# A Construção do Direito à Saúde na Itália e no Brasil na Perspectiva da Bioética Cotidiana

## The Construction of the Right to Health in Italy and in Brazil under the Perspective of Everyday Bioethics

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## Resumo

Este artigo busca percorrer as políticas de saúde italiana e brasileira em um recorte histórico das conjunturas econômicas e políticas do século XVIII ao século XX, na perspectiva de identificar elementos sinalizadores de aproximações e distanciamentos para compreender o processo de materialização do direito à saúde. Trata-se de uma pesquisa descritiva com abordagem qualitativa, tendo como fonte de dados documentos oficiais e revisão de literatura, numa perspectiva histórica. A análise dos dados é feita com base na bioética cotidiana. Os resultados obtidos mostram que, em ambos os Estados, a origem da concretização do direito à saúde é fruto da iniciativa dos trabalhadores com o propósito de satisfazer uma de suas dimensões: o direito à assistência à saúde. Percebem-se similaridades nos modelos de proteção social, a importância da Itália no processo brasileiro de construção do direito à saúde, distanciamento entre as novas ações estatais instituídas após as reformas sanitárias e a necessidade de se enfrentar, valendo-se de um sistema político de regras, o histórico conflito ético entre os direitos individuais e a garantia dos direitos sociais, especialmente o direito à saúde, nas duas realidades.

**Palavras-chave:** Direito à saúde; Bioética cotidiana; Política de saúde.

## Abstract

This article approaches the Italian and Brazilian health policies based on a historical overview of the economic and political conjunctures from the 18th century to the 20th century, so as to identify elements that signal similarities and differences in order to understand the materialization process of the right to health. The present study is a descriptive research with a qualitative approach. The data source includes official documents and a literature review in a historical perspective. The data analysis is carried out based on Everyday Bioethics. The results show that in both States the right to health is rendered concrete as a result of the workers' initiative, with the aim of satisfying one of its dimensions: the right to health assistance. The following aspects were observed: similarities in the social protection models, the importance of Italy in the Brazilian construction process of the right to health, differences between the new governmental actions established after the sanitary reforms, and the need to confront, by means of a political system of rules, the historical ethical conflict between individual rights and the guarantee of social rights, mainly the right to health, in both realities.

**Keywords**: Right to Health; Everyday Bioethics; Health Policy.

## Introduction

The modern project, idealized by philosophers since the 16th century and consolidated in the transition from feudalism to capitalism, beginning in the English Revolution in the 18th century, triggered profound changes in the way society was organized, thus leading to relevant advances, especially in the area of constitution of rights. Old truths that had been attributed to nature until then were replaced by men's awareness of their ability to understand and explain the adversities imposed by life in society and new social, political and economic relationships were established, promoting the appearance of the concept of the right to have rights (Mondaini, 2003).

Modern man, by leaving behind old truths, among which was the concept of nature as disorganized and the divine justification for the misfortunes of the country person, enabled the appearance of their own truth, choosing the contemporary self-illusion as structural doctrine (Bauman, 1999).

It is in this context of construction of order, as a principle of reality, that a historical awareness of inequality was raised, under which civil rights, or the right of citizens, began to be constructed, the beginnings of the philosophical foundations of human rights (Mondaini, 2003; Susser apud Berlinguer, 1997).

The first generation of rights - the rights to freedom - began with the American Declaration of Rights - approved in 1776, in the yet colony of Virginia - and with the Declaration of the Rights of Men and of the Citizen - sanctioned in France in 1789 (Mondaini 2003; Susser apud Berlinguer, 1997). These declarations laid the political foundations of human rights and emerged as a need to establish the choice for modernity.

Modernity, constructed under the aspiration of being modern, brought with it the risk of humanity not being able to face "the difficulties inherent to the nature of civilization [read modernity], which does not [or would not] submit to any attempt at reform" (Bauman, 1998. p. 8).

The 19th century, when modern life was materialized, was a landmark in the establishment of the social body order and in the human construction

that desires the need and certainty of the world. The intention of being modern appeared in the light of the modern self-illusion, which seems to have been the source of beautiful and atrocious human actions in the 20th century (Bauman, 1999). In response to such atrocities, there was also a second generation of rights, whose recognition was especially granted by the German "Weimar Constitution" from 1919 (Humenhuk, 2003).

Social rights appeared as a need, with their universal government-based character, whose maximum expression manifested itself after the 2nd World War (1939-1945), in the National States' proposal of construction of an ideal to be followed to protect human dignity, severely affected by the Nazi cruelties.

