Presidenza del Consiglio dei Ministri

COVID-19: PUBLIC HEALTH, INDIVIDUAL FREEDOM, SOCIAL SOLIDARITY

28 May 2020

CONTENTS

Presentation

In this opinion, the Italian Committee for Bioethics (ICB) seeks to provide a bioethical frame of reference to the many issues raised by both the COVID-19 pandemic and the measures taken to counter it. The ICB takes note of the exceptional nature of the threat posed by COVID-19 to the health of individuals and the community, which calls for renewed reflection a) on health, in its multiple dimensions (physical, psychological, social); b) on the relationship between individual health and public health; c) on the relationship between the principle of freedom and autonomy of the individual in managing his or her own health and the principle of solidarity.

In considering the dialectic between these principles, the ICB considers it essential to distinguish between "extraordinary" interventions (*lockdown* and limitation of citizens' freedom), adopted in the most acute phase of the pandemic and justified by the seriousness of the threat to public health and "ordinary" interventions, in line with current health policies (which as a rule do not conflict with individual autonomy, since they leverage citizens' awareness). The reflection of the ICB is particularly useful today, when efforts are being aimed at resuming the "normal" life of the country, without however excluding a return to using exceptional measures in correlation with a possible exacerbation of the pandemic curve. It should be noted that the reflection itself takes place in a climate of general uncertainty, due to the paucity of scientific knowledge so far on the virus and the still limited experience of interventions to counteract a pandemic of this seriousness. Dialogue is required between different branches of knowledge and social experience, in order to manage uncertainty.

The opinion takes into account the experience gained in the first months of the pandemic, in the dual direction of 1) taking stock of the *lessons learnt* (with reference to the preparedness and imbalances of the National Health Service (NHS); 2) providing an *overview of the challenges* that are still to be faced (assessment of the impact of public containment measures on fundamental rights, on inequalities between citizens, to verify that those which already exist are not accentuated, or new ones created, or that differences translate into inequalities). In this context, special attention is given to particularly vulnerable groups (from children, to people with disabilities, to the elderly, prisoners and others). Public contagion containment strategies range from actions that fall within the scope of ordinary public health policies up to the limitation of certain fundamental freedoms (due to their exceptional nature, according to the criteria of proportionality, efficacy and time limitation).

The ICB calls for: a) an overall rethinking of our welfare system, and its strengthening after years of cuts; b) taking account of the fact, dating back, that the alteration of ecosystems has favoured and favours the spread of previously unknown pathogens; c) a return to the fore of "ordinary" public health policies, which are based on the awareness of citizens as a fundamental element for the protection of health, when planning prevention measures for the phases following *lockdown*.

The opinion was prepared by the coordinators, Profs: Tamar Pitch, Monica Toraldo Di Francia, Grazia Zuffa and by the working group made up of the Profs: Luisella Battaglia, Stefano Canestrari, Marianna Gensabella, Assunta Morresi, Luca Savarino.

At the 28 May 2020 session the opinion was approved by the majority of those present, Profs: Salvatore Amato, Luisella Battaglia, Stefano Canestrari,

Carlo Casonato, Bruno Dallapiccola, Antonio Da Re, Lorenzo d'Avack, Mario De Curtis, Riccardo Di Segni, Gian Paolo Donzelli, Silvio Garattini, Mariapia Garavaglia, Marianna Gensabella, Assunta Morresi, Laura Palazzani, Tamar Pitch, Luca Savarino, Lucetta Scaraffia, Monica Toraldo di Francia, Grazia Zuffa.

Prof. Francesco D'Agostino voted against.

Dr. Maurizio Benato, delegate of the President of the National Federation of MDs and Dentists Colleges, Dr Amedeo Cesta delegate of the President of National Research Council, Dr. Paola Di Giulio delegate of the President of the Superior Health Council, despite being ex officio members without the right to vote, wished to express their support for the opinion. Dr. Carla Bernasconi, delegate of the President of the National Federation of the Orders of Italian Veterinarians, Prof. Carlo Petrini, delegate of the President of the National Institute of Health, absent from the session, without the right to vote, also expressed their support for the opinion.

Profs: Carlo Caltagirone, Maurizio Mori, Lucio Romano, Massimo Sargiacomo, absent from the session, also endorsed the opinion.

1. The bioethical framework

The ICB intervenes for the second time on the bioethical issues raised by the current COVID-19 pandemic, after the recent document that developed the specific topic of patient access to treatment under conditions of limited health resources[1].

For several months our country, along with almost all the world, has faced an unprecedented pandemic threat due to the spread of a previously unknown coronavirus, identified in December 2019. This virus can also spread from asymptomatic subjects and, in some cases, has serious and even deadly effects on health, percentages vary from country to country, depending on the age of the subjects and the severity of associated pre-existing conditions. In Europe, the soaring phase of the contagion curve seems to have ended. However, as the World Health Organization (WHO) points out, this does not mean that it is the end of the health emergency, which presumably will last until the discovery and large-scale availability of a vaccine and/or the development of effective treatments.

Almost all countries have put in place public health countermeasures never adopted before, in an attempt to "flatten" the contagion curve in order to contain and postpone the spread of the virus, so as to allow health systems to deal with the impact of the epidemic explosion. The choice of countermeasures has been, and is, particularly difficult for governments, as there are currently few scientific certainties regarding the virus.

The common exposure to the risk of contagion is, therefore, made more dramatic by the growing awareness of the limited nature of our knowledge. Covid-19 emblematically highlights how the risks are not only global in their scope, but also unpredictable owing to their complexity, pervasiveness and novelty. We still have no certainties, among other things, on what the real spread of the virus is within the population, the role and extent of asymptomatic cases, the seasonal behaviour of the disease, the degree of immunity of human beings, the time necessary to have an effective available vaccine in sufficient quantities to cover the various population groups.

This opinion takes note of the exceptional nature of the threat, which justifies the exceptional nature of the measures taken by public authorities. In particular, the state of profound uncertainty on the side of scientific knowledge has meant that *lockdown* measures have been adopted in many countries, including Italy, as the safest remedy for the containment of infection in the initial phase of greatest expansion of the epidemic. Months later, we note that they have in fact led to a drastic reduction in the rate of infection[2]. These are measures justified, as mentioned, by the emergency, but which have serious repercussions on the economic and social side, as well as on the psychological-relational one, and which therefore can only be temporary. However, we know, and it is an ongoing process, that these measures will be replaced, subject to falling virus transmission rates, by other less restrictive measures, which - presumably - will accompany us for many months, if not years. There is also the hypothesis of an alternation of more or less stringent measures in correspondence with the trend of the contagion curve. The new digital technologies for the tracing of contagions are placed in this context, in various application methods. Due to its complexity,

[1] Italian Committee for Bioethics (ICB) opinion, *Covid-19: clinical decision-making in conditions of resource shortage and the "pandemic emergency triage" criterion*, 8 April 2020.

