Freedom, Security & Justice: European Legal Studies

Rivista giuridica di classe A

2025, n. 3

EDITORIALE SCIENTIFICA

Rivista quadrimestrale on line "Freedom, Security & Justice: European Legal Studies" www.fsjeurostudies.eu
Editoriale Scientifica, Via San Biagio dei Librai, 39 - Napoli
CODICE ISSN 2532-2079 - Registrazione presso il Tribunale di Nocera Inferiore n° 3 del 3 marzo 2017

Freedom Security Justice
European Legal Studies

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2025, n. 3

Editoriale

FOCUS
Migration and Religion in International law: Research-based Proposals for Inclusive, Resilient, and Multicultural Societies

This focus is the final output of the research project of national interest Migration and Religion in International Law (MiReIL). Research-based Proposals for Inclusive, Resilient, and Multicultural Societies*, funded by the Italian Ministry of University and Research and by the European Union – NextGenerationEU in the framework of the "Piano nazionale di ripresa e resilienza (PNRR)"*

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Commenti e Note

RELIGIOUS MIGRATION, HEALTH, AND HEALTHCARE ORGANISATION

Davide Monego *

SUMMARY: 1. Introduction. – 2. The Right to Health in the Supranational Context. – 3. The Right to Health in the Italian Constitution. – 4. The Right to Health in Italian Legislation. – 5. Religious Factor and Migrant's Health: Cultural Mediation. – 6. Beyond Mediation.

1. Introduction

The problem of the protection of the right to health of religious migrants must first be framed within the more general one concerning the relationship between migration and health, so as to be able to grasp the contents of health protection, not only as set up in the legal regulation, but also from the point of view of their administrative guarantee, since, even considered in itself – and therefore even in the presence of adequate regulatory protections – the application phase may affect, possibly even unequally, the effective guarantee of the right.

In this perspective, the importance of the religious factor in the context of healthcare is relevant, a profile that obviously does not concern only the migrant, but with reference to this specific subjective category it appears more significant, given the ascertained heterogeneity of the flows that originate from an extremely large number of States, with a consequent miscellany of religious convictions, and more generally cultural identities, with which the host community necessarily comes into contact, including the healthcare system.

Double-blind peer reviewed article.
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This paper is part of the final output of the research project of national interest *Migration and Religion in International Law (MiReIL). Research-based Proposals for Inclusive, Resilient, and Multicultural Societies*, funded by the Italian Ministry of University and Research and by the European Union – NextGenerationEU in the framework of the "Piano nazionale di ripresa e resilienza (PNRR) – Missione 4, Istruzione e ricerca – Componente 2: dalla ricerca all'impresa – Investimento 1.1", Call PRIN 2022 released by DD no. 104 of 2 February 2022 [CUP J53D23005190006 – B53D23010420006].

2. The Right to Health in the Supranational Context

Even before being regulated by the Italian Constitution, the right to health finds recognition in the supranational context. In a nutshell, it is worth recalling the well-known definition of the concept of health accepted by the World Health Organization as a "state of complete physical, mental and social well-being",[1] thus exceeding the mere absence of disease: a notion aimed at directing public policies to the realization of a wide range of interventions (economic, social and of other nature), as suitable conditions to ensure that free and dignified existence without which it seems difficult to imagine the state of overall well-being evoked in the Preamble to the WHO Statute. A notion that, moreover, is so broad as to make it difficult to use when it is necessary to examine the degree of protection ensured by the health system, measurable in the same way as its suitability to provide everyone with that bundle of services (diagnostic, therapeutic, rehabilitative, etc.) necessary for the psychophysical care of the person.[2] Art. 25 of the Universal Declaration of Human Rights (UDHR) includes medical care in the varied set of goods (food, housing and so on) functional to ensure the individual a standard of living sufficient for his own well-being and that of his family.[3] For its part, Art. 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) requires the Contracting Parties to recognize the "right of everyone to enjoy the best conditions of physical and mental health that he or she is capable of achieving", adopting a series of measures of various content to this end.[4]

In the context of regional organizations, it is worth mentioning the "system" represented by the European Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and the European Social Charter (ESC), which constitutes its completion on the social front.[5] As is well known, the ECHR offers only a reflex protection of the right to health, which in fact does not find any formulation in it, which does not detract from the fact that the jurisprudence of the European Court of Human Rights (ECtHR) has reasoned about it in the light of certain expressly recognized rights, such as the right to life (Art. 2), the right not to suffer inhuman and degrading treatment (Art. 3) and the right to private life (Art. 8), sometimes invoked in response to the lack or insufficiency of the care guaranteed by the health service, sometimes instead in order to paralyze expulsion decisions, precisely because their

[1] Cf. the Preamble to the WHO Constitution, adopted in July 1946.
[2] In the sense that this formulation, due to its breadth, prevents it from being made the content of a fundamental right, see the opinion of the National Committee for Bioethics, Immigration and Health, 23 June 2017, pp. 1-26.
[3] On the value of the UDHR in judicial practice, see the contributions in S. TONOLO, G. PASCALE (eds.), *La Dichiarazione universale dei diritti umani nel diritto internazionale contemporaneo*, Torino, 2020.
[4] These include the reduction of infant mortality, the care of environmental and industrial hygiene, the prophylaxis, treatment and control of epidemic diseases, as well as "the creation of conditions that ensure medical services and medical assistance for all in the event of illness" (see Art. 12(2) ICESCR).
[5] On the ESC, for the profile in question here, see G. PALMISANO, *L'obbligo dello Stato di tutelare il diritto alla salute ai sensi della Carta sociale europea*, in L. PINESCHI (ed.), *La tutela della salute nel diritto internazionale ed europeo tra interessi globali e interessi particolari*, Napoli, 2017, pp. 189-205.

execution would have caused irreparable damage to the state of health of the subject, such as to constitute, depending on the case, inhuman treatment, unlawful interference in the private life of the person concerned or, more radically, a violation of the right to life.[6] The ESC, on the other hand, states that every person has "the right to take all measures to enable him or her to enjoy the best attainable state of health" (Part I, Para. 11) and, if he or she lacks economic means, to be guaranteed medical care (Part I, Para. 13).[7] Net of the necessary interposition of the legislator and the administration – common to the guarantee of effectiveness of the constitutional declarations of social rights[8] – it is understood that in this context there is a lack of European judicial protection in the strict sense of the word, the control carried out by the European Committee of Social Rights (ECSR) on compliance with the ESC having a different nature,[9] not to mention the subjective limit of effectiveness of the Charter, which tends to be limited to nationals of the Contracting States, resident or working in one of the States Parties (Annex CSE, Para. 1).

There remains the side of EU law. The competence in the field of "protection and improvement of human health" is certainly not "strong", being limited to a role of support for State policies through "actions aimed at supporting, coordinating or supplementing the action of the Member States" (Art. 6 TFEU), without prejudice to "the responsibilities of the Member States for the definition of their health policy and for the organisation and provision of health services and medical care" (Art. 168(7) TFEU).[10] The organization of health *welfare* obviously impacts on economic policy choices, which are to be maintained within the framework of State sovereignty. From this point of view, the principle of guaranteeing a high level of health protection in the policies and actions of the EU, also made explicit both in Art. 168(1) TFEU and in Art. 35 of the EU Charter of Fundamental Rights (CFR), implies a pre-existing competence which, with reference to the protection of health, does not allow for harmonization, as provided for in other sectors. Even clearer is the reference to "national laws and

[6] A. ALBANESE, *La tutela della salute dei migranti nel diritto europeo*, in *Rivista dell'Associazione italiana dei Costituzionalisti*, 2017, pp. 1-22, e C. CORSI, *Il diritto alla salute alla prova delle migrazioni*, in *Istituzioni del Federalismo*, 2019, pp. 45-75.
[7] See also Arts 11 and 13 of Part II.
[8] Cf. *infra* with regard to art. 32 of the Italian Constitution.
[9] Being oriented to produce "conclusions" on the reports submitted by States on the implementation of the Charter or to decide on collective complaints made against those States that have adhered to this procedure, in order to orient their legislative and administrative action in a compliant direction. On this point, see the remarks of C. PANZERA, *Compliance with international obligations and integrated protection of social rights*, in *Consulta online*, 2015, pp. 488-503, which enhances the "jurisprudence" produced by the Committee, such as to achieve an "updated and dynamic" interpretation of the text.
[10] See A. ALBANESE, *La tutela della salute*, cit., p. 1, as well as R. TARCHI, *European health systems to the test of immigration. Reflections on the margins of a Florentine conference*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2018, pp. 154-198. On the impossibility of currently building a European *welfare* model (also in terms of the means of financing) cf. A. PIOGGIA, *Diritto sanitario e dei servizi sociali*, Torino, 2024.

practices", as a parameter for defining the "right of access to preventive health care and to obtain medical treatment", made by the same Art. 35 CFR.[11]

On the other hand, with regard to migrants from third countries, there is, as is well known, a concurrent European competence (Arts 4 and 79 TFEU), widely exercised both with regard to regular migrants[12] and, even recently, with regard to irregular migrants[13], also laying down rules relating to the protection of health, which differ according to the relationship of the individual with EU territory and/or on the basis of the reasons for entry.

