

# Immigrants' health protection: political, institutional and social perspectives at international and Italian level

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## ABSTRACT

The issue of "immigrants' health" has been the subject of increasing interest in recent years, both in scientific literature and in the declarations of international health institutions. Specifically, the Resolution of the 61<sup>st</sup> World Health Assembly (2008), and the Report of the European Parliament on the reduction of the inequalities in health within EU (2010) are worth highlighting. There is a clear convergence in the orientations recommended to local Governments regarding the health policies and interventions to be adopted in this sector.

It may be stated that the health policies adopted in Italy in the 1980s have been pioneering in both European and international contexts. Enhanced by the unconditional recognition of the right to health, which is stated in the Italian Constitution, these orientations have been strongly suggested to the policy-makers through effective lobbying efforts.

Alongside ethical-legal recognition of the right to healthcare, the technical-scientific debate has also developed, especially following the publication of the WHO Report "Closing the gap in a generation" (2008). This has enabled the acknowledgement of the relevant role played by the socio-economic conditions which distinguish the different groups of immigrants. Moreover, the proposal of inter-sectorial policies and of an approach aimed at the empowerment of the community has become increasingly significant. In future, health protection for immigrants will be not only a priority as imposed by the recognition of health as a human right, but will also be more closely connected to capacities for the planning and support, at local level, of health promotion initiatives.

*Key words: Ethnic minorities, Migrant's health, Right to health, Social determinants of health, Health policy*

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*"The Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent..." (The Italian Constitution, 1948 - 32<sup>nd</sup> Article)*

## MIGRATION AND HEALTH IN AN INTERNATIONAL PERSPECTIVE

There is an identifiable thread, a '*fil rouge*', connecting the different statements regarding the

issue of immigrants' health expressed at international level by important institutions (1-3).

Some deal with this issue indirectly, such as, for example, the various conventions, recommendations, declarations, action plans,

etc., which, from the '50s until the present, have included different categories of subjects (e.g. workers) and populations considered "vulnerable" (women, children, the disabled, the elderly, refugees and displaced persons, among others), and which stress the need to avoid discrimination within these groups (4, 5). Other documents deal with this issue, again indirectly, by considering health as one of the various dimensions that characterize international immigration and development; an example would be Resolution A/52/314 approved by the General Assembly of the United Nations in 1997 (6). Others identify this theme as a central and specific issue. Among them, and of particular prominence, is the Resolution of the 61<sup>st</sup> World Assembly of Health (7), which invites the Member States to promote and support various lines of intervention which include these different variables in their entirety (Box 1).

Focusing solely on the European context, it seems useful to recall, *inter alia*, three recent documents (8-10).

In September 2007, the Conference "*Health and Migration in the EU: better health for all*

*in an inclusive society*" took place in Lisbon (in the period during which Portugal held the Presidency of the EU). The Conference produced some very interesting Conclusions and Final Recommendations.

It upheld the following assertions: immigrants represent a resource for the European Union; European migration policies have to be re-defined; universal access to health care assistance has to be seen as a prerequisite for European public health and an essential element for its social, economic and political development and the promotion of the human rights; and immigrants' health protection must not be seen solely as a humanitarian cause, but principally in terms of the need to reach the highest level of health and well-being for all in Europe. The final messages of the Conference can be summarised as: global problems require global solutions, health and migration are two global phenomena which require urgent global responses in relation to which the EU should assume a guiding role; and the reduction of poverty and the promotion of the integration of immigrants are fundamental key actions. Given that the lack of access to

## BOX 1

RECOMMENDATIONS OF THE RESOLUTION OF THE 61<sup>ST</sup> WORLD HEALTH ASSEMBLY (WHA61.17/2008)

[THE 61 <sup>ST</sup> WHA ASSEMBLY] CALLS UPON MEMBER STATES:	
1.	to promote migrant-sensitive health policies;
2.	to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
3.	to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;
4.	to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;
5.	to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;
6.	to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;
7.	to train health professionals to deal with the health issues associated with population movements;
8.	to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;
9.	to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals.

