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Health systems, fight against Covid-19 and digitalization: is global law the main way?

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ABSTRACT: Can we imagine the realization of a global health law that, starting from the dramatic experience of the coronavirus, leads the reorganization of health systems affected by the pandemic according to minimum legal standards based on the configuration of the right to health as a human right? These reflections are inspired by the discussion of the same issues at the round-table organized by the Universidad Internacional Menendez Pelayo, Santander, Spain, on 27 August 2020.

ABSTRACT: Può ipotizzarsi la creazione di un diritto sanitario globale che, partendo dalla drammatica esperienza del coronavirus, guidi il restyling dei sistemi sanitari colpiti dalla pandemia secondo standard legali comuni fondati sulla configurazione del diritto alla salute come diritto umano? Le presenti riflessioni traggono spunto dalla discussione di questi temi tenutasi presso la tavola rotonda organizzata dall'Università Internazionale Menendez Pelayo il 27 agosto 2020.

The right to the highest attainable standard of health is a human right recognized in international human rights law[1].

If health is a human right[2], it can be said that this feature has been accentuated by the epidemiological pandemic caused by Covid-19.

Therefore, the health, economic and social consequences of the emergency situation must be addressed by the States according to their own Constitutions and laws but also respecting minimum human rights standards.

Without any doubt, the role of the WHO has been and can be increasingly crucial[3] as its tools – conventions, binding regulations, recommendations – could be very useful to build a desirable global health law. In this perspective, the world health emergency could offer the opportunity to create a common legal basis for a "world health citizenship". In the meantime, to provide global solutions it's not so easy, taking into account the competency limits. In fact, with current legal order the achievement of the afore mentioned goal could get complicated because of the distribution of powers and jurisdictions among world organizations, regional institutions and single States. Even if the coronavirus knows no borders or domestic jurisdictions, in some way national legal borders still influence any attempt to globalize the response given by the rule of law to the pandemic and related issues.

Common standards and minimum technological and scientific requirements can be established by global entities to protect the equality and dignity of human beings. On the paper, priority criteria capable of discriminating against patients could be prohibited if we run the risk of treating only a part of them. Nevertheless, the financial means are allocated and managed at the state or at the most regional (i.e. European) level, so that the structure of the social and health systems is ultimately the exclusive competence of the States and impacts on the guarantee of rights.

So it's become clear how each State has responded to the unusual emergency situation in its way: from the compulsory lockdown to the search for further economic resources; from hiring new health professionals to improving healthcare at territorial and not hospital level; from the increase in intensive cares to the promotion of digitalized infection tracing and virus counter-actions; from investments in new vaccines and

[1] The International Covenant on Economic, Social and Cultural Rights, widely considered as the central instrument of protection for the right to health, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Article 12).

[2] Human rights are interdependent, indivisible and interrelated. This means that violating the right to health may often impair the enjoyment of other human rights, such as the rights to education or work, and vice versa. See Vienna Declaration and Programme of Action (A/CONF.157/23), adopted by the World Conference on Human Rights, held in Vienna, 14–25 June 1993.

[3] The need to trace the contacts of the infected has been highlighted by WHO, *Report of the WHO-China Joint Mission on Coronavirus Disease 2019 (COVID-19)*, 16-24 February 2020, https://www.who.int/docs/default-source/coronaviruse/who-china-joint-mission-on-covid-19-final-report.pdf, according to which «*Immediately expand surveillance to detect COVID-19 transmission chains, by testing all patients with atypical pneumonias, conducting screening in some patients with upper respiratory illnesses and/or recent COVID-19 exposure, and adding testing for the COVID-19 virus to existing surveillance systems (e.g. systems for influenza-like-illness and SARI)*».

therapies to support to businesses and the unemployed people; from the imposition of social distancing to the implementation of smart working; from precautionary measures at school, university, in the workplace and on means of transport to the programs of incentives for the purchase of new technological instruments. Likewise it's predictable that the future States' responses will also be quite autonomous and that each State legislation will impact on the citizens' rights quite independently of each other, including the decision about the degree and intensity of the limitations imposed on fundamental rights

The quality of democracy is a local issue, as well. Each State will choose the type of anti-covid measures and will decide, within the limits of its own Constitution, whether to manage the decision-making process in a transparent way, whether to involve parliaments to an acceptable degree or whether to reserve the most important decisions for governments that as such are further away from the popular will compared to the legislative assemblies.