3. The Right to Health in the Italian Constitution

Art. 32 of the Italian Constitution conceives health not only as an interest of the community but also as a subjective "protean" right.[14] Different subjective situations arise from this right,[15] partly attributable to the logic of negative freedoms, as the right of the individual not to be harmed in his or her psychophysical integrity and to refuse treatment, i.e. not to be subjected to health treatment without his or her consent, except

[11] It is also known that the CFR is unsuitable for creating new competences for the EU institutions or modifying existing ones, as pointed out both by Art. 51(2) CFR and Art. 6(1) TEU.

[12] There are many directives that over time have regulated the *status* due to non-EU citizens in relation to the reason for entry and residence in a Member State, and therefore of the residence permit provided for from time to time. Think, for example, of movement related to research activities (Directive 2016/801/EU of the European Parliament and of the Council *on the conditions of entry and residence of third-country nationals for the purposes of research, studies, training, voluntary service, pupil exchange schemes or educational projects, and au pair* placement of 11 May 2016) or to the performance of highly qualified jobs (Directive 2021/1883/EU of the European Parliament and of the Council *on the conditions of entry and residence of third-country nationals for the purposes of highly qualified employment* of 20 October 2021), sectors for which health coverage is provided.

[13] Obviously, we are referring to the Pact on Migration and Asylum, consisting of 9 regulations and a directive, approved in May 2024 but destined to become effective from 2026, succeeding the previous EU directives, which are still in force (Directive 2011/95/EU, of the European Parliament and of the Council *laying down rules on the attribution of third-country nationals or stateless persons, of the qualification of beneficiary of international protection, on a uniform status for refugees or for persons eligible for subsidiary protection, as well as on the content of the protection granted* of 13 December 2011, so-called Qualifications Directive; Directive 2013/32/EU, of the European Parliament and of the Council *on common procedures for granting and withdrawing international protection* of 26 June 2013, so-called Procedures Directive; Directive 2013/33/EU of the European Parliament and of the Council *laying down standards for the reception of applicants for international protection* of 26 June 2013, so-called Reception Directive) in order to standardise the regulation of the matter. Within the new Pact, Regulation 2024/1349/EU of the European Parliament and of the Council *establishing a return procedure at the border* of 14 May 2024, in its Art. 4(3) is without prejudice to the health protection rules provided for by the Return Directive.

[14] To use the expression of C. TRIPODINA, *Art. 32 Cost.*, in R. BIN, S. BARTOLE (eds.), *Commentario alla Costituzione*, Padova, 2008, pp. 321-332.

[15] G. SCACCIA, *Art. 32 Cost.*, in F. CLEMENTI, L. CUOCOLO, F. ROSA, G.E. VIGEVANI (eds.), *La Costituzione italiana. Commento articolo per articolo*, Bologna, pp. 226-231, as well as B. PEZZINI, *Il diritto alla salute a quarant'anni dall'istituzione del servizio sanitario nazionale: le criticità strutturali di un diritto sociale*, in *BioLaw Journal – Rivista di BioDiritto*, 2019, pp. 117-146.

in the cases provided for by law and always with respect for his or her dignity.[16] In part, however, they can be ascribed to the scheme of benefit rights (in this case the right of the person to receive health care), addressed to the Republic, as a set of public powers called upon to satisfy them.

The concretization of the constitutional "programme" on health was achieved through the introduction of the National Health Service (NHS), with its guiding principles of universality of recipients and globality of services, in the sense of ensuring everyone, regardless of income situation, the full range of appropriate health services, in the same way as the available scientific knowledge:[17] a public service that, from an organisational-performance point of view, depends on regional legislation and administration, the "protection of health" falling within the matters of shared competence between the State and the Regions,[18] in compliance with the transversal State competence relating to the establishment of the essential levels of health services, currently specified in the Prime Minister Decree of 12 January 2017, which therefore concretely represents the egalitarian content of the right to health services. If anything, the question remains open, in the same way as the constitutional provision understood in isolation, not so much about the subjective scope of the right, as that relating to the entitlement to the entire bundle of services falling within the Essential Levels of Assistance (LEA, according to the Italian acronym). With regard to the first aspect, Art. 32, in addition to not limiting the ownership of the right to the citizen alone, in sanctioning its fundamental character seems difficult to subject to a restrictive reading, if the adjective is given an interpretation that links it, on the one hand, to the inviolable rights of man, which the Republic recognizes as a whole (Art. 2 of the Constitution), and on the other hand to the concept of equal dignity referred to in Art. 3 of the Constitution, as well as the principle of substantial equality contemplated therein: all elements converging in making it an essential – precisely "fundamental" – feature of our form of social democratic State.

As for the second aspect, it is well known that constitutional jurisprudence has long "segmented" the content of the right in question, identifying an irreducible core, as a minimum safeguard of the dignity of the person, as such insusceptible to limitation by reason of the nationality of the beneficiary (or other criteria in any case disconnected from the function of the subjective situation), and incompressible by the legislature, not even in the face of other interests of constitutional rank, whether it is a

[16] F. MINNI, A. MORRONE, *Il diritto alla salute nella giurisprudenza della Corte costituzionale italiana*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2013, pp. 1-12.
[17] Law no. 833 of 23 December 1978 *Establishment of the national health service*, Art. 1.
[18] On the allocation of legislative power in health matters, cf. D. MORANA, *La tutela della salute fra competenze statali e regionali: indirizzi della giurisprudenza costituzionale e nuovi sviluppi normativi*, in *Osservatorio costituzionale*, 2018, pp. 1 -25, as well as C. FASONE, *Tutela della salute*, in R. BIFULCO, A. CELOTTO (eds.), *Le materie dell'art. 117 nella giurisprudenza costituzionale dopo il 2001*, Napoli, 2018, p. 283.

question of budgetary balance[19] or public security, from the point of view of the government of incoming flows. Such a prospect does not therefore exclude the admissibility of differentiations in the "further" part of the right, i.e. the one that exceeds the perimeter of what must be guaranteed to anyone in a situation of need.[20] A perspective that can undoubtedly lend itself to criticism, as in fact happened,[21] not so much because there must be a coincidence between the irreducible core and the essential levels in the field of health protection, since they are different concepts and with different purposes,[22] but because, once the bar of "essential" services has been set, wherever it is placed, this level should apply to everyone,[23] all the more so when the limiting criterion affects a fundamental good such as health and operates by virtue of a legislative choice relating only to the relationship of the interested parties with the territory.

Be that as it may, the distinction has been explicitly affirmed by the Constitutional Court, precisely with regard to Art. 32 of the Constitution (judgment no. 252 of 2001), and is reflected in national and EU legislation, even if, in the practice of the health

[19] Constitutional Court, judgment no. 195 of 29 October 2024, according to which "[t]his Court, moreover, has stated that '[it] is the guarantee of incompressible rights that affects the budget, and not the balance of this that conditions their due disbursement' (judgment no. 275 of 2016); from this principle it follows that these rights, and in particular the right to health, involving the primary needs of the human person, cannot be sacrificed as long as there are resources that the political decision-maker has the willingness to use for other uses that do not have the same priority" (point 10 of the *Law*).

[20] Thus the Regional Administrative Court for Sicily, sentence no. 1325/2016, which states that if the subjective situation of the migrant is not to be traced back to the irreducible component of the right to health, the claim will be assessed "together with the other public interests of primary rank relevant in terms of residence and permanence".

[21] For a series of critical remarks on this distinction, cf. A. RANDAZZO, *La salute degli stranieri irregolari: un diritto fondamentale 'dimezzato'*, in *Consulta online*, 2012, pp. 1-31, and A. RUGGERI *Note introduttive ad uno studio sui diritti e i doveri costituzionali degli stranieri*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2011, pp. 1-27, which observes that it is not clear where the basis of the distinction between part and part of the structure of rights lies.

