



## Cells in the Body Politic:

Social identity and hospital construction in Peronist Argentina

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## Abstract

This article examines the critical role played by social identity in the construction of hospitals in the Argentine health care sector during the 1940s and 1950s by uncovering the way in which the “jungle” of hospitals withstood attempts by the state to apply some sense of order, purpose, and centralized organization. The first section examines how physicians envisioned the “modern” hospital they hoped to construct. The second section reveals the important antecedents of nationalized hospitalization schemes found in the collaboration between physicians’ unions and the state. In the third section, an analysis of political speeches illuminates how Juan and Evita Perón packaged new hospitals as gifts to the people from their leader. The fourth section outlines specific plans to increase the number of hospital beds. The final section surveys examples of hospital construction to demonstrate how sub-national identities were instrumental to fragmenting both Argentine society and its hospital infrastructure.

*Keywords: Hospitals; Construction; Argentina; Identity; National Health Care*

## Cells in the Body Politic:

### Social identity and hospital construction in Peronist Argentina

J. Hagood<sup>1</sup>

#### 1. Introduction

On February 24, 1951, the anniversary of his election victory five years before, Argentine President Juan Perón gave a speech inaugurating the newly-completed Policlínico “Presidente Perón” in suburban Buenos Aires in which he summarized the Peronist vision for hospitals and their construction, noting the deplorable state of hospitals and health care that had existed before:

The medical institutions for the less favored classes should not be called hospitals but “inhospitables” because the primary sentiments are not of hospitality but of the absolute inhospitality that befalls the desperate poor in their fight for health and subsistence. A hospital in a civilized society has to be a home where pain is dismissed and where man is defended from death with the respect and love with which a human being should be defended against disease (Perón, J., 1951a).

His wife, Evita, had expressed similar sentiments prior to steering her Fundación Eva Perón (FEP) toward the construction of medical facilities. In a speech at the Hospital Penna in April 1948, she reported the following deficiencies in Argentine hospitals:

The physicians, nurses, and custodians – all of the staff – make extraordinary efforts, but they cannot avoid the difficulties arising from fifty years of abandonment. The equipment hasn’t been modernized, new hospitals haven’t been built, and General Perón must begin the work of building workers’ hospitals so that the working masses can be attended with dignity (Perón, E., 1948).

Evita’s comments are significant in that they highlight two components of the overall Peronist scheme for hospital construction: existing hospitals suffered from decades of neglect and, therefore, the working class needed new medical facilities. These new hospitals would not be “inhospitable” like the medical facilities that existed before. By extension, society had also suffered from decades of neglect and, therefore, needed a new, more hospitable, Argentina.

The speeches of Perón and Evita demonstrate the rhetoric surrounding the Peronist vision for hospital construction. Again and again, the Peronist public discourse on hospitals and public health connected improvements in health care to the needs of the people. Both Perón and Evita emphasized their personal connections to *los descamisados* or to whichever population they happened to address at the time. In this way, hospitals were a gift

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Perón bestowed upon specific groups of people, each with its own, clearly articulated sub-national identity. As a consequence, Peronism claimed ownership of hospital construction undertaken by a wide number of groups: federal and provincial governments, quasi-government entities (e.g., the FEP), and mutual aid societies (*mutualidades*) – particularly those of organized labor.

By the late 1930s, hospitals in Argentina had clearly emerged as the site where the sick received treatment as patients, physicians practiced medicine, and medical students learned the skills and knowledge necessary for their future careers. A number of general tendencies favored the concentration of health care in hospitals rather than its distribution across multiple physicians' offices. As medical education became a longer and more professional experience, internship and residency in a hospital where students could observe a wide variety of diseases and patients became a necessary and significant part of the medical student's experience. As enrollment in medical schools increased – particularly after the University Reform of 1918 – the sheer number of medical students requiring positions in hospitals supplied new medical facilities with the laborers necessary to staff them. In addition, the shift in medical practice towards specialization and teamwork obliged physicians to create a site where the consultations and surgeries such forms of medical practice required could take place. Health care also had become more dependent upon technologies such as X-rays, laboratory tests, and advanced surgical equipment increasingly possible only in a large facility like a hospital. Finally, the economics of health care meant that patients sought the lower costs that a large group of physicians or patients could provide. As a result, changes in health care transformed the Argentine hospital from the traditional site of charity and convalescence to the location where the diagnosis of illness and its cure took place. As *El Médico Práctico*, a weekly journal for practicing physicians, observed, “the concentration of medicine – under the form of hospitals, clinics, sanitariums, public assistance, *mutualidades*, etc. – attracts and absorbs a greater number of patients than could go to the physician's private office” (“Lo que hemos hecho,” 1946, p.1).

