



# Memory

## Training, teaching and research for a policy of national reconstruction in the health field

La capacitación, la enseñanza y la investigación para una política de reconstrucción nacional en el área de la salud

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**ABSTRACT** This text reproduces a speech given by Dr. Mario Testa on June 28, 1973 in the main hall of the Faculty of Medicine of the Universidad de Buenos Aires. The words of introduction preceding the text, written by Testa himself, provide the context of not only the historical moment the university was experiencing, just days after Rodolfo Puiggrós took office as the rector within the university's political overhaul, but also the meaning given to the project of pedagogical renovation. This project proposed redefining the relationship between the university and society, originating such projects such as the Instituto de Medicina del Trabajo (Institute of Occupational Medicine), the Instituto de la Madre y el Niño (Mother and Child Institute) and the Instituto de Patología Regional (Regional Pathology Institute) in the Faculty of Medicine; the Centro de Producción de Medicamentos de Base (the Center for Basic Drug Production) in the Faculty of Pharmacy and Biochemistry; and the Centro de Erradicación de Villas de Emergencia (Center for the Eradication of Shantytowns) in the Faculty of Architecture, among many others. Republishing these words, spoken almost 40 years ago, is a way of continuing to put into discussion the type of education and training health professionals receive with public funds.

**KEY WORDS:** Schools, Medical; Education, Medical; Human Resources Formation; Professional Corporations; Argentina.

**RESUMEN** Este texto reproduce el discurso pronunciado por el Dr. Mario Testa, el 28 de junio de 1973, en el aula magna de la Facultad de Medicina de la Universidad de Buenos Aires. Las líneas introductorias que lo anteceden, escritas por el propio autor, contextualizan no solo el momento histórico de aquella universidad, a pocos días de la asunción de Rodolfo Puiggrós como rector interventor, sino el sentido del proyecto de renovación pedagógica que proponía una redefinición de la relación entre universidad y sociedad y que dio origen a proyectos como el Instituto de Medicina del Trabajo, el Instituto de la Madre y el Niño y el Instituto de Patología Regional, en la Facultad de Medicina; el Centro de Producción de Medicamentos de Base en la Facultad de Farmacia y Bioquímica; el de Erradicación de Villas de Emergencia en la Facultad de Arquitectura, entre tantos otros. Volver a publicar aquellas palabras pronunciadas hace casi 40 años es poner en discusión el significado y el sentido de la formación de profesionales de la salud financiada con fondos públicos.

**PALABRAS CLAVE:** Facultades de Medicina; Educación Médica; Formación de Recursos Humanos; Corporaciones Profesionales; Argentina.

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## ABOUT THE SPEECH

These lines of introduction attempt to shed some light on the circumstances in which the words of the text that follows were pronounced, in a speech I gave in the main hall of the Faculty of Medicine of the Universidad de Buenos Aires (UBA).

It was 1973 and I was working as Delegate of the Rector, Rodolfo Puiggrós, within the political overhaul of the UBA. I was joined by a team of 25 people, all fully committed to the task at hand.

Héctor Cámpora was then president of the Argentine Republic and the political atmosphere during the time was so intense that traces of it persist to the present day, giving name to a way of doing politics that was expected to produce

great transformations: the seventies movement. A sign at the time proclaimed decisively: *Cámpora governs with the people, Perón leads the liberation*. The history that followed, however, has proven to be otherwise.

The University was not exempt from this climate and our call to action was to work on turning the traditional university into a “necessary” university. In order to attempt to do so, we introduced changes to the curriculum that were in line with the speech that follows. Moreover, we introduced behaviors that encouraged teamwork, that ideal so often spoken of and so little (or never at all) incorporated into health care practices.

With this very idea in mind, we suggested the possibility of collective exams, in small groups, instead of individual exams. This proposal was strongly resisted (as we had thought it would be) by the teaching staff and the students’ relatives, but not so much by the students themselves. The matter transcended the university sphere and we were summoned by a group of national senators (some of them doctors) to give explanations for our strange proposal. The meeting was held in the School of Public Health and our explanations of the reasons prompting us to make such a decision were able to calm somewhat the ruffled feathers.

However, there is a purpose to this foreword that goes deeper than what I have thus far expressed. Those of us who had the responsibility of directing the Faculty considered ourselves to be a collective and we acted as such, each of us assuming a role as befitted the circumstances with which we were faced.