[22] Cf. A. ROVAGNATI, *I livelli essenziali delle prestazioni concernenti il diritto alla salute: un primo esempio di attuazione della previsione di cui alla lett. m), II comma, art. 117 Cost.*, in *Le Regioni*, 2003, pp. 1141-1176 and, recently, A. PIOGGIA, *Diritto sanitario*, cit., p. 60. In one case, in fact, we are faced with a competent title, which allows the State to intervene with a uniform discipline, in which "essential", in essence, is what the legislator considers it to be at a given historical moment. The *amount* of health care that can be provided at a given historical moment depends, first of all, on the resources available, but also on the idea of health protection that a certain system assumes as its own. It is therefore a notion that is not only indeterminate, until it is filled with content, but also changeable according to the individual context. On the other hand, the theory of incompressible content responds in order to limit legislative discretion in outlining the contents of a fundamental right, so that, once identified, it should be stable, or at least relatively stable over time. It follows that the essential levels can coincide with the nucleus, or go beyond, in the sense of being more guarantee-oriented: as long as they do not go below the level of protection that it expresses (E. CAVASINO, *Perché costruire il diritto alla salute come 'diritto a prestazione' rende le forme normative dell'uguaglianza dipendenti dal limite economico-finanziario e ridimensiona l'effetto garantistico del 'contenuto minimo essenziale*', in *Rivista Gruppo di Pisa*, 2012, pp. 1-31). On the various ways of understanding essentiality with regard to LEAs, cf. also M. ATRIPALDI, *Diritto alla salute e livelli essenziali di assistenza (LEA)*, in *federalismi.it*, 15.11.2017, pp. 2-18.

[23] G. VOSA, *"Cure essenziali". Sul diritto alla salute dello straniero irregolare: dall'auto-determinazione della persona al policentrismo istituzionale*, in *Diritto pubblico*, 2016, pp. 721-762.

service, one has the impression that (fortunately) it is only apparent, the LEA represents for everyone, Italians or not, the necessary point of reference in the provision of services.[24]

4. The Right to Health in Italian Legislation

As is well known, the basic text on the regulation of migrants not belonging to the EU is the consolidated law on immigration (Legislative Decree 286/1998, hereinafter TUI, according to the Italian acronym), which outlines a specific discipline precisely with regard to "health matters" (Chapter I, Title V), in which there is a sort of gradation – in relation to the enjoyment of the right to health – depending on the position of the foreigner: from an equivalence with respect to the citizen to a (at least formally) more reduced protection. In fact, for foreigners who are legally present, the obligation to register with the NHS applies, or, in other cases, the obligation to provide health coverage through voluntary registration with the health service or insurance policy. Two categories are therefore outlined, depending on the residence permit held by the person concerned. The first – that of those obliged to register, which results in full equality of rights and duties with respect to the Italian citizen – is the most comprehensive, given that there are many residence permits contemplated by Art. 34(1)(2) TUI,[25] as well as other specific provisions.[26]

As just mentioned, the legal presence in the territory does not always result in the need to register with the NHS, remaining hypotheses in which what matters to the legislator is that health insurance still exists, whether it is the public one, through registration with the NHS or whether it consists instead in the stipulation of a health insurance policy covering injury and pregnancy. The identification of this additional category is partly express, partly by difference. The first area includes foreigners who

[24] See the next paragraph.

[25] For work, international protection, unaccompanied minors, awaiting adoption, people applying for citizenship, medical care, to name a few. It should also be noted the interpretative-integrative scope assumed on this point by the Agreement signed in the State-Regions Conference in 2012, containing *Indications for the correct application of the legislation for health care to the foreign population*, subsequently implemented by 13 regions (see, for example, Article 21 of the Friuli Venezia Giulia Regional Law 31/2015): an agreement aimed at avoiding the repetition of the discrepancies found in the application of the TUI in the various Regions, given that they end up translating into violations of a fundamental right. Despite the time that has elapsed, it seems that not all critical issues have been overcome, according to P. OLIVANI, D. PANIZZUT (eds.), *Attuale legislazione sanitaria italiana per comunitari e stranieri irregolarmente presenti e attuale fruibilità di tale legislazione a livello delle regioni*, Fifth report, 2025.

[26] Other titles can be identified on the basis of different regulatory sources, as in the case of prisoners, pursuant to Article 1 of Legislative Decree no. 230 of 22 June 1999, *Reorganization of Penitentiary Medicine, pursuant to Article 5 of Law no. 419 of 30 November 1998*, or on the basis of extensive interpretations (such as for permits for health reasons in the event of expiry of a previous title and subsequent illness that does not allow them to leave the country, according to Interpretative Circular 5/2000, adopted by the Ministry of Health, containing *Indications for the application of Legislative Decree no. 286 of 25 July 1998*, published in the Official Gazette no. 126 of 1 June 2000.

have entered Italy for study purposes and those placed as *au pairs* (Art. 34(4) TUI), regardless of the duration of the stay. In the second, all the others, regardless of the (not mentioned) entry and permanence qualification, provided, however, that the latter lasts for more than three months (Art. 34(3) TUI and Art. 42(6) of Presidential Decree no. 394/1999).[27]

If, on the other hand, the foreigner is in an irregular situation, he or she is still ensured, at accredited public or private facilities, "urgent or in any case essential, even continuous, outpatient and hospital care for illness and accident" (Art. 35(3) TUI and Art. 43 of Presidential Decree no. 394/1999), as well as being subject to preventive medicine programs to protect individual and collective health. To clarify the scope of the words "urgency" and "essentiality", endowed – especially the latter – with a certain scope of indeterminacy,[28] the ministerial interpretative guidelines issued in 2000 come to the rescue. Urgency refers to "care that cannot be postponed without danger to life or damage to health". On the other hand, "health, diagnostic and therapeutic services, relating to pathologies that are not dangerous in the immediate and short term, but which over time could cause greater damage to health or risks to life (complications, chronicity or aggravation)" are essential.[29]

Finally, on the side of "essential" care, it should be noted that it is Art. 35(3) TUI itself that qualifies in these terms the entire range of treatments inherent in certain situations concerning the person, such as pregnancy, maternity, minors, situations in which, therefore, given the all-encompassing nature of the protection guaranteed, there is equal treatment with respect to the citizen (and obviously to the legal foreigner).

The coordinates of urgency and essentiality therefore represent the legislative measure of the irreducible core of the right to health, affirmed in constitutional jurisprudence,[30] and then translated into corresponding provisions of the TUI, among other things in a logic of continuity with respect to the previous health legislation, as regards the "urgent hospital care" due to foreigners, as established both by the so-

[27] The same, for example, for religious personnel, volunteers, researchers. For a more extensive discussion of the various types of residence permits relevant to the problem relating to the health coverage of foreigners, see C. CORSI, *Il diritto alla salute alla prova*, cit., p. 45, as well as L. MEZZETTI, *I sistemi sanitari alla prova dell'immigrazione. L'esperienza dell'Italia*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2018, pp. 1-25.

[28] A. D'ALOIA, *Diritti e Stato autonomistico. Il modello dei livelli essenziali delle prestazioni*, 2003, pp. 1063-1140.

[29] See Circular no. 5/2000, cit., p. 41. Similar formulas were then transfused into art. 63 of the LEAs, approved by D.P.C.M. of 12 January 2017, published in the Official Gazette of 18 March 2017, no. 65.