On its side, the role played by the fake news in this process can be considered as a dependent variable: it depends on how authoritative both public controls and scientific communities are, on a case-by-case basis. Nonetheless, supranational authorities should be able to evaluate, and if necessary reject, priority criteria in patients' access to treatment and new vaccines or restrictions to health care that are unreasonable and inhumane, given that it's not ethical to lose humanity to gain immunity. The same world organizations can lead the debate about how to make globalization and market control compatible.

Public health, economic system and digitalization are part of the challenge for the future health policies at global level: taking into account that the main point is how to re-designed the social-health systems that have been struck severely by the pandemic.

In particular, it's necessary to strengthen in an efficient way the increasing virtual health relationships and overcome the digital divide by adopting incentives for incremental use of digital tools and protecting fundamental rights at the same time.

The set of antidotes to the coronavirus spread, apart from announced vaccines and specific therapies which would represent the final solution to this problem. 1) Tests must be carried out in a detailed and well-focused way: both serological tests and swabs in the strict sense. 2) Treatment of the infected subjects, by combining effect of hospital and territorial cares in addition to telehealth: the latter useful for first-instance diagnosis and basic treatments, pending specific therapies and vaccines. 3) Tracing by Apps and other contact tracing systems. 4) Control of State borders together to check of clinical parameters for subjects who pass through and adoption of consequential measures. 5) Management of subjects who have come into close contact with coronavirus infected people even if asymptomatic[4]: we need ability to identify them, to

[4] See HE, X., LAU, E.H.Y., WU, P. *et al.*, *Temporal dynamics in viral shedding and transmissibility of COVID-19*, *Nat Med* 26, 672–675 (2020). https://doi.org/10.1038/s41591-020-0869-5; FERRETTI AND OTHERS, *Quantifying SARS-CoV-2*

track them down and treat them after evaluating their health conditions and deciding what to do, whether to arrange quarantine, isolation, further clinical exams, etc… 6) To face and solve the problem of the false negatives improving the quality of the swabs test is needed: relationship between science and law is a central point.

Promoting the better functioning of artificial intelligence tools is absolutely fundamental. Go straight to the point, contact tracing apps and telemedicine[5] are among the most important artificial intelligence tools applied to the healthcare in the perspective of contrasting coronavirus.

Regarding to contact tracing app, it is known that some countries, especially in the Far East, have already employed data driven solutions to counter the spread of coronavirus.

It is clear that it is possible to allow public institutions to take the best decisions through the collection and analysis of data. But that result can be achieved only through a responsible approach to the problem.

Besides, it should be noted that the European Union has provided a common reference framework for contact tracing apps. The European model has been outlined by the PEPP-PT Consortium (Pan-European Privacy-Preserving Proximity Tracing).

Indeed, we must not forget that as far as the contact tracing system is concerned, there was first a series of acts of direction from the European Union, which Italy has taken into account in the development of the app, such as: 1) The recommendation of the European Commission (8th April 2020), in which it was stated the need to adopt a Toolbox of shared measures, which were consistent with current legislation; 2) The letter in which the European Data Protection Board (EDPB) addressed the Commission (14th April 2020), which was about to adopt the Guidelines; 3) The Guidelines of the European Commission (16th April 2020), in which reference is made to the GDPR principles, such as proportionality, consent to processing, data minimization in matter of contact tracing; 4) The EDPB Guidelines on the use of location data and contact tracing tools in the context of the COVID-19 outbreak (21st April 2020).

Seeking a valid legal basis for the data processing carried out by the app, it is worth mentioning the Article 52 of Nice Charter according to which where restrictions on the exercise of rights and freedoms are to be adopted, they must be provided for by law and respect the essence of those rights and freedoms. Moreover, pursuant and GDPR and e-Privacy Directive, it's necessary to make a choice between two models of legal

transmission suggests epidemic control with digital contact tracing, in *Science*, 08 May 2020: Vol. 368, Issue 6491, https://science.sciencemag.org/content/368/6491/eabb6936.full.

