai tempi dell'emergenza from Covid-19', in which the author emphasises the need for the reference to science not to translate into a disengagement of politics.

[8] Const Court 18 january 2018, no 5; Const Court 20 May 2016, no 116; Const Court 5 December 2014, no 274.

be a reasonable choice based on the scientific findings in the legislature's possession[9].

And this is what the Constitutional Court stated in Judgment No 282 of 2002:

'an intervention on the merits of therapeutic choices in relation to their appropriateness could not arise from assessments of purely political discretion on the part of the legislature itself, but should provide for the elaboration of guidelines based on the verification of the state of scientific knowledge and experimental evidence acquired through institutions and bodies appointed for that purpose[10]'.

It is clear, therefore, that the Court reserves a sphere of autonomy to science that is counterbalanced by the power of the legislature, which is called upon to provide for the protection of constitutional rights and duties. This is necessarily a limited power, since there is no complete freedom of intervention. In any case, the legislature is called upon to compare itself with the state of scientific knowledge acquired and with experimental evidence, essentially with a canon of scientific and technical reasonableness[11]. And it is precisely the residual margin of legislative discretion that ensures not only the protection of the rights at stake through balancing operations, but also the intervention of judgments of legitimacy by both the Constitutional Court and administrative judges.

In fact, one speaks of the so-called scientific reasonableness to refer to the assessment of the plausibility of the legislative choice, since full adherence to scientific data is not considered sufficient for the purposes of a judgment on the legitimacy of legislation. The scientific reasonableness test comprises a twofold step: first, it is necessary to assess the correctness of the scientific datum/assumption on which the legislative decision is based, and, subsequently, to analyse the justifiability of that following decision.

Respect for the scientific premise on which the legislative decision is based seems to be identified as the first canon in the light of which to assess the legitimacy of the legislation itself, avoiding specious or even inconsistent scientific references. However, mere adherence to the scientific datum does not – and cannot – exhaust the analysis of the legislature's choice: the balancing of opposing interests carried out by the legislature must appear plausible, and therefore justifiable on the basis of the data and technical knowledge provided[12], but a further element against which the legitimacy of the regulation based on scientific findings is assessed is the publicity of the opinions provided by the STCs[13].

The necessary and rightful publicity of the technical-scientific documentation on which the following regulatory decision is based is required for two reasons. The sovereignty of the people, which legitimises the legislative body, is 'held back'[14] in the case of science-based regulations, since the legislature's decisions must necessarily and logically conform to the findings of other parties – in this case technical experts and scientists.

In addition, to meet a purely logical necessity, it is only through access to this scientific documentation that it is possible to judge the proportionality and appropriateness of the consequent choice made in the legislative sphere, thanks to the analysis of the technical data on which it is based. Thus, this makes the 'democratic acceptance' of the choice based on this documentation possible.

Legislation in areas characterised by an intrinsic technical nature requires a special role for the legislator, who is necessarily limited in decision-making activity by having to

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[9] See S Penasa, 'La ragionevolezza scientifica delle leggi nella giurisprudenza costituzionale' (2009) Quaderni costituzionali, 817.

[10] Const Court 16 June 2002, no 282.

[11] See U Adamo, 'Materia non democratica e ragionevolezza della legge' (2018) Consulta online, 300.

[12] Given the intrinsic character of uncertainty inherent in scientific knowledge and experience, when assessing legitimacy it is necessary for the legislative choice to be verified on the basis of the data provided and on the "consistency of the scientific premise available to the policy maker", Acocella (2020).

[13] See TAR Lazio no. 7282/2020 of 30 June 2020 in the context of the judgment on the legitimacy of the obligation to vaccinate against influenza for certain categories of subjects, on this occasion the Regional Administrative Court held that it could not evaluate the technical-scientific premises underlying the decision introducing the obligation as they were not published; on the same line see Lazio, sez. I quater, 22 July 2020, no 8615 whereby the applicants were granted the right of civic access to 5 minutes of the CTS, which are mentioned in the texts of the Prime Ministerial Decrees that followed in the management of the first phase of the pandemic.

[14] Acocella (2020); on retained sovereignty see also LR Perfetti, 'I diritti sociali. Sui diritti fondamentali come esercizio della sovranità popolare nel rapporto con l'autorità' (2013) Dir Pubblico, 1.

conform to the knowledge provided. In order to ensure respect for institutional balances, the protection of the rights at stake and, above all, to ensure the possibility of intervention by the Constitutional Court, legislative discretion is not eliminated. The Committee of Experts' opinion plays a fundamental role in this situation. It must be given to the legislature in advance so that its members can comply and prove the plausibility of the choice made at a later date, and, secondly, it must necessarily be made accessible to the population, thus ensuring that the population can verify the proportionality and reasonableness of the legislative choice[15].

3. Scientific Data and the Court's Review: The Legitimacy of Compulsory Health Treatment

One specific area in which the law-science relationship has always played a greater role in institutional political debates is that of health protection. Health, as a fundamental right of the individual, is protected by Article 32 of the Italian Constitution. This provision makes it possible to identify the twofold version of the fundamental right to health, namely as a fundamental right of the individual and as an interest of the community.

It is possible that, in certain situations, these dimensions may find themselves in conflict. For example, circumstances in which the individual's freedom of self-determination in the field of health, which translates into the possibility of choosing and refusing certain treatments, finds itself in conflict with the equally important collective interest of public health[16].

Article 32 of the Constitution provides the possibility that, in certain situations, the individual dimension may be sacrificed in order to protect the collective interest in public health, subjecting this possibility to a reservation of the law and setting the insuperable limit of respect for human dignity[17]. The imposition of compulsory health treatment falls precisely within this ambit, as a legislative provision may introduce therapeutic obligations on certain individuals on the grounds of ensuring the protection of the community[18]. In the area of healthcare, legislative activity is bound by scientific-technical findings, as the choice of whether and what healthcare treatment to impose on the population must be based on them.

A heated debate has developed in doctrine and jurisprudence concerning the conditions under which a law imposing compulsory health treatment can be considered legitimate. In this context, it is the Court's task to verify whether, in the face of the conflict between the individual and collective dimensions, the legislature has struck a correct balance, one that is not disproportionate to the aim pursued.