[2] See Imperial College, COVID-19 Responsive Team, Report 20: *Using mobility to estimate the transmission intensity of Covid-19 in Italy*: *A subnational analysis with future scenarios*.

the problem of how to use them for the benefit of public health in respect of the protection of personal data will not be addressed in this opinion, but postponed for subsequent in depth-analysis[3].

The ICB deems appropriate a reflection on the pandemic and the measures taken to counter it, in light of the delicate relationship between individual health and public health, while keeping in mind the different (physical, psychological, social) dimensions of human health.

In this reflection, the ICB starts from the unanimous belief that health is a primary good. For our Constitution, the protection of health is a fundamental right of the individual as well as of the community: the public commitment for the protection of health derives primarily from the principles of universality and equality.

Our public health service is inspired by principles that, both ethically and legally, revolve around the centrality of the person and the protection of his/her right to health, respecting freedom (freedom of choice in selecting the care location, patient autonomy in the right to be informed of treatments and refusal or renunciation of those already started; right to privacy etc.)[4]. The epidemic emergency has, however, laid emphasis on the principle of solidarity, with which autonomy and the rights of individuals must be combined. The principle stems from an awareness of the interdependence among human beings and, therefore, of the possible effects of protecting the health of each person on the health of others. Solidarity is primarily expressed as individual responsibility, which has become mandatory with the emergence of the epidemic, following correct behaviours to protect from infection not only for oneself, but also for others. Therefore even subjects at least risk have a duty to protect themselves from infection, in the interest of those most vulnerable. In the discussion on strategies to combat the epidemic, it is possible to note tension between individual health and public health and between the bioethical principles in place to safeguard one and the other. On the one hand, in the international context, the role of public health has become increasingly important, to the point of being considered a fundamental dimension of human security[5]. On the other hand, as mentioned, the

[3] The issue of privacy in relation to the use of personal data has already been addressed by the ICB in two opinions: *Mobile Health Apps: bioethical aspects,* 28 May 2015; *Information and communication technologies and big data: bioethical issues,* 25 November 2016. The protection of personal data is not just an individual right to privacy issue. As mentioned in the document *Contact tracing and democracy: open letter to decision makers,* promoted by the Nexa Center for Internet and Society, "the power generated by the access and treatment of large amounts of personal data is capable of profoundly changing relationships and relations between people and especially between different social actors, between consumers and businesses and inevitably between citizens and the state. The right to the protection of personal data, which has become a fundamental right for the first time right here in Europe, attempts to govern this power and has a much wider perimeter than the simple protection of confidentiality and privacy, a right to which many in this period are abstractly willing to give up in exchange for safety on their health" (https://nexa.polito.it). On the subject of the protection of personal data during the COVID-19 epidemic, see European Data Protection Board-EDPB, *Statement on the processing of personal data in the context of the COVID-19 outbreak*, 19 March 2020, https://www.garanteprivacy.it/home/docweb/-/docweb-display/docweb/9295504; the opinion of the Spanish Bioethics Committee, *Informe del Comité de Bioética de España sobre los requisitos ético-legales en la investigación con datos de salud y muestras biológicas en el marco de la pandemia de COVID-19*, 28 April 2020.

[4] Recently, the centrality of the principle of autonomy was reaffirmed by Law 219/2017.

[5] Report of the Secretary-General Human Security, A/64/701, 8 March 2010; Report of the Secretary-General, Follow-up to General Assembly Resolution 64/291 on Human Security, A/66/763, 5 April 2012.

individual's right to health and autonomy must accord with the principle of solidarity, recognising the interdependence between human beings. However, it is not only the responsibility of the individual, but also the collective responsibility (of the State and its institutions) to link up with solidarity so that both the burden of the pandemic and that of restrictive measures do not create new inequalities, or accentuate existing ones. This includes, for example, interventions to relieve the burden of measures to close economic activities, which affect categories of citizens who are more disadvantaged than others.

Finally, with respect to the connection between the public dimension and the individual dimension of health, it should be remembered that current public health policies do not conflict with individual autonomy, since they usually leverage the awareness of citizens. This does not exclude the possibility of recourse, where this fails and where deemed necessary, to mandatory interventions, which however are treated as exceptions.[6]

In the framework of reference outlined, between health and individual rights and public health, this opinion aims to reflect on the measures to contain the epidemic, trying to identify, even in the state of uncertainty mentioned above, the ethical criteria to adhere to, such as proportionality, the effectiveness of interventions, the evaluation of undesirable effects.

Attention must be turned to the "ordinary" horizon of public health interventions[7] which need to be strengthened to "prepare" to sustain long term collective efforts - by individual citizens, communities, institutions - to counter the virus. Particular attention is also required for those groups considered particularly vulnerable, because they are more exposed to the danger of contagion and at the same time more affected by the severity of the measures necessary to counter it.

Finally, it should be noted that all the reflection is carved out in a climate of general uncertainty, in which awareness of the still scarce scientific knowledge on the nature of the virus impacts our lives on different levels: we cannot predict whether we will be able to restore the economic and social levels that existed before the pandemic.

For this reason, the processes of scientific elaboration, in which we also place hope, must be rethought in the light of systematic and continuous global and interdisciplinary collaboration. To manage the uncertainty in which we are immersed, we need trust: but more than just relying on specialists, we must rely on dialogue between different branches of knowledge and social experience. As a consequence, politics cannot neglect the dependency of countries on one another and the need for a relationship of mutual support in a common action for the survival and maintenance of adequate levels of well-being. Welcoming the exhortation of the *European Group on Ethics in Science and New Technologies*, it is therefore hoped that the pandemic emergency will be re-elaborated as a call to collective commitment to foster solidarity, both at the European and global level[8].

[6] We can cite the case of vaccines, addressed by the ICB in the unanimously approved motion, *The importance of immunisation*, 24 April 2015. In conclusion, the ICB recommends that all efforts be made to maintain adequate coverage through health education, not excluding their obligatoriness in the event of an emergency.

[7] See the ICB opinion, *A call for safeguarding the National Health Service,* 26 January 2017.