## BOX 2

## THE "BRATISLAVA DECLARATION ON HEALTH, HUMAN RIGHTS AND MIGRATION". EXTRACTED FROM THE DUTIES:

Work toward overcoming the barriers to the enjoyment of the access to protection of health for people on the move through capacity building and awareness raising for health providers, policy makers, health management planners and health educators as well as other professions allied to health services delivery.

Support public health research to enhance and strengthen national and international surveillance and information systems and to strengthen and support evidence-based programmes for the health of people on the move.

Take steps to reinforce and incorporate the health dimension into development and cooperation policy following the principle of "health in all policies".

Promote migrants' participation in programme planning, health services delivery, and evaluation.

Take steps to train and educate health-care providers, policy makers, health management planners and health educators, as appropriate, on addressing health-care issues associated with population mobility and disparities in health services between geographical locations.

Encourage host countries to consider the invitation of the Parliamentary Assembly in the Resolution 1509 (2006) to eliminate any requirement on health service providers and school authorities to report the presence of irregular migrants to the authorities.

qualified care is a central issue for immigrants, the Conference recommends the prioritization of equal and culturally sensitive access for all immigrants. Strengthening cooperation with the aim of fulfilling essential health needs is crucial for the prevention of disease at its origin and for ensuring better health everywhere in today's globalised world context, and urgent political decisions should open the way to practical solutions (11).

Less than two months later, the 8<sup>th</sup> Conference of the Ministers of Health of the 47 countries of the Council of Europe took place in Bratislava in November 2007, with the title *"People on the Move: Human Rights and Challenges for Health Care Systems"*, at which the *"Bratislava Declaration on health, human rights and migration"* was approved. The Declaration, recalling other statements such as the European Social Charter, and demonstrating a systematic interpretation of the binomial "health and migration", set out twenty areas of duties "to address the challenges that human mobility generates for human rights within the health field and for health care systems..." (Box 2).

Finally, in March 2011 - due in part to lobbying by NGOs (12-14) - the European Parliament approved a *"Report on reducing health inequalities in European Union"*, exhorting the Member States to confront the inequalities in access to health care, including those faced by

illegal immigrants, especially pregnant women and children (15).

It is emphasized that "... health inequalities are not only the result of a host of economic, environmental and lifestyle-related factors, but also of problems relating to access to healthcare" (point P) and that "... in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for undocumented migrants" (point AD). Therefore, among other recommendations, the European Parliament calls on the Member States "...to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; ...to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation" (point 5); "...to promote access to high-quality legal advice and information in coordination with civil society organizations to help ordinary members of the public, including undocumented migrants, to learn more about their individual rights" (point 8); "...to ensure that all pregnant women and children, irrespective of their status, are entitled to and actually receive social protection as defined in their national legislation" (point 22).

In conclusion, it would appear that, considering the events of the last five years, a common and clear

sensitivity has developed, on the part of the "health world" at international (and, more specifically, European) level, regarding the complex background and consequences of human mobility. This vision may be interpreted as based upon the principle of the right to health, conscious of the significance of incorporating within government policies not only an ethical but also a social dimension, paying special attention, among immigrants, to those groups which are most vulnerable (women, the elderly, the mentally ill, asylum seekers and refugees, illegal immigrants, Roma), from a culturally sensitive and inter-sectorial perspective.

In spite of the clearness and completeness of this vision of the migratory phenomenon, with regard to its implications for health, it is necessary to emphasize the precariousness and the uncertainty of the processes of implementation at local level, taking account of the non-binding nature of these pronouncements.

More specifically, the EU does not have any binding influence upon the single Member States for the health protection of immigrants, due to the "principle of subsidiarity", which implies intervention by the European Community only when the goals of the planned action cannot be sufficiently achieved by the single Member States (16).

Moreover, it has been noted that, unfortunately, the current economical and financial crisis poses a significant risk to the application of these statements. An example of this problem may be given by the recent restrictions on health care rights for immigrants (and, even more notably, the stigmatizing governmental approach, labelling immigrants as a source of infectious risk for the native population, together with the effort to "use" health as a pretext for expulsion to countries of origin), occurring in Greece, the "symbol" of the current European crisis (17).