In fact, one speaks of a review of scientific reasonableness to indicate the space that the Court has carved out for itself to be able to assess precisely those legislative choices characterised as being based on technical-scientific knowledge. Notwithstanding the fact that the area of law imposing medical treatments is located within the macro system of science-based laws, whereby legislative discretion is limited by technical-scientific findings, the Court cannot refrain from reviewing the constitutional legitimacy of such provisions. The Court's intervention is particularly important in light of an assessment of the appropriateness of the balance between the dimensions in which the right to health is articulated made by the legislature itself.

In the specific case of laws introducing compulsory health treatments, the balancing act carried out by the legislature follows two guidelines: 1) the assessment of the state of facts, and 2) the consideration of the available scientific findings. The fact that the legislature's choice must be based on scientific findings does not preclude the possibility that the Court's review may be avoided. Indeed, it is the Court's task to verify whether the legislature's choice can be placed within 'an area of scientific reliability in the light of the best knowledge attained at a given historical moment'[19].

The legislature's choice must therefore possess certain characteristics. In order to be considered legitimate, in the first place, the

[15] See Del Corona (2023).

[16] See S Cassese, 'I Rapporti etico-sociali', in G Branca, Commentario alla Costituzione (1984).

[17] See F Vecchi (2017), 'Lo svolgersi del diritto statuale attraverso il parametro universale della dignità umana, al bivio tra questioni etiche, memoria storia e secolarizzazione (a proposito di Recte Sapere)'. Studi in onore di Giuseppe Della Torre, ed by G Bonini, E Camassa, P Cavana, P Lillo, V Turchi, 223-233.

[18] See B Liberali, 'Vaccinazioni obbligatorie e raccomandate tra scienza, diritto e sindacato costituzionale' (2019) BioLaw Journal, Rivista di BioDiritto.

[19] See C Dionisi, 'La disciplina delle vaccinazioni obbligatorie al vaglio della Corte Costituzionale'. Fides, humanitas, Ius. Studi in onore di G. Labruna (2007) 1577.

appreciation of evolutionary dynamics is fundamental, given the transitory nature of scientific knowledge, which by its very nature is likely to be superseded. The legislator's choice must appear reasonable, for example suitable for pursuing the intended purpose. With regard to this requirement, it is interesting to note how the scientific findings and the technical data available also come into play in the judgment of legitimacy: the assessment of the appropriateness of the legislative choice for achieving the intended objectives is translated into its consistency with the technical knowledge available[20].

Lastly, the Court considers that the rule must possess the requirement of proportionality, which is present where the legislature's choice is proportionate and there were no alternative measures suitable for pursuing the same purpose involving a lesser sacrifice of the rights involved.

Following numerous interventions in this area, the Constitutional Court, through the development of its jurisprudence, has identified the requisites through which it can carry out its review of the legitimacy of laws imposing medical treatment[21].

In particular, starting with the historic judgment no. 303 of 1990, the Court established that a law imposing medical treatment must meet three requirements in order to be considered constitutionally legitimate. Firstly, the treatment imposed must be aimed not only at preserving the state of health of those subjected to it, but also at preserving the state of health of others. Secondly, it must not adversely affect the state of health of those subjected to it, except only for those consequences that appear normal and therefore tolerable. Lastly, it is necessary that the law provides for the payment of an equitable indemnity in favour of the injured party in the event of damage that transcends the 'normal and therefore tolerable' consequences referred to above, in addition to the parallel protection for compensation[22].

Thus, in the peculiar case of laws imposing medical treatments, the subject of the legitimacy assessment at the judicial level is not only the exercise of legislative discretion in relation to the technical knowledge available, but also the actual choice of a given treatment on the basis of its characteristics. It therefore seems to be possible to state that the technical-scientific datum that becomes part of the legislative decision-making process also plays an important role in the judgment of the legitimacy of that process.

3.1. A Specific Case of Compulsory Health Treatment COVID-19 Vaccines

Recently, the COVID-19 pandemic and emergency response has brought the question of the legitimacy of legislative choices aimed at introducing compulsory vaccinations into the spotlight.

In an attempt to stem the ongoing pandemic emergency, the Italian legislature, with Decree Law no. 44 of 2021, introduced the mandatory nature of the COVID-19 vaccination for certain categories of persons, in relation to the particular professional activity carried out and/or their particular state of health. The complaints lodged against the provisions of this decree-law were twofold. On the one hand, it was alleged that there was unequal treatment and therefore a violation of Article 3 of the Constitution[23]. On the other hand, it was alleged that, due to the

[20] With Judgment no 14 of 2023, the Constitutional Court deals with judging the legitimacy of certain provisions introduced by d.l. no 44/2021 introducing compulsory vaccination for health personnel. In their review of the reasonableness of this choice, the judges of the Court referred to the findings and contributions drawn up by the Italian Medicines Agency, from which it clearly emerges that such an obligation on the part of the professional category in question can be considered useful for the twofold purpose of protecting the health of the workers themselves, as they are more exposed, so as to ensure the full efficiency of healthcare facilities, and, in addition, better ensure the health of hospitalised patients who, as such, are more exposed to risks.

[21] Among the various intervention of the Italian Constitutional Court in the area of compulsory vaccination the most important judgments are: Const Court no 303/1990; Const Court no 5/2018; Const Court no 14/2023; Const Court no 25/2023.

[22] These requirements elaborated in the evolutionary path of Italian constitutional jurisprudence have been taken up by the latest rulings on the subject of compulsory vacinations, particularly with the judgment number 14 of 2023. See C Iannello (2023), La ratio dell'obbligo vaccinale nella recente giurisprudenza costituzionale <Dirittifondamentali> accessed 15 November 2023.

[23] For a full analysis about the measures taken by Italian Institutions during the Covid-19 emergency see M Gnes, 'Le misure nazionali di contenimento dell'epidemia da Covid-19' (2020) Giornale di diritto amministrativo.

peculiar procedure followed for the approval of these vaccines, a violation of the requirements of legitimacy imposed by the Court itself[24].

In fact, the proponents asserted that, because of the peculiar procedure followed for its approval, the treatment aimed at preventing COVID-19 infection did not comply with one of the requirements demanded by the Court's case law, namely the fact that it was not established that there were no possible negative effects on the health of those who were subjected to it.