A wide variety of autonomous social groups built hospitals in Argentina, and this contributed to a uncoordinated, fragmented, and unevenly developed health care infrastructure. Physician Ubaldo Matera, writing in the official publication of the Ministerio de Salud Pública (MSP, Ministry of Public Health, founded in 1947 as the Secretaría de Salud Pública), described the situation as follows:

Today there exist numerous ‘medical services’ directed at the public in the different hospitals and clinics, characterized by the most varied denominations: all those dependent upon the [MSP], the provincial and municipal governments, and the private charity institutions. The voluntary and obligatory *mutualidades* have a function uniquely restricted to their members, but we can consider them as public services as well. All of this progress in collective medical care that completely or partially covers the risk of disease for many millions of persons forms a true jungle of institutions without any real connections between them. Their technical value, in general, is frequently beneath their objectives and the patient very rarely finds the shortest path to recovery (Matera, 1949-50, pp.323-324).

## II. The Modern Hospital

Argentine physicians of the 1940s believed that the evolution of hospital care over time reflected the characteristics of each age and, as a consequence, the most contemporary concept of the hospital was, necessarily, “modern” and in tune with current conception of health care. Religious orders had founded the first hospitals in Argentina, and, as a consequence, religious criteria dominated the structure of health care up until the 1800s. The hospital was a refuge for the sick, old, invalid, and orphaned where material assistance combined with spiritual care. Hospitals in Latin America originated as outreach by the Catholic Church, nuns often staffed medical facilities, and society generally intended these services for the poor and indigent. Up until the early twentieth century, those who

could pay for medical care sought it through the services of an independent physician in his office or at home. In 1943, Abelardo Irigoyen Freyre, the first minister of Public Health for the Province of Santa Fe, reflected:

The creation of hospitals of beneficence (charity) and asylums for the poor directed by ladies and gentlemen of our society represented the first step towards a rational and modern organization of social services. Initially intended as a moral imperative, like an extension of Christian charity, little by little it became increasingly important in medical and government circles – to the point that today it is a vital part of social medicine and government programs (Freyre, 1943, p.151).

In the nineteenth century, the professionalization of medicine and the creation of medical schools transformed the hospital from a site of Christian charity to the domain of physicians and medical students. Over time, the interest in scientific and medical investigation at the hospital and the desire to make precise diagnoses of patients combined to emphasize the role of medical instruments, laboratory tests, and pathology. However, many physicians believed that the emphasis on diagnosis took medicine away from its curative mission. For example, in 1940 D.E. Laval presented a paper entitled “El Hospital Moderno” at the first Latin American Conference on Hospitals in which he noted:

In this century there began a new evolution in the concept of hospital care. Limiting the efforts to alleviate and cure the sick is insufficient: in almost all illnesses, despite its brilliant progress medical technique is inefficient if it is not logically and sufficiently supported by intelligent social action. The patient does not want only to be diagnosed with precision and then have his pain treated adequately. He also wants to be considered as a human being with a past and a future as well as family, friends, a job, and a physical and mental way of life in an environment that isn't hygienic and whose conditions must be exactly known and considered by his physicians (Laval, 1940, p.8).

A significant part of the modern hospital's development was its categorization into facilities tiered by the scope of its mission. Although the modern hospital grew in size because of medical technology, larger numbers of patients and physicians, and the increasing complexity of health care, advocates of modern hospitals and social medicine also promoted smaller, community-oriented health clinics. Physicians and bureaucrats ascribed many names to these clinics (e.g. *centro de salud*, *puestos de higiene*, and *servicios sanitarios*), but generally speaking the often-used term *unidad sanitaria* (public health unit or center) reflected the role played by the clinics in rational public health planning while allowing for the diversity of missions and configurations. For example, in their 1945 treatise *Hospitales: Unidades Sanitarias* physicians Carlos Carreño and N. Alberto Yanzon R. described how “each clinic constitutes a complete department of health that centralizes, coordinates, and locates under one office all of the public health works and, often, social welfare in one location” (p.143). At the same time, these centers promised a radical transfer of public health and medical care from urban to suburban and rural populations. Carreño and Yanzon (1945) believed that the *unidad sanitaria* also promised to “decentralize public health (removing it from the capital or large population center) in order better to distribute it and take it to all of the regions of the country” (p.143).