[8] European Group on Ethics in Science and New Technologies (EGE), *Statement on European Solidarity and the Protection of Fundamental Rights in the COVID-19 Pandemic* (March 2020):

The experience of the past months and the debate that has followed today call for deeper reflection on the issues of public and social ethics that the epidemic raises or dramatically highlights. A reflection that looks ahead to the choices that will have to be faced in the coming months.

2. The lessons learnt: preparation for the extraordinary event, imbalances in the "ordinary" health system

Aware of the margins of unpredictability with respect to the problems that new pathogens can raise, it is nevertheless worth asking whether the pandemic could have been foreseen and mitigated by adequate preparation.

Already in 2005 the World Health Organization (WHO) had drafted recommendations to the member states of the United Nations in anticipation of the possibility of a flu pandemic caused by a persistent virus, such as avian influenza which appeared in 2003, inviting them to prepare national plans to mitigate the impact[9]. In the last decade, authoritative international organizations, supported by the work of scientists from different disciplines, have raised the alarm on the risk of virus epidemics, on the basis of the increasingly frequent recurrence of epidemics such as SARS, MERS etc. In addition to the September 2019 Report of the *Global Preparedness Monitoring Board*[10], internationally, mention should be made of the work of the *Global Health Security Index*, promoted by the *John Hopkins Bloomberg School of Public Health*, which shows a general lack of preparation even in countries with the most developed health and social systems[11]; at national level, the *National plan for the preparation and response to a flu pandemic* (prepared in 2006 after the avian influenza in 2003 by the Ministry of Health) has not been updated since 2010.

It remains to be understood - but it is not the subject of this opinion - why the majority of states have faced the current pandemic without adequate preparation[12].

In any case, the enormous spread of the contagion, with its numerous victims, means that the issue of *preparedness* for health emergencies has today a dramatic new significance[13]. We note in passing that this is an issue to be

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"Trust and transparency: This pandemic should be seized, not as an opportunity but as a call, to foster solidarity at the European and global level".

[9] See *WHO Global Influence Preparedness Plan* (2005), https://www.who.int/csr/resources/publications/influenza/WHO_CDS_CSR_GIP_2005_5.pdf.

[10] The 2019 report of the *Global Preparedness Monitoring Board*, an independent body for the prevention of health emergencies headed by the World Health Organization (WHO) and the World Bank, is significantly entitled *A World at Risk*, https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf.

[11] https://www.ghsindex.org/wp-content/uploads/2019/10/2019-Global-Health-Security-Index.pdf.

[12] A significant exception is South Korea, which has faced the current pandemic strengthened by the severe test faced with the *Severe Acute Respiratory Syndrome* – MERS in 2003. South Korea has managed to contain the virus with better results than European countries, making extensive use of tests, strict quarantine rules for those tested positive, tracking of social contacts of those tested positive. See K. HILLE, E. WHITE, *Asian lessons in virus control*, in "Financial Times", March 17, 2020. However, although these measures were promptly adopted, even Korea has had to face again a return of the infection to its capital Seoul, after only a short period of respite.

[13] On the theme of *preparedness*, see also the aforementioned opinion of the ICB on the COVID-19 emergency, p. 5. It can also be remembered that, at the supranational level, on the occasion of other epidemics, for example in the case of bovine spongiform encephalopathy (the so-called "mad cow disease"), reference was made to the "precautionary principle" to set the action of individual states in order to achieve common levels of protection. The precautionary principle was

considered in the broader context of prevention, as a priority tool for the protection of public health, and that it has been present, as a concern for the health of all the inhabitants of the planet, as a fundamental bioethical issue, since its beginnings in the 70s[14]. *Preparedness* is therefore only apparently a new element: the pandemic emergency actually highlights a duty to which we have long been called, to take care of health in a preventive way, bearing in mind the close interdependence not only among human beings themselves, but also among all living things. This topic will be taken up later.

In addition to scarce preparation for the emergency, the acute phase of the epidemic has also revealed the "ordinary" deficiencies in our health system. Notwithstanding recognition of the enormous and generous efforts of the health personnel of hospitals and family doctors, and of the huge commitment to reorganisation at the socio-health level carried out in order to deal with the emergency, the shortcomings of *family medicine and territorial services*, heavily penalised over the years, have come to light. In particular, the insufficiency of the system of prevention has been highlighted. This is also significant in the phase of overcoming confinement in homes: to avoid the resumption of activities and social exchanges leading to new peaks of infection, it is necessary to have defined epidemiological screening plans, laboratories able to quickly analyse biological samples, protective equipment easily accessible to all. We are already moving in this direction, but much remains to be done. There is a need for efficient and branched community medicine, precisely in the sector in which the most worrying deficit has been recorded. These deficiencies are only partially attributable to the cuts of recent years to public health service. More at the root, the overall balance of the system should be rethought - between prevention and treatment, family medicine and high specialization, territory and hospital – given how it has developed in an unbalanced way over the decades. A relevant question is in particular the lack of integration between the social component and the health component. In other words, it seems necessary and urgent to implement the relationship of continuity-integration, with a synergy of objectives (despite the difference of functions) between hospital and territory, the importance of which has been underestimated in recent years, given that a model of public healthcare centred on large hospitals has been privileged.

To this there must be added the strong regional imbalances in the possibility of access to quality care, including home care. Such an imbalance has led to a worsening of "iniquitous inequalities"[15] in various sectors, which the ICB has repeatedly drawn attention to[16]. As far as the current emergency is concerned, one need only think, just to give an example, of the fact that in some territories, many people who needed palliative care and pain therapy did not have access to

introduced in the EU precisely to manage scientific uncertainty relating to environmental and health risks. See the ICB opinion, *Precautionary principle: bioethical, philosophical and legal aspects,* 18 June 2004.

[14] V. R. POTTER, *Bioetica*: *Ponte verso il futuro*, tr. it., Sicania, Messina 1971.

[15] As explained in the Introduction of the ICB document, *Bioethical guidelines for equal access to healthcare* (25 May 2001), inequalities in the destinies of populations and individuals attributable to human responsibilities are identified as iniquitous, that is, unjust. From the point of view of distributive justice, practical measures, to mitigate the effects of these de facto disparities, may require differentiated treatments in favour of those most disadvantaged.

[16] See among other documents the ICB Motion *Inequalities in healthcare during and after childbirth: a national emergency,* 29 May 2015.

it; while in others the Palliative Care Network was able to promptly reorganise itself and give its essential help to patients with coronavirus[17].