The debate arises, as anticipated, as a result of the different procedure used for the approval of the COVID-19 vaccine, which, due to requirements linked to the strict necessity and urgency of the context in which it was developed, was characterised by the simultaneous carrying out of the different stages in which the procedure is implemented.

The procedure governing the marketing authorisation of drugs is governed by EU Regulation 726/2004, which provides for two different procedures: a standard one and an exceptional one. The Regulation specifies that the latter can only be used under the conditions laid down by the same European legislation. In the case of the COVID-19 vaccine, a procedure was used that is not regulated by the 2004 regulation, but by the different EU Reg. 507/2006, providing for a third procedure that is in an 'intermediate' position with respect to the standard and exceptional procedures provided for by the 2004 regulation.

The 2006 Framework provides that 'in the case of certain categories of medicinal products, in order to meet unmet medical needs of patients and in the interests of public health, it may […] prove necessary to grant marketing authorisations based on less complete data than is normally required[25]'. Although such a procedure may represent a solution in terms of timeliness, on the other hand, inevitably, the consequences of such advantages 'are paid for in terms of certainty and stability of the findings[26]'.

The question, therefore, seems to arise as to the legitimacy of the balancing act carried out by the legislature during the pandemic period. Although the legitimacy of a balancing act in which the collective dimension of the right to health is subordinated to the protection of collective health is well established, can the same be said if this result is arrived at on the basis of data which, by their very definition, are incomplete and uncertain?

The answer to this question, pending before the Constitutional Court, was provided by the Council of State in Judgment no 7045 of 20 October 2021, in which the judges dwelt stressed the legitimacy of the imposition of treatments whose marketing authorisation is conditional on the basis of the procedure introduced by Regulation 507/2006. The administrative judges, analysing how such a procedure 'does not constitute at all an uncertain and dangerous shortcut contrived ad hoc to deal with the health emergency', affirmed how it represents instead 'a procedure of a general nature capable of being applied even outside the pandemic situation[27]'. The conditional nature of the marketing authorisation of a drug, according to the administrative judges, does not affect safety procedures, requiring only that ongoing studies be completed or that it be confirmed that the risk/benefit ratio is favourable.

In ascertaining the legitimacy of the legislature's choice, the Council of State, in its ruling no. 7045, provided valuable indications that make it possible to delineate the relationships and roles of the different protagonists in scientific legislative events, especially the legislature, the scientific community and the Constitutional Court. Although the legislature must be limited in that it must necessarily make reference to science, there seems to be an 'inevitable margin of uncertainty that also characterises scientific knowledge in the construction of truths that can be acquired over time […] and an undeniable margin of discretion in balancing the values at stake»; this discretion «must be used in a reasonable and proportionate manner and, as such, is subject to the legitimacy review of the judge of laws and the administrative judge'[28].

4. The Place of Technique: Public Administration Decisions

Public administration is the natural place where technical assessments are the parameter on which to base a decision involving an interest of general importance[29].

[24] See paragraph number 3

[25] EU Regulation 507/2006, rec 3.

[26] See A Mangia, 'Si caelum digito tetigeris. Osservazioni sulla legittimità costituzionale degli obblighi vaccinali' (2021) Osservatorio AIC, 3.

[27] Italian Council of State judgment no. 7045/2021.

[28] See B Liberali, Le vaccinazioni ai tempi del Covid-19, (Pubblicazioni del Dipartimento di Diritto pubblico italiano e sovrannazionale/Università degli Studi di Milano, 2021).

[29] See D De Pretis, Valutazione amministrativa e discrezionalità tecnica (Cedam, 1995) 178.

In the sphere of discretion, which typically characterises administrative action, two different forms can be distinguished based on technical discretion and administrative discretion. Despite some similarities, to date these forms of discretion are distinguished on the basis of the presence of a weighing of public interests, present in the hypotheses of decisions falling within the sphere of administrative discretion, yet absent in the cases of decisions falling within technical discretion, characterised by being limited to the reception of technical-scientific evaluations taken as a basis. Technical discretion is characterised, according to today's doctrine, by the positive nature of the scientific conditioning inherent in its assessments[30].

To date, therefore, doctrine is almost unanimous in identifying the distinction between administrative discretion and technical discretion in the weighing of a public interest, which is only present in administrative discretion, while technical discretion is defined in relation to the high degree of technicality of which the rules are applied[31]. Scientific criteria can replace the margins of appreciation and the ability to issue an opinion that characterise those decisions in which the public administration is called upon to evaluate opposing interests of equal public importance.

Once the doctrinal approach regarding the distinction between the two forms of discretion for the Public Administration's activities has been clarified, it is necessary to identify the reasons that support the thesis according to which decisions based on technical-scientific evaluations are based in public administration activities. At the same time, it would be necessary to assess the conditions – elaborated by administrative and constitutional jurisprudence – that inform the procedure on the basis of which they are elaborated legitimate.

The activity of the Public Administration appears to be more flexible, and therefore less constrained, than that carried out by Parliament, whose investigative powers are limited and poorly regulated. On the other hand, the lack of flexibility of the legislative instrument to guarantee an adjustment of the regulations to the state of available knowledge is emphasised.

It is therefore necessary that this activity – consisting of the incorporation of technical and scientific information and knowledge as the basis for decisions of public importance – be expressly delegated by Parliament to the public administration[32]. It is precisely the presence of the delegation included in the primary source to a regulatory source of secondary rank that makes it possible to ensure a more appropriate performance of technical-scientific assessments, making this transfer of functions adherent to the constitution[33].

In this case too, the COVID-19 pandemic experience seems to offer a fitting example. The entire regulatory structure of pandemic management was in fact based on the bi-univocal relationship between primary sources, especially decree-laws, whose purpose was to delimit the space within which secondary sources, and d.p.c.m[34]., as necessary administrative acts intended to introduce restrictive measures consistent with technical-scientific assessments drawn up by the CTS[35].