The development of hospitals also reflected the economic reality of practicing physicians. The major problem lay in physicians dividing their time between low-paying hospital work and private practice. On purely economic terms, neither commitment was sufficient on its own to support a physician. As a consequence, part-time physicians generally staffed hospitals. Physicians' unions – especially those affiliated with specific hospitals – repeatedly lobbied for full-time employment while physicians themselves often bemoaned the quality of care part-time medical professionals provided to patients. *El Médico Práctico* outlined the obvious solution:

What is evident and indisputable is that medical workers – integrated into the hospital – should be full-time employees. In this way the hospital would profit as an effective health institution. The patient would profit because he would be properly attended. The physician – and all medical workers – would profit because he would be properly dedicated to his job without being pulled away by other interests. The patients would not resist – as sometimes happens – being admitted because they would know that they would be properly attended, certain that the professional was dedicated to their exclusive attention, handing over his heart and soul to curing their illness. And this would also establish a permanent attitude of sympathy that is increasingly vital between patients and medical workers (“Sobre médicos y hospitales,” 1951, p.1).

However, as Laval’s description of the modern hospital emphasized, economics did not entirely drive prescriptions for developing modern hospitals staffed by full-time physicians. The social mission of the hospitals was vitally important. Writing as early as 1938 in Chile, D.G. Fricke responded to the economic argument by remarking that those who “propose that in a hospital one must have a technical director and an administrative staff forget that a hospital isn’t a commercial establishment that makes a profit or loss, but an establishment of a social character; and likewise it must give a social return.” From Fricke’s perspective, “the director of a hospital needs to be a director-technician, a physician, and – if possible – a sociologist at the same time” (1938, pp.19-20).

At the same time, physicians clearly understood and articulated the social mission for physicians beyond the hospital walls and the unique role that the hospital or *unidad sanitaria* could play. Irigoyen Freyre believed that “the hospital has an importance already much more transcendental than that of the ancient concept of a place of help, a refuge for the sick and diminished. It has a scientific and social mission of much great transcendence. The physician is not resigned to waiting for the production of disease in order to go to aid the sick; he tries to save man from them” (1943, p.152). Carreño and Yanzon (1945) promoted the notion of the hospital as an institution that could “contribute to the collective health, improving the environment in which it works toward the preservation and promotion of the health of the community – given that in dedicating its activities to suffering it realizes a humanitarian mission and is a genuine product of civilization” (p.14). The physicians went further, maintaining that, “the modern hospital is an institution that – like the school and the barracks – prepares the citizenry to fight against a specific enemy that in this case is disease” (p.14). In a similar way, Juan Lazarte, a long-time supporter of both the unionization of physicians and a strong government role in health care, believed that the well-equipped and staffed *unidad sanitaria* “stops attending only to its admitted patients and extends its services to those not hospitalized” (1948, p. 175).

### **Antecedents of the Peronist State’s hospital construction plans**

Beginning in 1943, physicians and leaders of the Federación Médica de la República Argentina, the national physicians’ union, worked with the Ministry of Labor, then under Perón’ control, as members of a commission entrusted with developing plans for federal intervention in public health. On the government side, Eugenio Galli, chairman of the Dirección Nacional de Salud Pública y Asistencia Social (founded in 1943 and a direct precursor of the MSP), had embraced a policy of centralization of authority and planning that would at the same time redistribute health care to distant parts of the country. Early on, Galli observed:

In Buenos Aires there are numerous institutions with their corresponding medical services... that through the lack of coordination in their functions limit their sphere of action. With the establishment of a single authority it will be possible to coordinate these dispersed efforts and resources and arrive in an expedited form at a rational plan of public health that must bring the benefits of hygiene and health to the most remote regions of our country (“Editorial: la centralización,” 1943, pp.4-5).

Physicians' union president Victorio Monteverde and fellow leader Luís Tettamanti joined Galli in steering the commission toward a plan for both coordinating health care and developing a scheme for the construction of hospitals and *unidades sanitarias* throughout Argentina. The commission's work also firmly endorsed the eventual government takeover of medicine, as the construction of public health facilities throughout the country would have provided places of public employment for physicians.

In the August 1944 edition of the official journal of the physicians' union, Tettamanti described the plan. He argued that the *unidades sanitarias* would "begin policies of preventive and curative medicine that are the fundamental bases" of the project of state-controlled medicine (Tettamanti, 1944, pp.14-15). Each *unidad sanitaria* would serve a population of five thousand with a medical staff made up of general practitioners and surgeons as well as specialists, dentists, pharmacists, nurses, social workers, and paramedics. These medical professionals would provide care to the sick in the center's clinic and periodically examine the healthy members of its population. Tettamanti noted that the commission was planning a second level of hospitals, tentatively set at one for every thirty *unidades sanitarias*. These secondary public health centers would consist of a hospital, preventive medicine clinics, and facilities for surgery, trauma, maternity, and specialties.