For that reason, the authorship of the following text which bears my name (and to which I would still sign my name today, as I did almost forty years ago) is not exclusively mine but rather of the team - what I would call today *collective subject* - that we created and that we encouraged our students to create. It would not have been convenient, prudent or strategic to make this confession at that time, but it would be unjust not to make it today.



Mario Testa and Asia Selvin. 1973

**SPEECH DELIVERED BY DR. MARIO J. TESTA, DELEGATE OF THE POLITICAL OVERHAUL FOR THE FACULTY OF MEDICINE, ON JUNE 28, 1973**

Comrades:

The national and popular government presided over by comrade Cámpora and led by Lieutenant General Perón has initiated a period which shall produce profound transformations in the life of the country. These transformations are the first step towards the enormous task of National Reconstruction, in an attempt to recover as quickly as possible from the deterioration caused by 18 long years of misgovernment, especially after 1966, during what we may consider an era of national catastrophe.

We all know the facts: violent repression becomes necessary when economic oppression leads to the decline of the workers' wage share from 55% of the domestic income to much less than 40%. The handing over of national patrimony requires the presence of well-paid accomplices within the country: in the companies, to conduct from here the business of sending abroad what was stolen from the workers; in the labor unions, to silence protests; and in the police force, to offer a definitive solution to the problem.

How does this relate to the Faculty of Medicine of the Universidad de Buenos Aires? It is relevant because a single opprobrious fact perfectly summarizes this well-known story: more than 60 children out of every 1,000 that are born alive die within their first year of life. This number has been on the rise in recent years. The little ones who die are, in the great majority, the children of those same workers that have been impotently watching how their wages deteriorate. This means that there is an obvious relation between both facts that should at least make us reflect on our own work. What are we teaching? How are we doing it? Who are we doing it for and for what purpose?

The national and popular government has stated firmly and with conviction its stance regarding the problems of the country. In the area of health, the highest authorities have similarly spoken with decisive words. As comrade Cámpora stated:

Our government will advocate the implementation of a unified national health system without boundaries among provinces, communities or workers' unions. This system will have to guarantee an ascendant flow in its planning of programs, capturing the expectations and needs of the people. It will be aimed at promoting integration between the work of the technical teams and the needs of the population, and will also promote awareness about other health needs.

Another essential aim of our Justicialist [Peronist] government will be the promotion of a national industry of pharmaceutical and biological products, through the regulation of imports and the elimination of free trade in this industry, thus putting an end to speculation and profit.

In another section of the speech he made in Congress, Cámpora further explained this proposal:

...the services must be provided to everyone for the simple fact of being human, without establishing differences. To that end, these services will be in principle free of charge, and all cultural, geographical and economic barriers which create privileges and restrict access to health services shall be removed.

Furthermore, free enterprise should not exist for those intervening in problems related to health care, as this encourages unfruitful competition among entities and systems, produces considerable cost increases, creates health care inequalities, makes indiscriminate use of technology and leads to unequal resource distribution, dishonest and individualist medical practices and unnecessary use of medical drugs which favor overly sophisticated or inconsequential types of medical care.

These proposals have been fully corroborated by the Undersecretary of Public Health, with some additional specifications regarding their financing. As he stated, "we shall discourage any solutions based on a new tax on workers' wages and the direct payment of medical services." He also highlighted that the reconstruction will be carried out using the hospital as the base upon

which the network of services will be reorganized. Moreover, he announced the creation of national health training which would include the entire health team.

In order to understand what these proposals truly mean, it is necessary to analyze them in light of the current state of the health sector in our country.

The major issue existing at the time comrade Campora took office, and which I want to highlight here presently, is the lack of control over the direction of the health sector nationally. On the other hand, this sector can be considered to be in an alienated situation, conditioned by the organizational chaos, the uncontrolled competition, the alienation of health professionals themselves, the existing instability and insecurity, and the total absence of solidarity between professionals and the people and of popular or professional participation in the state of health of the country.

Since the revolution of May 25, the State's tendency has been not to assume responsibility for financing the health system. This situation, worsened by wage deterioration, housing shortage, absence of preventive medicine, and the stagnation in the growth of public hospital infrastructure, leaves those sectors of the population most in need of State aid especially unprotected. What is more, the recently enacted Law 19337 on hospital decentralization conceals behind the seemingly good intention of streamlining administration the devious purpose of unloading onto the community the responsibility for sustaining the system.

Hence, even in the public sector health is subjected to the law of supply and demand, and diseases become a source of profit. Profitability takes precedence over the provision of health care.