Although the Constitutional Court has sanctioned the possibility of assessing the

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[30] Reference is made to the studies of Cammeo and Presutti in which the technical qualification of administrative discretionary activity was resolved in its being determined by criteria of administrative technique, those criteria that the legal norm suggests in relation to the needs of public administration in the activity aimed at specifying the content of an imprecise norm, see F Cammeo, Corso di diritto amministrativo, and E Presutti, Discrezionalità pura e discrezionalità tecnica; for a reconstruction of the doctrinal evolution on the subject see D De Pretis.

[31] See M Giannini, Il potere discrezionale (Giuffrè, 1939).

[32] See S Cassese, La disciplina legislative nel procedimento amministrativo. Un'analisi comparata (1993) Il foro italiano.

[33] The principle of administrative legality has been traced back by the Constitutional Court (5/2021) to the provisions of Article 23, which, by providing for a non-parliamentary reservation of the law, allows for the delegation to a secondary source of the determination of the content of measures characterised by a high degree of technicality. Recently, the issue of the nature of the statutory reserve referred to in Article 23 of the Constitution was the subject of Judgment no. 171 of 2023 of the Constitutional Court, in which it was reiterated that 'what the law is required to do, when it confers administrative powers, is to define the content and manner of their exercise (Judgments no 5 of 2021 and no 174 of 2017) that delimit the discretion of the administration, whose activity must always find a legislative cover, albeit elastic'.

[34] See M Rubechi, 'I DPCM della pandemia: considerazioni attorno a un atto da regolare' (2021) Federalismi.

[35] 'Comitato Tecnico Scientifico' (Technical Scientific Committee).

constitutionality of science-based laws reserving a space for intervention, such syndication appears to be bound by the limited investigative powers enjoyed by the Court itself[36].

Hence, the administrative judge's margin of reviewability is better reconciled with the need for verification of administrative decisions that are characterised by being traced or referable to the sphere of so-called technical discretion. In fact, it is now common knowledge that the divergences separating administrative and technical discretion are also reflected in the different margin of maneuvers that the administrative judge has – limited by the assessment of a public interest in the first case, broader in the second[37]. The limits that exist in the hypothesis of review of administrative discretion are not justified with respect to the exercise of technical discretion, which concerns the mere application of technical rules.

However, despite the fact that doctrine speaks of 'weak intrinsic review', referring to the limited possibility for the administrative judge to verify the sufficiency and correctness of the technical data employed and not to substitute the assessment employed by the administration, the administrative judge's control appears to be the most suitable place within which to place the verification of the correctness of the technical assessments employed in the decisions falling within the so-called technical discretion of the Public Administration.

5. Concluding remarks

In the light of the considerations made thus far, it appears to be possible to say that legislation in the technical-scientific sphere is as necessary as it is peculiar. As this article highlights, the legislature's intervention, although indispensable, takes place in a context that, by its very nature, is necessarily limited by the data provided by subjects who normally remain outside the decision-making process.

The peculiarity of such legislation is reflected in a series of specific requirements that it must possess since a margin of legislative discretion must necessarily remain, total and full adherence to the technical data provided is not sufficient to be considered legitimate. In particular, the choice made by the legislature is required to be plausible, meaning justified on the basis of the data provided to it by the experts in the sector. Furthermore, the opinions rendered by the latter must be consultable and therefore public, so as to ensure both the participation of the population in the decision-making process and the verification of the requirements of reasonableness and proportionality of the choice made by the legislature itself.

This is also the context of laws imposing compulsory health treatment, which are placed within the dichotomy between the two dimensions of the fundamental right to health that, in such contexts, are in conflict. In the specific context of laws imposing health treatments, in addition to the requirements for science-based laws further requirements are implemented that also concern the specific treatment that the legislator has chosen to impose. Following a copious jurisprudence of legitimacy on this type of legislation, we can now say that these provisions must be aimed at protecting both individual and collective health, the treatment imposed must not create damage greater than that considered tolerable, and, the legislation must provide for compensation mechanisms in the event that such damage occurs.

In the context of the review of the legitimacy of this specific legislation, the Court is concerned with analysing the correctness of the balancing act performed by the legislature, which, although limited in that the legislature's role necessarily relies on knowledge provided by others, cannot be entirely excluded, and this is also to ensure the margin of intervention of the constitutional judge and the administrative judge.

The Court's will have to carry out a review of scientific reasonableness, thus verifying whether or not the legislature's choice is supported by the technical and scientific knowledge available; this decision must also be reasonable, meaning suitable for achieving the desired result, proportionate, there must be no suitable alternatives for pursuing the same result involving a lesser sacrifice in terms of protecting rights, and, finally, the dynamic and evolving nature of the knowledge on which the legislation itself is based must be demonstrated. This is a specific area in which other principles and requirements are added to the traditional ones, due to the fact that in addition

[36] See A Iannuzzi, Istruttoria e valutazioni tecnico scientifiche (Rivista Gruppo di Pisa, 2017).

[37] In 1999, the Council of State Sec. IV, no 601 made a significant ruling. This was the first time it was affirmed that there is a possibility of directly verifying the reliability of technical operations. This verification is done from the perspective of ensuring that the technical criteria and application procedures are correct.

to the role of the legislature, whose centrality remains assured, the intervention of other subjects is also envisaged.

The series of limitations faced by the legislature in this area, which are also reflected in the Court's review due to the limited nature of its investigative powers, are reduced when the technical assessment is delegated to the public administration. In fact, the Public Administration is vested with broader investigative powers, since its decisions can be completely based on technical-scientific findings; in addition, there is also a broader scope of the administrative judge's review, which goes beyond the limits of the justifiability of the Public Administration's choice, going so far as to ascertain and verify the validity of the data assumed by the latter for the purposes of its decision.

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SECTION II
REPORTS

Glocal Approach and the Green Budgeting Rules

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Abstract. The article focuses on an empirical case of 'glocal' interaction, highlighting the ratio of green budgeting rules and providing some experiences from the municipalities of Venice and Växjö and the French State. These examples show that local public sector is able to play a driving role in implementing green operational tools functional to pursue environmental objectives: from local examples, international principles and rules were conceived and, as in a virtuous circle, it helped local and national communities to introduce best practices in the subject-matter.

