

The Right to Health and Social Inclusion: Clinical Psychology and Medico-Legal Aspects

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ABSTRACT

This paper aims to review certain aspects of the right to health, an inalienable right of citizens protected by Article 32 of the Constitution. In an initial phase, we begin with the concept of health adopted by the World Health Organization and subsequently expanded upon in the Ottawa Charter. A detailed analysis is devoted to Article 32 of the Constitution.

Another aspect addressed in this paper is the role of care and the burden borne by the caregiver looking after a patient with a neurological condition; the aim is to examine the issues faced by the caregiver in the care relationship and the right to health.

Keywords: Right to Health, Disability, Inclusion

Introduction

The right to health is the only right defined as fundamental in the Constitution, and it belongs to the category of inviolable rights. It is considered both as an individual right and as an objective interest of the community. With the establishment of the National Health Service, the protection of the right to health ensures that every individual, even those in difficulty, has the opportunity to access the necessary healthcare services. Furthermore, the law provides for the possible obligation to undergo medical treatment and identifies the limits to which such an obligation is subject.

We shall therefore focus, without claiming to be exhaustive, on the concept of health, the main constitutional aspects and the various manifestations of the right to health, as well as on the determinants of health and the impact arising from them.

Health and the Right to Health

To define the concept of the 'right to health', as set out in Article 32 of the Italian Constitution, we must refer to the definition of 'health'.

In 1948, the United Nations agency specializing in health matters, namely the World Health Organization, was founded.

It is responsible for promoting health and has as its primary objective "the attainment of the highest possible level of health". The WHO defines 'health' as 'a state of physical, mental and social well-being' and not simply as 'the absence of disease or infirmity' [1].

In 1896, with the adoption of the Ottawa Charter, it was clarified that health requires a whole range of conditions to enable its realization and safeguarding, and it was stated that "the fundamental conditions and resources for health are peace, housing, education, nutrition, income, a stable ecosystem, sustainable resources, social justice and equity".

The main objective of the Charter was to identify common health targets for everyone by the year 2000 [2].

Health is not something static but a dynamic process [3]. Moreover, the Charter itself outlines the guidelines necessary to achieve a person's physical and mental well-being, establishing that "thanks to a good level of health, the individual and the group must be able to identify and develop their aspirations, satisfy their needs, modify the environment and adapt to it".

Under Law No. 833 of 1978, the Italian legal system established the National Health Service on the basis of these principles; subsequently, the Court of Cassation also recognized "the new

dimension that health has taken on, no longer understood as the mere absence of illness, but as a state of complete physical and mental well-being" [4].

Article 32 of The Constitution and Links to other Provisions of the Constitution

The right to health is recognized by the Italian Constitution in Article 32, and the first paragraph states: "The Republic protects health as a fundamental right of the individual and in the interest of the community, and guarantees free medical care to the indigent".

The following paragraph establishes that "no one may be compelled to undergo any specific medical treatment except in accordance with the provisions of the law.

The law may in no case violate the limits imposed by respect for the human person." The right to health is an individual, absolute and primary right, and it also emerges that this has a sort of "complex" character due to the fact that the protection provided is not merely of an objective nature, since we are simultaneously dealing with a genuine subjective right of the individual [5].

The concept of health protection entails the maintenance, for the benefit of the individual, of their physical and mental well-being and requires targeted actions for development and promotion.

Health is emphasized through innovative approaches, which examine not only the biological dimension but also factors relating to the healthiness of the environment in which individuals find themselves and socio-relational factors.

Article 32 of the Constitution considers the right to health to be 'fundamental'; it is the only constitutional right to which this adjective is applied. However, this does not mean that the right in question is hierarchically superior to other rights; our constitutional system is characterized by an open and pluralistic structure, and there are no values or rights that are superior to others and which are exempt from the balancing of interests [6].

The Constitutional Court has specified that "the protection of rights must always be 'systematic and not fragmented into a series of uncoordinated rules that are potentially in conflict with one another'" [7].

Were this not the case, there would be an unlimited expansion of one of the rights, which would become a 'tyrant' in relation to the other constitutionally recognized and protected legal situations, which, taken together, constitute an expression of human dignity' [5].