[30] See Constitutional Court, judgments of 7 July 1998, no. 267 and 7 July 1999, no. 309, which dealt with the rules on the reimbursement of services rendered abroad or in any case by structures other than public or affiliated ones: conditional reimbursement, in violation of the essential content of the right to health, to prior authorization, even if the intervention could not be postponed, and it was not possible to obtain timely assistance within the NHS. In the same sense, Constitutional Court, judgment of 6 July 1994, no. 304. On the side of indispensable care, and therefore to be guaranteed under penalty of infringement of the minimum content of the "primary and fundamental" right to health, see Constitutional Court, sentence of 12 October 1988, no. 992, with regard to the case of a diagnostic service that can only be provided by a private centre, illegitimately excluded from the possibility of reimbursement.

called Mariotti law (law of 12 February 1968 no. 132), and by law no. 833 of 1978.[31] An approach that is also confirmed at the EU level, in the Return Directive, which asks Member States to guarantee, to the greatest extent possible, "emergency health care and essential treatment of the disease" to migrants awaiting repatriation and those in administrative detention.[32]

However, as anticipated, while it is evident that the legislative logic implies a difference in the degree of services due, depending on whether they are contained in the perimeter of urgency and essentiality (irregular foreigner), or whether they exceed it (Italian citizen and equivalent regular foreigner), it seems that the LEA, in medical practice, end up constituting the common point of reference, thus making the legislative differentiation "impalpable".[33] In fact, a broad interpretation of Art. 35(3) TUI which allows the facility concerned to provide a wide range of services, even on a continuous basis, given that, in the face of a pathology, it will not be difficult to diagnose possible "complications" or "aggravations", which make it worthy of treatment. In any case, the medical assessment of the nature of the problem and the consequent health treatments is decisive, as the Constitutional Court has explicitly stated,[34] and there is no dispute animated by petitions aimed at contesting the refusal of treatment. In fact, in court, the profile concerning the extension of the migrant's health protection emerges above all when the pathology is invoked against removal orders, i.e. in a context in which the prerequisites for the temporary non-expulsion of the irregular migrant are more stringent than the category of essential services to which he is entitled (and which the health facility has recognized him).[35]

Another issue, valid on a general level and not only in relation to the migrant population, is that of health inequalities, on which much has been written, especially in terms of the asymmetries resulting from the exercise of regional legislative competences and the organizational discretion of administrations, including health

[31] A. PITINO, *Quarant'anni (e più) di tutela della salute degli stranieri in Italia (dalla legge n. 833/1978 istitutiva del Servizio sanitario nazionale al d.l. "sicurezza" n. 113/2018)*, in *Corti supreme e salute*, 2018, pp. 631-652.

[32] See Articles 14(1)(b) and 16(3) of Directive 2008/115 of the European Parliament and of the Council *on common standards and procedures in Member States for returning illegally staying third-country nationals of* 16 December 2008, in the Official Journal of the European Union of 24 December 2008, pp. 98-107.

[33] In these terms C. CORSI, *Il diritto alla salute*, cit., p. 45, and first in the same direction E. GROSSO, *Stranieri irregolari e diritto alla salute: l'esperienza giurisprudenziale*, in R. BALDUZZI (ed.), *Cittadinanza, corti e salute*, Padova, 2007, p. 57.

[34] Constitutional Court, sentence of 5 July 2001, no. 252.

[35] Article 19 of the TUI, among the various cases of non-expulsion, in paragraph 2, letter d-bis includes that of foreigners who are in "health conditions deriving from particularly serious pathologies, not adequately treatable in the country of origin [....], such as to determine a significant prejudice to their health, in the event of return to the country of origin or provenance". The particular seriousness seems to allude to a morbid situation in addition to the one that could also imply an "essential" service. The Court of Cassation excluded the relevance, in order to block the expulsion, of those "maintenance and control treatments which, although indispensable to ensure a *spes vitae* for the patient, go beyond the instrumental correlation with the immediate effectiveness of the non-deferrable and urgent health intervention" (Court of Cassation, sentence of 24 January 2008, no. 1531).

authorities.[36] Organizational choices that are also likely to weigh more heavily if related to people who, for various reasons, are already in fragile conditions, as frequently happens for migrants, especially irregular migrants.

5. Religious Factor and Migrant's Health: Cultural Mediation

The religious factor obviously interferes in the same way on the relationship between the migrant and the health organization, regardless of the health outcome resulting from the sphere (more or less extensive) of services that can be provided.[37] However, it is clear that the wide range of assistance that is due to him, in terms of standardization and – even more, perhaps – in terms of clinical practice, makes this interference very significant, both from a quantitative point of view (i.e. the opportunities for contact between the confessional conviction and the health service), and qualitatively, when the health treatment involves ethically sensitive profiles, in relation to which the difference in values between patient and doctor can create, at least in hypothesis, more intense conflicts. It is equally clear that the problem also arises for the natives, who do not necessarily profess the same faith, but so is the fact that the probability of an encounter between different cultural-religious spheres is decidedly more probable in the relationship with the foreigner and, in particular with certain components of the migrant community, those who do not recognize themselves in the Judeo-Christian stock, or in any case in the context of Western values, which, in essence, represents the cultural substratum of reference for the Italian health worker.

It is therefore appropriate to reflect on the issue, even if among the determinants of health, i.e. among the factors that most condition – in terms of effectiveness – equality in access to health services, and therefore the level of social inclusion of the individual, the religious convictions of the migrant seem to take on a less intense role than other factors,[38] such as the level of education, language difficulties, lack of

[36] Cf. on this point A. PIOGGIA, *Il diritto alla salute alla prova della differenziazione: autonomie, organizzazione e dis-eguaglianza*, in *Istituzioni del Federalismo*, 2020, p. 45, who recalls how, depending on the region or geographical area, mortality rates, waiting times for individual services, life expectancy at birth often change, the quality of care etc., as well as, among the many authors who have dealt with the topic, L. CHIEFFI, *Equità nella salute e nei servizi sanitari tra politiche europee e interventi statali*, in *Corti supreme e salute*, 2022, pp. 175-196, and G. TARLI BARBIERI, *Alcune osservazioni sparse sull'equità nella salute e nei servizi sanitari*, in *Corti supreme e salute*, 2022, pp. 299-315.

[37] As is well known, religious freedom also enjoys multi-level protection, which involves both constitutional guarantees (think of Arts 19, 7 and 8 of the Constitution), and supranational guarantees (art. 18 of the Universal Declaration of Human Rights, 18 of the International Covenant on Political and Social Rights, 9 of the European Convention for the Protection of Human Rights and Fundamental Freedoms, 10 Charter of Fundamental Rights of the European Union).

[38] Without denying that the problem exists, and certainly not only in our legal system, as R. TARCHI observes, *I sistemi sanitari europei,* cit., p. 193, with reference to some cases that occurred in Germany and Austria.

knowledge of bureaucratic procedures, precarious housing conditions,[39] labour exploitation, not to mention other forms of even greater vulnerability, such as the previous migratory path, often punctuated by violence, and having been victims of trafficking or forced prostitution: but sometimes also structural, i.e. relating to the way in which the health service is organised, not only from a legal-formal point of view but also from the point of view of its *de facto* performance, and therefore administrative.[40]

The religious convictions of the individual, however, affect – at least potentially – many aspects of the therapeutic relationship. Firstly, on the very access to care, which could be hindered as it is incompatible, even if only for the modalities of the service, with the precepts of one's own beliefs, as in the case of women Muslim patient who refuses to be examined by male health workers, if a female doctor is unavailable in the structure, albeit for contingent reasons.[41] Or refusal to give birth by caesarean section.[42] In addition, there is the possibility of requests concerning non-conventional therapies or drugs in the light of our health protocols, but in accordance with certain religious convictions.[43] Even before that, the distance between doctor and patient, in relation to the way of understanding illness, pain, death, as well as other situations that in any case imply the use of a health facility, such as birth and the voluntary interruption of pregnancy, to give some examples, make it difficult to establish that therapeutic alliance functional to the best possible health outcome. Nor can it be excluded that misunderstanding (as a result of communication that does not pay attention to "cultural" diversity) leads to an incorrect diagnosis, with damage to the patient, or to removal from the health service, with negative repercussions both for the individual, who does not see his right to health realized, and for the community.[44]

[39] Sometimes particularly degraded as happens in the so-called. "informal settlements" on which A. VERONA, E. PINNA, *La condizione sociosanitaria delle persone dimoranti negli insediamenti informali della provincia di Foggia*, in *Bollettino epidemiologico nazionale*, 2023, pp. 6-13.

[40] For an overview of the inequalities in the field of the right to health of the migrant population and about the related, multiple and concurrent, reasons see, among many, M. TOGNETTI BORDONA, *Immigrazione, disuguaglianze nella salute fra "razza" e spazio transnazionale di cura*, in M. TOGNETTI BORDONA, P. ROSSI (eds.), *Salute e inclusione sociale degli immigrati*, Milano, 2016, p. 7, as well as M. TERRANEO, *Ineguaglianze nell'utilizzo dei servizi sanitari*, op. cit., p. 53.

[41] For this hypothesis, see B. SERRA, among others, Valetudo et religio: *radici e declinazioni di un rapporto indissolubile (coordinate preliminari*, in B. SERRA (eds.), Valetudo et religio: *intersezioni fra diritto alla salute e fenomeno religioso*, Torino, 2019, p. 51.

[42] As happens for some women of Muslim faith, as the Bioethics Committee recalls in the opinion cited in note 2.