The rules of the game are that health care = profit. It is only natural, then, that "attention-based" institutions should proliferate and prevail over those focused on prevention, since a healthy community conspires against profit-making.

The business is orientated towards the middle- and high-income segments of the population, which have private health insurance, co-insurance, and the like, and to a specific group of patients: the acute patient, the surgical patient, and the parturient patient, who yield great profits. Only exceptionally is attention paid to the chronic patient, who becomes poorer for having a long-term condition. And since no one can

make a profit off a person with no money, it is cheaper for them to die.

The system is perfected in order to maximize profits. Thus larger organizational structures appear, marking a significant change in the nature of the traditional and luxurious private hospitals. These are the health care monopolies, which will from now on attempt to manage the business of disease.

They resort to mass advertising in order to monopolize sectors which are very profitable and exclusive to highly specialized medicine. With their "window display services" they sell an image of professionalism and "scientific" capacity, but in truth are governed by the law of *attending more patients with increasingly fewer resources*.

This transformation of the private subsector occurs in spite of the progressive increase in the cost of medical technology, because the clients have also changed. The life raft is found in the growth of the funds of employment- and union-based health care providers and the possibility of generating numerous contracts with that social group.

Mutuals and union-based health care emerged as expressions of solidarity and as the result of demands made by the sectors involved. However, events that will progressively change their nature have become visible: namely, the growing interest of health care monopolies in the medical care of the productive sector, which they regard as a source of financing for the expansion of their health care companies. The explanation for this is that the service capacity of union-based health care covers barely 5% of the country and is concentrated in Buenos Aires and a few other industrial cities (such as Rosario and Cordoba). Therefore, the majority of employee contributions have to be redirected to private institutions, through direct contracts or through medical federations or associations, which operate as mechanisms of financial intermediation and business management. In many cases, identifiable groups take advantage of this situation, utilizing politically the management of the health of their members and the considerable sums of money involved in order to perpetuate themselves as union leaders and to obtain personal benefits, to the detriment of the workers.

This brings us to consider an aspect rarely discussed: prevention in the health of workers.

Health plans are futile if the focus is not on the prevention of diseases. For workers, health insurance is worthless if the machinery and working and living conditions keep making them sick. So far, not only has prevention in workplaces been insufficiently implemented but its administration has been kept in oligarchical hands. Not until that extremely important health sector is handed over to the people will the deep-seated interests of the regime be touched.

The participation of doctors in this situation is not homogeneous. Firstly, the great mass of doctors wanders exploited in a maze designed by the health care monopolies. These doctors are subjected to "efficiency" regimes and must provide attention to more and more patients with less and less resources and as quickly as possible. They are subjugated economically, discouraged scientifically, and have no kind of social protection, not even if they fall ill. This is a case of true exploitation of which, in general, are they unaware; further, they often become accomplices of the very same exploitative system that is using them.

Small clinics and private hospitals are organizational attempts made by the most cunning and unscrupulous of individuals, as they offer a type of medical attention which they well know cannot reach the level it should.

Lastly, there are the real businessmen of the health sector, who profit from the sickness of the people and exploit their own colleagues.

Evidently, the interests of the majority of doctors who receive general fees in clinics and no payment whatsoever in hospitals – such as the part-time medical residents in public hospitals – and even of many of those who are paid and salaried, oppose the interests of the health care monopolies. Nevertheless, this mass of doctors is swept into minor or secondary struggles, and encouraged by their own exploiters they end up acting against their own interests. They are unaware of the fact that their own impoverishment is what allows their employers to grow wealthier and the "health companies" to grow larger.

The businessmen and professionals interested in the health business keep selling their colleagues the fraudulent hope of returning to the medicine of the liberal professional, that flourishing medicine of private doctor's offices, of medical privileges, of individualist advancement through "scientific" competence, and so on. The unions, acting contrary to their bases and their history, do not seek to shed light on the real causes of the situation. They ignore the essential fact that the great majority of doctors do not have privileges to defend, working all day in terrible scientific and working conditions and coming to terms with the fact that they have no other aspiration other than making ends meet with three jobs. This group of exploited doctors has two op-



From left to right: Mario Testa and Rodolfo Puiggrós. 1973

tions: to keep letting themselves be exploited or to understand themselves as health workers. Once again the options are oppression or liberation: to marginalize themselves from the people in order to keep the scraps of privilege that they now receive from their bosses, or to join the people in the process of social and national liberation.