Rethinking the overall balance of the system is a task shared by several European countries with developed public health services. It must be urgently addressed to strengthen a system which, despite these shortcomings, has been found to be the one most capable of withstanding the impact of the pandemic and - due to its universality[18] of rebalancing, at least in part, the inequalities that the pandemic tends to exacerbate.

3. The most important challenges facing us

As already stated, we are in the midst of the battle against coronavirus with limited knowledge not only on the characteristics of the virus, but also on the relative effectiveness of the various public policies implemented in the different countries to contain the epidemic and their undesirable side effects, especially on the economy and resilience of the social body.

Among the many issues, in this opinion the ICB has chosen to focus on some that appear to be priorities at this time: an overview of the impact of public containment measures a) on the fundamental rights of citizens[19]; b) on the accentuation of previous inequalities between citizens and on the emergence of new ones, with particular reference to some particularly vulnerable groups, such as children, disabled people, the elderly, prisoners and others.

4. Public policies for epidemic containment

While waiting for the vaccine, countries have put in place epidemic containment measures. These are of various types ranging from widespread information campaigns on hygiene measures, useful medical devices (such as masks), appropriate behaviour regarding physical distancing, to the introduction of prohibiting certain behaviours and activities.

As for the former, these actions fall within the scope of ordinary public health policies, following the consolidated democratic path of appealing to the civil awareness of citizens, to which the state is required to offer adequate support (through information, dedicated services, etc.).

As for the latter, in the countries where the rule of law is in force, prohibitions require the careful reflection of institutions, but also that of the citizens to whom they are addressed, when the limitation of certain fundamental freedoms[20] is

[17] Without however modifying, in a restrictive sense, the activation and acceptance procedures, at a basic and specialist level, of the normal assistance guaranteed by the Network. In the field of palliative care, the fundamental problem remains of the lack or insufficient integration with the therapies directed to treating the disease. This is a pre-existing deficiency that in the past weeks has had dramatic consequences, not only in terms of lost lives, but also of extreme suffering that could have been avoided. On the importance of implementing palliative care networks on the national territory, see the opinions of the ICB, *Deep and continuous palliative sedation in the imminence of death,* 29 January 2016; *Bioethical reflections on medically assisted suicide,* 18 July 2019.

[18] See the ICB opinion *A call for safeguarding the National Health Service,* 26 January 2017.

[19] The aforementioned EGE document also moves in the same direction, and urges European countries to make this assessment, calling for vigilance "about the necessity, evidence, proportionality of any policy and technological intervention that, even temporarily, suspends fundamental rights".

[20] See the Council of Europe document, which provides states with an unprecedented guide to tackling the ongoing health crisis in compliance with democratic rules and values (*Respecting*

involved. The issue has been the subject of debate, also in Italy. On a legal level, limitations such as those of freedom of movement, assembly, economic initiative, religion are to be considered not in conflict with the Constitution, when it comes to facing a serious threat to public health. On an ethical level, these measures respond to a principle of solidarity, in consideration of the interdependence between individual and collective health, particularly close in times of pandemic. However, due to their *exceptional* nature, these measures should respond to criteria of *proportionality*, *efficacy*, *limitation* in time, and the possibility of judicial appeal. Proportionality calls for the utmost attention of the authorities in choosing the measures, evaluating the different levels of invasiveness and controlling their consequences, especially *the undesirable effects*. The social tolerability of the measures must also be taken into consideration, since, as we will see later, they impact differently on different social groups, accentuating inequalities. Especially if it is deemed necessary to adopt the most restrictive measures, these should be justified by evidence of their effectiveness. However, in relation to this last requirement, the limits must be underlined at this stage, in consideration of the still insufficient knowledge on the virus and its methods of spreading. As for the time limitation criterion, this is all the more stringent, the more invasive the measures are. This calls on governments to make a special commitment to support research and dialogue with science (the topic will be discussed in more detail later).

A further element must be carefully considered in the implementation of exceptional measures: the risk that they may be considered a precedent even in the future requires that their exceptional nature must always be present in the debate and in public communication. In addition, the rules should be as clear and unambiguous as possible, trying to avoid their being multiplied, so as not to undermine public confidence in the work of institutions in times of crisis.

These criteria are valid also and above all in the post-lockdown phase. After the period of home confinement and the ban on individuals' movement unless for reasons of necessity, aimed at the exclusion and/or extreme limitation of social contacts, countries are moving towards risk containment strategies compatible with social functioning. In the initial phase of fighting coronavirus, the strategies followed by countries, even those that share a common democratic tradition, were not identical[21]. Again, the essential role of research, together with international cooperation, should be remembered not only to speed up the preparation of a vaccine, but also to evaluate the containment policies to be implemented, in terms of benefits and costs, taking into account the many variables at stake in dictating

Democracy, Rule of Law and Human Rights in the Framework of the COVID-19 Sanitary Crisis, April 7, 2020). The document draws the attention of the Member States to the need to deal effectively with the crisis, while ensuring that the measures adopted do not undermine the fundamental European values of democracy, the principle of legality and fundamental rights. The Council of Europe must therefore continue its mandate by ensuring that the measures taken are proportionate to the threat of the virus and limited in time.

[21] At the moment there is not a single containment model for the epidemic and there is much debate as to whether an extreme model like the Chinese one could be applicable in countries with different socio-political and cultural traditions. Hence, as the *Nuffield Council on Bioethics* notes, the importance of research to evaluate the effectiveness of extreme *lockdown* measures on the one hand, and social costs on the other, especially in terms of mental health and employment: in order to have indications on the proportionality of these measures, https://www.nuffieldbioethics.org/assets/pdfs/Ethical-considerations-in-responding-to-the-COVID-19-pandemic.pdf.

each specific strategy. An interdisciplinary type of research is required which holds together natural and social sciences.

5. The relationship between science, politics, information

As already pointed out by UNESCO[22], an international collaboration effort is needed (all the more desirable given the difficulties that occur at this level) and, together, "an interdisciplinary dialogue between scientific, ethical and political actors"; as well as a close relationship of dialogue and collaboration between research and the political decision makers, in the clarity of their respective roles. Political choices cannot be legitimised only by science: politics has the particular and irreplaceable task of mediating between different needs of society and of composing them in an overall design in the public interest. This is evident, if we think about the undesirable effects of some virus containment measures such as blocking a large part of production activities: valid from an epidemiological point of view, but with heavy economic and social repercussions. The burden of choice, in the delicate evaluation of costs/benefits, is the main terrain of politics.