Keywords*: green budgeting rules, "glocal" approach, environmental protection*

1. Introduction

Environmental issues, especially climate change, are affecting various aspects of traditional administrative states[1]. The principles of climate law are imposed on national systems through an increasingly effective climate litigation[2], which is influencing the traditional notion of separation of powers and the manner by which judges abide by and apply rules. Furthermore, these issues are influencing one of the most important aspects of State's

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[1] The "law of the transition", involving a thorough change in the environmental and digital fields, affects the area of administrative law, creating new principles, tools, operational models, key components of the new legal order created by the Next Generation EU and the Recovery and Resilience Facility. For a comment on the relation between the 'transition' and the Italian legal system, G Severini, 'La transizione come ordinamento giuridico' (2022) <https://www.giustiziainsieme.it/it/diritto-e-processo-amministrativo/2544-la-transizione-come-ordinamento-giuridico>.

[2] On this topic, W Kahl and MP Weller, 'Climate change litigation. A handbook' (Bloomsbury 2021); F Sindico and M Moise Mbengue, 'Comparative climate change litigation: beyond the usual suspects' (Springer 2021); J Peel and HM Osofsky, 'Climate Change Litigation', ARLSS (2020) 16:1 21; L Burgers, 'Should Judges Make Climate Change Law?' TEL (2020) 9:1 55; J Setzer and R Byrnes, 'Global trends in climate change litigation: 2019 snapshot policy report' <https://www.lse.ac.uk/granthaminstitute/wp-content/uploads/2019/07/GRI_Global-trends-in-climate-change-litigation-2019-snapshot-2.pdf>; S Maljean Dubois, 'Climate Change Litigation', Max Planck Encyclopedia of International Procedural Law (OUP 2018); K Bouwer, 'The Unsexy Future of Climate Change Litigation' (2018) Journal of Environmental Law 30:3 483; S McCormick et Al., 'Strategies in and Outcomes of Climate Change Litigation in the United States' (2018) Nature Climate Change 8:9 829; DA Farber and C Piñon Carlarne, 'Climate Change Law (Concepts and Insights)' (New York 2017); D Bodansky et Al., 'International climate change law' (OUP 2017); J Pell, H.M. Osofsky, 'Climate Change Litigation. Regulatory Pathways to Cleaner Energy' (CUP 2015); M. Wilensky, 'Climate Change in Courts: An Assessment of Non-US Climate Litigation' DELPF (2015) 26:131; OC Ruppel et Al., 'Climate Change: International Law and Global Governance. Legal Responses and Global Responsibility' (Nomos I 2013); D Markell and GB Ruhl, 'An Empirical Assessment of Climate Change in the Courts. A New Jurisprudence or Business as Usual?' (2012) Florida LR 64:1 15; L Butti, 'The Tortuous Road to Liability: a Critical Survey on Climate Change Litigation in Europe and North America' (2011) SDLP 11:2 32; HM Osofsky, 'The Continuing Importance of Climate Change Litigation' (2010) Climate Law 1:1 3. As for the Italian literature, A Pisanò, 'Il diritto al clima e il ruolo dei diritti nei contenziosi climatici europei' (ESI 2022); R Louvin, 'Spazi e opportunità per la giustizia climatica in Italia' (2021) DPCE-online 935; M Magri, 'Il 2021 è stato l'anno della 'giustizia climatica?'' (2021) AmbienteDiritto 1; S Valaguzza, 'Liti strategiche: il contenzioso climatico salverà il pianeta?' (2021) Diritto processuale amministrativo 293; F Scalia, 'La giustizia climatica' (2021) Federalismi 1.

sovereignty, especially legislation relating to accounting and public finance. Indeed, this is becoming one important field of interaction between global regulation and local and national levels of governing.

According to the OECD initiative, the "*Paris Collaborative on Green Budgeting*," launched at the One Planet Summit in December 2017, European countries, with France in the lead, have initiated the process of using green budgeting to assess the alignment of the central government budget with respective international commitments, such as the Paris Agreement on climate change. In 2021, the OECD, together with the EU Commission and IMF, presented the paper "*Green budgeting: towards common principles*"[3] and the EU Commission's DG-Reform presented the *EU Green Budgeting Project* at the COP26 Conference, on the basis of the European Union Green Deal. In 2022, the OECD presented a new paper named "*Aligning Regional and Local Budgets with Green Objectives. Subnational Green Budgeting Practices and Guidelines*".

Taken together, these papers focus not only on a high-level political commitment, attributing a central coordinating role to finance, environment and/or climate ministries, but also on subnational levels of government (SNGs) and on state-owned enterprises (SOEs) that are "often responsible for substantial GHG emissions and environmental impact and should be included in green budgeting frameworks"[4].

As a matter of fact, long before 2017 some subnational governments started to implement green budgeting rules, as the city of Venice (2006) and the municipality of Växjö (2003), while others, like Sardinia, Oslo and Andalusia are implementing it at the local level at present. Under a set of common principles, green budgeting is shaping national and subnational levels, as well as state-owned companies, toward a different approach to budgeting rules and toward an organizational effort to support these changes, inside local actors and outside, through an independent assessment from national authorities.

Green budgeting rules seem to become increasingly central in order to achieve environmental and climate goals and appear as an important empirical example of a "glocal" interaction, where the global (environmental and climate objectives, as well as general principles of green budgeting rules) interact with the local (concrete implementation of these rules in order to achieve the objectives), creating a mutual exchange between those two dimensions and levels of governing[5].

This interaction is the topic of this article and is explained in the sections below.

2. The ratio of green budgeting rules

The term "green budgeting" first emerged in 1987 from the Brundtland Commission's report on "Development and environment", which recommended that "the major central economic and sectoral agencies of governments should now be made directly responsible and fully accountable for ensuring that their policies, programmes, and budgets support development that is ecologically as well as economically sustainable".

From this definition it is possible to infer that green budgeting rules are one important application of the principle of sustainable development, which inspires a large number of international agreements concerning the protection of the environment in its various components. For instance, as now required by art. 2, par. 1, lett.

[3] "Green budgeting means using the tools of budgetary policymaking to help achieve climate and environmental goals. Green budgeting entails a systematic approach to assess the overall coherence of the budget relative to a country's climate and environmental agenda and to mainstream an environmentally-aware approach across all policy areas and within the budget process", ibi, p. 5.