The second generation of rights originated with the Universal Declaration of Human Rights, proclaimed on December 10th, 1948, by the United Nations Organization, with a third generation that appears as an answer to the resulting process of social destruction and loss of land ownership that occurred with the 2nd World War – rights to solidarity and quality of life – which include, among other things, the right to peace and the environment (Amadigi, 2005).

In the area of health, as a result of the atrocities practiced by humanity, bioethics appeared in the 1950s and 1960s as a possibility to seek solutions and answers in accordance with human actions, as well as to think about the effects caused by biopower, exercise of power to control bodies, established because of the need to maintain and control the order established by modernity.

Finally, in the 1990s, a fourth generation of rights began to be constructed, so that the political globalization imposed by neo-liberalism could be fought against (Bonavides apud Lima et al., 2005).

Thus, one can perceive that the rights have been and continue to be thought of, constructed and established, based on the process of transformation of the social organization.

The present article sought to outline the health policies established by the National States of Italy and Brazil, in the perspective of identification of aspects that indicate their coming closer to or moving away from one another in each of the economic and political conjectures, to understand the process of materialization of the right to health.

Reflecting on the nature of this object and the multiplicity of dimensions involved – both objective (political, social and economic) and subjective – everyday bioethics was selected as the analytical framework to guide this discussion, an instrument of general bioethics that aims to seek consensual solutions, using rational and reasonable arguments for routine human actions.

This is a qualitative study conducted in a historical perspective, including the analysis of official documents and a literature review.

## The Right to Health in Italy and Brazil: Advances and Regressions

By reviewing Guzzanti's thesis[1], it was observed that the expression of the right to health in Italy is initially seen as a right to health care in a model of mutual solidarity founded on society's tradition of mutual help, created by Italian workers as they faced the new urban industrial reality of the 18th and 19th centuries. Attracted by new job opportunities, country people migrated with their families to the cities, in search of new opportunities. Upon arrival, they found themselves to be objects of exploitative production, without fair salaries and rights and without the right to protection against diseases, invalidity, maternity, incapacity to work and old age. In short, without rights to a respectable life.

At the end of the 19th century, the State granted legal personality to mutual help associations, justifying this with the argument that health is a common asset and thus must be subject to effective control[1]. Subsequently, this self-management model ended and the social security and assistance system of mutual funds was created. Social security had been optional until then, and it was replaced by mandatory social security, founded on two prerogatives: a cooperative initiative, based on voluntary contribution of associated workers, and a corporate initiative, resulting from the hiring of

1 GUZZANTI, E. *Evoluzione storica del Servizio Sanitário Nazionale*, 1999. Available at: <https://www.cesdaldspace.it/retrieve/2894/Bibliografia+Tesi.pdf>. Accessed on: July 16th, 2007

workers and expressed as equivalent contributions between employees and employers (Bellucci apud Cosmacini, 2005).

The 20th century was marked by innumerable governmental actions directly associated with the right to health. Mutualism, the model of social security of diseases, continued to exist in the pre-fascism period and it was (re)invented by the fascist government, based on central institutions that began to represent the mutual funds[2].

After the 2nd World War, in December 1947, the Italian Constitution was promulgated, and it became effective on January 1st, 1948. Article 32 of this constitution states: *The Republic protects health as a basic right of individual and collective interest, and it guarantees free treatment to those in need [...]* (Repubblica Italiana, 1947).

In the 1960s, Italy was undergoing great difficulties and it did not experience the welfare state, unlike social-democratic European countries. In addition, the evolution of the demographic profile of the population, the increase in health needs and the growing debt of mutualism, strongly fragmented into innumerable insurance and health plan organizations, require the system to be (re) considered (Cavicchi, 2005; Berlinguer, 1997).

In the period between the 1960s and the late 1990s, Italy underwent innumerable health reforms.

In 1965, Giovanni Berlinguer, who was then a social doctor and member of the Italian Communist Party, had developed a plan, based on studies conducted by him in 1964, where he predicted the equal distribution of health care in Local Health Units and the replacement of the principle of security of illness for the principle of social security, by means of hygienic-preventive and environmental actions.

However, the Parliament delayed the discussion about the Health Reform proposal (Teixeira, 1989) and decided, in 1968, to implement a Hospital Reform to take advantage of the entry of autonomous hospitals to replace the public social assistance and charity institutions.

According to Berlinguer et al. (1988), this Reform caused a complex hospital crisis and, ten years later, in December 1978, there arose a wide social mobilization for a health reform, with the participation of thousands of individuals from civil society, especially workers, as the result of a process of ideological and political fights (Berlinguer et al., 1988).