Speaking to the editors of *Mundo Médico*, another weekly publication for physicians in Buenos Aires, for the September 1944 issue, Monteverde provided more details on what the commission later finalized into a three-tiered organizational structure ("Sobre oficialización, 1944, p.42). As proposed, the bottom tier consisted of *unidades sanitarias* apportioned to every five thousand inhabitants or to a twenty-five-kilometer radius. Where population densities did not permit this distribution, the plan envisioned *unidades* with wider areas of responsibility. Each center would provide preventive and curative medical care to its residents through a limited number of beds and a health care team whose members would enjoy full-time state employment and annual paid vacations, periods of continuing education, and stability through a career ladder. As envisioned, new medical school graduates could enter the system after two years of residency at a large urban hospital.

The middle tier of the commission's plan accounted for health care facilities on the order of one for every thirty *unidades*. These proposed secondary centers would consist of a 1,500-bed hospital with clinical, surgical, trauma, maternity, pediatric, specialist, radiology, physical therapy, and laboratory services along with a blood bank, an isolation wing, and clinics for hygiene and preventive medicine. In addition, the secondary center would act as the base for a mobile team of specialists serving the needs of the center's *unidades sanitarias*. These specialists would supplement the general health care provided at the smaller facilities while also allowing for the treatment of special cases at the *unidades* themselves when transportation to the secondary center for hospitalization was impossible or unadvisable.

Regional public health administrations comprised the upper tier in the commission's proposal. Each regional center served the needs of ten secondary centers and the 300 *unidades sanitarias* underneath them. According to Monteverde, the tertiary center's responsibilities for its region would include: the administration and coordination of public health; hospitals for chronic patients, asylums for the mentally ill, and rehabilitation facilities; the organization of programs for preventive medicine and sanitation as well as the disinfection and extermination of disease vectors; and the planning of engineering projects for public sanitation. In addition, each regional public health administration would receive the results of annual health surveys performed by the *unidades sanitarias* – including the creation an index card with health information for each resident – to generate a regional health report to be reported to the state.

The commission did not work in a vacuum, and other physicians published similar ideas on the organization of medical facilities. For example, Carreño and Yanzon's book on hospitals included a section outlining a similar hierarchical organization. The authors envisioned *unidades sanitarias* that covered a wider radius

(forty to fifty kilometers) and stressed the importance of placing the secondary centers in areas of “social, economic, cultural, and political importance” in order for them to be effective” (Carreño & Yanzon, 1945, p.51). The *unidades sanitarias* would be the centers “towards which all of the socio-medical efforts will converge” (Carreño & Yanzon, 1945, p.51). In 1944, Perón, then Secretary of Labor, noted in the dedication of a new Tuberculosis Clinic that the facility was “the result of our common work in the Secretariat or in Public Health, where a nucleus of modest men and workers are realizing a constructive effort that isn’t a perfect ideal but is a necessary archetype for the moment in which we live” (Perón, J., 1944a). Clearly, a rational plan for medical facilities fit the needs of physicians’ unions, advocates of state-led public health, and political leaders. Still, Perón would later fit hospital construction into his own vision of social justice and the need for palpable accomplishments in the health care sector.

### **The Peronist vision**

As noted above, for Perón a more “hospitable” clinic would both protect the neediest members of Argentine society and educate them in a healthy way of life: “These hospitals of the New Argentina... in order to protect our people and especially to protect the poor are also a school. Here the patient should receive not only health care but also should see in it an example of a life as hygienic as his home should be: clean, hygienic, and dignified” (1951b). As protectors and educators of the working class, a Peronist hospital would not suffer from a lack of investment. Perón observed: “Our hospitals worry excessively about economy. How is it possible that in the defense of men’s lives we think of economy, when we waste millions on things that have no value and no importance? This is why I am very pleased... [that the FEP] has provided for this home with generosity” (1951a). Evita also often stressed maximum effort when describing hospital construction. For example, she promised to “continue to build other hospitals... In order to help *los descamisados argentinos* we don’t have to lessen our efforts. Physicians, nurses, the governor, the president of the nation, my modest self – we all are fighting together for the health of our people” (1948).

Finally, Perón emphasized again and again the metaphor of the hospital as a home, and in most speeches for hospital dedications he entreated the population served by the hospital to take care of the new medical facilities constructed for them. For example, in an October 1949 speech dedicating a *unidad sanitaria* in a rural village in the Province of Santa Fe, Perón stated:

I want to make clear to all of you, citizens of San Vicente, that this hospital belongs to you. Take care of it and do all that you can to maintain it in its current state of cleanliness, care, and repair with its beautiful park where patients in their convalescence can walk. Think of it as a home for all. Most important is to care for it because this hospital, here, in San Vicente, isn’t anyone’s but, as I said, everyone’s. Here you will find, despite the hardships that illness brings with it, the happiness of being taken care of in your own home in the most conscientious way possible because you can trust your health to capable physicians (Perón, J., 1949).