The health team is made up by a wide range of professionals, technicians and other employees, whose situations are not homogeneous. Some of them live in the almost idyllic situation which was the privilege of doctors during the first half of this century. Others, of which the nursing staff is a paradigmatic example, are subject to exploitation comparable to that which doctors employed as wage laborers by the system undergo. Excessively long shifts which are unreasonably prolonged beyond tolerable levels, insufficient salaries which force health personnel to resort to odd jobs or to holding more than one job, inadequate levels of training, and poor working conditions in the hospitals first affect the weakest link in the chain. Thus, health personnel pour their frustration onto those who cannot make their protests heard: the patients.

There is no staff training program or policy to direct training towards the satisfaction of the obvious needs of the population, because the centers for decision-making regarding health and regarding health care personnel do not exist or are not connected with one other. This generates excesses or partial insufficiencies, which lead to two unsatisfactory situations: competition triggered by few available job positions, or distortions in the composition of the health team.

At the same time, the geographical distribution of the health staff and the population is such that there are areas with one doctor for every two hundred inhabitants and others with one doctor for every five thousand inhabitants. This is a clear consequence of health services not being based on the needs of the population.

Additionally, the health team is composed of one nurse for every doctor, or 0.7 formally trained nurses for every doctor. There are also evident shortages in crucial specialties such as geriatrics, anatomic pathology, and epidemiology, among others. What sacrifices are we making to be able to ask people to study nursing, knowing that it is a profession that is demanding,

underpaid and unrecognized by society? In such conditions, studying nursing is a heroic act, and to do so at the University is a bold act, unless it is done in a developed country. I pay my respects to the bold and to the heroic. But yet again we come to the same result: the deterioration of people's health.

## Medical drugs

The industry built around medical drugs sharply reveals what the greed of businessmen and imperialist penetration have achieved in our country. This situation should be analyzed in terms of the medical drug market, the prices of drugs and the situation of dependence.

The medical drug market is one of a very special type. It involves consumption which, except in the case of self-medication, is not chosen by the consumer but rather is handled by the doctor who prescribes the medicine. This type of consumption creates a special relationship between doctors and pharmaceutical laboratories, as the laboratories designate a significant amount of resources to highly specialized advertising aimed at doctors and which in some cases assumes the characteristics of "bribery."

Moreover, the literature distributed by laboratories is almost the only source of information where doctors can learn the latest news on drugs and medicines; needless to say, such information is not always as accurate as it should be.

The price of medical drugs is so high that drugs make up almost 40% of the population's total expenditure on health. Prices are fixed at best under oligopolistic conditions, for the same reasons that characterize the market: there is no competition in the quality or price of similar products because it is the doctor who makes the decision. This is why advertising has such a significant incidence on the price, as evidenced by the items that form part of the propaganda aimed at doctors – gifts, excellent literature with superb quality printing, "person-to-person" marketing, distribution of free samples – in addition to the advertising aimed at the bulk of the population. It is estimated that at least 22% of the budget of the most important laboratories goes towards advertising.

Another element that artificially raises the price of drugs is the diversification of products that reproduce similar ones that already exist in the market. Adding infinitesimal quantities of vitamins, antispasmodics, alkalizers, acidifiers, or any other substance to an existing product makes it possible to change its name and, more interestingly, double its price. This practice has found no opposition in the official entities in charge of authorizing the introduction of new medicines.

Naturally, the intermediary process that allows the product to reach the consumer increases the price even more, already excessive from the outset. It is estimated that, on average, pharmaceutical wholesalers add 22% and pharmacies 12% to the price of the product when they receive it. Some variations on this practice exist, such as the considerably lower increase applied by union-based health care providers, which add only 9% to the manufacturer price.

Thus far we have considered elements which, although unjustly increasing the price of medicines, can be considered "normal" in an industry governed by the harsh laws of capitalism. However, there are also other elements that cannot be considered as anything but theft. They acquire different forms, of which the best-known are: overcharging for imported supplies, which constitute the majority of inputs for some laboratories even when the same products are manufactured within the country with competitive prices and quality; and sending profits illegally out of the country, disguised within the accounting line-items which are the specialty of such companies. These are just some of the forms the plundering assumes.

Lastly, the relationship of dependence the Argentine pharmaceutical industry has with foreign companies from imperialist countries is directly evidenced by the remittance of foreign currency by way of payment of technical royalties, which are unnecessary in many cases due to the existence of alternative technologies available in the national market or available at a lower price. However, these technologies cannot be used because the contract that allows the use of the prestigious "brand" includes the obligation to use that technique or, in simpler words, because the national company is a subsidiary of the parent company and must defend its interests.