The Health Reform led to the creation of the "*Servizio Sanitário Nazionale* – SSN (National Health Service)[3]", regulated by Law 833/78, which was committed to modern health awareness, based on a social democratic ideal, with a proposal of universal access and decentralization of health care, thus representing an advance for the more fragile sectors of Italian society (Berlinguer et al., 1988). The motto was "right, health and guarantee of health care to all" and the doctrine principles were as follows: globalization, equality, universality and oneness. This country had finally managed to break away from mutualism and established a health system that was committed to full citizenship as a universal right and, in this way, to the universal right to health[1].

However, the situation in Italy in the 1980s, like the situation of other western societies, was marked by a relevant increase in the demand of needs and spending on health care, because life expectancy at birth and population aging had grown. In addition, the strength of the market, industry and technology, in addition to the effects of the Reform of 1968 (increase in the number of hospital beds and hospital spending) caused Italy to seek measures that could result in "conditions to" enable the offer to be adequate, compared to the new demand. Thus, the State chose the path of reduction in spending, guided by the perception that the guarantee of the right to health would depend on a reduction in costs (Cavicchi, 2005).

The Italian government created a system of co-participation of society, based on the argument of the need to increase SSN funding. The "ticket" was instituted, through which average-complexity care began to be paid by society to guarantee free health care for low-income citizens. Therefore, a policy that was aimed at equity (Repubblica Italiana, 1986).

2 MEZZANO, A. *I danni del fascismo*. Available at: <http://xoomer.virgilio.it/fiamma/I%20DANNI%20DEL%20FASCISMO%20PDF%20ridotto.pdf>. Accessed on: February 14th, 2009.

3 *Serviço Sanitário Nacional* (National Health Service).

By 1990, this country was riddled with political-economic instability and dissatisfaction in several civil society sectors. This context, in addition to the innumerable difficulties to stop spending on health, determined, according to the State, the specific need to seek urgent adequacy solutions. In 1992, a new health management model was founded – *aziendalizzazione*[4] –, through the *De Lorenzo Garavaglia* Reform, resulting from the state perception of the guarantee of a universal right to health being dependent on this adequacy (Cavicchi, 2005). Based on this model, the private system became a great partner of the State. This reform corresponded to the regionalization of the system and, in this new managerial context, a new subject was born: technocracy, represented by its collegiate and general directors (Cavicchi, 2005).

Non-profitable private companies took over health management, reducing the role that had been played by cities until then (Mendes, 1999). Management moved to a technocrat government and spending began to be managed by the ASLs – *Aziende Sanitárias Locais* (Local Health Management Offices) –, represented by their regional general directors. Thus, this management instrument enabled the regions that began to protect health with a public purpose to have greater autonomy (Cavicchi, 2005).

However, the difficulties remained. The need to reduce spending, in the context of a continuous evolution of social requirements, continued to be a serious problem for the State. While pursuing the means to deal with this question and, along with it, efficiency, efficacy and equity, the Italian government decided for a third reform in 1999 – the *Riforma Bindi* –, which established Norms for the Rationalization of the SSN (Repubblica Italiana, 1999). By observing the *Plano Sanitário Nacional 2006-2008* (2006-2008 National Health Plan), it was perceived, in the legal field, that the State is committed to the legal guarantee of the universal right to health (Repubblica Italiana, 2006).

In Brazil, the first form of social protection appeared with the organization of categories of workers in the form of mutual help associations, on a private and voluntary basis, aiming at the resolution of problems of invalidity, illness and death (Lima et al., 2005). The first "*montepio*" (pension fund) appeared during the time of the empire, in 1835; it functioned through mutualism and it was known as *Montepio Geral dos Servidores do Estado* (Gentil, 2006).

In a political context of great social and economic transformations to include the capitalist way of production, the government of the First Republic, in the beginning of the 20th century, turned to the construction of the first public health policies, among which was the health reform, necessary to fight the epidemics and maintain the coffee exportation policy, the main economic source in Brazil at that time (Verdi, 2002).

In 1923, the *Caixas de Aposentadorias e Pensões* (CAPs – Pension and Retirement Funds) were established, with the purpose of providing pensions, retirements, savings and medical care to maritime workers, railroad workers and their families (Oliveira e Teixeira apud Cortes, 2002). These CAPs were organizations of private right, aimed at specific groups of civil servants and structured according to social security principles, a model that connects the benefits provided to the contributions of insured individuals (Lima et al., 2005).