The classification of the right to health as a fundamental right reflects the fact that health falls within the category of inviolable rights enshrined in Article 2 of the Constitution, which states that "the Republic recognizes and guarantees the inviolable rights of the individual, both as an individual and within the social groups in which his or her personality is expressed, and requires the fulfilment of the inalienable duties of political, economic and social solidarity".

As a fundamental right, it is non-transferable, imprescriptible, inalienable and non-disposable. Health is a right inherent

to the individual; it cannot be transferred to others and is imprescriptible. The inactivity of the right-holder does not entail its extinction or loss; the right belongs to the individual from birth until death.

The fact that it is irrevocable means that the right-holder cannot deprive themselves of the right to health, even though there is provision for the possibility of temporarily or permanently refusing certain treatments.

The characteristic of non-disposability applies to every right to freedom, but the right to health does not fall within ordinary cases. However, there are situations in which the right is entirely non-disposable and in others where it is only relatively so; there are therefore certain limits to the right to health in its individual aspect [8].

The right is attributable to the individual and applies to any person subject to the legal system, whether an EU citizen or a non-EU citizen; any differences may concern the legal regime governing treatment, but cannot affect the ownership of the right. The judgment of the Joint Divisions of the Court of Cassation, No. 796 of 1973, emphasized the nature of the right as an 'absolute subjective right of primary importance for the human person' which is effective erga omnes.

No attacks or interference are tolerated in the sphere of individual health, and a dimension of freedom is highlighted [5].

The right to health is recognized as the individual's right to receive healthcare services which, in the case of so-called 'indigent' persons, takes on a significance that requires treatment to be provided free of charge.

This highlights the service-oriented aspect of the right, which is exercised through specific interventions involving the treatment, prevention and rehabilitation of individuals.

Alongside the subjective legal positions relating to the right to liberty and the rights of individuals to receive positive benefits, there is the objective aspect concerning the public interest inherent in the right to health, which provides that all persons present on Italian territory are entitled to good health conditions (Judgment No. 258/1994 summarizes the conditions under which compulsory medical treatment is lawful:

- whether the treatment is aimed not only at improving or preserving the health of the person undergoing it, but also at preserving the health of others, since it is precisely this additional purpose, relating to health as a collective interest, that justifies the restriction of that human self-determination inherent in everyone's right to health as a fundamental right (see judgment No. 307 of 1990).
- whether it is anticipated that the treatment will not adversely affect the health of the person undergoing it, save for those consequences which, due to their temporary nature and minor extent, appear to be normal for any medical intervention and are therefore tolerable (ibid).
- whether, in the event of further damage to the health of the person subjected to compulsory treatment – including illness contracted through infection caused by prophylactic vaccination – provision is nevertheless made for the payment of 'fair compensation' to the injured party (see

judgment 307 cited above and see now Law No. 210/1992).

And this is irrespective of the parallel right to compensation, which applies whenever the practical implementation of the law imposing the treatment or its actual execution is not accompanied by the precautions or conducted in accordance with the methods prescribed by the current state of scientific knowledge and medical practice in relation to its nature, on the basis of subjective grounds for liability and with the full compensatory effects provided for in Article 2043 of the Civil Code: judgment No. 307/1990 cited above).

The protection of health as a matter of public interest is pursued through the imposition by the authorities of prohibitions and obligations, which may result in restrictions on rights protected by the Constitution. The most common situation is the imposition of compulsory medical treatment, which entails a reduction in the individual's freedom of health with the aim of protecting the collective interest. Other elements of public interest relating to health are set out in Article 3 of the Constitution. Not only the central government, but also other public bodies, have the duty to 'remove economic and social obstacles which, by effectively limiting the freedom and equality of citizens, prevent the full development of the human person and the effective participation of all workers in the political, economic and social organization of the country' [9].

Article 3, paragraph 2, of the Constitution establishes a claim against the State, which is required to provide facilities, resources and personnel suitable for ensuring an ideal standard of health for every individual; the State must seek to implement an appropriate policy not only of treatment but also of prevention by addressing the possible causes and situations that may pose an obstacle to the psychological and physical well-being of the community.