[43] Think of the case of the Hindu who refuses drugs containing components of animal origin, asking for less (or not) appropriate alternatives from a clinical point of view (B. SERRA, *Religione e Sanità. Per una realizzazione laica del diritto alla salute*, in *Diritto e religioni*, 2017, pp. 477-496). Or to parents who ask the pediatrician for a certificate attesting to the virginity of their minor daughter or, more radically, to the African woman who would like to be subjected to a criminally sanctioned operation, such as genital mutilation (cf. B. SERRA, Valetudo et religio, cit., p. 9).

[44] If only because, since the health service is mainly financed by general taxation, the result is an inappropriate use of public resources, also considering the probability that an inadequate treatment implies aggravation of the pathology, with the consequent return of the person concerned to the health facility, possibly in the acute phase of the disease.

Even the institution of informed consent, which is a condition of lawfulness of any health treatment,[45] may be affected, in terms of guaranteeing the effectiveness of the right to therapeutic self-determination and therefore to the "freedom to dispose of one's own body",[46] which presuppose information tailored to the concrete situation of the recipient – so as to be really understood by him or her – a situation that can be strongly influenced by his religious affiliation.[47] Without forgetting the cases in which the very regulation of informed consent comes into conflict with the multi-subjective dimension of the decision, in social contexts in which the decision-making autonomy of the patient – which is at the heart of law no. 219/2017 – is essentially reabsorbed into the community autonomy of the family to which they belong, or of an even larger community, or delegated to a single family member,[48] precluding in all these hypotheses an individual and personal manifestation of the choice (favourable or not) about the treatment suggested by the doctor.

These are situations that, while sharing a common denominator, find differentiated solutions, which, however, regardless of their contents, are sometimes in tension with the consolidated health protocols, due to their religious nature, such as to impose themselves on the believer, as they are centred on non-negotiable values. Some of the cases indicated above clash with criminal prohibitions,[49] or with principles of our health legislation, such as that of clinical appropriateness,[50] others find a solution in

[45] A condition now formalized thanks to Law 219/2017, which regulated the various operational aspects, but present in the jurisprudential elaboration even before its approval (on the subject, see, after Law 219/2017, L. BUSATTA, *A un anno dalla legge 219 del 2017: la sostenibilità costituzionale della relazione di cura*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2019, pp. 95-115; for the previous period E. ROSSI, *Profili giuridici del consenso informato: i fondamenti costituzionali e gli ambiti di applicazione*, in *Rivista Associazione Italiana dei Costituzionalisti*, 2011, pp. 1-12).

[46] See Constitutional Court, judgment of 9 February 2023, no. 14, point 16.1 of the *Law*.

[47] B. SERRA, *Sanità, religione, immigrazione. Appunti per una realizzazione equa e sostenibile del diritto alla salute*, in *Stato, Chiese e pluralismo confessionale*, 2016, pp. 1-31, underlines that if "there is a lack of a common evaluative horizon" due to the different religious coordinates, the information usually provided to the native patient risks being insufficient, therefore misunderstood or not understood, with the double risk of undergoing treatment that is not understood or of refusing it as incompatible with one's faith.

[48] For example, the husband in a Muslim couple, who sometimes interfaces with the health personnel in place of the wife, whose silence therefore requires qualification.

[49] As in the case of female genital mutilation, which, among other things, although it may fall within the general criminal provision that punishes personal injuries, has been incriminated with a special rule (Article 583 *bis of* the Criminal Code), which aggravates the sanctioning treatment. Even the refusal of caesarean section, if it puts the health of the unborn child at risk, must be overcome if the urgency requires the doctor to intervene, even if this contravenes a religious precept. Precisely because of the delicacy of the constitutional goods at stake (self-determination of the mother, health and/or life of the unborn child) also in relation to the responsibility of the health worker, C. PICIOCCHI, *La salute interculturale*, in S. BAGNI, M.C. LOCCHI, C. PICIOCCHI, A. RINELLA (eds.), *Interculturalismo - Lessico comparato*, Napoli, 2024, pp. 595-607, highlights the importance of fostering a dialogue that leads the mother to adopt a decision to protect the health of the unborn child.

[50] Referred to in art. 1(2) of the Legislative Decree no. 502 of 30 December 1992, *Reorganisation of health regulations, pursuant to Art. 1 of Law no. 421 of 23 October 1992*, which excludes the provision of services at public expense that are not effective from a scientific point of view. It follows that the Hindu mentioned above will not be prescribed alternative drugs to those with an animal component if they are considered irrelevant to the pathology found. On the other hand, the same Law 219/2017

legislative provisions[51] or in methods of organization of the service already present and which at the limit can be more structured.[52] The general profile, relating to the intercultural modalities to which the therapeutic relationship should be informed, currently seems to be addressed above all through the use of cultural mediators (not only linguistic but also and above all), provided for, as an ancillary service to health care, in almost all regional laws dedicated to the issue of the social inclusion of migrants.[53] These are professionals called upon to act as a bridge between different cultures, including religious profiles, and this solution is the subject of conflicting evaluations. There are those who appreciate its use, proposing if anything a real institutionalization, instead of the "external" solution, which instead seems to be the usual one.[54] On the other hand, there are those who point out some critical issues, such as the lack of national recognition of the figure with relative uncertainty (and variability depending on the local context) of the eligibility requirements and the training courses provided, and a certain indeterminacy about the boundaries of the

provides that "the patient may not request health treatments contrary to the law, professional ethics or good clinical-care practices" (art. 1(6)). The Court of Cassation stated that "The patient may consent or consent to a health treatment but not claim that one be carried out if deemed unnecessary by the doctor" (order of 9 December 2021, no. 39084).

[51] Art. 1(3) Law no. 219 of 22 December 2017, *Rules on informed consent and advance treatment provisions*, for example, explicitly provides for the possibility of the patient to delegate not only the acquisition of information, but also the decision-making phase to others, whether it is the husband, or other family member or a third party, provided that the patient is capable of understanding and willing, otherwise a legal representative takes over. Therefore, in the case presented in the text, in which the husband responds instead of the wife, the latter may delegate him for this purpose, thus exercising her right to choose, following the forms of law. Obviously, the question remains open whether it is a real choice (inspired by religious reasons or not), and not the consequence, "simply" suffered, of belonging to a community in which the role of women is subordinate to that of men. A huge problem in terms of the right to self-determination, but one that does not appear at all easy to solve by the doctor, when providing the individual service. Even more so within a structured healthcare organization also in terms of the quantity of services to be performed in a given unit of time. In the absence of adequate formalization of the delegation, however, the silence of the wife will be equivalent to a refusal of processing, and if this were to derive precisely from the idea that the delegation itself, as it attests to the autonomous role of the woman, is incompatible with the religious context to which she belongs, it would undoubtedly result in an irreducible conflict between religion and the protocol on informed consent, which could then also be rethought in order to enhance the "community" dimension of the choice, even if it does not seem easy to translate the concept into an adequate legal form, which is also necessary for the purpose of excluding the doctor's liability, pursuant to article 1(6) of Law 219/2017.

[52] For example, in the case of a request for a visit by a doctor of the same sex as the patient.

[53] Cf. ll. Reg. Campania 6/2010, art. 18 and 19, Emilia-Romagna 5/2004, art. 13, Friuli-Venezia Giulia 9/2023, art. 12, Marche 13/2009, art. 10 and 12, Puglia 32/2009, art. 10, Toscana 29/2009, art. 6. Even where the regional legislator has not intervened on this point, the Regions have provided through administrative acts, or in this sense the health authorities have operated in implementation of the discretion due to them (see for example AUSL Umbria 1, resolution of the Director General 573 of 27/04/2017). On the other hand, a legal basis can still be found at the national level, in Art. 42(1)(d) TUI, which encourages all local authorities to conclude agreements with the private social sector with experience in the field of the protection of immigrants, to find intercultural mediators in order to "facilitate relations between the individual administrations and foreigners belonging to the different ethnic, national, linguistic and religious groups".

[54] On this subject, see the contributions published in C. BARALDI, V. BARBIERI, G. GIARELLI (eds.), *Immigrazione, mediazione culturale e salute*, Milano, 2008. Mediators are often provided by associations, cooperatives, or other specialized agencies.

respective competences. Or remembering that the mediator's intervention is not always appreciated by the doctor and/or the patient, as it is felt as an interference in a very delicate sphere such as that of health,[55] or because it is sometimes reduced to a mere interpreting activity. And that in any case, given the extreme subjective variability of experiences, even within the same religious confession, cannot be a definitive and always functional solution.[56]

The fact remains that the spread of this tool seems to demonstrate a general appreciation of its use,[57] which in various contexts has proved not only essential to the provision of the health service itself, but also a factor of attraction and approach to the health service by non-native users.[58]

6. Beyond Mediation

There are certainly also other solutions that can be imagined and, to a certain extent, concretely imagined, such as the guidelines containing good practices developed by voluntary organizations in the sector, sometimes together with health authorities, in order to offer indications to operators calibrated on the most widespread religious denominations.[59] Although it is true that these documents in some way

[55] F. FARINI, *Traduttore o interprete morale? Il mediatore culturale nelle relazioni terapeutiche*, in *Il Mulino*, 2012, pp. 59-82, with regard to the interaction of the mediator in the context of risky sexual behaviours, highlights, in the light of a concrete case history, not only the frequent reticence of the person who turns to the doctor, but also a "sanctioning" attitude on the part of the mediator, which ends up silencing the patient's voice, which certainly does not facilitate the health worker and appears to be inconsistent behaviour with respect to the very purpose of mediation.