## THE ITALIAN EXPERIENCE OF IMMIGRANTS' RIGHT TO HEALTH

Regarding the situation in Italy, it must first be noted that some precise health policies relating to the health of migrants were outlined by legislative measures dating from the late 1990s, but which first appeared, albeit in a juridically unstable form, in 1995.

The current regulations on the available health care services for immigrants date back to a comprehensive law, entitled "Single Text on Immigration" (D.Lgs. 286, articles 34<sup>th</sup>, 35<sup>th</sup> and

36<sup>th</sup>) approved in 1998, and successive regulatory provisions (mainly the DPR 394/1999, articles 42<sup>nd</sup>, 43<sup>th</sup> and 44<sup>th</sup> and the Circular n. 5 del 2000 of the Health Department).

The "philosophy" of these deliberately "inclusive" health policies can be summarised in two major areas: 1) the complete equality of rights and obligations, regarding both health and rights to health care, between Italian citizens and foreigners legally present (with stay permit), with complete health care cover from the public health system; 2) the broad possibility of health protection and health assistance also for undocumented immigrants, especially for women and children, and in relation to infectious diseases (18, 19).

However, an "inclusive" health policy needs to be accompanied by a real willingness to collaborate on the part of the local authorities, which over time have acquired a fundamental role in the provision of social and health services for foreigners, in terms of implementation and maintaining effectiveness. Indeed, article 117 of Constitutional Law No. 3 of 2001, which introduced modifications to Title V of Part II of the Constitution, enabled the Regions and Autonomous Provinces to define regulations on health issues for all residents, including immigrants, while migration remains one of the issues in which the State maintains complete legal authority. The theme "health and immigration" seems ambiguously suspended between the "exclusive" legislation of the State and the "competing" legislation of the autonomous Regions and Provinces. Devolution within the complex process of federalism, which implies interconnection between the various institutional levels involved in the health system, results in uncertain pathways of responsibility, which can jeopardise the successful application of health care policies, and preventing them from achieving their institutional mission (as may indeed also occur in matters of health care for Italian citizens) (20, 21).

The ambiguity that is created between policies on migration (a central government competence) and health care policies (a regional administration competence), may be seen in the following three examples:

- the introduction of the crime of irregular entry and sojourn in Italy through the approval of law No. 94/2009, the so-called "Security Package";
- the appeals presented by the Government to the Supreme Court, between 2009 and 2010, on the constitutional legitimacy of the regional laws on migration in Tuscany, Puglia and Campania;

- the application of the provisions of Legislative Decree No. 30 of 2007 which activated the EU Resolution for the free mobility of European Union citizens (2004/38/CE).

With regard to the first case, during the parliamentary discussion on the Security Package there was an attempt, by the Northern League (Lega Nord) to repeal the provision (D. Lgs. No.286/1998, art. 35, para 5) which prohibits health and administrative personnel from reporting illegal immigrants who use health services; mainly motivated by ideological reasons, this represents a serious interference in the health sector, and could have posed a serious threat to immigrants' right to health care (22). Although the proposal was abandoned, and therefore the prohibition of denouncement remains in effect, the introduction of the crime of illegal entry and sojourn, as pursuable by the authorities, has placed the health professionals (doctors, nurses, administrative staff, etc.) in a difficult practical, ethical and deontological situation; according to one legal interpretation, a public officer should be obliged to make a denouncement to the public authorities if during the exercise of his or her profession the irregular status of an immigrant comes to light, but this is contradicted by another law of the State, the aforementioned "Single Text on Immigration", which sets out the rules on health care for illegal immigrants. These two contrasting laws, regarding the prohibition to and conversely, the obligation to denounce, have given rise to confusion, ambiguity and the use of discretion. The Regions, which had in part also taken a stance against the proposal for the repeal of the prohibition of denouncement, therefore had to provide prompt clarification of its validity. The Ministry of the Interior subsequently issued a circular (No. 12 of 27 November 2009) confirming that the law on public security had not repealed the previous rules and that, as a consequence, doctors and other workers within the health care sector remained obliged to observe the prohibition on reporting illegal immigrants seeking health care services, with some limited general exceptions (e.g. firearm injuries) (23).