Subsequently, in 1933, the Vargas government created the *Institutos de Aposentadorias e Pensões* (IAPs – Institutes of Retirements and Pensions) – autarchies linked to the Labor Ministry – with mandatory contributions from employers and employees, aimed at providing benefits to professional categories of urban workers, such as maritime and port workers, federal civil servants, factory workers and commercial workers, while other type of workers, both urban and rural, were excluded (Malloy apud Cortes, 2002; Finkelman, 2002). Thus, the right to health was still limited to a part of the population.

After the end of the Vargas government, especially from Juscelino Kubitschek's government, there was an intensification of industrial economic growth in the country, which generated a shift of economic centers towards urban areas and triggered the increase in health demands, thus promoting the expansion of medical care services of the *Previdência Social* (Social Security) (Mendes, 1999).

4 Health management directed by non-profitable private companies (Mendes, 1999).

With the onset of the dictatorship in Brazil, in 1964, market interests in the health sector became stronger and the government created, in 1966, the *Instituto Nacional de Previdência Social* (INPS – National Institute of Social Security), consolidating the private medical care model (Mendes, 1999). This institute began to concentrate a great amount of financial resources and provide care for a higher number of workers. However, citizens who did not have an employment relationship continued not to have rights to health care.

In the period between 1968 and 1974, Brazil underwent a time known as the "*milagre econômico*" (economic miracle), when the market ideology arose in the entire society and the idea of health as a consumer good was disseminated (Luz, 1991). The policy adopted by the government prioritized accelerated economic growth with high production rates, leading to an expansion of job offers for categories of specialized workers, in detriment to a reduction in the salary of the majority of the population. This led, as a result, to an increase in consumption of more privileged classes and, consequently, to income concentration in Brazil (Luz, 1991).

In the mid-1970s, due to the context of social crisis experienced in Brazil, the Health Movement expanded, formed by the integration among intellectuals, academic professionals and health professionals, who were dissatisfied with the existing health inequalities. This movement began to fight for the *Sistema Único de Saúde* (SUS – Unified Health System) – universal and equal – and for the re-democratization of the country, which was consolidated a decade later (Da Ros, 2005; Escorel, 1998).

In 1976, the *Programa de Interiorização de Ações de Saúde* (PIASS – Program of Expansion of Health Actions to the Countryside) was launched, aiming to bring a basic and permanent public health structure to communities living in Northeastern Brazil, which could help resolve medical-health problems with greater social repercussions. Subsequently, in 1979, this program was extended to the remaining regions, reflecting the principle of a new approach to social security (Finkelman, 2002).

In the following year, the government created the *Sistema Nacional de Previdência Social* (SINPAS – National System of Social Security), separating the sector of benefits from medical care, which were both under the responsibility of the INPS. This institute continued to be responsible for the control of benefits exclusively, while the newly-created INAMPS became responsible for medical care (Cohn and Elias, 1996).

In the beginning of the 1980s, the *Ações Integradas de Saúde* (AIS – Integrated Health Actions) were established, considered an advance towards the proposal of the *Sistema Único de Saúde*; and, subsequently, in 1987, the *Programa de Desenvolvimento de Sistemas Unificados e Descentralizados de Saúde* (SUDS – Program for the Development of Unified and Decentralized Health Systems) was implemented (Finkelman, 2002). Both proposals were defended by the Health Movement.

The year 1986 was a landmark in the history of health policies in Brazil, due to the occurrence of the most relevant health-political event of that time: the *8ª Conferência Nacional de Saúde* (8th Brazilian Health Conference). With a democratic character and high adherence of different sectors of society (Mendes, 1999), the theme of health as a duty of the State and a right of citizens was included in the list of topics of this conference, in addition to the reformulation of the *Sistema Nacional de Saúde* (National Health System) and sector funding, prioritizing the relationships between health and citizenship (Finkelman, 2002).

The historical fight of the health movement was reflected in the approval of the chapter on health in the Brazilian Federal Constitution of 1988 and creation of the *Sistema Único de Saúde*, which is an innovation in this country (Escorel, 1998). Public Health, which had been part of a health sector model privileged by the military regime and associated with the logic of neo-liberal privatization, centralized in the medical-industrial complex, could experience a new beginning.

Through the *Sistema Único de Saúde*, the Brazilian State began a process of social construction, aiming to build a new space of health construction. With a unique public character in the entire national territory, the SUS chose the principles of universality, comprehensive health care (comprehensiveness) and health care equity (equity) as the basis of its doctrine, as well as regionalization, hierarchical

structuring, decentralization, resolvability and community participation as its organizational principles.