[56] For a summary of these critical profiles, see B. SERRA, *Sanità, religione*, cit., p. 24.

[57] As attested by some field research, in the context of the provinces of Reggio Emilia (A. CHIARENZA, *Servizi sanitari* migrant friendly *ed aperti alle diverse culture: l'esperienza dell'Azienda USL di Reggio Emilia*, in *Immigrazione, mediazione culturale*, cit., p. 47), Trento (A. PASSERINI, *Il progetto dell'Azienda Provinciale per i Servizi sanitari della Provincia Autonoma di Trento per l'accesso ai servizi da parte della popolazione immigrata*, in *Immigrazione, mediazione culturale*, cit., p. 60), as well as in the Tuscany Region (M. BONCIANI, B. CANGIOLI, E. CONFALONI, Mum Health*: un intervento per la promozione della salute globale delle donne migranti in Toscana*, ibid., p. 71 ff.). M. TERRANEO, *Ineguaglianze nell'utilizzo*, cit., p. 75, proposes to strengthen this service. On this point, cf. also A. FANTAUZZI, *Il rapporto medico-paziente immigrato. (In)comprensione e pratiche di mediazione linguistica e culturale*, in *Il Mulino*, 2010, pp. 1-42.

[58] Interesting on this point is the case history reported by P. ROSSI, *La discrezionalità organizzativa nella facilitazione dell'accesso degli immigrati ai servizi sanitari*, in *Salute e inclusione*, cit., p. 125, with regard to the experience of some hospitals and counselling centres located in the Milan area, in which the presence of the linguistic and cultural mediator has attracted a foreign user (of the same linguistic stock, obviously) coming from other cities and/or provinces, thus also being essential in a "promotional" perspective in terms of facilitating access to health care. C. PICIOCCHI *La salute interculturale*, cit., p. 595, also in relation to the supranational context, includes the service of intercultural mediation (therefore not only religious) among the "determinants of health".

[59] Think of the *Carta delle buone pratiche per il pluralismo religioso e l'assistenza spirituale nei luoghi di cura* deliberated by the Lombard association "Together to take care", a charter included in a substantial 2017 survey on *Salute e identità religiose. Per un approccio multiculturale nell'assistenza alla persona*, available at the address https://prendercicura.it/documenti/, or the recommendations on *L'accoglienza delle differenze e specificità culturali e religiose nelle strutture sanitarie ospedaliere e*

schematize, and therefore stiffen the behaviours resulting from religious affiliation, to the detriment of the adaptations and variations that they often undergo in the passage from the place of origin of the cult to that in which the believer's life is subsequently placed,[60] they can still offer an aid,[61] if a widespread presence in the territory is ensured, which does not seem to be happening.[62] In this perspective, the Codes of Ethics of the health professions[63] could also underline the need for an intercultural approach, since, although they are not normative sources, this would serve to highlight the importance of taking the religious requests of the patient into the greatest possible consideration. From this point of view, it being understood that any reference to the religious phenomenon is lacking, both in the Code relating to doctors and in that concerning nurses, it is precisely the latter that is most easily interpreted in this direction, since it makes explicit the need to enhance the "conception of health and well-being" of the patient (Art. 3), emphasizing the ethics of "listening and dialogue" (Art. 4), and the need to address the ethical dilemmas of the patient (Art. 5).[64] If we then look at the guidelines on informed consent deliberated by the various health authorities, we notice that there is no explicit reference to the patient's religious context, while the references to information that must be provided in a way that is not only complete and up-to-date but also understandable for the recipient[65] seem to allude to the different cultural level (understood as the level of education), rather than to the

territoriali della regione Lazio, adopted in 2010 by the ASL Roma E, in collaboration with the Association "Religions for Peace", the Interreligious Table of Rome, the Hospital Volunteers Association, the Ascoltare-le-sofferenze Association, the Dare Protezione Association, Cittadinanzattiva Tribunal for the Rights of the Sick, the Academy of History of Health and with the support of the Lazio Volunteer Service Centres, together with representatives of different religions, available at www.volontariato.lazio.it/documentazione/documenti/55005500AccoglienzaDifferenzeReligiose_Opuscolo.pdf.

[60] The only residual role played, for these reasons, by such acts of *soft law* is highlighted, B. SERRA, *Sanità*, cit., p. 27. It can also be observed that certain religions are in themselves difficult to enclose in a unitary model, as is the case, for example, for Hinduism, described in terms of "a myriad of faiths, cultures and philosophies", with characteristics connected to the different geographical distribution of believers and family traditions, precisely in the aforementioned recommendations on *The Acceptance of Differences*, cit., p. 29.

[61] All the more so where the guidelines, recommendations or whatever else they are defined, are drawn up at the local level, making use of the contribution, as normally happens, of the confessions settled in that territory, which will know well what behavioural changes may have occurred in contact with a different religious, social and economic reality: so as to be able to represent the current way in which the respective believers live the relationship between religion and health.

[62] At least in the same way as an examination, certainly not exhaustive, on the websites of many health companies and on the assumption that these documents, if present, would be advertised there.

[63] That is, that of doctors in 2014 (but modified in 2016 and 2017) and that of nurses dating back to 2019.

[64] The statements found in the Doctors' Code, on the other hand, appear more nuanced, limiting themselves to highlighting the importance of the "alliance of care based on mutual trust and mutual respect for values" (Art. 20), and requiring the doctor to adapt communication to the recipient's ability to understand (art. 33), principles that can certainly be interpreted extensively, but they could also be understood as related to a sphere other than the religious one.

[65] See, for example, the very recent guidelines (2024) adopted by the University Hospital Policlinico "*G. Rodolico – San Marco*" Catania (available on its website).

different way of understanding the concepts of health, disease, need, profile that could also be introduced, given the weight it can play in the individual case.

The "pluralistic" training in the religious field of health personnel appears to be a further aspect on which local authorities (and related instrumental bodies such as health authorities) are called to act (and invest), already in the light of the model configured by the TUI.[66] Obviously, it is not realistic, nor probably compatible with the available budgetary resources, to think that, in addition to strictly clinical competence, a wealth of knowledge can be added such as to allow health personnel to relate "on an equal footing" with any user, given the now established heterogeneity of migration flows. However, it is reasonable to enhance training courses (including university ones) that on the one hand allow students to learn the impact on access (in a broad sense) to care, deriving from the faith settings of the most widespread confessions in the territorial context of the host Country; on the other hand, and even before that, that they affect the way of setting up the relationship with the patient who is the bearer of religious and cultural conceptions that are not homogeneous to that underlying national health protocols.[67] There has often been talk of a "narrative method",[68] as a suitable solution to ensure a greater understanding of the dynamics underlying the request for care. This seems to imply a relationship in which, in practice, the patient is placed in a position to tell his or her experience, before the specific symptom. Which in turn implies that the principle according to which the "time of communication is time of care" (Art. 1(8) of law no. 219/2017) is valued, with a consequent organization of the health service.

As has been correctly pointed out, the way in which the administration organizes the service, exercising its discretion, can affect not only the profile of the provision of the service (in terms of quantity, quality, economic sustainability) but also the conformation of the right itself, in relation to the idea of person and need that it presupposes, risking to determine, as organizational choices vary from region to region (if not from company to company health), a corresponding diversification of health rights, which would be even more serious than "managerial" inequalities.[69] Contact

[66] See art. 42(1)(e) TUI, in the part in which it provides for "the organization of training courses, inspired by criteria of coexistence in a multicultural society and the prevention of discriminatory, xenophobic or racist behavior, intended for operators of public bodies and offices", which especially in the first part of the proposition can well be understood as applicable to the context of "intercultural" care relationships. It should be noted that almost all the regional laws mentioned above on cultural mediation (see note 53), provide at the same time for the activation, by the regions, of training courses for their employees, aimed at reducing potential conflicts in the field of public services.