The Right to Healthcare Services

In 1978, Law No. 833 established the National Health Service, based on the principle of universal healthcare, enabling everyone to receive the necessary healthcare services, regardless of their financial means; the State has a duty to guarantee this form of protection. The right to health is protected in different ways depending on the legal system.

A comparison can be made between Italy, which aims to ensure that everyone receives the necessary care, and the United States of America, where the healthcare system is predominantly in private hands, with public assistance programmes provided only for certain categories of people (pregnant women, the elderly and people with disabilities). Nevertheless, the State has a duty to ensure that individuals have the right to access healthcare, regardless of whether the service is provided by the public sector.

Constitutional Law No. 3 of 2001 reformed Title V of Part Two of the Italian Constitution, allowing, amongst other things, the implementation of Article 5 of the Constitution, which recognizes local authorities as representative bodies that predate the formation of the Republic and acknowledges their decisive role, as they are the bodies closest to the citizen [10].

The Constitution identifies, in the second paragraph of Article 117, the matters over which the State has exclusive legislative power, and in the third paragraph lists the matters falling within the scope of concurrent legislation, in which legislative power lies with the Regions, with the exception of fundamental principles, which are reserved for State legislation: health protection falls within the scope of concurrent legislation and therefore the State is required to identify the fundamental principles, and thus to ensure and guarantee the so-called 'minimum standards' [11].

The Constitutional Court has further clarified that there can be no curtailment of the 'irreducible core' of the right to health and that this is safeguarded by the Constitution 'as an inviolable aspect of human dignity' and that, in order to preserve it, 'minimum standards' of care must be promoted. This defines the Essential Levels of Care (L.E.A.), which are "the benefits and services that the National Health Service (SSN) is required to provide to all citizens" [12].

The L.E.A. have recently been reformed, with the aim of broadening the scope of protection. Every citizen has the right to receive these services; however, a simple request is not always sufficient for them to be provided. The State has, in fact, the duty, before providing a service, to verify the existence of a specific medical prescription demonstrating the necessity and appropriateness of the treatment [5].

The choice of doctor and the facility providing the service, however, is left to the discretion of the individual.

The public authority has a duty to arrange appropriate forms of protection for the individual, but what is of paramount importance is the core of the right to health, which must always be guaranteed to every person within the national territory.

Free Treatment for the 'Indigent'

Article 32 of the Constitution guarantees free healthcare for the indigent, as the right to health is a fundamental right of the individual and a matter of public interest. On reading this article, it is important to note that the Republic does not merely protect the indigent, but 'guarantees' them the necessary care.

The public authority thus has a duty to take active measures to safeguard the health of every individual when it is compromised. The Republic's task is to bear the costs incurred by the individual; it is worth recalling that at the end of the nineteenth century, the so-called 'Crispi Law' provided that the State should be a direct participant in the system and responsible for the provision of services.

This approach, with Law No. 833 of 1978 and a move towards universal coverage, was confirmed through the establishment of the National Health Service. The choice for the State to intervene through its own action stems in part from political considerations but also depends on legal grounds: Article 32 refers to the public interest, which entails the need for the State (though not exclusively) to act as the guarantor of social rights and to take active steps to provide care.

Article 3, paragraph 2, of the Constitution provides for the elimination of all 'social handicaps', meaning it is the State's

duty to intervene to meet the individual's needs whenever the potential development of their personality is at risk [13]. The objective is no longer merely the protection of life but, following social development and technological progress, to ensure that every individual enjoys the standard of well-being to which they are entitled. The choices to be made remain with the legislature, as recognized by the Constitutional Court, which has expressly stated that 'the margins of discretion are to be assessed solely by the legislature' [14].

Compulsory medical treatment and its limits "No one may be compelled to undergo a specific medical treatment except where provided for by law," states the second paragraph of Article 32. The individual's right to self-determination in relation to medical treatment is established; such treatment may not be imposed, except in specific cases expressly provided for by law. Compulsory medical treatment is defined as "any type of diagnostic or therapeutic procedure imposed on an individual" [15,16].

Current legislation grants the health authority the power to order compulsory medical treatment, applying the provisions of the law and exercising technical discretion. A reading of the second paragraph of Article 32 reveals its negative formulation, whereby, in conjunction with other interests, a violation of rights is permitted, subject to specific limits.