[5] Regarding the telehealth general framework see EUROPEAN COMMISSION, *Communication Com(2008)689 on telemedicine for the benefit of patients, healthcare systems and society*, 4 November 2008, whose aim is to support Members States in achieving large-scale and beneficial deployment of telemedicine services, by building confidence in and acceptance of this new technology, taking into account that the level of telemedicine spread must be measured both on the demand side (citizens) and on the supply side (healthcare facilities). Therefore, Member States are warmly invited to assess and adapt their national regulations enabling wider access to telemedicine services, by addressing issues such as accreditation, liability, reimbursement, privacy and data protection

basis: either the consent of the data subject to be expressed at the time of the installation of the app; or to resort to the public interest.

As estimated by scientists, to be successful a app for contact tracing requires a minimum download threshold of at least 60 per cent of the population.

Unfortunately, the maximum number of people who downloaded and are using the app in some country is only about 15 or 20 percent: the reasons for the failure are to be found, in my opinion, in the fact that the use of the app is discretionary (merely recommended) and not mandatory.

Despite of the global dimension of the pandemic, each State must adopt the most appropriate countermeasures according to its own legal set of rules and, above all, constitutional order. When supreme values to be protected such as public health, public safety and people's lives get in the game, fundamental rights and freedoms can be limited, albeit in an appropriate and proportionate way. For example, limiting the fundamental rights in compliance with its own Constitution in order to make mandatory the upload of the app or the manual tracing (i.e. for people who don't have a smart-phone), along the lines of vaccination policy.

Privacy or data protection? Informed consent o not consent[6]? Anonymous processing or pseudo-Anonymous processing[7]? Everyone was concerned about the protection of personal data, ignoring the problem of getting the minimum threshold of participation instead. This issue is missing in the public debate.

As shown, the download of the app is on an exclusively voluntary basis. Only the personal data processing is based on the public interest.

Differently from this approach, it should have been taken advantage of the public interest not only to justify the processing of personal data but also to impose the download as mandatory, perhaps by promising benefits (vouchers, phone top-ups or charge card) to those who join, in any case avoiding disparity of treatment of course.

From the perspective of safeguarding of human fundamental rights, which have to be balanced with the effectiveness of the instrument adopted, it is necessary to be aware that to identify the legal basis legitimizing the use of an app, mandatory or voluntary, the app's specific functionality should be considered as a dependent variable.

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[6] P. QUINN, *The anonymization of research data – a pyric victory for privacy that should not be pushed too hard by the EU data protection framework?* in *European Journal of Health Law*, 2017, no. 24, p. 14, considers consent unnecessary in cases like this.

[7] See LOCAL GOVERNMENT ASSOCIATION – LGA, *Transforming social care through the use of information and technology, London*, 2017. For the healthcare sector, it has been recommended appropriate training and skills development in privacy and security measures for processing personal health data. An adequate training and skills development are required for social services as well. It is a challenge for staff to ensure that data is collated, shared and used in a way that reassures service users that their data is protected; therefore, it is vital that training is provided to improve skills in this area. For further details see OECD, *Recommendation of the Council on Health Data Governance*, Paris, 2019.

In this regard, the potential of an app is limitless, as demonstrated by experience: mass screening; the provision to users of useful telephone numbers or updated information and insights about the epidemic's trend; the regular detection and control of clinical parameters; geolocalization; remote medical support; remote monitoring of virus-positive and/or isolated patients; the transmission of alerts or warnings to individuals who present suspicious symptoms or who have been in contact with infected patients; verifications of compliance with the measures of social distancing and obligation to stay at home; and the transmission of information to police forces in order to facilitate the execution by them of institutional purposes. All these objectives are abstractly compatible with the multifunction purposes of an app designed for contact tracing. And, in all likelihood, the app could perform a variety of other functions.

The element of citizens' confidence in institutions remains the keystone of the system, as shown by other experiences (e.g., the electronic health record example). Neverthless, if trust is lacking, there is no alternative to the legal obligation to ensure a higher public interest.