The system is internally consistent: the socio-political and economic situation of the country is consistent with the situation of dependence on imperialism and with the power exercised by the oligarchy; the state health policy is consistent with the role played by employment-based health care providers and the private subsector; and the business of the health monopolies is consistent with the business of occupational medicine. And, consistently, profits end up where they always do: in the vaults of the oligarchy and imperialism. So the cycle closes, while the health of the people lies in wait.

We have arrived to this situation through a history partly conditioned by a type of politics. Let us look at the successive stages of this process.

Before Perón, two subperiods can be distinguished starting from the beginning of the century: one that extends up to the crisis of 1930 and another that extends from that year until 1945. Both periods are characterized by the same liberal economic appraisal of problems in the health field, in spite of the attempts or pronouncements on the part of certain proto-sanitarians and administrators.

During the first period, a double system of health care exists, with no points of contact between the two parts. On the one hand, there is a private subsector for rich patients and a relatively well-off middle class that are able to access this private medicine because medicine is relatively "cheap" in the sense that it does not make use of complex equipment or instruments. Private doctors' offices and private hospitals constitute an efficient health care network for that social group. On the other hand, there is the public hospital, generally supported by the provincial or local government, dedicated to charity work (the most important institution that groups public hospitals together at a certain point is the "charity society") and thus frequented by the poor, including almost the entire working class.

The best health care is provided by the private subsector, which is governed by a strict market mechanism, in which the "client" is in charge of the full cost of the health care and the doctor is guaranteed a distinguished social status and a relatively high income. The public or semipublic hospital is, in general, a small and isolated institution which is not obliged to provide services to the

entire population, but it serves doctors as a place of training and learning, which, in the course of this subperiod, is what turns the public hospital into a center of scientific importance.

Progress made in matters of public health depend more on general infrastructure projects (for example, running water) than on isolated preventive measures (for example, vaccination).

The most outstanding aspect of this subperiod in terms of health care is that three important characteristics become firmly established: that there is one type of medicine for the rich and another for the poor, that there is medicine for the big cities but not for the countryside, and that there is a large interest in quickly restoring the health of the productive sector, that is, of the workers.

During the second part of this period, important changes can already be noticed. Medicine becomes increasingly more complex and, consequently, expensive. Private hospitals are no longer accessible to a large part of the middle class, especially taking into account the circumstances of the 1930 crisis and its subsequent effects. The public hospital now becomes established as a scientific center and its level of complexity increases, incorporating equipment and instruments that private institutions cannot afford given their dimensions or cost. Therefore private hospitals are no longer better, but they are still more expensive; and as health care in the public hospital is free of charge, it is comprehensible that it now attracts a large part of the former clients of the private subsector. Nevertheless, as the system of private doctor's office continues, a connection between both subsectors appears: the consultation at the private doctor's office coexists with the use of the public hospital by the same patient for auxiliary examinations, certain types of treatment and even inpatient admission, which responds to the need of creating an outlet that mainly serves the interests of the private practice of medicine.

The beginnings of a partial mechanism of solidarity appear among relatively closed groups: the union-run mutuals in the working class and the health care institutions of foreign communities. Both try to maintain some characteristics of the private subsector, but divert the payment of the service from the client to the group as a whole.

Another characteristic evidenced during this time period is the expansion of the public health

field through centrally-directed programs that carry out massive immunizations of the population and address environmental sanitation issues. This is manifested institutionally through, for example, the consolidation of the Malbrán Institute [Instituto Malbrán] as one of the centers for the preparation of biological elements and vaccines and as a reference laboratory of international renown. Alvarado undertakes his fight against malaria.

With Perón, the State takes firm leadership of the process. This period is characterized by a different understanding of health problems. This is logical, because the political framework is modified and the people are actors of the process. Health is interpreted as a right to which not only the sick but also the healthy are entitled.

The transformations are deep. The Department of Hygiene becomes the Ministry of Public Health. Carrillo establishes for the first time in the country a consistent plan that covers all aspects of health for all of the population. The idea of coverage is demonstrated through the increase in the number of beds in the public subsector, which doubles. This increase is done in such a way that the accessibility to the services of rural population is facilitated, by means of a better distribution of these services all across the national territory. The hospital acquires, moreover, a size, complexity and prestige never equaled, before or after. It continues to be an important scientific center, but also a place where the population receives the health care and treatment it deserves.