Consequently, provision is made for the possibility that an individual may be compelled to receive a specific healthcare service, in contrast to the normal exercise of rights, where it is the rights holder who decides whether or not to avail themselves of a given right, in addition to the provisions of Article 23 of the Constitution, according to which "no personal [or financial] obligation may be imposed except in accordance with the law". Self-determination is, however, limited by the interests protected by the first paragraph of Article 32, which, as previously explained, recognizes the 'fundamental right of the individual', but also 'the interest of the community'.

The obligation, imposed by law, to subject an individual to medical treatment must be justified solely not by individual health, but by the need to protect public health. Nowadays, it is not unusual for an individual to refuse certain medical treatments; however, their freedom of choice to decline changes when the outcome of the treatment benefits the community, and thus the individual is obliged to undergo the treatment.

Compulsory treatment must always respect the limits imposed by law and human dignity. A ruling by the Constitutional Court highlights the justification for such an obligation when it is directed 'not only at improving or preserving the state of health of the person subject to it, but also at preserving the state of health of others, since it is precisely this further purpose, relating to health as a matter of public interest, that justifies the restriction of that human self-determination which is inherent in everyone's right to health as a fundamental right [17].

Social Model of Disability

The social model of disability aims to address the restrictions and discrimination faced by people with disabilities and the

struggle to secure their rights. This model highlights inequality and identifies the barriers (which render people disabled), draws attention to the human and civil rights that are denied, and outlines the necessary actions to be taken.

- **English version of the social model:** it analyses the impact this has on people with disabilities and the structural interventions required to support them;
- **minority group:** the American version focuses in particular on the social roles and attitudes that lead to a failure to accept people with disabilities;
- **impairment model:** focuses on the significance of the impairment that distinguishes people with disabilities from those without; this perspective, is not yet fully developed, but its scope lies in research, studying the incidence of certain forms of illness;
- **independent living model:** highlights the desire not to conform to role expectations, focuses on environmental influences, self-advocacy and the removal of barriers, and the pursuit of independence.
- **post-modern deconstructionism:** recognises the fundamental need to rethink the social model, whilst maintaining that solutions to problems must be sought through interventions addressing environmental factors. The authors identify the need to foster a political identity that empowers people with disabilities and legitimises their role in society.
- **The continuum:** Zola (1993) (18) proposes a universal strategy, in which the concept of fluid and contextual disability applies to the entire population.
- The relationship between ability and disability is viewed as a continuum in which the complete absence of disability, just as the complete absence of ability, represents extreme cases of purely theoretical interest.
- **Discrimination:** this focuses on the importance of avoiding discrimination to promote equality. People with disabilities should not be viewed as a protected group but must receive fair treatment.

Social Inclusion: The Inclusive Perspective

Social inclusion is based on the recognition of an individual's right to be free from social and occupational exclusion. From this perspective, the strategies and measures implemented for people with disabilities must be aimed at removing all forms of social exclusion that they may encounter in their lives. According to Lepri (2011), when discussing social inclusion, various aspects must be considered:

- **Physical Inclusion:** the person with a disability frequents the same physical environments as other people
- **Functional Inclusion:** the person with a disability uses the physical environments;
- **Relational inclusion:** the person with a disability establishes positive relationships within the family and with other people
- **Temporal Inclusion:** the person with a disability experiences the normal life cycle, following the various stages of development
- **Civic Inclusion:** the person with a disability has rights and responsibilities;
- **inclusion of services:** the disabled person uses the services

available to all citizens.

People construct their own identity based on the image others have of them. The social representation built upon a person's image allows us to look beyond what a person with a disability has, to understand who they are and how they function within the context, and how the context functions in relation to them [18]. To respond to an inclusive approach and recognize the person with a disability as a person, it is necessary to address certain needs which the author defines as 'needs for normality'.