With regard to the appeals on the presumed constitutional illegitimacy of the laws on migration in Tuscany, Puglia and Campania, the regional provisions were contested by the government on the grounds that they exceeded the competences of the regions; according to the Italian government then in office, local provisions for the protection of the right to health care, if extended to illegal

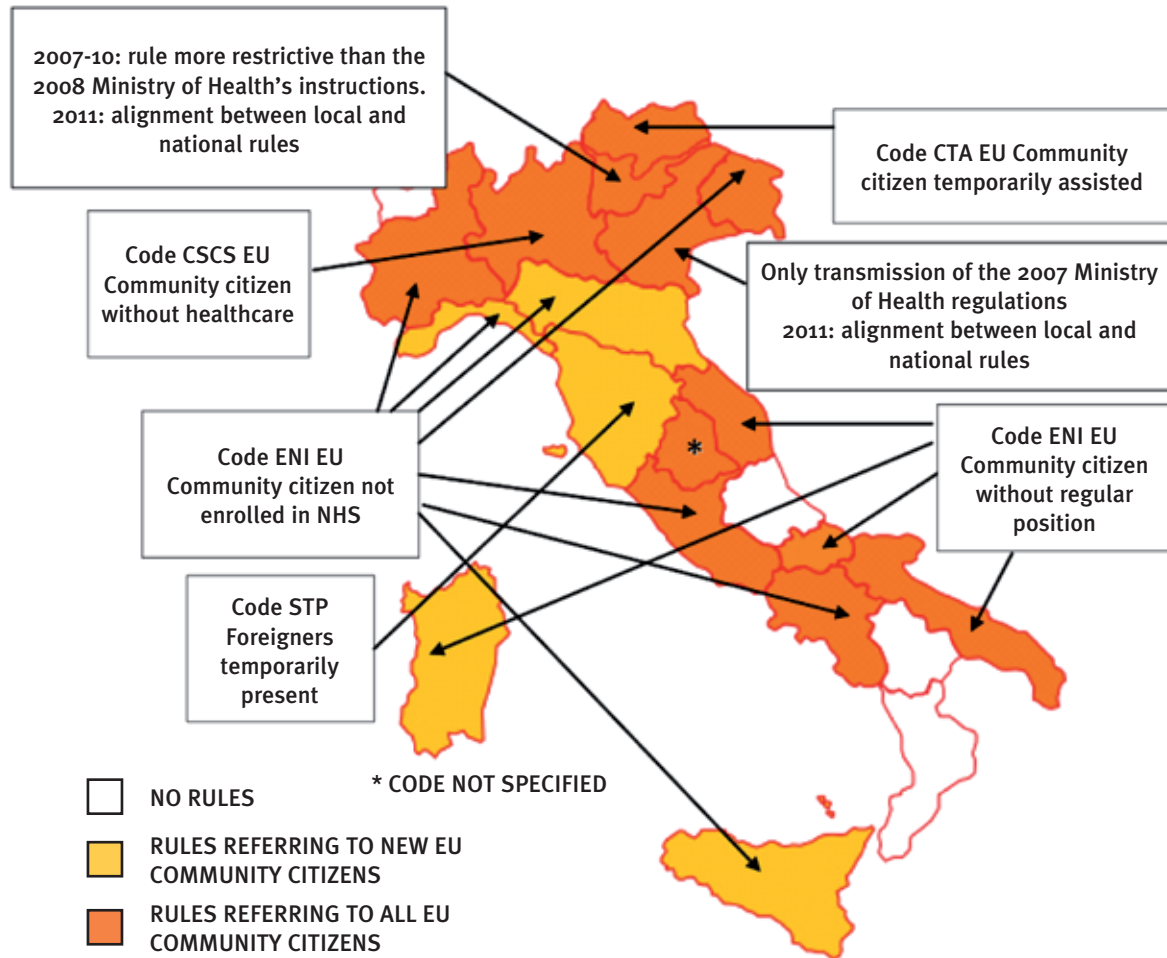
immigrants, would be considered to affect the regulation of the entry and sojourn of such immigrants, matters reserved to the exclusive competence of the State. However, the Supreme Court rejected the government's appeal in all three cases (Sentences No. 269 of 2010, No. 299 of 2010, and No. 61 of 2011) - only in part for the regional law in Puglia, but not in relation to health - reaffirming, with regard to health care for immigrants, the "irreducible nucleus" of the right to health, even with reference to foreigners without a valid stay permit. Indeed, this right to health is "protected by the [Italian] Constitution as an inviolable aspect of human dignity" (Sentence No. 252 of 2001), in conformity with the view already expressed by the Court, according to which "the foreigner is [...] entitled to all the fundamental rights that the Constitution recognizes as owned by the person" (Sentence No. 148 of 2008) (24).