The impulse given the organization of the working class has profound implications in the management of the health system, which is shown through the creation of union-based health care providers dedicated to provide care to the population to which they correspond. This process is carried out within the framework of a national policy and under the direction of the State, as it participates in the management of the union-run health care providers. It will be at a later stage that the liberation from the State's regulation will determine their anomalous growth and the transformation of their nature.

The free education guaranteed at all levels of instruction, the promotion of educational policy and the high social status that was a traditional characteristic of physicians were largely the causes of the overcrowding of medical schools by



applicants not only from the oligarchy, but also from the middle class.

In other areas, the public health work developed is of such a magnitude that it translates into the eradication of some of the endemic diseases that traditionally affected our country (such as malaria), the considerable reduction of some social diseases (such as tuberculosis), and the promotion of preventive medicine, all of which create a firm foundation to achieve, in this period, the best health rates the country has had.

Starting in 1955, a period begins that leads to the health policy situation we currently endure. This situation responds to a political approach consciously developed and which in no way is the result of "unfortunate technical measures." There should not be errors or self-deceptions in this respect; this is not about steps taken forward or backward, or changes of governments within the same regime. The ideology of the dominant groups is consistent, and so is one of its manifestations: health policy. The contradictions that arise within the regime are quickly defeated; the law on medical drugs sponsored by Oñativia is short-lived and has no real impact.

The political framework of the period consists of an oligarchic, dependent capitalist system, in which the main objective is increasing the profits of the privileged group. A clear position regarding health thus appears: health as a source of economic resources or, in other words, health as a business. In total agreement with that principle, the State directs a deliberate policy to destroy the control and the management that the central level of the government exercised over the health system: the Ministry becomes a Secretariat and then an Undersecretariat with the subsequent loss of control over personnel and expenditures.

Once again the scheme of different types of health care according to the social class and according to the productive sector at which they are aimed is repeated. There will be health for those who possess capital; it is expensive and luxurious health care for the oligarchy. There will also be a cheaper, impersonal, and even oppressive health care for those who produce the wealth, the workers, and which is motivated by the convenience of returning them quickly to the production process. Finally there is a third type of health care, of which it is convenient that the State take charge,

a type of health care which is not a business: the care of children, elderly people and chronic patients. For those who have no money, the marginal population of the industrial production system, the country people, the shantytowns residents, and the unemployed, there will be disease. The situation is further exacerbated by the freezing or reduction of the public hospital budgets, many of them resorting to the improper acquisition of funds through the contribution of the population, illegally made compulsory by means of the "hospital donation collection groups." In this way, the equation of inequality is established:

wealth = oppressors = health  
poverty = oppressed = disease

This situation does not originate of itself. It originates with the arrival to power of local anti-Peronist medical "intelligence," and introduces "experts" hired by the great centers of economic power, whose two main political postulates are shown in their report: 1) health care is expensive and somebody has to pay for it; 2) the payer should neither be the State nor the oligarchy. At a technical level, this translates into the program of hospital decentralization and into the concept that the State must support hospital maintenance *secondarily*.

From that moment on, the system of hospital fees is established.

This system is the basis to unload on the population the weight of the cost of their health care and for the businessmen of medicine to do business. The experts' report mentioned previously recommends the decentralization of health programs, which become dependent on local management; this constitutes an important step backwards in the fight against malaria, Chagas disease, yellow fever, etc. The Malbrán Institute is dismantled and reduced to a precarious condition. The same happens to the Pharmacology Institute [Instituto de Farmacología], leaving the field open to private institutions.

Through these actions, our dependence in terms of health is established. The report issued by these "hired experts" is the doctrine and the spearhead of imperialism, which finds in the national supporters of foreign interests its "agents of implementation" that obediently comply with the

suggestions they receive, while a number of pro-imperialist governments provide the legislation necessary to consolidate the situation.

The policy guiding this history described above has its correlation in the way medicine is taught. This correlation is not absolute and is subject to certain imbalances during some periods for two main reasons. On the one hand, due to the lack of connection between the centers of decision-making regarding actions in health and the centers of training of human resources for the execution of these actions. No mechanisms existed to coordinate the decisions about actions and the consequent need to train staff for that purpose. And on the other hand, due to the enthronement of a social group which was homogeneous in its social project but heterogeneous in its political identification. The result was insufficient flexibility to adapt teaching to the changing conditions of the historical process.

Today, there are serious internal contradictions that affect the possibility of directing the work of the Faculty of Medicine towards objectives in line with the comments of the comrades Cámpora and Liotta.