Speaking in August 1952 at the dedication of the FEP’s Policlínico “Evita” (only weeks following her death in July 1952), Perón urged the assembled crowd of hospital employees, dignitaries, and workers:

I ask that you take care of it, because it is yours; and I ask that the staff of this home take care of it and that they bring to it the inspiration and the orientation that Eva Perón gave to all of her works... that each one of the humble people of this neighborhood, and of any other neighborhood of the Republic that comes to its doors, finds a heart open to taking care of you, soothing your physical and moral pain and that this home is,

for many centuries, the representation of the true love that must reign between *los argentinos* (Perón, J., 1952).

### III. The Peronist Plan

The tendency of Peronism directly to engage diverse and autonomous social groups did not prevent Ramón Carrillo, the first minister of public health in Argentina, from articulating in the First Five-Year Plan (FFYP) a comprehensive and universalizing scheme for hospital construction and organization that in 1947 predated yet did not foresee the subsequently fragmented nature of Peronist hospital construction. Instead, Carrillo saw his plan as the next logical step within the discourse concerning the health care sector in Argentina. Of primary importance to the FFYP and the MSP was the notion that the state could bring organization and planning to solve social problems.

Speaking at a conference on hospital administration in 1950, Ramón H.P. Ramos, technical sub-director of hospitals in the MSP, described the situation as follows:

The modern state creates the highest organization within each country but also imposes... a special mysticism intimately bound to feelings of responsibility. These two principles of order and ethics animate and characterize the age of reconstruction in which Argentine public health is working and fundamentally differentiates the hospitals of the present from those of the past. Making all social classes equal before disease has created technical, economic, social, personnel and construction problems – difficult but not unsolvable (Ramos, 1950, p.199).

Carrillo, Ramos, and the rest of the MSP leadership clearly posited the location of public health problems in the nation's interior and rural areas. The phenomenon of *la plétora médica*, in which an overabundance of physicians crowded urban areas leaving much of rural Argentina without immediate medical assistance, underscored the need for state intervention and organization to address social problems largely affecting the rural interior. Because of this, the MSP could praise recent developments in health care, social medicine, and medical facilities while deploring the over-concentration of these efforts in urban areas – places where the MSP justifiably felt health care was already sufficient. For example, Ramos observed that, “the social work of projecting the hospital towards the community, initiated twenty years ago in Argentina, had remained relegated only to the most important urban centers, leaving the rural centers and sparsely settled areas completely abandoned” (1950, p.196).

The MSP identified the measure of improvement in the nation's public health as the number of hospital beds in Argentina. This statistic drove MSP planning, public pronouncements, and political lobbying more than rates of mortality and fertility, endemic disease, and the number of physicians per capita despite the fact that the uneven distribution of physicians and medical professionals was at the center of the health care problem in Argentina. Carrillo and the MSP emphasized the construction of hospitals and *unidades sanitarias* for three reasons: new medical facilities would require a wide array of medical professionals; jobs at new facilities would provide economic incentives for physicians, nurses, etc. to leave dense urban areas for the rural interior; and new buildings would give a concrete example of the state's interest in the health of its citizens through its palpable projection into the rural interior. As a consequence, the number of hospital beds and plans to increase this statistical measure of public health guided Carrillo's policies.

In their earlier publication, Carreño and Yanzon had stated that the accepted statistical goal was 5 beds per 1,000 inhabitants (1945, p.15). When Carrillo took control of state-level public health planning in 1946, the number of hospital beds in Argentina totaled 66,300 or 4.1 per 1,000 inhabitants in a population of roughly 16 million. Clearly, using Carreño and Yanzon's formulation would mean that Argentina was already close to the number of beds necessary, and this would severely lessen the power of the MSP's argument for new construction outside of

urban areas despite the fact that the national statistic hid regional disparities. As a solution, Carrillo and the MSP doubled the goal to 10 beds per 1,000 inhabitants. This allowed Carrillo to state that in 1946 Argentina lacked nearly 100,000 hospital beds. Moreover, this large number also supported his contention that the existing system distributed hospitals unevenly and inequitably while needlessly duplicating services in urban areas.

Carrillo’s proposal for the organization of hospitals and *unidades sanitarias* built upon the three-tiered plan proposed by the commission headed by leaders of the physicians’ union – despite the fact that union leaders were largely non-existent in the MSP’s bureaucracy or Carrillo’s inner circle. Carrillo added additional tiers to the top and the bottom of the organizational chart. For the uppermost layer, the MSP proposed large urban hospitals of 500 or more beds. For the bottom, Carrillo put forward the notion of *puestos sanitarios*: health posts staffed by a nurse and capable only of emergency hospitalization (Martone, 1951, p.224). In the beginning, Carrillo advocated a policy aimed at increasing the numbers in the two bottom tiers: *puestos sanitarios* and *unidades sanitarias*. These facilities targeted underserved areas, had a smaller financial footprint than the largest urban hospitals, and could be up and running relatively quickly.