[67] Since 1998, the National Committee for Bioethics has recommended encouraging the training of medical and nursing staff in order to allow an "understanding of different cultures and to foster a dynamic meta-cultural relationship" (Abstract Opinion on *Problemi bioetici in una società multietnica*, and, in more detail, the full text on p. 6). The fact that a similar invitation is found in the 2017 opinion, already mentioned, leads us to think that the progress has not been sufficient.

[68] B. BERT, *Medicina narrativa*, Roma, 2006, as well as C. IAGNEMMA, *"Il tempo della comunicazione costituisce tempo di cura": l'approccio narrativo nella Legge n. 219 del 2017*, in *Giurisprudenza penale* web, 2019, pp. 1-13.

[69] A. PIOGGIA, *Il diritto alla salute*, cit., p. 37 ff.

with religious migrants poses the same problem, depending on how the care relationship is constructed, e.g. investing or not in mediation services[70] (and their configuration),[71] or establishing or not integrated listening centres within health facilities,[72] or creating clinics dedicated to migrant users, or to its most fragile components,[73] or by activating specific ways of relating to the individual.[74] All choices allowed (although not imposed) by law, such as to manifest a certain idea of the state of need (in a strictly clinical sense or also extended to further aspects) and of the way of taking charge of it (more or less "participatory" with respect to the patient) and therefore of the person who is the bearer of it:[75] in essence more or less adherent to the implementation of the principle of substantial equality, which finds its raison d'être in prefiguring the task of public authorities to remedy factual asymmetries, which hinder the development of the person, as the foundation of the entire spectrum of social rights.

It goes without saying that this implies not only a change of cultural perspective in the organization, but also an availability of adequate resources, which, as we know, health care has lacked for some time, as also demonstrated by the financial invariance clauses that often accompany laws that are important from the point of view of the realization of fundamental rights, such as the one on informed consent,[76] which would certainly justify investments in the ways of involving the patient in the construction and sharing of that wealth of information functional to a decision that takes into account all the aspects that connote the identity of the person. On the other hand, further confirmation can be drawn from the territorial inhomogeneity that seems to

[70] Given that at the moment they seem to be professionals external to the structure, with "contractual recognition still uncertain" (P. ROSSI, *La discrezionalità organizzativa*, cit., p. 139), but who could instead be structurally included.

[71] Looking at the various solutions that have come true in the Milanese context, narrated by P. ROSSI, *La discrezionalità organizzativa*, cit., p. 125, it is not the same to guarantee the continuous presence of cultural mediators (not to mention their number) two days a week or five, or only one afternoon a week, or to involve them only "on call".

[72] In particular, "health and listening" centers with a multidisciplinary composition, where the term "listening" alludes to a perspective that is not only strictly health, although functional to it.

[73] Cf. P. ROSSI, *La discrezionalità organizzativa*, cit., p. 132, in relation to hospitals in which an outpatient clinic, on certain days, is used to receive only foreign users.

[74] By introducing a "cognitive interview" prior to the medical examination (P. ROSSI, *La discrezionalità organizzativa*, cit., p. 131). It is true that the solutions discussed in this note and in the previous ones are sometimes mainly aimed at solving problems of linguistic comprehension (as for certain mediation experiences), sometimes at orienting the foreigner with respect to the public services (but also the private social sector) that he may need based on his socio-economic condition (think of the "cognitive interview" and the listening centers): but, even apart from the fact that these experiences have revealed their suitability to satisfy other relational needs (think of the ability of mediators to establish an often intense relationship of trust with the user), it remains true that these are organizational ideas that seem to be expendable also with regard to the profile of the "religiously oriented" therapeutic relationship.

[75] The theme, in the broader context of the relationship between administration and recipient of the public service, is further developed in A. PIOGGIA, *Il "riconoscimento dell'altro" e la pubblica amministrazione. Una prospettiva nell'orizzonte costituzionale della cura*, in *Costituzionalismo.it*, 2025, pp. 51-78.

[76] See Art. 7 of Law 219/2017.

characterize the experiences mentioned above,[77] not to mention that sometimes they also appear to some extent precarious, as they are built in a voluntaristic logic of intra-organizational cooperation,[78] linked to the ability of the individual professionals involved, which can fail, jeopardizing the continuity of the solution itself. The road to go therefore still appears long, but this does not mean that we must give up on it.[79]

It is difficult to hypothesize whether a push in the direction foreshadowed within the scope of these observations can result from the substantial resources that the National Recovery and Resilience Plan (PNRR) has allocated to the health sector, the subject of a specific "Mission" (number 6), in turn subdivided into two "Components", the first of which[80], which could be most relevant here, concerns the strengthening of territorial assistance, through the creation of Community Homes (Case di Comunità), Community Hospitals (Ospedali di Comunità) and Territorial Coordination Centers (Centrali operative territoriali), and the reinforcement of home care[81]. Ministerial Decree 77/2022, dedicated precisely to the provision of "models and standards for the development of territorial assistance in the National Health Service" represents the regulatory reform relating to the standards of the structures being built (such as the Community Homes and Community Hospitals) and the health services (such as home care and telemedicine, for example) to be provided.

In the context now under examination, it seems that above all the Community Homes are the proximity structures suitable – if only in the abstract – to favor that cultural-religious intermediation, in the interest of the foreign patient, of which has been said so far, not because in the DM 77 there are specific references to this problem, let alone as regards the necessary professional figures, among which linguistic mediators are not included, for example, but for how they are described and for the function they are called to perform. They should in fact constitute "the physical place, of proximity and easy identification to which the assisted person can access to

[77] In this sense, with regard to cultural mediation, see the observations of R. ARIA, *Il diritto alla cura e la tutela della salute riproduttiva delle donne migranti*, in A. BRAMBILLA, P. DEGANI, M. POGGI, N. ZORZELLA (eds.), *Donne straniere, diritti umani, questioni di genere,* Padova, 2022, p. 134.
[78] P. ROSSI, *La discrezionalità organizzativa*, cit., p. 140.
[79] Without underestimating the financial issue, in the sense that organizational solutions, whatever they may be, cannot go beyond that limit, beyond which the resilience of the health system as a whole would be put at risk (R. TARCHI, *I sistemi sanitari europei*, cit., p. 193).
[80] Entitled "Proximity Networks, Facilities and Telemedicine for Local Healthcare Assistance", it provides for a series of investments relating to "Community Homes and Person Care" and "The Home as the First Place of Care and Telemedicine". The latter in turn includes projects pertaining to integrated home care, the implementation of Local Operating Centers and Telemedicine, as well as an investment concerning the "Strengthening of Intermediate Healthcare and its Facilities" (Community Hospitals).
[81] The second Component concerning "Innovation, Research and Digitalization of the Health Service" should also be mentioned, including projects related to "Technological and Digital Upgrading" as well as "Training, Scientific Research and Technology Transfer", mainly linked to improvements in hospital facilities (provision of modern equipment, anti-seismic interventions, and so on), and the implementation of the Electronic Medical Record. The total European allocation for Mission 6 amounts to over 15 billion euros (about 7 billion for each of the 2 Components), to which additional resources from the Complementary Plan and other funds must be added, for a total of around 20 billion euros (cf. 7th GIMBE Report on the National Health Service, https://salviamo-ssn.it/attivita/rapporto/7-rapporto-gimbe.it-IT.html, relating to the state of progress of the reform in 2023, p. 154).

be able to come into contact with the health care system", the one "in which the SSN coordinates and integrates with the system of social services [...], with a horizontal and transversal approach to needs, also taking into account the personal dimension of the assisted person", a place where "the community of assisted persons is not only the recipient of services but is an active part [...], designing new service solutions, contributing to building and organizing the opportunities it needs in order to improve quality of life and of the territory, putting relationships and sharing at the center of its values"[82]. If we really want to move from the abstract perspective to the concrete one, realizing the "tendential overturning of the relationship between service and need for real care"[83], the organization of such structures should be enriched with professionally trained figures to provide a response to the "religious" health need of the patient, whether a migrant or not. Whether it is those already provided for by DM 77 (GPs, PLSs, specialists, nurses, social workers), but adequately trained, or others (such as linguistic mediators), whose usefulness for this purpose seems confirmed by the practice highlighted within this contribution.