Acceptance

Being welcomed is a fundamental need for every human being, but the experience of being welcomed is permeated by both positive and negative emotions. For example, within a family, when a child has a disability, acceptance becomes a sense of duty, and the family's acceptance of the child will depend on various factors, such as how and when the disability was discovered, the parents' psychological resilience, and the level of support they can receive. The family's response to the need to welcome a disabled child may be one of overprotection towards a person perceived as weaker and unable to defend themselves. "In reality, what frightens parents and from which they wish to protect their child are not the dangers of the world—which should not be underestimated—but the possible consequences of aggressive emotions which, partly due to a sort of social taboo, cannot be acknowledged" [18].

A less common attitude is to deny limitations; the consequence of this is a tendency to underestimate the deficits of the person with a disability and to think that they should be able to do the same things as everyone else.

The result is difficult to manage because it tends to confuse the general framework of rights with what a person is actually capable of doing, given their abilities and limitations.

"Overprotection and the denial of limitations are, one might say, two sides of the same coin"; both create difficulties within the family unit and an inability – at least initially – to meet the child's need for acceptance [18].

The support parents can receive from outside is crucial, as it prevents the family from becoming isolated and enables them to access local services and join a support network with other families facing similar circumstances.

The social support provided by services does not always offer relief; indeed, the relationship between families in difficulty and professionals can sometimes be a source of further stress if the services are not well organized "Ensuring a warm welcome for parents who have a disabled child requires at least three conditions on the part of the services and their staff: a strong and stable partnership with the family; a positive approach focused on building on existing strengths; the renunciation of professional omnipotence" [18].

The imagination when discussing social inclusion, attention must be paid to the imagination; it is about giving people with disabilities the chance to have a dream for their future. The risk that parents may have no dreams for their child's future

may stem from disappointment or guilt, but above all from concerns about what the child might do when they grow up or what their place in the world will be. As Lepri (2011) states, the absence of fulfilling social roles for people with disabilities can completely extinguish parents' ability to imagine possibilities.

"The possibility that a person may attain, particularly on a psychological level, an emotional state that allows them to progressively engage with the roles that life presents to everyone, is linked to the fact that this is anticipated in the imagination of the parents and all the educational figures that person will encounter on their journey of growth" [18].

Reception and imagination are the foundations for planning a project that can become a dream come true. A plan is a way in which the mind engages with reality in order to bring about tangible change; everyone needs plans to shape their own lives. As Lepri (2011) argues, a plan allows us to anticipate the future, thereby revealing each person's potential and limitations. In the case of people with disabilities, who face additional limitations, the idea of a life plan is often postponed or even abandoned altogether. The fundamental need for a tailored approach to support people with disabilities is often met with inadequate responses. There is a tendency to believe that it is more effective to use "a series of redundant and fragmented programmers (often reduced to mere techniques) in which everyone is allowed to intervene and where, often, there is no overarching direction to provide meaning and purpose" (Lepri, 2011, p.89), rather than committing to planning a life project. The lack of planning makes it more difficult for people with disabilities to develop a sense of self-integration. It would be helpful if services provided support with planning, which should not be aimed solely at meeting basic needs, limited to activities designed and proposed with a focus on everyday life, but rather planned with a broader.

As Lepri (2011) points out, good planning always involves confronting limitations. Limitations imposed on the plan by reality, by the context and, of course, by the person's own limitations.

For those who support people with disabilities in realizing their life plans, draw on creativity and imagination through projects made possible by educational mediation.

Education

The aim of empowering people with disabilities to take charge of their own life plans requires an educational approach based on normality, to avoid the risk of education becoming mere welfare provision. The difference between education and care lies in the fact that the former considers the person for what they can become, the latter for what they 'are'. Education is a necessity that fosters personal development and differs from a care-based intervention.

Lepri (2011) highlights two aspects: the first concerns the ontological nature of the educational project, which has a beginning, a development and an end. Objectives must have timelines and deadlines; 'the temporal nature of the educational project is necessary for many reasons, not least to allow for the possible redefinition of objectives during the course of the project and their final evaluation' [18].

The second key aspect of an educational project concerns the appropriate distance between the educator and the learner: the relationship must be asymmetrical, as the educator must have the ability to anticipate, plan and propose measures aimed at improving the learner's living conditions.

“In the development of an educational project, this asymmetry must be kept constantly in mind; indeed, it must be allowed that, over time, a quantitative and qualitative change in the relationship and in the development of autonomy takes place” [18].