In the *unidad sanitaria*, “each individual and each family must be known, and each intervention by the health center must be accurately recorded” (Secretaría de Salud Pública, 1948, p.43). Members of an ideal staff included a physician, a tuberculosis expert, a pediatrician, a midwife, and a psychiatrist. The goal of the *unidad sanitaria* was to provide equal time to the curative, prophylactic, and social branches of medicine as envisioned by Carrillo. He argued that a combination of all three aspects of medicine was easier for the smaller health centers than for the larger hospitals that necessarily concentrated on patients needing curative care (Carrillo, 1949, p.464). At the same time, the MSP had a social, cultural, and political mission in mind for the *unidades sanitarias*. Speaking in 1950, Ramos revealed:

It is anticipated, in the immediate future, the development of a stage that will see more plans for social services that will make all of the hospitals not only places of patient care and treatment, scientific research, prevention, etc. but also a cultural center that extends its actions to the community. There already exist in the interior of the country thirty-seven hospitals with movie theaters, and even in the smallest establishments – rural hospitals of four beds – a program of cultural extension has been envisioned wherein it is proposed that the waiting room can be transformed in the afternoon into a conference room, theater, or classroom. In addition, currently under construction are movie theaters and stages for cultural productions and pageants in all of the hospitals that care for chronic patients (1950, p.209).

In theory, the FFYP called for significant hospital construction under the guidance and control of Carrillo. Decreto No. 16.242 (June 11, 1947) stated: “All matters concerning hospital facilities, studies, projects, construction, rehabilitation, preservation, and improvement that the State faces will be under control of the Secretaría de Salud Pública [the immediate precursor to the MSP]” (“Todo lo referente a construcciones hospitalarias, 1947, pp.86-87). In practice, the various provincial public health ministries and the FEP joined the MSP in hospital construction.

*Hospital Beds in Argentina* (Ministerio de Salud Pública, 1952, pp.15, 19)

	1946	1951	% Change
Ministerio de Salud Pública (MSP):	15,425	27,351	+77%
Provincial Public Health Ministries:	8,100	23,278	+187%
Fundación Eva Perón (FEP):	0	18,130	N/A
Other:	<u>42,775</u>	<u>45,850</u>	+7%
Total beds:	66,300	114,609	+73%

From 1946 to the end of the FFYP in 1951 the number of hospital beds in Argentina increased by 48,309 (an additional 3 beds per 1,000 inhabitants). However, the dominance of non-MSP institutions undercut the relative success suggested by this statistic because the lack of MSP control over the new beds weakened Carrillo's ability to implement or justify a comprehensive, nationalized hospital infrastructure. Fully 69% of the total number of hospital beds added between 1946 and 1951 were largely the result of construction by the provincial public health ministries and the FEP. Therefore, an important point is that the total number of hospital beds built by the MSP, the FEP, and the Peronist-controlled provincial governments were nevertheless under Peronist control but not under the direction of Carrillo. The 11,926 beds added by the MSP between 1946 and 1951 were the result of 61 new medical facilities, 41 of which were *unidades sanitarias* of less than twenty beds each. Although the latter certainly met the MSP's policy goals of reaching sparsely settled, rural, and underserved communities, the MSP's two new regional hospitals, which between them accounted for nearly 1,000 of the new hospitals beds, had begun as government projects before 1946 and were not truly components of Carrillo's plan (Ministerio de Salud Pública, 1952, p.101).

Carrillo's primary problem in hospital construction was that the MSP "was not engaged on a *tabula rasa*" (Ross, 1988, p.137). The provincial governments, the FEP, and the *mutualidades* – particularly the *obras sociales* of organized labor – competed with the MSP for projects, funding, and political support. Although in 1948 the MSP decreed that its hospital program should serve all Argentine citizens and not specific interest groups such as members of labor unions, the scarcity of resources dictated that the interior receive priority (Archivos de Salud Pública, p.1). The pronouncement also hinted at the fact that during the years of the FFYP the *mutualidades* and the FEP built large urban hospitals targeted to and funded by specific interest groups. Within Peronism writ large – that is, Peronism beyond the Peronist state – Carrillo's efforts lost out to Perón's and Evita's interest in delivering social justice in the form of hospitals and medical care to the working class and *descamisados*, sub-national identities that were the foundation of Peronist political support. In addition, the significant increase in provincial hospitals demonstrated the ability of Peronist provincial governments to resolve public health issues below the federal level and closer to the lives of everyday citizens.