We have already opened the doors of the Faculty and the University to all those who wish to study there. While this act represents the solution to one problem, it is at the same time the creation of another problem, as it implies stretching the University's capacity to the maximum in order to admit the great quantity of students we expect will attend.

However, the problem of University admissions should neither be considered an isolated case, nor a purely political demand of students, nor a slogan of protest with which to distinguish between friends and enemies. The problem of admissions is yet another manifestation of a situation that must be considered as a whole in order to frame it within a historically determined process and to propose permanent solutions to its cyclical repetition as a problem.

In order to do so we must keep track of students once they have entered the University, to see what happens to them from that moment onward. A first observation that we are concerned about is the number of students that abandon their studies before finishing. Even under a restricted admission system this problem

has extremely serious characteristics. What implications would unrestricted admission have? How can it be solved and in what time frame? To these questions there is only one answer that is unacceptable, and so has been at once rejected: that solving this problem is impossible.

And there is more. It is obvious that the Faculty of Medicine, and the Medicine program in particular, does not only teach the art of healing. This Faculty, in addition to teaching such skills, also provides social and professional training in the framework of a global policy and social project. This framework is the liberal professional and economic project that, with some vicissitudes, prevails in our University since its inception. This expression of the liberal project, in terms of doctor training, is the professional who sees health as a market in which he forms part of the supply and the sick part of the demand. This image is further reinforced by what many self-proclaimed developed countries try to sell us as the supreme wisdom in the health field.

In addition, this professional point of view is necessarily associated with an expected social status that gradually leads the student, who began studying Medicine with a passion for service and love of people, to have an oligarchic and dehumanized view that feeds into the cycle of domination and dependence.

- What are we teaching our student comrades?
- What training are professor comrades receiving?
- What participation do worker comrades have in decision-making?
- What are we doing for the health of the people?

The period of National Reconstruction to which we are committed requires reviewing the contents of the teaching and research carried out in the Universities, in the Faculty of Medicine in our particular case, in order to place them at the service of the people, which is their only justifiable reason for being.

Teaching and research are the basic duties of a Faculty and are therefore of unquestionable importance within its work. Both can be the expression of a struggle that has been defined by General Perón as the great national cause: dependence or liberation.

This cause has already been described in this speech. Dependent training is that which stems

from our cultural dependence and assumes as its own the project of liberal economic medicine, no longer acceptable even to lucid defenders of the capitalist countries. As an example of this situation we highlight a fact that is in appearance indisputable: clinical medicine is taught at the University Hospital. However, public health experts know that of every thousand sick people that request medical attention only one is taken to the University Hospital, because the particular characteristics or difficulty of the case require that level of complexity.

Medicine is taught through that patient and in that environment. The remaining 999 are left out of what the faculty considers convenient to teach. Moreover, the conditions in which the disease originates, the environment in which the epidemiological situation develops, be it the workshop, the factory, the shantytown, the neighborhood or the dazzling world of consumerism and alienation, do not fit into the picture offered to the eyes of the student. If the student has not completely lost all social awareness, then he will learn the broader picture on his own; otherwise that student will forever be an incomplete being, incapable of developing his capacities to the fullest for the benefit of the people to which he is indebted.

The origin of that elitist and market-oriented conception of medicine and health is already known. It comes from the same country that permanently invents theories and concepts to justify its dark ideology, many times exposed for what it is.

Demand and supply and the doctor-patient relationship are terms of an allegedly scientific jargon that is used as an instrument of cultural penetration. Therefore, we have to be extremely critical and consciously keep in mind national and popular principles when thinking about what should be taught and how, and what we need to learn. We can only think with national consciousness if we look at our own country's specific problems, as we have stated in the preceding paragraphs, instead of looking abroad to see what is modern, what keeps us up-to-date with that truncated and treacherous science. Thinking with popular consciousness means opening our senses to the life that takes place on the streets every day, which does not enter into laboratories or classrooms but awaits and fights for the development of a historical process that we cannot be left out of if we want to comply with our duty. The contact that

allows us to perceive the contents of this historic unfolding can start with a broad debate among those of us present here.

Those who are most affected by the aggressions of the physical or social environment are the people who can speak with the strongest conviction to what is happening and what the people want. Maybe – and only maybe – manual worker comrades cannot express their feelings with words as beautiful as ours, but let there be no doubt that their words will be fairer, because they come from a first-hand experience that cannot be replaced by anything.