[4] Highlighting that "a critical hurdle for many countries is the sometimes weaker PFM capacity at the subnational level. Central governments have a responsibility in enabling PFM reforms to trickle down to local levels through a capacity development strategy", ibi, p. 25.

[5] A typically "glocal" perspective understands that global problems need local solutions, and local solutions are to be implemented by administrative tools: see J Gupta et Al., 'Climate change: a 'glocal' problem requiring 'glocal' action (2007) Environmental Sciences 4:3 139. For A Mihr, 'Glocal Governance. How to Govern in the Anthropocene?' (Springer 2022), 5: ''Think global, act locally' is the essence of glocalism. Glocal governance means that local stakeholders, such as businesses, civil society, city councils, authorities, and activists actively participate in decision-making. Different stakeholders, including local, international, and domestic ones, make decisions on standard rules and regulations while operating, controlling, implementing, and enforcing them locally and wherever needed. Many of these decisions meet global or international standards".

c) of the Paris Agreement, "this Agreement, in enhancing the implementation of the Convention, including its objective, aims to strengthen the global response to the threat of climate change, in the context of sustainable development and efforts to eradicate poverty, including by: […] Making finance flows consistent with a pathway towards low greenhouse gas emissions and climate-resilient development"[6].

It seems that budgeting processes, as the primary way of giving priorities to the action of a public or private body, are therefore central in order to pursue climate objectives. In this sense, the budget, and in particular, public budgets – those of the State, subnational public levels and State-owned companies – can be better understood if described as "public goods", in the meaning offered by the Italian Constitutional Court, judgement n. 184/2016[7].

In particular, it is possible to say that a financial statement no longer consists of a simple financial document, but rather that it represents an informative document from which it is possible to comprehend the developments, in terms of social progress, of the entity involved. In this sense, the so-called "new" budgets, such as those for social, gender and environmental purposes, find their *raison d'être* in the inability of the traditional financial statement to quantify in numerical terms the objectives set and the results achieved through management activities.

The central issue is that the new economic, social and environmental vision promoted by the UN Agenda 2030 and the European Green Deal[8] introduces a much broader, complex and interdisciplinary dimension to the traditional economic, patrimonial and financial budgeting rules. In this sense, public and private bodies are requested adopting novel environmental classifications to inform the population of the level of achievement of a "sustainable development" in a given territory. As explained by the OECD, on the one hand, "green budgeting means using the tools of budgetary policy-making to help achieve climate and environmental goals" and it must entail "a systematic approach to assess the overall coherence of the budget relative to a country's climate and environmental agenda and to mainstream an environmentally aware approach across all policy areas and within the budget process"[9]. On the

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[6] See BJ Preston, 'The influence of the Paris Agreement on climate litigation: legal obligations and norms (Part I)' (2021) Journal of Environmental Law 33:1 1; Id., 'The influence of the Paris Agreement on climate litigation: causation, corporate governance and catalyst (Part II)' ibi 227; L Ramajani, 'The 2015 Paris Agreement: Interplay Between Hard, Soft and Non-Obligations' (2016) Journal of Environmental Law 28:2 337; S Maljean-Dubois, 'The Paris Agreement. A New Step in the Gradual Evolution of Differential Treatment in the Climate Regime?' (2016) RECIEL 25:2 151; B Mayer, 'International Law Obligations Arising in relation to Nationally Determined Contributions' (2018) TEL 7:2 251; TR Young, 'UNFCCC, Kyoto Protocol & Paris Agreement. Halting Steps Toward Paris Implementation' (2018) Environmental Policy and Law 48:2 113. For the evolution of the international climate related governance see G Çapar, 'What Have the Green New Deals to Do With the Paris Agreement? An Experimental Governance Approach to the Climate Change Regime' (2021) RQDA 141.

[7] The Italian Constitutional Court has explicitly stated in that judgement: "the budget is a 'public good' in the sense that it is functional to summarise and make certain the choices of the local authority, both in terms of the acquisition of revenue, and the identification of the implementation interventions of public policies, a mandatory burden for those who are called to administer a particular community and to submit to the final judgment relating to the comparison between the planned and the realized". In other words, the specification of procedures and objectives, and related budget, in which the implementation of public programs takes shape is part of the democratic investiture: "the functional nature of the preliminary and final budgets, to whose non-approval, not surprisingly, the legal system links the loss of the consensus of democratic representation, presupposes as inseparable characteristics the clarity, significance, specification of the implementation interventions of public policies" (par. 3).

[8] The Communication of the Commission, COM(2019) 640 final, states: "National budgets play a key role in the transition. A greater use of green budgeting tools will help to redirect public investment, consumption and taxation to green priorities and away from harmful subsidies. The Commission will work with the Member States to screen and benchmark green budgeting practices. This will make it easier to assess to what extent annual budgets and medium-term fiscal plans take environmental considerations and risks into account and learn from best practices". Then, the Annex to the communication states that among the action 'Mainstreaming sustainability in all EU policies', from 2020 onwards, initiatives to screen and benchmark green budgeting practices of the Member States and of the EU must be carried on.

[9] OECD, 'Green budgeting. Towards common principles' (2021) <https://www.oecd.org/gov/budgeting/green-budgeting-towards-common-principles.pdf>.

other hand, green budgeting "can also contribute to informed, evidence-based debate and discussion on sustainable growth"[10].

The most important aspect is that green budgeting rules stem from the few yet highly ambitious local experiences, making for an invaluable set of examples of a global and local interaction, where local experience stimulates a global process of thinking and implementing common rules and principles that, as in a virtuous circle, influence local agency into addressing common global issues.

3. Local examples of green budgeting experience and the interactions with higher or different levels of government

The Italian experience starts from Venice, where in 2006 the Environmental Reporting of the City of Venice (Bilancio ambientale del Comune di Venezia) was adopted. It is important to observe that this experience led, in 2009, to a reform of the national Government Accounting and Public Finance Act (Law n. 196 of 31 December 2009), to the definition of a national environmental accounting, and to a reporting methodology for Italian subnational level of government[11]. As the Bilancio ambientale of the City of Venice states, an "environmental report is an innovative tool for assessing the management capacity of a public administration to support the processes of qualification of environmental governance at local level".