In February 2007, by means of Legislative Decree No. 30 of 2007, Italy implemented European Resolution 2004/38/CE on the right of European Union citizens and their families to move and settle freely within the territory of the Member States. The untimeliness of the measure, nearly three years after the European Resolution, and the concomitant entrance (1 January 2007) of Romania and Bulgaria in the EU, created considerable confusion and the widespread use of discretion within the health services. Not only were tens of thousands of "neo-communitarian citizens" immediately excluded from health protection, as they were unable to meet the necessary conditions in order to obtain health assistance (possession of the European Health Insurance Card - EHIC - or legal work and/or registered residency), but also the directions later provided by central government were unclear and in some cases contradictory (Circulars issued by the Ministry of Health on 3 August 2007, 19 February 2008, 24 July 2009, and eleven more in less than a year). For this reason the regions, in a non coordinated fashion, had provided very different answers not only in relation to procedure but also with regard to possible levels of health care, especially with reference to the socially and economically vulnerable (Figure 1) (25).

This "pendulum of competences" generates a high level of risk in terms of creating inequalities not only in the terms of access to health services, but also in terms of the health profile of the immigrant population on a territorial basis. For this reason, the Health Sector of Caritas in Rome founded an "*Observatory on local policies on healthcare for*

FIG. 1

## LOCAL RULES FOR THE (NEW) EU COMMUNITY CITIZENS WITHOUT HEALTHCARE



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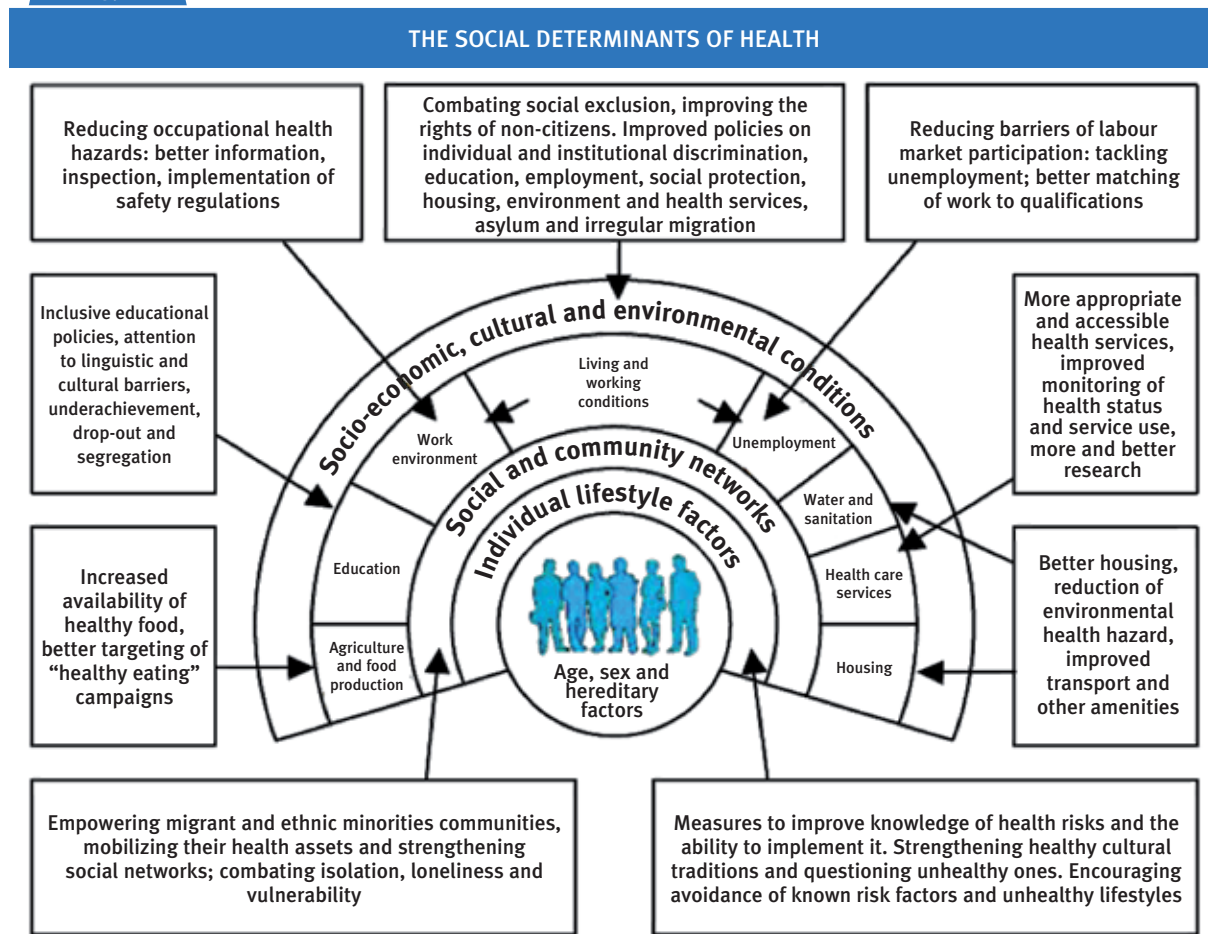
Geraci S, Bonciani M, Martinelli B, 2011

foreigners" in 1995, which has operated more systematically since 1998. It has carried out several specific research studies and produces periodic reports, the most recent of which was published at the end of 2010, included in a governmental project financed by the Ministry of Health and coordinated by the Italian National Institute of Health. This last research project