Within an educational relationship, the changes that occur along the way affect not only the learner but also the educator.

Role

The concept of role is linked to the concept of status; status is the structural aspect of a social position, whereas role is the dynamic aspect. To clarify the meaning further, “a role is the behavior expected of those who hold a certain status” [19].

As Lepri (2011) explains, in addition to ‘acquired status’, there is also an ascribed status that relates to a person's characteristics (gender, age, health, presence of a disability).

In a context of social inclusion, if a person is viewed in a negative light because of characteristics associated with their ascribed status, the social role assigned to them will consequently be devalued.

Ascribed status, which is based on the image of the disabled person as an eternal child who will never attain the maturity of adult competence, means that the social roles to which the person might aspire are typical of the world of childhood.

To overcome the attribution of devaluing roles, opportunities must be created that allow for the construction of an acquired status and roles that value the person.

“It is clear that the opportunity to take on a valued role is closely linked to the level of social inclusion of a person with a disability. In this context, social inclusion becomes both the end and the means for the enhancement of roles, since it is precisely through interaction and the opportunity for exchange that roles are defined and legitimized” [18].

From this perspective, for social inclusion to be possible, all the points outlined above must be taken into account; every person, not just those involved in education, must put into practice what Canevaro calls ‘good practices’—these are individual actions that lead to the reorganization of an institutional pathway that takes everyone into account [18].

Conclusions

The purpose of this paper is to highlight how essential it is to foster a welcoming and responsible environment towards people with disabilities and their lives, so that they too can be full members of society, contributing as much as possible.

The growing need of our times is for society to be able to respond to the needs of inclusion and to the full right to be members of society without any form of discrimination and/or stigmatization.

Every person has their own dignity and must be respected, regardless of their circumstances: “Every life is meaningful, and the sense of its importance—immense for those living it—or at least the sense of its uniqueness, must be recognized at every moment of life's journey” [20].

References

1. Cfr. <https://www.who.int>; v. inoltre <https://www.salute.gov.it>
2. Ottawa Charter World Health Organization WHO. 1986. https://www.euro.who.int/_data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf
3. Luciani M. The Right to Health: A Comparative Law Perspective. 2022. <https://www.europarl.europa.eu/portal/en>
4. Judgment of the Court of Cassation, First Civil Division, 16 October, No. 21748, section 6.1 of the reasoning of the decision.
5. Morana D. Health as a Constitutional Right. Health as a Constitutional Right. Turin, Giappichelli. 2021. 1.
6. Luciani M. The Right to Health: A Comparative Law Perspective. The Right to Health: A Comparative Law Perspective.
7. Constitutional Court Judgment No. 85/2013, available at www.cortecostituzionale.it
8. Pezzini B. The Right to Health: Constitutional Aspects. The Right to Health: Constitutional Profiles. Dir Soc. 1983. 33.
9. Crisafulli V. The Constitution and Its Fundamental Principles. The Constitution and Its Fundamental Principles. Milan. 1952.
10. Petrone LM, Pisaneschi A. The Italian Constitution: Reform of Its Title in Dizionario di Economia e Finanza. www.treccani.it. On the allocation of legislative powers between the State and the Regions, see, for example. Constitutional Law. Turin, Giappichelli. 2022. 420.
11. Constitutional Court. Judgment No. 141/2016.
12. Constitutional Court Judgment No. 267/1998; No. 252/2001.
13. Constitutional Court Judgment No. 200/2005.
14. Constitutional Court Judgment No. 103/1977.
15. Law No. 6972 of July 17, 1890.
16. Constitutional Court Judgment No. 185/1998.
17. Zola IK. Disability Statistics: What We Count and What It Tells Us—A Personal and Political Analysis. Journal of Disability Policy Studies. 1993. 4.
18. Lepri C. Unexpected Travelers: Notes on the Social Integration of Persons with Disabilities. Milan, FrancoAngeli. 2011.
19. Maciotti MI. The Concept of Role within the Framework of General Sociological Theory. Rome–Bari: Laterza. 2002.
20. Yourcenar M. *Memoirs of Hadrian*. Gallimard. 1974.