In the 1990s, the *Leis Orgânicas da Saúde* (Organic Laws on Health) – Law 8,080 and Law 8,142 – were edited, the first forms of regulation of the system created. In addition, the several *Normas Operacionais Básicas* (NOBs – Basic Operational Norms) were edited, aiming to continue the SUS operationalization process and consolidation of the right to health.

Although this Health System had been presented, in the legal sphere, as a very promising proposal, it showed signs of fragility in the 1990s. The achievement of the re-democratization was a fact, but this decade was marked by the apex of the Brazilian social apartheid and a government characterized by their negligent approach, which restricted their resources to foreign interests.

In view of the great social contrasts, still significant number of illiterate individuals, high child mortality index in Northern and Northeastern Brazil, and fast-growing unemployment rate, "the so-called modern times[5]" triggered by the neo-liberal model insisted in luring Brazil into establishing its legacy of reproduction of capital and supremacy of individual values (Viana and Dal Poz, 2005).

In addition, there was a relevant limitation: the supplementary (private) system, which began to show signs of expansion in the beginning of the 1980s and, subsequently, became stronger in the 1990s, together with SUS, was consolidated as an option for 40 million Brazilians who were dissatisfied with the governmental proposal and had conditions to afford other models that they considered good[6]. The expansion of this model gave signs that the SUS, achieved by society, had not become universal, but rather fragmentary, aimed at the three quarters of the Brazilian population (140 million individuals) who represented the majority of this society: the poor.

In view of the high child mortality index in Northern and Northeastern Brazil, the Ministry of Health created, in partnership with the United Nations Children's Fund (UNICEF), the *Programa de Agentes Comunitários de Saúde* – PACS (Health Community Agent Program) in 1991, initially implemented in these two Brazilian regions and, subsequently, in the entire country (Souza Lima, 2008).

Based on the positive results of this program and due to the emphasis of the *Norma Operacional Básica 93* (Basic Operational Norm)[7] on to the development of local health care systems, the Brazilian Ministry of Health launched a new political proposal that aimed to stress the SUS role in the construction of its process: the *Programa Saúde da Família* (Family Health Program). Founded on the same logic of three countries that began to outline this strategic model in the 1980s – Canada, Cuba and England – the *Programa Saúde da Família*, now known as *Estratégia Saúde da Família* (Family Health Strategy), chose the family and their social space as the basic center of approach to health care (Souza Lima, 2008). It was based on the concept that providing health services in the community itself could contribute to the social production of health.

## The Right to health in Italy and in Brazil: moving closer to or further away from each other

By analyzing the dynamics of the historical construction of the right to health in Brazil and in Italy, it was observed that, in both contexts, social protection systems are not created as the result of an action from the providing State. The initial paths followed to guarantee this protection, ideologically similar, were materialized from the actions of the Brazilian and Italian working classes. Brazil and Italy began this construction based on the social

5 Our bold type.

6 MENDES, E. V. *O dilema do SUS*. Available at: <http://www.gices-sc.org/ArtigoEugenioVilacaDilemaSUS.pdf>. Accessed on: April 23rd, 2008.

7 It should be emphasized that the NOB 93 represents an instrument to promote decentralization in several dimensions; not only outpatient and hospital health care were provided financial aids. There have been advances, in numerical terms, because 62.9% of cities were granted a certain type of management (semi-complete, partial or incipient); however, once only 4.6% were granted an advanced type of management (semi-complete), in terms of municipal systems, the increase in decentralized responsibility was not significant (Cunha, 2001).

models of mutual help to guarantee health care, required by capitalism, the new model of social organization brought about by the English Revolution.

Thus, it was possible to see that, in both National States, the principle of materialization of this right began in response to a reaction of civil society, organized according to the needs they experienced, when workers awaken to the need to gather and collectively face the problems resulting from the way of production. Beginning with this new reality, the mutual help model was created, aiming to fulfill the health care dimension of the right to health. Both National States only showed concern about concrete living conditions and, in this way, about man's health in society, when they understood that the guarantee of workers' health also meant the guarantee of maintenance of growth in the economy, in the new social organization model.

In Italy, the model established by mutual help workers was perceived by the State as a threat to their actual interests. This observation resulted in the creation of a health care and social security system whose key aspect converged towards social control. It was decided that self-management of the social protection of mutual help would be maintained, although with a legal personality. Subsequently, this model ended and the mutual funds were created. This system was (un)committed to the right to health, fragile, limited, excluding and unequal, because, according to Cosmacini (2005) and Guzzanti (1999), it was based on corporate security, which (dis)regarded the context of the Italian working class: the majority of country workers were formed by farmers without the ability to contribute.