The tool is ideally conceived as a sequence of different operating modules concerning the explanation of the policies and commitments of the administration, the construction of a system for the collection and management of "relevant information" through a reclassification of environmental expenditure, the assessment of consistency between the policy objectives and the achievement of environmental issues to which financial resources have been dedicated, the evaluation module with composite eco-efficiency indicators. This methodology "allows [one] to verify the degree of realization of the 'declared intentions' by the administration, for that part of environmental interventions carried out on the territory that fall within the direct management of the Municipality and that generate the use of financial resources (both investments and current expenses)"[12].

After the Venice experience, in 2009, the Italian agency for the environment (Istituto superiore per la protezione e la ricerca ambientale – ISPRA), published operational guidelines for the implementation of environmental reports (bilancio ambientale) in order to help municipalities to reach their environmental strategic and operational goals, improve policy coherence, and communicate internally and externally about their achievements[13].

As for the national government level, in 2009 the national Accounting And Public Finance Law (196/2009) was modified with the introduction of article 36, par. 6, according to which "the Final Statement of Account shall also contain, in a special annex, a description of the outturns of expenditure for programmes of an environmental nature in order to highlight the resources employed for environmental protection and activities involving the safeguarding, conservation, restoration and sustainable use of natural resources and the natural heritage".

In the "ecobilancio", definitions and classifications for environmental expenditures are those adopted for the European System for the Collection of Economic Information on the Environment SERIEE (Système Européen de Rassemblement de l'Information Economique sur l'Environnement), which identifies two types of complementary environmental expenditure: expenditure for "environmental protection", classified according to the Classification of Environmental Protection Activities and expenditure (CEPA), and expenditure for the "use and management of natural resources", classified according to the Cruma classification (Classification of Resource Use and Management Activities and expenditures). The "ecobilancio" illustrates the primary expenditure for

[10] OECD, 'Paris Collaborative on Green Budgeting. Green Budgeting Framework Highlights' (2020) <https://www.oecd.org/environment/green-budgeting/>.

[11] Indeed, at the national government level, green budgeting involves the production of three main documents: the "ecobilancio dello Stato", based on draft budgets; the "ecorendiconto dello Stato", based on closed accounts and the "Catalogo dei sussidi ambientalmente dannosi e dei sussidi ambientalmente favorevoli".

[12] See Agenzia per la protezione dell'ambiente e per i servizi tecnici (APAT), 'Il bilancio ambientale del Comune di Venezia' (2006) <https://www.isprambiente.gov.it/files/pubblicazioni/quaderni/ambiente-societa/3704_Bilancio_comune_Venezia.pdf>

[13] <https://www.isprambiente.gov.it/files/pubblicazioni/manuali-lineeguida/3455_bilancio_mlg_50_2009.pdf>

each Ministry and each Mission, preliminary and final.

The central (and local) administration is quite complicated and composed of many entities, some of which are formally private. That is why the ownership of State-owned companies implies compliance with budgetary rules towards the achievement of environmental objectives as imposed on the State and this is obtained mainly through the consolidated financial statement, which offers a complete vision of the economic, financial and patrimonial situation of a group of entities, collecting all the statements of the bodies involved. In this case, a green consolidated financial statement is obviously connected to the green objectives set out by the holding company or body[14].

Another local example of green budgeting implementation is from the Swedish city of Växjö[15], whose experience dates back to 2003, as part of a broader sustainability strategy, with the aim of making it "the greenest city in Europe"[16]. It is important to underline that the resources to be included in the first version of the ecobudget were selected through a participative process, within a coordination team, involving local, environmentally aware politicians and the stakeholders, regularly discussing the environmental problems of the municipality.

To accomplish this, two documents, regarding both the ordinary budget and an ecobudget, were prepared. For the municipality of Växjö, the ecobudget, as a tool through which to highlight how the municipality was utilising local as well as global natural resources, was conceived as an instrument to guide the public administration toward environmental aspects, and therefore "the use of the ecobudget gave the administration a conceptual framework for thinking about environmental initiatives to be made and both costs and opportunities related with them"[17].

Following this, the two budgets were reunited into a one document. Environmental resource use objectives and a corresponding set of indicators were incorporated into draft budget programs during the financial budget preparation and the entire budget had to be voted on by the city council[18]. Obliged to use the same methodology on drafting each part of the respective budget, each municipal department was then considered responsible for achieving the objectives and for incorporating the budget indicators into their action plans[19].

On the understanding that the ecobudget needs an action upstream and a control downstream, two other tools were conceived: the Environmental Program and the Master Plan, in order to set out the main goals, future aspirations and detailed measurements for different sub-programs, and a Performance Measurement System, left to individual implementation by every municipal employee[20]. Eventually, the city council appointed an ecobudget manager, who presents a report to it every six months in order to take appropriate measures in case a target was missed. The underlying idea of the municipality of Växjö's ecobudget is that this document is not a static one but is intended as a dynamic process subject to changes just as environmental objectives change[21]. It is interesting to note that the example provided by the Swedish city

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[14] See OECD, 'Green budgeting. Towards common principles' (2021) 25: "The commitments made by state-owned enterprises are being developed, with green budgeting being an evolving practice. Many countries surveyed by the OECD are progressively integrating sustainability-related values into government SOE ownership policies. For example, SOE ownership policies in France and Norway require SOEs to reduce their GHG-emission footprints and report their progress in their annual reports".

[15] J Alpenberg and T Wnuk-Pel, 'Environmental performance measurement in a Swedish municipality. Motives and stages' (2022) Journal of Cleaner Production 370:133502.

[16] The Declaration for Sustainable Växjö 2030 states that: "with the declaration […] we promise to take our local and global responsibility for people, the environment, and the economy. We who live, reside, and work in Växjö by 2030 will not cause any negative effects on the climate as a community. Europe's greenest city in 2030 is climate and eco-smart, safe and trusting, fair and responsible, growing and inclusive, green and healthy. With this declaration, we invite everyone who is willing and able to participate to contribute". See J Alpenberg and T Wnuk-Pel, 'Environmental performance measurement', cit., 4: "the overall objective of these efforts was to secure a healthy environment for generations to come. This was going to be done through utilizing local as well as global natural resources (land, water and the physical environment), in a resource-efficient and eco-sustainable manner".

[17] Ibid., 4.

[18] Ibid., 4.

[19] Ibid., 5.