In this field too, the role of information, by institutions, technical-scientific committees, the media is crucial. The completeness and transparency of institutional information strengthen public confidence: this trust is all the more precious in a time of difficult choices. The media, professional journalists, public broadcasters play a key role in acting as a link between the news coming from government bodies and technical-scientific committees and the public. It pertains to their competence and professional ethics to give correct information, adhering to the truth of the facts, avoiding sensationalism, trying to prevent panic and arouse feelings of cooperation[23]. The communication professionals' right-duty to provide information, a fundamental right in any democracy, can, if correctly implemented, be a valuable vehicle for the free and responsible assessment by citizens of the restrictive rules laid down by the authorities, and this regards both their proportionality and their duration and effectiveness.

6. The undesirable effects of disease containment policies

It has already been stated in the premise that the initial adoption of extreme *lockdown* measures was successful in blocking the rapidity of the spread of the infection. However, undesirable effects have also emerged, linked both to the block of economic and social functioning, and to economic, social, cultural inequalities and those related to gender, age, health conditions or disability. The strong inequalities of resources that already characterise our societies are likely to deepen, both because of contagion and disease and due to the measures to deal with it[24].

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[22] Cf. UNESCO International Bioethics Committee and World Commission on the Ethics of Scientific Knowledge and Technology, *Statement on COVID-19: Ethical Considerations from a Global Perspective*, 26 March 2020.

[23] *Respecting Democracy, Rule of Law and Human Rights in the Framework of the COVID-19 Sanitary Crisis*, cit., par. 3.3.

[24] The consideration of *the undesirable effects of* the contagion containment *policies* is linked to the criterion of proportionality of the measures chosen. It deserves particular attention, all the more because at the moment there is still no evidence of efficacy that can safely guide the choice of pandemic containment models.

It is true that we are all in the same boat, if we understand the boat as our planet. However, the starting levels of health are different, as well as the economic resources available. The restrictive measures, in turn, cannot but impact very differently on those who travel in first class and those travelling in second or third[25]. With obviously different outcomes on the physical and mental health of the sailors. If we are in the same boat, it is also true that it is very difficult, if not impossible, to save ourselves, without others. Human beings are social beings, and as such are interdependent with each other and with the surrounding environment. Taking care of each other is not, therefore, only a moral obligation, which arises from the recognition of the "vulnerable" component, which is in each of us; it is the only way to ensure the health and survival of each and all. And there are "others" with particular vulnerabilities: we should take special care of them.

The first risk to report is that of creating and or increasing inequalities. For example, in the *lockdown* regime, the distinction - however reasonable and obligatory - between necessary and unnecessary activities, exposes workers of the former to greater risk, compared to others who remain at home. On the other hand, home confinement impacts the population differently, starting with housing conditions. Think of those who live in very small and dilapidated houses, or in situations of overcrowding, or contending with violent partners. The same right to education, now implemented through digital tools, is severely compromised for those who, at home, do not have these tools or an adequate connection. The impact is all the more serious for the most disadvantaged groups, as will be discussed in detail in the next paragraph: among others, the most fragile and vulnerable subjects such as children, the elderly, people with disabilities, patients with non-covid pathologies, the homeless, the inhabitants of Roma camps, prisoners.

Even the right to physical and mental health is at serious risk. As far as psychological health is concerned, the traumatic effects of a long quarantine are reported from many quarters. Again, mental health is more at risk for people with previous problems. In the current debate about the timing and methods of the phases following the *lockdow*n, the appeal to "health first" often occurs. The slogan is sometimes used in a simplified way to contrast health with the resumption of work activities. There is, of course, some truth in a situation where health is threatened by a very serious danger and survival is the primary goal. However, health understood as "feeling well" is also linked to having confidence in the future, job security, acceptable economic conditions, the possibility of being with loved ones.

Not even the emergency can make us forget the many dimensions of health and how health is dependent on the possibility of using a multiplicity of direct and indirect resources: among which, in addition to those of an economic nature, certainly important, and remembered by all several times, is the presence of a network of affection and social relationships, the absence of which can negatively affect people's health through the psychological states it activates (depression, anxiety, etc.)[26] . The containment measures have resulted in new forms of poverty and deep states of loneliness: think of the elderly, people with disabilities, the sick, the many who lived the last stages of life separated from their loved ones.

[25] On the concept of inequality, see A. SEN, *La disuguaglianza*: u*n riesame critico*, tr. it. Il Mulino, Bologna 1994.

[26] See the Introduction to the ICB document, *The living conditions of women in the third and fourth age: bioethical aspects of social health care,* 16 July 2010.

7. The most vulnerable groups

The pandemic and the measures taken to contain it make evident the vulnerability pertaining to us all, but they also create new forms of economic and social vulnerability, as well as exacerbating pre-existing conditions of particular vulnerability.

A particularly significant impact occurs on *children* and *adolescents*. Traumatic experiences in childhood, which include different forms of violence, cumulative exposure to adverse events, material and psychological deprivation, can lead to pathologies in adulthood and generate significant social damage. Hence the need for particular attention to the repercussions of disease containment measures on the psychological balance of children[27], as well as taking particular care to make these measures as tolerable and understandable as possible. In addition to the psychological aspect, the medical aspect also emerges: during the emergency many children with chronic diseases were not adequately followed up, running the serious risk of worsening their health. In addition, many children did not carry out recommended vaccinations, due to the improper closure of several vaccination centres, and also because of the parents' fear of contracting the infection by going to health facilities[28].

The closure of schools and the blocking of educational and training institutions, although necessary, have dramatically increased the level of social exclusion, for those who are already at the greatest risk of dropping out of school.

In an emergency, the highest price is however paid by *children with disabilities*. The fear is that without schools, without therapies, without home care, children and adolescents with different degrees of disabilities will regress, since no special distance learning has been provided for them. Hence further discrimination reported by families, for which the most fragile subjects are paying for the weaknesses of the Italian school system.

People with disabilities, whether they are minors or adults, live, in fact, a condition of particular vulnerability that forced physical distancing can only exacerbate. As recalled by the *UN Convention on the Rights of Persons with Disabilities*, the latter is given by the interaction between the impairment and the barriers placed by society, and there is no worse barrier than isolation. Social inclusion is in fact an integral part of the rehabilitation process which, as the ICB notes in 2006 in the opinion *Bioethics and Rehabilitation*, must always be addressed to the person according to an approach that is not merely medical, but bio-psycho-social[29].