At that time, the economy of southern Italy was mostly based on agriculture, its industrial complex was poorly developed and the number of dependent workers was small. By seeking health care in the outpatient clinics of a city, farmers often caused conflicts of authority, because cities considered them to be contributing users of mutual funds, whereas these funds saw them as poor individuals who, therefore, should be protected by the city. This conflict of authority resulted in inefficient health care (Guzzanti, 1999).

Moreover, unequal treatment provided to workers, employees, and those dependent on public or private organizations, in addition to the fact that public availability was restricted to hospital-outpatient health care (D'Aragona apud Silei, 2004), showed that inequalities were also present in the inner dynamics of this system.

From the perspective of everyday bioethics, this corporate security model, mutualism, was not co-substantiated by rational arguments that respected human rights, among which was the right to health of all individuals. Its construction occurred according to unjust principles, once the guarantee was restricted to health care and it was provided unequally, not giving fair opportunities to all, so that they could take advantage of the potentialities that were in fact their right (Berlinguer, 2000).

Although this system's lack of functionality had been evidenced, in terms of the (lack of) commitment to the right to health, during the Fascist regime, the mutual funds became a parallel organization that was concentrated in a single institution – *l'Istituto Nazionale per l'Assicurazione contro le Malattie*- INAM (National Institute of Social Security against Diseases) –, aiming to exercise more political-economic power.

This new organizational model served as an instrument to fund the purchase of armaments and to support propaganda policies (Guzzanti, 1999). It is important to emphasize the fact that legitimization of these actions was based on the impossibility of society expressing its power to fight against the policy adopted.

Likewise, the work of the Brazilian State on social protection in this country began with the control of the mutual help model constructed by workers. The State passed the *Lei Elói Chaves* (Elói Chaves Law – 1923) and created a corporative model initially represented by the *Caixas de Aposentadorias e Pensões* (CAPs – Retirement and Pension Funds), which were also founded on mutualism.

Although, in the concrete sphere, the CAPs have not changed the mutual fund system that was started by workers in the 19th century, this governmental action reflected an awakening of the National State to organize a social protection system. However, these CAPs were created in the context of the modern need for control of the social body order, in a non-universal way. Brazil experienced its first health and

urban reform; the former aimed to control the epidemics to maintain the social body productive, while the latter aimed to promote foreign investment.

In light of everyday bioethics, it is possible to infer that the model of corporative social protection, the CAPs, and the first Brazilian public policies did not begin from the consensus that health is a right to citizenship and that the providing Democratic State should (and must) be morally committed to its effectiveness. The social protection and public policies on health aimed to guarantee protection against diseases to the one considered a necessary instrument – the Brazilian worker – so as to materialize the ideal of being open to foreign capital. In the context of control of the order, the State worked on that which represented the Other of the order, the lack of order, chaos.

The CAPs were consolidated with the creation of the *Institutos de Aposentadoria e Pensão* (IAPs – Retirement and Pension Institutes) in the 1930s, a mechanism to control society that began with the Vargas government. In this period, Brazil was ideologically close to Italy once again. The New State arose in the context of Italian Fascism and Fascism had centralized the mutual funds in centralizing organizations. In Brazil, these organizations also increased medical care coverage to certain categories when it established a mandatory contribution. The right to health care remained unequal, restricted to part of the population.

The fall of the fascist regime after the 2nd World War led to a period of fight for the democratization of the Italian State and the Constitution of 1947 expressed the force of popular democratic unity constructed during fascism. However, the right to health was considered, not as the result of a broad debate, but rather as "the fruit of political maturity, of a general climate, of an impulse towards radical reforms" (Berlinguer apud Teixeira, 1989. p. 197). Even after the institutional commitment of protecting health, the country continued to think about protection against diseases.

In view of the hegemony of the Christian Democratic Party in this post-war period, the relationship among politicians of the bureaucratic machine of the National Italian State, which involved concessions, especially in the form of votes, and public benefits, and which was expressed in the model of mutual funds and maintained to finance private initiative, was contradictory to the proposal of the Universal Declaration of Human Rights, in terms of the guarantee of the right to health.

In this way, it is perceived that, although the international context was directed towards the guarantee of social rights, Italy had not found neither the time nor space to think about the right to health, because it prioritized economic development without considering the ethical arguments necessary to (re)construct society.