We, together with all our worker comrades, are part of a national and popular government and thus we have the duty to do what the people want.

Comrades, Jericho's walls will not fall down at my command, but for the time being, I am contented with symbolically tearing down the walls that make the Deanship of the Faculty of Medicine a medieval fortress. I hope that other comrades working at this university do the same if they are surrounded by walls that isolate them.

That may imply more work for everyone, and more time dedicated to tasks that not everyone may like but that are the only basis for Reconstruction, which is an imperative, to take place. And what is the time we dedicate to this task in comparison with the time that our combatant comrades can no longer make use of, having fallen in action or having been repressed by the regime or by traitors?

Research is another cornerstone of this university. What else can be said that has not been said yet? I do not think it worth reopening at this stage an old debate that I consider thoroughly worn out, because by using antinomies it represents a false problem: Pure research versus applied research. National science versus supranational science. Research versus teaching. Committed science versus true science. Truth versus politics. How long will we continue this unfruitful and misleading discussion? Indeed, it is incited only to distract us from the true discussion, which is whether we determine the contents of research or whether the scientific policies are determined by imperialism and its conscious or unconscious internal allies. Again, and not gratuitously, the dilemma is the very same one that our indisputable leader, Lieutenant General

Perón, has posed with great lucidity: liberation or dependence.

It is evident that, in the same way that we put the work of this university at the service of health care programs, research activities will have to be connected with these programs and with the guidelines established by the relevant governmental areas for a national and popular scientific policy, with its own contents and original methods, in close relation with what the health care worker must know.

Physical and human infrastructure is important in research activities, but I want to highlight that it is also necessary to encourage everyone's creativity in this area. Some research must originate in the laboratories, but we should remember that medicine is a biological science with social implications and, as such, many organizational aspects can help solve its problems. This social technology can be "researched" without complex equipment on the basis of the formidable workforce the students represent.

Do we know, for example, what consequences the drinking water supply in a shantytown has in the health condition of its residents? No, we do not, and that is a vital piece of information to estimate the results of the actions the popular government is developing.

However, within laboratories the work must also be connected with national and popular interests. This may provoke an ironic smile in those who worship science as a god that is greater than man and therefore cannot be touched by his dirty and sweaty hands. "Untouched by human hands!" as a dear friend of mine stated in English years ago with his poetic Salta accent, as if there were something noble and worthy in this world that is not touched by human hands.

In this respect, I just want to remark that I understand the individualist passion a researcher can feel for the method he uses, but it is indispensable to highlight that popular interests have no reason to come into opposition with scientific rigor.

National principles, on the other hand, require that the research contents, the methods used, the funds received and the purpose given to the results be analyzed critically and in detail by the researchers themselves, their assistants and collaborators, by the workers and students, and by the organized population whose verdict is the only one that cannot be contradicted.

If the Faculty of Medicine is open to all the people, its teaching and research programs will simultaneously be university extension programs, because the ultimate duty of a University is, at this stage of the liberation process, to transfer knowledge to the people.

In summary, the most general guidelines directing the work of this political overhaul will be at the service of the struggle for liberation within the framework established by the national and popular government.

Solidarity as an expression of the Argentina we want, participation as a work method and demythologization of the role of science as absolute truth will be the principles that will organize our work.

At this stage, I would direct my concern to the problem of University admissions, the creation of health sciences programs that allow for the progressive development of skills of increasing importance, the integration of study with work and research for students, the decentralization of teaching, and the placing of our work at the service of the people through coordination with the health care plans of the national government.

Fellow professors and staff members, worker and student comrades, from this moment on you are invited to carry out, in each class or place of work, a discussion about the problems we have posed. For this purpose, working groups or committees should be formed with everyone's participation, in order to start implementing the most democratic governance of this university possible and in order for answers to the problems that concern us to emerge. The government of the political overhaul, in turn, will form committees at the level of the Deanship to receive the proposals developed in the different centers of mobilization. This should be carried out immediately, as our comrade Minister of Education has asked the authority of the University's political overhaul his viewpoint on the new University Law, in consultation with all who take part in the work done in our houses of study.

These proposals should be communicated before August 15, but that does not mean that the debate ends on that date. What we have begun today is something permanent. The doors of the Deanship will forever remain open. Never again will we turn our backs to the people; rather,

we will face the people and remain alongside them, beating upon the doors of liberation with a steady hand and a young heart until they are opened or tumble down.

Comrades, let us get to work.

#### CITATION

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