Had Peronism presented a truly national project for the Argentine health care sector, it would have spoken with one voice and not suffered from a variety of officially-sanctioned institutions working at cross-purposes. While it is not surprising that provincial governments continued to pursue their own policy goals and initiatives despite efforts at centralization, the idea that other parts of the Peronist apparatus – particularly the FEP and the unions' hospital construction – subverted Carrillo's and the MSP's universalizing plans suggests that, for all its nationalist-sounding rhetoric and public policy pronouncements, the Peronist project for a "New Argentina" was in some ways rhetorical cover for the personal aggrandizement of Perón and Evita through the cultivated support of autonomous social groups with clear sub-national identities.

The history of Peronism's actions within the health care sector bears out this conclusion, and the result certainly reflected not a national, state-led scheme of hospital organization and management but a jumble of medical facilities predominantly connected in some way (if only by being named after Perón, Evita, or other key parts of the Peronist canon) to Peronism. Indeed, by 1949 all efforts at the nationalization of hospitals had ceased, and in the Second Five-Year Plan (SFYP) Carrillo retreated significantly from hospital construction. By 1954, the MSP actually controlled 2,266 fewer beds than in 1951 (Diarios de Sesiones de la Cámara de Diputados, 1954, p.57).

Hospitals under provincial control had increased by 14,117 to 37,395. The FEP added no more hospitals after Evita's death in 1952 and gave what it had built to the state – but to the Ministry of Labor and not the MSP.

#### IV. New Construction

Although in the end the MSP undertook no construction projects during the execution of the SFYP, discussions during the planning stage included the consideration of new hospitals and *unidades sanitarias*. More specifically, on December 3, 1951 Perón made a radio address asking citizens to contribute to the SFYP:

I want to make a final call to people and institutions – and in a special way to the labor unions – [to] send to the President of the Republic your petitions and anxieties so that they may be studied... I want to tell the people that not all of the necessary works that you request can possibly be realized, but you will assure that the planning – based upon our current information and the requests of the populace itself – will permit us to implement a rational and just distribution of the works (1951b).

The public petitions and subsequent responses reveal the extent of the need for medical facilities in rural areas and the manner in which the state adjudicated and accommodated these needs. The MSP granted many requests for *unidades sanitarias* and larger hospitals from regions of political or economic significance. For example, Galo Pared, press secretary for the Sindicato Obrero de Oficios Varios in El Zapallar, Province of Presidente Perón (present-day Chaco), requested the inclusion in the SFYP of medical facilities originally included in the FFYP but as yet not realized:

The catastrophic loss by our children – participants last year in the 'EVITA' Youth Soccer Championship – demonstrated the lamentable state of our children's health. I urge the immediate construction of a hospital as well as the nationalization of the emergency room and the designation of a physician for the maternity center. This will be the first step toward the decentralization of the caravans of the sick that come daily to the emergency room that had to be transformed into a hospital and maternity ward – many times requiring the placement of beds in the waiting area because of the lack of space, which leaves a lamentable impression (AGN, Legajo 45, No. 13.638).

One year later, the government noted the inclusion of a hospital construction project in the SFYP in response to Pared's request:

For the important city of El Zapallar, the most progressive of the northeast of the province, located in the center of one of the richest agricultural regions with significant cotton production, support for a project is proposed... [to include] the creation of a hospital with a capacity of 120 beds. Today in this city there is only a *unidad sanitaria* without facilities for admitting patients (AGN, Legajo 45, No. 13.638).

However, the MSP also took into account the need to apply resources in the most efficient way possible. In one example, the government denied the request from the Sindicato Obrero de Oficios Varios of Landeta, Province of Santa Fe for a hospital. The official response reasoned that the small size of the town (2,000 people) did not “justify the construction of a hospital or a ‘rural’ type of facility” (AGN, Legajo 45, No. 9.375). Instead, the construction of a hospital in nearby Piamonte would serve the citizens of Landeta. Notably, Piamonte's request came from the local chapter of the Peronist party (the Unidad Básica Peronista). The population of Piamonte (4,000 inhabitants) justified “the necessity of having a hospital that at the least represents a ‘minimally functional center’ or rather a rural hospital of 30 beds, conceived and constructed in a way that can foresee the probable addition to the

nearby population and serve other localities that are within its radius of action and region of influence” (AGN, Legajo 45, No. 9.678).