has attempted to describe the variability among Italian Regions, collecting and examining a total of more than 700 official documents issued from 1995 until the first half of 2010. These were then analyzed according to a specific methodology in order to identify and apply key indicators characterizing health policies (guidelines; the presence of institutional observatories for the ongoing analysis of health needs; intervention oriented towards prevention and health promotion; opportunities for specific

education and training; pathways for linguistically and culturally competent health care; the guarantee of health care for illegal immigrants; and the planning of projects to assist socially vulnerable EU citizens). This has enabled two synthetic indices to be produced, representing the level of progress and the impact of local policies on the immigrant population, highlighting objective discrepancies and evident inequalities in the availability of health services (26).

As a result of these considerations, at the end of 2008 an Inter-Regional Committee was established by the Health Commission of the Conference of Regions, in order to create a stable form of comparison and collaboration among the Regions, as well as a form of negotiation between the Regions and the State, on the issues of immigrants' health and health care assistance,

FIG. 2



Source: Migration and health in the European Union (10). The diagram is inspired by a presentation from Dr Nani Nair, TB Regional Advisor, on 15–16 September 2005 at the WHO Regional Office for South East Asia consultation on the social determinants of health, subsequently adapted by T. Koller to address determinants of the health of socially excluded migrant populations. The well-known "rainbow" is from Dahlgren & Whitehead (1991)

and to reduce the discretionary interpretation of national laws (27). After two years of work, the Committee produced the document *"Directions for the correct application of legislation for health care assistance to the foreign population by the Italian Regions and the Autonomous Provinces"*, which was approved by the Assembly of the Regional Health Authorities and which currently awaits final institutional approval prior to adoption at national level.