At the moment, moreover, this is a prospect whose realization is anything but taken for granted, both because it is not imposed at the regulatory level, since the aforementioned regulation moves in a perspective of integration of the profiles of "traditional" health and social assistance, so to speak, and because the activation of the Community Homes is, for the most part, still deficient. The deadline for their realization (and the same can be said for the Community Hospitals) expires in June 2026, which is why it is conceivable (and certainly desirable) that by that date they will be completed, if nothing else from the construction point of view, also because otherwise there would be a problem with European funding, linked, as is known, to the achievement of the set targets. However, according to recent evaluations by the Parliamentary Budget Office on the state of implementation of Mission 6[84], the completion in terms of structures and, above all, the effective activation of the services envisaged therein, which obviously also presupposes the existence of the necessary human resources, will require a considerable effort, considering that in many regions the delays are, at the very least, significant, demonstrating the persistent difficulty in ensuring a homogeneous progression of the reform, both in terms of the construction profile and in terms of the services provided[85], the latter problem which could be affected by the problems of financial coverage of the costs of the additional health

[82] Thus the Annex 1 to Ministerial Decree 77, p. 26.
[83] R. BALDUZZI, *Gli* standard *(e il modello) dell'assistenza sanitaria territoriale: prime considerazioni*, in *Corti supreme e salute*, 2022, n. 2, p. 470.
[84] On this point, see Parliamentary Budget Office, *Focus tematico. Il PNRR e la riorganizzazione del Servizio sanitario nazionale*, 2025, n. 3, available at https://www.upbilancio.it/focus-tematico-n-3-22-maggio-2025 .
[85] The two aspects are obviously connected, since it cannot be thought that a structure that is not yet completed can be active, or fully active.

personnel required for this purpose, but also of those relating to the low attractiveness that, in general, seems to characterize the SSN[86].

Considering, albeit in summary, the data concerning the progress of the reform, limited to the Community Homes, we realize that the number of tested structures, compared to those planned, is very low today[87]; that the territorial distribution of the completed Community Homes is anything but homogeneous[88], despite one of the objectives of the reform being precisely that of an infrastructural rebalancing between the various areas of the country; that the number of structures in which the services made mandatory by DM 77[89] are all active is equally low, and even lower is the number of the territorial distribution of the completed Community Homes with the presence of doctors and nurses in accordance with the standards of the ministerial decree[90]. And also – and probably, correlatively – from the financial point of view, there is an imbalance between the expenditure incurred until the end of 2024 and the remaining expenditure, which is much higher[91]. This situation undoubtedly justifies the Parliamentary Budget Office's concerns about the risk of a failure to complete the reform in its entirety (including not only the Community Homes covered by the PNRR, but also those planned by the regions), or at least a difficulty in making the territorial facilities that have been completed by the June 2026 deadline operational.

It is true that certain data dates back to 2024 and that there has undoubtedly been progress during 2025, but it does not seem that it is of such an extent as to avert such concerns[92]. On the contrary, the observation about "the strong delay accumulated on

[86] See Parliamentary Budget Office, *Focus tematico*, cit., p. 24.

[87] Out of over 1,000 planned Community Homes, only 38 have been tested and approved, while 9% of the construction sites have yet to start, with a situation of greater delay mainly localized in some regions of the South (Parliamentary Budget Office, *Focus tematico*, cit., p.13).

[88] The greatest delays mainly concern some regions in the South (*Focus tematico*, cit., p. 13)

[89] That is, in the hub Community Homes, there will be primary care, home care, outpatient specialist care for certain pathologies, nursing services, appointment booking, integration with social services, basic diagnostic services, continuity of care and a blood draw station, while the spoke Community Homes will have a smaller range of services provided.

[90] The presence of active services is, overall, still rather limited in the Community Homes and Community Hospitals and highly diversified among regions (Parliamentary Budget Office, *Focus tematico*, cit., p.17, but see also the following footnote no. 92).

[91] Cf. Parliamentary Budget Office, *Focus tematico*, cit., p.14, "in the two-year period 2025-26, the remaining 85.4 percent of the financial allocation" must be used, amounting to 2 billion euros.

[92] If we compare the situation of active services in the various proximity facilities, described in the Agenas Summary Report of the DM 77/2022 monitoring results for the second half of 2024, with that covered in the subsequent report for the first half of 2025 (all available on the Agenas website, www.agenas.gov.it), we certainly get a sense of progress in the results, but it is rather slow progress. We can give some examples by comparing the planned Community Homes (P) with those where all mandatory services have been activated, without (A) and with (B) the presence of doctors and nurses, in 2024 and mid-2025. In Veneto, out of 99 planned Community Homes, there was a shift from 4 A in 2024 to 16 in 2025, and from 2 B to 3. In Tuscany out of 156 P, we find 11 A in 2024 and 23 in 2025, while those of type B were and are 7. In Puglia out of 123 P, there was a shift from 0 in 2024 to just one of type A in 2025. In Sicily out of 163 P, in 2024 there were only 2 A, no B, while in 2025 there were 5 A, 2 B. In Abruzzo, out of 42 P, none had even one active service by mid-2025. In Calabria out of 63 P, there was a shift from 1 A in 2024 to 2 in 2025, none of type B. In Friuli Venezia Giulia out of 32 P, to date none has all services active. Of course, it would be more useful to be able to make a comparison,

the roadmap and, above all, the abysmal distance between the Regions" still seems current, although formulated by the Gimbe Foundation in relation to the situation existing at the end of 2024[93]. Considering that the months separating us from the deadline for the implementation of the PNRR are not many, and that unfortunately the times for carrying out public contracts are, as is known, very long, so the work to be done really seems significant.

Not to mention the problem of the sustainability of current expenditure for the personnel that will populate these structures, expenditure that is not financed by the PNRR and that will therefore have to be financed under current legislation. The same DM 77/2022 contains a financial invariance clause (art. 4), which therefore refers the solution of the problem to budget choices. The Parliamentary Budget Office, recording an increase in dedicated funds, thanks to previous budget laws, observed that "Overall, the appropriations for territorial care personnel may not be entirely adequate to ensure standards, but appear sufficiently sized to allow a significant expansion of the services provided"[94]. This seems to realize a not entirely reassuring prospect, since the purpose is to ensure the full and lasting operation of these structures (and of the others envisaged by Mission 6, of course[95]).

A positive impact of the reform of territorial assistance on the relationship between the religious migrant and the health service, assuming of course that it is completed, and that this happens in an equal way from a geographical point of view, which remains to be seen, is at the moment a hypothesis, to be verified in light of future developments, without however having too many illusions.

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region by region, between tested and approved Community Homes (and not just planned ones) and activated services, since, obviously, the testing and approval is a necessary prerequisite for the operation of the Community Homes, but this is not possible in light of the data available in the various documents cited so far. The aforementioned circumstance of a low number of tested and approved facilities, despite a high number of projects started, certainly impacts the services available. Moreover, in certain local areas there were already existing proximity facilities similar to the Community Homes, such as the Community Health Centers (Case della Salute), which underwent adaptation to the new ministerial standards, in which it is reasonable to think that the range of services provided is at least reduced until the related works are completed. However, it is not just this, since in Lombardy the Court of Auditors found the presence of Community Homes (and also Community Hospitals) provisionally accredited with limited services, both in terms of hours and medical presence (Court of Auditors - Regional Audit Section for Lombardy, Implementation of territorial healthcare assistance in the PNRR of Lombardy. Control on management pursuant to art. 7, paragraph 7 of Decree-Law no. 77 of 31 May 2021, Resolution 21 November 2024 no. 238).

[93] See the Press Release on Mission 6 of the PNRR dated May 6, 2025, substantially in line with the findings of the 7th GIMBE Report, cited, p. 168.

[94] Parliamentary Budget Office, *Focus tematico*, cit., p. 23.

[95] Even in Community Hospitals, which are facilities aimed at performing an intermediate function between home and hospital admission, the contact between health needs and religious beliefs takes place. For these facilities too, the same considerations already made can be repeated, both regarding the opportunity (if not the necessity, in homage to a constitutionally conforming interpretation of Articles 32 and 19 of the Constitution) to provide adequately trained healthcare staff, and with regard to the state of implementation and the number of Community Hospitals with active services (see Parliamentary Budget Office, *Focus tematico*, cit., p. 21, which notes that many regions lack Community Hospitals with active services).

ABSTRACT: The paper examines the link between migration, religion and healthcare, especially from the point of view of the administrative organization of the healthcare service, highlighting some hypotheses of tension between the religious dimension and the provision of care, as well as some solutions that have emerged in the practice of health authorities, aimed at ensuring a better understanding of the religious needs of the patient, in his or her relationship with the doctor and the public structure involved.

KEYWORDS: religion – migration – right to health – healthcare service – cultural mediation.