Letter to the Editor

Italian National Health Service immunized by COVID-19?

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Key words

COVID-19 • Italian national healthcare system • Litigation • Indemnity reparation

Dear Editor,
After lots of reforms the Italian healthcare system has changed on many levels from the inspirational idea of National Healthcare System (NHS) and its universality [1-3]. At the same time, recent Italian Legislation has expanded the perimeter of citizen's right of health, beyond psycho-physical well-being, but better as an extension of self-determination right. The aforementioned principle was also emphasized by a recent Italian Supreme Court pronunciation, that stated the right of compensation for injuries of the self-determination principle, putting the right of health within the sphere of the rights of freedom [4, 5]. Moreover, the Legislator with Laws no. 24/2017 and no. 219/2017 has strengthen the role of doctor in society, doctor-patient fiduciary relationship and citizens' accountability [6, 7]. In this legislative framework, COVID-19 emergency displayed the great strengths, but also the weaknesses of Italian NHS, always considered as one of the best in the world [8]. As professionals in healthcare, with a *forma mentis* more prone for the juridical aspects of medical art, and from these considerations, we draft emerging implications on the holding of our NHS after COVID emergency, mainly in a risk management way, proposing some solutions, especially as the state of emergency continues.
First of all, on the model of clinical risk prevention, Authors emphasize a deflationary approach, already well organized in many hospitals, but to be extended to the whole health sector, especially to protect general practitioners, who were unable in this emergency to handle all requests and are potentially exposed to litigation. In this horizon, the medico-legal causal assessment of any improper conduct and their eventual health consequences becomes pivotal, in order to quickly and effectively filter patients' claims, already growing, rose by COVID-19 patients but also by non-COVID-19 patients. For this purpose, medico-legal support is advocated for a better overall evaluation, in order to reduce judicial issues between *costumers* and professionals.
Secondly, and logically after the causal assessment of the health damage, it is to contemplate the introduction of an indemnity system opposed to current compensation method, considering both the contingent state of *force majeure,* subsequent to national emergency declaration by the Council of Ministers [9], and the impossibility of granting same health rights to people as in peace-time, given the sudden *revolution* of Healthcare Service. In this sense, looking at European Legislation, there is already a tradition of indemnity-compensation, both in France and in Germany, for example regarding nosocomial infections, where liability system is characterized by the formula of no-fault or objective liability. In a healthcare system such as the French one, with the prevalence of a Bismarck mutualistic funding, the interest in better control of the health damage outlay was certainly greater. This would allow to plan ahead and better the disbursement from health damage, first of all by the structures. As for years and as stated by the Gelli-Bianco Law no. 24/2017, with this approach hospitals could have better knowledge of their budgets and consequently of their self-retention fund. The most important implication of this methodological approach, the no-fault liability, is not to blame medical conduct, since there is no purpose of *offense* repression in the medical activity as a whole, in particular during this extraordinary emergency. The French principle is so simple on the procedural front that effective on the deflationary and economical level: if the error could be attributed to the frailty of the Institutions, responsible for the public service, who failed to guarantee the right to health because unprepared to manage a irresistible situation -here pandemic-, health-workers' responsibility, but also healthcare managers' responsibility, must be excluded [10-14]. The patient then, such as in hospital infections or compulsory vaccination, has any *onus probandi* and receives an indemnity, financed by mutual insurance funds for illness. In this special condition of emergency and exception to the natural rule, in view of *factum principis,* planning an adverse event management method, prior to the lawsuit, could be fundamental. Fair compensation for damage is granted, with the incomparable advantage of knowing previously the relative value.
The question of liability in the COVID-19-era arose urgently. Authors do not consider possible and disagree to undo responsibility at all: responsibility is the fundamental element that guarantees the professional diligence in particular, and the care of mankind in general. Nor do Authors agreed, as professionals, on the amendments, withdrawn, of deleting *d'emblée* the liability of the structures towards damages to operators. The insurance companies, called into question already by the Gelli-Bianco Law, will also have to commit themselves to the protection of the health professionals and health system [7]. We conclude by discussing the very foundations of the current financing

https://doi.org/10.15167/2421-4248/jpmh2022.63.1.1858

and organization system of healthcare. The pure Beveridge model works with a general taxation system and with the instruction on the correct use of such a precious and expensive system, therefore Authors appeal to collective commitment, without forgetting that this model alone is no more sustainable. Rethinking healthcare architecture and taking the lesson from the emergency, we should clarify relations among stakeholders (State, Regions, Local Authorities) and strengthen the Regional primary care system. On this perspective, the synergic participation of all health players is needed in order to build a mechanism in which the State intervenes not only to compensate deficits, but also to encourage a more efficient Regional health organization, integrating both the territorial medicine and the hospital management. The pandemic forced all the players – stakeholders, clinicians and citizens – to rethink our precious healthcare system, particularly its resilience, to still ensure health right for all in the future.

Acknowledgments

We dedicate this study to the memory of our Professor Antonio Osculati, our greatest instrument, rethinking to Quintilian, "that without which the matter cannot be shaped to achieve its purpose".

Ethical approval

Not applicable.

Conflict of interest statement

Authors state no conflict of interest.

Funding sources

This article did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Authors' contributions

AR: conception or design of the work and drafting. VB: conception or design of the work and drafting. CC: drafting and final version approval. GB: drafting and final version approval. PB: drafting and final version approval. JQ: drafting and final version approval. LPT: supervision and final editing.

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Received on November 10, 2020. Accepted on February 28, 2022.

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How to cite this article: Radogna A, Bolcato V, Carelli C, Bini G, Braga P, Quaiotti J, Tronconi LP. Italian National Health Service immunized by COVID-19? Medico-legal considerations. J Prev Med Hyg 2022;63:E4- E5. https://doi.org/10.15167/2421-4248/jpmh2022.63.1.1858