### IMMIGRANT HEALTH FROM THE PERSPECTIVE OF SOCIAL DETERMINANTS OF HEALTH

Besides outlining the orientation of health policies at international, national and local level, it

is also fundamental to attempt to summarize the prevalent routes taken at a scientific level, which should always provide the reference and foundation for a coherent health policy (1, 8, 28, 29).

Probably the most interesting element of all is the emergence, also in the field of immigrant health, of an approach based on the bio-psycho-social paradigm, on the analysis of the dynamics related to health and on the causal chains that determine them. This approach has always been influenced by the theme of "social determinants of health", especially after the publication of the WHO Report "Closing the Gap" in 2008 (30). This has enabled a revision of the spectrum of health determinants identified by Dahlgren and Whitehead (1991), starting from the socioeconomic conditions that characterize the different groups and communities of immigrants (Figure 2).

It is clear that this systemic view supports the need to adopt inter-sectorial policies, in the true spirit of "Health Promotion" (31), which currently has as its slogan "Health In All Policies".

Indeed, with reference to the complex construct of health and the role of socio-economic determinants, the research carried out in the United States by Robert Putman, aimed at improving the impact of integration processes and "social capital" on the quality of community life, appears particularly important (32).

The concept of social capital may be explained in terms of civil tradition and the heritage of relationships, reciprocity and social inter-connectivity. It should be emphasized that, in the presence of high levels of social tension triggered by ethnic heterogeneity and poor integration, it tends not to be the interracial conflict that prevails, but rather the drive to social disintegration, isolation, and lack of commitment and social trust, not only towards the "ethnically" different, but indeed also in relation to one's peers.

This leads us to reflect on the necessity of promoting strategies able to reduce social distance, facilitating the processes of integration and strengthening public trust in institutions. In this sense, social capital can become a key to the orientation and evaluation of public policies sustaining the development of new forms of collective organization.

Universalistic health systems, as in the Italian case, tend to recognise the importance of adopting initiatives protecting the health of all immigrants, including those without regular documents, on the basis of the recognition of health as a fundamental, primary right of the individual.

The adoption of a similar "systemic" overview involves reference to models of intervention marked by complexity, characterized by multifaceted action, and permitting the integration of different professions and points of view, with flexible strategies, and close attention to context (33, 34).

### **INSTITUTIONAL AND NON-INSTITUTIONAL LEVELS OF RESPONSIBILITY FOR IMMIGRANTS' HEALTH**

The Italian legislation emerged in 1998, organically but not by chance; on the contrary, it was the result of sustained advocacy by sectors of civil society, which had begun about ten years earlier. Indeed, immigration in Italy became a social phenomenon in the early 1980s, but its real

dimensions went unnoticed in policy, inasmuch as the first immigration law did not appear until 1986, and a regulatory intervention plan was not drafted until 1998. However, the mid 1980s saw the spontaneous and uncoordinated emergence of various voluntary groups from both religious and secular backgrounds (examples include Caritas in Rome, Naga in Milan, the Red Cross in Genoa, the Biavati in Bologna, the Salesians of St. Clare and the University in Palermo) which organised primary level outpatient clinics in order to guarantee the right to healthcare for excluded foreigners. In June 1990, the then Deputy Prime Minister Claudio Martelli, promoter of the Martelli Law on immigration enacted in February of the same year, participated in a meeting in Rome of all those who were concerned with immigration, at which the representatives of these various local groups met for the first time. From this encounter it became apparent that these more or less isolated experiences could be brought together and shared; this represented a progression from personal commitment to a collective consciousness of a new reality: from the need to face an emergency due to a lack of preparation and organization in the public sphere, to the need to understand, study, and acquire experience in meeting with these "new citizens"; from the right that was in practice denied or hidden, to a new willingness to confirm, also at the legal level, that health is a common asset (35). This opened discussion in Italy on migration medicine, and those dedicated pioneering doctors and healthcare workers in this field emphasized that it was concerned not only with disease and risk, but also represented an opportunity to reconsider the person in his or her entirety (as composed not only of body and psyche, but also of culture, expectations, desires, and so on) and in a context (inclusion or social vulnerability, the effects of policies regarding the reception and integration of immigrants, prejudices and discrimination), a perspective that we would now define as "global health" (36).