[20] Ibid., 5.

[21] In any case, from the website of the city results that since 1993, the emissions of fossil carbon dioxide have been reduced by 48% per inhabitant.

was followed by other local entities, in other parts of the world, including throughout Asia[22].

The last example, regarding an upper level of government, is from the French state, where the first green budgeting experiments were conducted mainly in cities and large municipal associations, supported by the Institute for Climate Economics (I4CE), a think tank founded by the Caisse des dépôts et consignations (CDC) and the French Development Agency (Agence Française de développement – AFD)[23].

In this case, the national government is the pioneer of a green, specifically climate concerned, budgeting and several municipalities and municipal associations followed the example[24]. In particular, article 179 of the French Budget Act 2019-1479 of 28 December 2019 stipulates that the government shall submit to the Parliament, as an appendix to the budget bill, a report on the environmental impact of the budget.

On this basis, in September 2020 the "*Report on the Environmental Impact of the Central Government Budget*" was drafted to replace the previous ecological transition financing report. The Report is made of three parts: part I describes the environmental impacts of the budget's appropriations and tax expenditures and how they measure up against France's commitments (i.e., the main results, also mission by mission); part II updates the information presented the previous year in the ecological transition financing report as an appendix to the 2020 budget bill (i.e., consolidated view of all funding directed toward the ecological transition, both public and private); and part III presents an overview of environmentally allocated public resources and tax measures, using the methods adopted by OECD and Eurostat.

In this case, methodological principles are better determined, since the classification method considers "the multidimensional aspect of the environment by identifying the impact of expenditures on six environmental objectives that were inspired by the European taxonomy of activities"[25], also attributing a color tag for each of the environmental objectives in accordance with a scoring system made by three different voices: favorable expenditures; unfavorable expenditures; and neutral expenditures[26].

4. Evidence shown by local examples

These experiences of green budgeting show that local public sector can play a driving role in implementing new green models that can be followed by other organizations, both public and private, at higher levels and in different territories in order to pursue environmental objectives.

Specifically speaking of public finance, one of the main issues of enabling environmental concerns into budgeting processes is identifying all the environmental targets and consequently all the suitable indicators to track the progress towards meeting those targets, which is a pre-requisite for undertaking a more comprehensive green budgeting approach. In this sense, general principles are central. These are now stated into the OECD, *Green budgeting: towards common principles*, 2021[27] and constitute a sound basis that need a constant review in order to meet old and new objectives imposed on national states by international agreements.

Thirdly, implementing green budgeting rules, as well as other types of budgeting rules (e.g., gender or social) requires a strong political commitment, that is more common to find at a local level rather than at a national level, even though the consequences of climate change are forcing central states to rethink all the tools necessary to achieve environmental and climate targets[28].

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[22] ICLEI 'Managing environment and poverty in Asian cities: An ecobudget guidance' (2010) <https://iclei-europe.org/fileadmin/templates/iclei-europe/lib/projects/tools/push_project_file.php?uid=LMA5E9FZ>.

[23] The Institute for Climate Economics (I4CE) is a non-profit research organization that provides independent policy analysis on climate change mitigation and adaptation, promote effective, efficient and socially fair climate policies among national and local authorities, financial institutions, and companies and therefore to develop green budgeting methodologies.

[24] Since 2020, the regions of Occitanie, Grand-Est and Brittany have all launched green budgeting practices, adopting a pragmatic approach within a broader planning and programming regional activity, cfr. OECD 'Aligning Regional and Local Budgets with Green Objectives: Subnational Green Budgeting Practices and Guidelines' (2022) <https://www.oecd.org/governance/aligning-regional-and-local-budgets-with-green-objectives-93b4036f-en.htm>.

[25] Ibid., 7.

[26] Ibid., 8.

[27] <https://www.oecd.org/gov/budgeting/green-budgeting-towards-common-principles.pdf>.

[28] R Biesbroek et Al., 'Do Administrative Traditions Matter for Climate Change Adaptation Poli-

5. Final remarks

Green budgeting practices are an evolving subject matter that are country-specific and fit within the existing national finance legal frameworks. This is the issue that needs to be addressed for European countries: common principles and common methods need to be implemented at a European level through binding rules. It is no coincidence that the legal shape of the European climate law is a regulation[29].

Nonetheless, the analysis showed how, from local examples, international principles and rules were conceived and, as in a virtuous circle, it helped local and national communities to use the gained experience to introduce best practices at a national level and back to the local and the international one as a mutual exchange.

Following local examples, the OECD, together with the European Commission (DG-REGIO), developed the paper *Aligning Regional and Local Budgets with Green Objectives. Subnational Green Budgeting Practices and Guidelines* in 2022[30], with the aim of assisting any region or city in identifying its strengths and potential gaps for starting a green budgeting practice or improving an existing one. This paper provides a self-assessment tool (SAT) that allows the user to evaluate where they stand across seven green budgeting dimensions. For each dimension, there is a series of sub-criteria against which the user ranks their level of experience ranging from "advanced" to "none".

As seen, green budgeting rules are an evolving field and the success of reaching environmental objectives will emerge from an intelligent interaction among global, national and local levels[31].

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cy? A Comparative Analysis of 32 High-Income Countries' (2018) Review of Policy Research 35:6 881.

[29] The regulation (EU) 2021/1119 (European Climate Law) established the regulatory framework for achieving the objective of climate neutrality under the Paris Agreement by 2050, based on the consideration that climate change is "by definition a cross-border challenge and coordinated action at Union level is necessary to effectively complement and strengthen national policies. Since the objective of this regulation, namely the achievement of climate neutrality in the Union by 2050, cannot be sufficiently achieved by the Member States but can rather, by reason of its scale and effects, be better achieved at Union level, the Union may adopt measures, in accordance with the principle of subsidiarity as set out in Article 5 of the Treaty on European Union" (recital n. 40).

[30] <https://www.oecd.org/governance/aligning-regional-and-local-budgets-with-green-objectives-93b4036f-en.htm>.

[31] See also IMF, 'Climate-Sensitive Management of Public Finances-Green PFM' (2021) <https://www.imf.org/-/media/Files/Publications/Staff-Climate-Notes/2021/English/CLNEA2021002.ashx>.

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