The attention, already present in our country on the condition of people with disabilities in the current emergency[30], must therefore be targeted from time to

[27] See the initiative of SIPPED (Italian Society of Paediatric Psychology), which has made available to the Ministry of Health a free consulting service and telephone and online support called Lègami/legàmi.

[28] It should be borne in mind that an interruption of vaccinations, even if only for a short period, can lead to an accumulation of susceptible subjects and, therefore, to a greater risk of new epidemics as has already happened in past years for measles (see *Appeal of the Calendar for Life Board: maintain and increase coverage by reorganizing vaccination services and reassuring the population,* https://www.sip.it/2020/04/24/mantenere-ed-incrementare-le-coperture-vaccinali-nei-bambini-e-negli-anziani-evitiamo-di-aggiungere-epidemie-alla-pandemia/)

[29] ICB Opinion, *Bioethics and Rehabilitation*, 17 March 2006.

[30] See the news published on the website of the Presidency of the Council of Ministers, Office for Policies in Favour of Citizens with Disabilities, http://disabilita.governo.it/it/notizie/oms-linee-

time to calibrate the support measures according to the different disabilities, bearing in mind that apparently neutral measures, such as the use of masks, may, for some mental disabilities, may be difficult to accept, and that the difficulty of accessing telematic supports, where adequate facilitators are not provided, reinforce the risk of marginalisation for many people with disabilities.

Other particularly vulnerable groups *are people with serious non-Covid diseases* who risk seeing their situation aggravated by the impact of coronavirus on the health system*; the elderly and institutionalized elderly*, *people locked up* in prisons. As regards these last two groups, the ICB continues the reflection it began some time ago, reporting the particular vulnerability of subjects whose health is totally in the hands of the institutions supervising them, albeit in different capacities. Drawing attention to them again is all the more important today, at the moment of maximum health crisis.

People with non-Covid pathologies constitute a varied group, in which vulnerability has a different weight depending on the severity of the disease, and includes, among others, patients with rare diseases, cardiovascular and neurological diseases, cancer patients and onco-hematological patients[31], immunocompromised patients[32], those generally defined as "chronic" patients. For all, the right to care in the emergency encounters many difficulties. Some appear objective, such as the restructuring of hospital departments implemented to make room for the facilities dedicated to Covid, and the related need to concentrate the medical staff of other specialist units in these facilities. Others are subjective. These patients in fact face two fears: on the one hand, the first caused by the increased risk of infection, which keeps them away from hospitals, and on the other, the second is connected to a possible worsening of the pathology, due to the lack of medical checks. Often the first, amplified by the emotion with which the emergency is presented by the media, takes precedence over the second. Hence the decrease reported by several parties in the use of hospital care by both chronically ill patients and by patients in acute crisis, with serious repercussions in terms of risks to health and life. In this sense, activation of telemedicine assistance services can be of help[33], in order to reconcile the two objectives set out in antithesis by the Covid emergency, helping to combat that sense of distrust and abandonment, which can lead not only to postpone necessary medical checks or interventions, but also to the discontinuation of already established and practicable therapies.

Among the mentioned groups with particular vulnerabilities, special consideration should be given to the *elderly*, primarily because they have paid and are still paying the highest price in terms of human lives. This is especially

guida-su-disabilita-ed-emergenza-sanitaria/ and, at an international level, the guidelines published by the WHO on April 27, 2020, *Disability Considerations During the COVID-19 Outbreak,* http://disabilita.governo.it/media/1365/who-english-covid-19-disability.pdf.

[31] Ministry of Health, *Recommendations for the management of oncology and ono-hematology patients during COVID-19 emergencies*, 10.03.2020.

[32] Ministry of Health, *Recommendations for the management of immunocompromised patients residing in our country during COVID-19 emergencies*, 27.03.2020.

[33] The activation of telemedicine services must be calibrated according to the physical, but also psychological and social conditions of the individual recipient, trying as much as possible to address the risk that the digital divide creates further inequalities between patients. See National Institute of Health (ISS) Report COVID-19, n.12/2020, *Interim provisions on telemedicine healthcare services during COVID-19 health emergency,* 13 April 2020, https://www.iss.it/documents/20126/0/Rapporto+ISS+COVID-19+n.+12+EN.pdf.

true for, the most fragile, those confined in Nursing Homes[34]: the fact of being admitted to social and health institutions, without any chance of leaving, transforms this potentially protective factor into an additional danger. In other words, they have paid the price of the general unpreparedness of the health system before others and more than others in identifying the chain of infection, in correctly informing the care workers on prevention measures, and finally in providing them with the personal protective equipment to avoid contracting the disease[35]. The inability to cope with coronavirus in Nursing Homes has expanded the previous inefficiencies and distortions in care to the elderly, which are still widespread, despite the fact that in Italy there is no shortage of good experiences. In particular, a culture of abandonment emerged, combined with an authoritarian attitude in managing the lives of fragile people[36]. It is hoped that this painful affair will be an opportunity to rethink and redesign the system of taking charge of the most fragile, the elderly, with a preference for home-based care, as the place of care and protection[37]; while in the short term, ensuring that adequate prevention measures are adopted throughout the country[38] by providing specific prevention guidelines for health and social residences for the elderly.

The situation of *persons deprived of their liberty and imprisoned* is particularly critical, also because the starting conditions are critical, and are already difficult to reconcile with the principles of punishment, which, according to art. 27 paragraph 3 of the Constitution cannot consist of treatments contrary to the sense of humanity and must aim at the re-educating of the sentenced person. Prisoners, male and female, represent a "*highly vulnerable bio-psycho-socia*l"[39] group, which must be recognized the right to equal opportunities in health protection. However, this right "*contradicts the very condition of the deprivation of liberty*"[40].

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[34] In Italy, according to Italian National Institute of Statistics (ISTAT) data from 2015, there are 12,828 residential health and social care facilities which include Nursing Homes (RSA), they host over 382,000 patients, including 288,000 elderly people over 65.

[35] Significant data from the National Survey on COVID-19 contagion in residential and social and health facilities, of the National Institute of Health in collaboration with the National Guarantor ~~of~~ for the rights of people detained or deprived of liberty. The 3,276 facilities that responded to the Survey represent 96% of the total. Some data provided by the Third Report, as at April 14, 2020 https://www.epicentro.iss.it/coronavirus/pdf/sars-cov-2-survey-rsa-rapporto-3.pdf: from February 1 the number of deceased was 6,773, either swab positive (364), or with flu-like symptoms (2,360). In total, this is 40.2% of the deaths attributable to COVID. Regarding the difficulties encountered in managing the emergency, the staff cites first of all the lack of protective equipment, secondly the impossibility of carrying out swabbing testing detecting positivity.