In this period, the accelerated industrialization process that began with Juscelino Kubitschek's government in Brazil also reflected the choice for a policy that prioritized economic investments, in detriment to social development. Due to this choice, it is observed that Brazil, like Italy, neglected the importance of making an ethical commitment to the right to health.

In Italy, in the 1960s, the level of resistance of the workers' movement, allied to the (new) meeting of parties to make institutional decisions, sowed the seeds of hope to reform the social way of organization that was reflected in health, and to strengthen the fight of workers' unions to raise new health awareness.

In view of this situation, the Italian Communist Party, founded on the popular fight and seeking to provide answers to social demands, proposed the Berlinguer Plan, based on the creation of a health model with actions that go beyond the guarantee of health care for diseases. However, this project did not find sufficient support to be approved by the parliament, because the strength of political connections prevailed on behalf of a hospital reform.

This Hospital Reform, performed in an isolated way in 1968, in a context of technological advance that did not consider a broad health policy, seems to have been proposed to face the mutual funds' indebtedness, due to the increase in demand for services. Thus, it is possible that its objective was to provide resources to respond to the increase in such demand, representing an emergency measure, rather than a proposal of global (re)structuring of public health. Cavicchi's thinking (2005. p. 19) is in accordance with this inference, when arguing that this Reform "began from the end".

However, in Brazil, the 1960s were marked by a significant growth in medical care provided by Social Security. The creation of the *Instituto Nacional de Previdência Social* (INPS – National Institute of Social Security), in 1966, consolidated the work of the medical-industrial complex, supported by the military government, thus reflecting the (lack of) ethical commitment to the right to health.

In the end of the 1960s and beginning of the 1970s, Brazil experienced its "economic miracle", marked by the adoption of policies that promoted the concentration of income in the upper classes of society, in detriment to the impoverishment of the remaining social classes. In truth, this miracle resulted in precarious health conditions for people and the strengthening of market ideals, thus increasing inequalities and affecting the materialization of the right to health.

However, this repressive period of military dictatorship caused the rise of a new approach in the area of health, which became the theoretical-ideological structure aimed at fighting for the Health Reform in this country: the Health Movement (Escorel, 1998).

Italy, however, was socially organized and strengthened in terms of representation of its unions, local autonomies, and professional and category associations, in the 1970s. This social cohesion enabled this country to finally undergo its Health Reform and break away from the harmful mutual fund system, thus achieving the right to health, recognized in the Constitution of 1948. In this way, society obtained the *Serviço Sanitário Nacional* (National Health Service).

This event in Italy occurred at the same time that Brazil was undergoing a political turmoil, in which the organization of the social movement that led the fight for the Health Reform began. The repercussion of the ideals of such movement on the collective imagination enabled the convergence of different organized social groups, increasing their ability to face problems and giving an eminently democratic character to the Brazilian achievement of the *Sistema Único de Saúde*.

It was possible to realize that, in both countries, the strengthening of organizations due to historical changes resulted in a broadening of the concept of the right to health that surpassed the reduced limits of care. In the second half of the 20th century, quality of life in the workplace began to be considered. In addition, the timing and ideology found in the Italian and Brazilian movements for Health Reform were concurrent, between the end of the 1970s and the end of the 1980s.

In contrast, in the 1990s, Brazil and Italy became ideologically distinct from each other.

The Italian period between 1978 and 1992 was not marked by political choices capable of materializing the ideological concept of the health movement, but rather by great cultural emptiness, resulting from the constructed argument that health is exclusively dependent on the economical policy and, consequently, on financial resources, thus leading to great social and ethical harm. The conservative political choices for rationing and reduction in spending harmed the dignity of Italian citizens, because they caused the right to health, achieved for and by these citizens, to be dependent on the reduction in costs and search for efficacy. The choice for the health management model known as *aziendalizzazione* prevented the limitations in the process of materialization of reform ideals from becoming visible (Cavicchi, 2005).

On the other hand, in the 1990s, Brazil focused on how to face the limitations revealed in the process of materialization of the SUS. The city management model, one of the SUS organizational principles, indicates the need for actions that actually enable them to begin to exist in the realm of reality. Thus, the National State selected a program that could provide the conditions to implement this process: the *Programa Saúde da Família* (Family Health Program). From an ethical point of view, the Brazilian attempt showed, in the legal sphere, a moral commitment to consider relevant questions of collective interest.