Following the first exchanges of experience in the clinical-epidemiological sector, the various groups working in Italy have also gradually managed to develop an approach to health policy planning. This has resulted in a grass-roots movement on the part of public sector health workers and civil society as a whole, strongly motivated and characterized by a high profile in specific skills. Typically of this form of group, the movement is distinguished by its focus on free contribution, commitment and liberty, and has ensured its credibility in terms of its analysis



of the phenomenon and the proposals it offers. The creation of the Italian Society of Migration Medicine (Società Italiana di Medicina delle Migrazioni, SIMM) in 1990 should be viewed in this context. Since its founding it has influenced, through its constant lobbying and advocacy, most national health care policy decisions in this sector, which has led to the enactment - not without controversy and difficulty - of the inclusive laws mentioned above (for documents, analyses and proposals produced by SIMM, see [www.simmweb.it](http://www.simmweb.it)).

While SIMM fully performs its political and scientific mission at the national level, it is the local level (Regions and Autonomous Provinces) that require specific attention and skilled intervention, since this is the level at which it is possible to influence decision-making and organization through the lobbying networks typical of civil society. The first SIMM local groups, the GrIS (Gruppi Immigrati e Salute - Migrants and Health Groups) emerged spontaneously and occupy a key position in the context of commitment and attention typical of migration medicine. In this dualism of national and local levels, even the fields of scientific research and methodological reflection assume a key role, as may be seen by high levels of attendance and participation in the Consensus Conferences held every two years since 1990 in Sicily. The scientific proceedings of these meetings constitute a milestone in the development of knowledge on health care issues for, with and among immigrants. The GrIS fulfil at a local level the function performed by the SIMM nationally, but with the advantage of everyday engagement, shared space, common partners and mutual awareness. It is not by chance that the local context has facilitated the emergence of reflection on reciprocal commitment; the idea that the immigrant is not a passive object but rather a subject involved in the processes of integration and if necessary, the provision of health care; and the transition from support and advocacy to empowerment. At local level these ideas transcend words to become practice and action.

The GrIS provide a locus for participation, where each individual and group shares a common project, constructed on the basis of their own possibilities and capacities. Various actors (public, private, social, voluntary associations, institutions) are able to come together, at times with contrasting viewpoints but always with the constructive scope of promoting diversity (37).

There are currently 12 GrIS in Italy, which provide valuable field observation from quite different contexts (from Lombardy to Sicily, from Lazio - where the first GrIS was established - to Calabria, where it is still under construction). They function as laboratories for health care policy and primary care and, we dare say, represent one of the most advanced manifestations of the new perspective on public health as proposed by the international documents mentioned above.

## CONCLUSIONS

In accordance with the 2008 World Health Assembly Resolution on the Health of Migrants, Member States should demonstrate commitment to migrant-sensitive health policies and practices. With the purpose of promoting migrant health on the international agenda, the WHO, in collaboration with IOM and the Ministry of Health and Social Policy of Spain, held a Global Consultation on Migrant Health on March 2010 in Madrid, which produced a technical Report (38). In particular, this consultation report presents an outline for an operational framework to guide action by key stakeholders, suggesting key priorities and corresponding actions in each of the following thematic areas: Monitoring migrant health, Policy and legal frameworks, Migrant-sensitive health systems, and Partnerships, networks & multi-country frameworks. We are convinced that the guidance provided in this report indicates the right direction for the future, according centrality to the cultural dimension.

*"If medicine is to achieve its full purpose, it must enter into the full political life of its time, and must indicate all the obstacles that impede the normal completion of the life cycle"* wrote the German pathologist Rudolf Virchow in 1848, contributing to drafting of the first inclusive health policy for the whole population in modern history (39). In these terms one might currently interpret the cultural attempt - which precedes the organizational effort - to identify tools for the construction of equitable policies for health care without exclusion.

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