[36] In the aforementioned National Institute of Health Survey, 14,118 restraints were reported. While considering the limitations of the telephone survey on such a sensitive issue, however, the data calls for further attention on the issue of the restraint of the elderly, previously reported and denounced by the ICB (See the ICB opinion, *The bioethical implications of medical restraints,* April 23, 2015).

[37] *See* G. LIOTTA, L. PALOMBI, M.C. MARAZZI, *Ora basta RSA, si punti decisamente sull'assistenza domiciliare*, in "Quotidianosanità.it", 30 April 2020. This does not mean that all the elderly can be cared for at home, but it should be understood as a recommendation so that institutionalisation is considered a last resort.

[38] In more detail, calling for the provision of protective equipment, with the highest priority, for both guests and operators, to ensure the coordination, control and constant monitoring of the facilities in compliance with the guidelines. See the document of the HelpAge Italia non-profit association, which is part of the HelpAge global network.

[39] This is what was stated in the opinion of the ICB, *Health "within prison walls",* 27 September 2013.

[40] *Ibidem*.

This contradiction calls for a commitment from the institutions, which must be strengthened in this emergency[41].

The people locked up in prisons are in already overcrowded living environments where it is not possible to follow the indications of prevention and physical distancing, as happens "outside" prison walls. If people are locked up, however, prison is an open place, also unfortunately for the spread of the contagion, where many workers enter and leave every day. It is therefore a high-risk location for both detainees and prison officers.

On the basis of the principle of equal opportunities in health protection, measures to reduce the risk of infection are therefore called for by reducing the number of prisoners (also taking into account that around 30% of prisoners are in pre-trial detention)[42]. A periodic screening plan for all staff and detainees must be prepared by the health authorities as well as the organisation of living spaces in order to guarantee, as much as possible, distance between people. In addition, premises must be set up inside or outside the prison for the individual isolation of positive prisoners. Special support to deal with the psychological stress related to the restrictions for contact with family members and volunteers is also desirable, together with the search for solutions to safely resume work and educational activities[43].

With regard to those deprived of their liberty, it is also necessary to consider persons currently detained in the *Permanence Centers for Repatriations (CPR)*, which are also often crowded and where it is difficult to maintain physical distance. Here, too, careful consideration must be given to the psychophysical stress to which these people are subjected.

Migrants without a residence permit represent another group that is highly at risk, both for the economic situation in which they find themselves (take for example, the impossibility of working, above all, but not only, as agricultural labourers, domestic workers, carers, etc.) and the difficulty in accessing health services[44].In some countries it has been decided, for these reasons, to proceed with their mass legalisation, to make these people "visible" and therefore more protected against the risk of infection, both for themselves and for those with whom they come into contact. Under such conditions, with regard to the socio-economic aspect, it enables the *male and female workers, working "off the books"* without any form of protection, to be found.

There are also *Roma and Sinti people*, many of whom live in sites generally without adequate sanitation (and sometimes without toilets), in overcrowded

[41] This is also recommended by the Council of Europe in the document of 7 April 2020.

[42] The regulatory capacity of at least 47,000 people should be reached, even if, to ensure the isolation of those who are positive, it is calculated that it would be necessary to drop to less than 40,000 people.

[43] These are indications in line with what is indicated by authoritative international bodies, such as the WHO guidelines contained in the Report *Preparedness, Prevention and Control of Covid-19 in Prisons and other Places of Detention,* 15 March 2020, and *Statement of principles relating to the treatment of persons deprived of their liberty in the context of the coronavirus disease (Covid-19) pandemic,* published by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on 20 March 2020.

[44] See the opinion of the ICB, *Migration and Health*, 23 June 2017. In that document the focus was identified "in the protection of 'health', a principle carved into the Italian constitutional identity as a social right, that is, as an asset of the person and the community, to be guaranteed, in its essential content and without discrimination, to everyone on the national territory, regardless of whether people have reached our country legally or not, whether they are illegal migrants, refugees, asylum seekers or so-called economic migrants".

conditions and without traditional forms of livelihood (carousels, iron and copper collectors, beggings, etc.). For those living confined to so-called camps, any type of outside help (apart from volunteering) was suspended during the lockdown. Their already precarious health conditions due to the very low quality of life can only worsen due to the restrictive measures in place[45].

8. A particular and transversal iniquitous inequality

The measures taken to contain the spread of the pandemic have a different impact depending on gender. First of all, we point out the serious problem of family violence: confinement accentuates the risk run by women (and children) of being subjected to violence by abusive partners. The Donne in Rete contro la Violenza (D.i.Re) association, which brings together 80 anti-violence centres, reports that there were 2,857 requests for help between March 2 and April 5, that is 74.5 percent more than the monthly average of 2018, the latest on record.

However, the impact of restrictive measures also has other effects: in fact, they risk deepening the inequalities of the economic and social resources between men and women, and, in perspective, of limiting the freedom and opportunities of the latter more than those of the former[46]. The traditional division of labour, still persistent, entrusts to women the majority of domestic work and care work. This means that, in a situation where schools and kindergartens are closed, and will remain so at least until September if not later, with distance learning (and, as often stated, there is a difficulty in accessing digital devices and an adequate internet connection) many women find it impossible to continue their work outside the home with sufficient ease, or at least with the same continuity as their partner. Unemployment and the wage gap are likely to persist and worsen even after the end of confinement. Globally, the female-dominated work sectors, such as services and the service sector in general, are and will be those most affected by the crisis. In addition, many women have informal jobs without welfare and social security protection[47]. The Committee hopes that due attention will be paid and the necessary resources will be used to diminish and mitigate gender inequality that certainly dates further back in time, but is particularly serious today. Inequality has negative repercussions not only on the psycho-physical well-being of women, but also on children both boys and girls, and more generally on the entire community, being made up of men and women.

9. Final considerations

The current pandemic, therefore, and the measures taken to contain it, worsen the social and health conditions of important segments of the

[45] See the appeal of Dijana Pavlovic in “L’Inkiesta”, April 3, 2020

[46] See "La Repubblica", May 2, 2020, where the results of a study published in the World Bank Blogs are reported: "There is a high risk that gender inequalities will widen during the pandemic and that cultural and social achievements will evaporate, in the accumulation of human capital, economic emancipation and the specific weight of women and girls in society".