## Final Considerations

By analyzing the process of construction of rights, researchers perceived that each generation appeared as a way to give support to the effects resulting from the modern self-illusion. In view of the unchanging feudal life context, humanity chose a life of movement and implementation of a modern project as their fate, a destiny to be achieved. This

choice, expecting to embrace order, the need, and the certainty of the world, posed risks, expressed in cruel human actions that were performed in modern and post-modern times, with the appearance of the contingency. Such risks interconnected objective and subjective human dimensions: the new expected needs, which appeared from intense and permanently fragile social relations as the result of material conditions of existence.

With regard to the object of this study, the right to health, it was possible to understand that the power of subordination exercised by the capitalist way of production, regulated by an individualistic society that does not function, in terms of the approval of social relations, is a relevant aspect that limits the possibility of confluence towards a common construction of the right to health.

This organization model, inhumane in its structural principles, prevents the materialization of the right to health, once individual rights become more important than social rights.

According to this logic, it is necessary to face the historical ethical conflict between the protection of individual rights and the guarantee of the right to health, using a system of rules, for this right to be consolidated as a positive purpose. Berlinguer (2004. p. 116) agrees with this perception by arguing that capitalism has "tragically slowed down" the consolidation of human rights.

By observing the evolution of the right to health in Italy and Brazil, one can perceive that the origin of the materialization of this right, fruit of the workers' initiative, seems to result from the human need to immediately respond to problems that prevent their existence and, in this way, compromise their strength to work.

In the same way, both countries adopted similar strategies in their policies on social protection, in terms of the materialization of the health care dimension of the right to health. In the majority of historical processes, these strategies are distant from one another in time, although, in the 20th century, which was marked by a restriction of freedom with the Italian Fascism and the New Brazilian State, models of social protection were closer to each other in time and ideology.

With regard to the Health Reforms, there is an important distinction in terms of the forces to fight that are involved with the origins of such processes. In the Italian context, this was triggered by the movement of workers and, subsequently, incorporated by other social strata; whereas, in Brazil, the process was inverted, because it appeared in the scientific sphere and gained adherence of social movements throughout time.

This particularity can be partly explained by the difference in potential force and autonomy between the Italian and Brazilian working classes. In the 1970s, the Italian workers were strongly integrated, whereas, in Brazil, due to the dictatorial regime and great political repression, the only social spaces where it was possible to hold debates and unite forces were the universities, although such spaces were also severely restricted.

Despite the above mentioned differences, Italy and Brazil managed to experience the highly expected health reform, the need to place health at the center of reflection and action, in the sense of constructing systems regulated by universality. Both countries achieved, in the legal sphere, the status of health as a universal right, a sine qua non for the right to life to be taken advantage of.

By analyzing the evolution of health policies in both States, similarities were observed, in terms of the model of social protection adopted in Italy (19th century) and Brazil (20th century), in addition to the Italian cooperation in the Brazilian Health Reform process.

By observing the temporal and ideological encounter between Brazil and Italy, in the 20th century, in contexts of restriction of freedom (the New State/ Fascism) and clamor for freedom ("health as freedom", motto of both reforms), and considering Italy as a country belonging to the Old World, whereas Brazil is a young country, it could be stated that "time" becomes meaningful in the construction of historical processes that depend on choices and ethical and political arguments involved with such processes.

Thus, it is understood that there are temporal differences in the construction of the right to health and that this needs to be created as an actual right for societies to advance beyond the ideological achievement, broadening, for this purpose, the social imagination about values that permeate the choices in this social development model.

However, throughout the process of construction of the right to health, beginning with the Italian Health Reform of 1978 and the Brazilian Health Reform, it was understood that the political-ideological achievement of the Italian Reform had not advanced towards the realm of reality. The *De Lorenzo Garavaglia* Reform had brought about a health management model founded on the need to reduce spending and promote efficacy.

This Italian health management model was not ethically committed to the Italian society, once it had become more distant from the workers' achievement in the Reform of 1978 and took on a role in saving finances. In other words, a real management instrument (Cavicchi, 2005).

In its turn, Brazil was committed, in the legal sphere, to the fragilities that permeated the consolidation of the SUS in the realm of reality, indicating its availability to turn the intention of municipal health management, an achievement of the SUS, into action. The creation of the *Programa Saúde da Família*, in 1994, pointed to such availability.

## Notes

1. *Instituto Nacional de Seguridade contra Doenças* (National Institute of Social Security against Diseases – authors' translation).

2. *Instituto Nacional de Previdência Social* (National Institute of Social Security)

3. *Instituto Nacional de Segurança no Trabalho* (National Institute of Labor Security)

4. *Serviço Sanitário Nacional* (National Health Service – Cosmacini, 2005).

5. *Sistema Precursor de Seguridade Social* (Preceding System of Social Security – Melchiades, 2002).

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