[47] See also R. HUTT, *The Coronavirus Fallout may be Worse for Women than for Men*, in "World Economic Forum", March 12, 2020; A. RINALDI, *Donne e uomini: perché si rischia un passo indietro*, in “Econopoly”, 23 Aprile 2020; A. CAMILLI, *Donne e lavoro: perché la pandemia rischia di spingerci indietro*, in “Internazionale”, 27 April 2020.

population[48]. In Italy, in addition to the measures taken by the government, a great and meritorious effort is underway through the organised voluntary work of territorial associations, but also by individual citizens, in order to at least partially mitigate the consequences of the emergency on the most fragile population. However, the situation is not expected to improve in the coming months and in any case the mobilization of volunteering is not enough today let alone tomorrow. An overall rethinking of our welfare system, and how to strengthen it after many years of cuts, is therefore necessary. A good welfare system highlights and leverages the interdependence between human beings, that is, solidarity, without which the two fundamental values of freedom and equality do not exist, or they exist only for few people (and very few females).

a) Between individual responsibility and collective responsibility

Hence, reasoning on the risk that could be taken at this stage, in placing the almost unequivocal emphasis on *individual responsibility* regarding adherence to the measures to prevent the spread of infection. If the appeal to individual responsibility is justified at this time, the exclusive emphasis on it is likely to lead to resentment and aggressive behaviour by citizens towards other citizens accused of non-compliance with these measures. This emphasis goes hand in hand with the underestimation of collective responsibility, which, in a democratic society, lies with the State and its institutions. This underestimation is not only "discursive", but very real: it is up to the State to create the conditions for a healthier life (pollution, etc.), to provide measures that protect individuals and public health with respect to the risk of disease, to implement such social policies to enable everyone to lead "healthy lifestyles".

The crisis we are going through is an opportunity to redefine priorities and hierarchies, since we have realised that those who are most indispensable are often the most fragile, the most precarious, the most exploited, that is, all those who perform jobs that can only be done "in person": essential trades such as the production of food and basic necessities, the maintenance of the network of services, the healthcare system, the provision of care for dependents and everything that is called social work.

The transition from individual responsibility to collective responsibility calls for this situation to be addressed, and leads to a redefinition of job hierarchies - and therefore of working conditions and wages - being brought closer to reality.

The assumption of responsibility by citizens also implies another aspect: taking care of others (*care*). Thinking of responsibility as related to concepts of relationality and limitation allows the transition from the individual dimension to the social-collective dimension: today more than ever, the responsibility of each and everyone is expressed by taking account of how one’s actions affect not only one’s neighbours, but also those who are geographically distant and those who have yet to be born. It also allows to link this to another basic concept of bioethics, that of "care": not only self-care but also care for the other and other inhabitants of the planet.

In other words, individual responsibility can be delineated as both the responsibility *of* and the responsibility *for*. In the first case this means that one

[48] The hardest impact on the most fragile and disadvantaged groups is found in all countries: in the United States, for example, the most affected by the disease are of African descent, Latinos, and in general the poorest people.

acknowledges responsibility only as regards the consequences of our actions, while in the second case responsibility is taken for others (we take care of the consequences on others). This second meaning is more closely related to collective responsibility. Solidarity comes into play here, understood as an awareness of the unavoidable *interdependence* of all human beings on each other and between humans and other living beings[49], which entails adherence to a "circular" concept of health: with the health of each and every person being dependent also on the protection of the "natural" environment and the welfare of non-human animals.

We do not yet know the origin of this specific virus. However, we know that viruses which can be lethal for humans can have different origins, ranging from the laboratory, to human behaviour that does not respect basic hygiene rules in the consumption and sale of wild animals, to crossing the species barrier. The alteration of ecosystems and subtraction of the natural habitat from wildlife has often favoured the spread of previously unknown pathogens. The animal origins of diseases and pandemics – recently, such as AIDS, Sars and Covid-19 today - are a reality well known to those who have been involved in public health for years; local wild animal markets can be ideal opportunities for their transmission. Furthermore, since research is carried out on viruses, in order to know their behaviour, study their possible impact on humans, and find relative treatments and vaccines, this calls for vigilance and continuous monitoring of the laboratories involved, so as to avert as far as possible the risk of an accident involving virus escape.

The coronavirus pandemic will sooner or later pass but the choices we are called to make today will change our lives for a long time[50].

b) Between behaviours defined by law and *empowerment*

The exceptional nature of the measures taken in the most acute phase of the epidemic has already been mentioned, justified by the exceptional nature of the threat of the coronavirus. It has already been stressed that these measures cannot be continued beyond the emergency[51].Therefore, in planning prevention measures for the phases following lockdown, "ordinary" public health policies come back to the fore: they revolve around the awareness of all citizens and are pivotal in the defence of public health and jointly of individual health. When people

[49] This acceptation of individual responsibility is opposite to that which is hegemonic today, which presupposes the absolute independence of the "good" citizen from all others and especially towards the resources of the State. In addition to Jonas and Lévinas, the extensive feminist literature on care can be cited.

[50] In fact, the crisis we are experiencing transcends national borders and requires global solutions to the point that the only serious criticism addressed today to the authorities on predictive matters is that they did not firmly support, after SARS, the research that would have made available to the medical world truly effective means of action against the new epidemic. We are elements of an ecosystem in which the health of every human, animal and environmental element is strictly interdependent with the others. For this reason we should think of an integrated approach and speak of a "circular health" (One Health) whose key word is interdisciplinarity and in which collaboration between the world of human medicine and that of veterinary medicine is fundamental.

[51] This is also underlined by the aforementioned EGE document: "Restrictions of rights and freedoms that are imposed to save lives in an emergency situation, however - included those implemented through technological surveillance through mobile devices through to drones and surveillance cameras - need to be removed, and data destroyed, as soon as the emergency is over or infringements are no longer proportionate".

are made aware of the facts and scientific advances and are confident that public authorities act with the utmost transparency, they are generally very willing to adapt to virtuous behaviour for their own good and that of others.

In other words, acting to increase people's ability to "master" their own health is the royal road for public policies in an open society, choosing to leverage subjectivity (while not excluding exceptions). Historically, it has also been successful in eradicating many diseases and saving many lives, thanks to the simple adoption of hygiene rules by the great majority of citizens[52].

[52] As Yuval Noah Harari writes (The World After Coronavirus, *Financial Times*, March 20th, 2020): “today billions of people wash their hands, not because they are afraid of soap police, but because they understand the facts”.