Finally, and in the majority of cases, when responding to requests the MSP had already assumed the mindset of a coordinating role for the federal government instead of approving and subsequently funding construction. For instance, the Sindicato de Sanidad y Afines in Gualaguaychu, Province of Entre Ríos requested the nationalization and modernization of its local hospital (the Policlínico Centenario) as well as the addition of an emergency room and a nursing school (AGN, Legajo 47, No. 8.692). The official response noted that while approval required further study, the government would follow the overall direction of the SFYP: “Projects of medical care will be regulated through the national public health organization in such a way that the management is centralized and the execution decentralized under the responsibility of the provinces, municipalities, and unofficial medical care entities” (AGN, Legajo 47, No. 8.692). The nationalization of the hospital infrastructure was no longer an option – a dramatic change from the FFYP’s proposed 83,000 new hospital beds.

As noted above, the provincial public health ministries constructed the bulk of new medical facilities during the Peronist era. In the province of Santa Fe, this program had begun with the creation of the first provincial Ministerio de Salud Pública in 1941. A significant component of Santa Fe’s public health policy was the construction of hospitals and *unidades sanitarias*. As Lazarte documented in 1948:

For some years in Santa Fe a series of hospitals were created that we could call... regional or rural and all of those services were coordinated with a hospital located in Rosario (Hospital Freyre) and another in Santa Fe that would provide the function of public health centers with specialists for the region and general practitioners for the area. This form of concentrating services in a region or in a big hospital is highly beneficial for the organization of public health (p.175).

In neighboring Entre Ríos, the Dirección General de Salud Pública (General Public Health Board) transferred many existing municipal hospitals to provincial control while also constructing new facilities. In March 1949, the Dirección proudly reported:

The importance of medical services in our province depends directly on the Dirección General de Salud Pública, which includes 47 hospitals, clinics, and emergency rooms with 4,555 beds. Some 410 physicians, 204 pharmacists, 168 dentists, 28 biochemists, and 51 obstetricians distributed throughout the fourteen *departamentos* [counties] of Entre Ríos practice their professional mission with true zeal and dedication making our body of professionals dedicated to healing a one of the most prestigious among the Argentine provinces. It will be very difficult today to find even a small population in the *entrerriana* countryside without access to the services of a physician, a pharmacist, or a hospital, clinic, or emergency room” (“Reglamentación de la Carrera Médico-Hospitalaria, 1949, p. 5).

Other than federal or provincial hospital construction, the FEP represented the single largest entity that undertook hospital projects in Peronist Argentina; and it was common to refer to it as a “state within the State” (La Nación, 1950). Under the guidance of Evita Perón, the FEP invested in large hospitals primarily near concentrations of worker housing. FEP-constructed facilities were a way for Peronism to make direct and visible contributions to the health and well-being of targeted populations of the working class and *descamisados* who supported the movement. While the MSP spoke of rationality, organization, centralization, and bettering the health of all Argentine citizens, FEP hospitals emphasized the love of Perón for the specific group of people for whom the facilities and medical services were intended. For example, when inaugurating a children’s hospital in Catamarca, the first FEP facility, Evita pronounced:

This children's hospital that today opens its doors and as a guarantee carries the illustrious name of General Perón is the living message that the president has wanted to send to all *catamarqueños*. It is neither the work of Perón's wife nor that of the Fundación de Ayuda Social [FEP]. It is the result of General Perón's orders because under his solitary guidance these monuments for the humble people of this province – so loved by all of us – have been built brick by brick (1950a).

Still, far more important than the initial construction in the interior of the country were the large hospitals built in suburban Buenos Aires. The Policlínico "Presidente Perón", the second FEP-built hospital, consisted of 600 beds, five wings with five stories, windows for ventilation and sunlight, a reading and research, a pharmacy, a laboratory, facilities for cancer treatment, an allergy clinic, up-to-date equipment for X-rays and electrocardiograms, ophthalmology, dentistry, orthopedics, ear/nose/throat, surgical facilities and operating theaters. In addition to touting these important technical aspects of the hospitals, both Perón and Evita emphasized the "humanizing" aspect of FEP-built medical facilities – particularly in contrast to the "inhospitable" ones from previous eras. Upon dedicating the Policlínico Presidente Perón in 1951, Perón remarked: "This hospital incarnates the humanization of medical care, implanting the true regime of a hospital for workers" (1950). Evita later pointed out to him:

My general, this isn't the work of Perón's wife, this is the work of a handful of men and women that work in the Fundación, self-sacrificing and anonymous, in order to collaborate with your patriotic dream of forming a socially just, economically free, and politically supreme Argentina. The [FEP] – following the motto of General Perón that "better than speaking is doing, and better than promising is fulfilling" – carry out this hospital policy from the inspiration of General Perón, who charged us with building the humanized hospitals he dreamt of for the Argentine workers. The Fundación fulfilled these dreams because the Fundación was born from the Argentine people and because it dearly loves the Nation's *descamisados* (1950b).

At the time, the FEP envisioned the construction of 35 hospitals with 15,000 beds. As noted above, by 1951 the FEP had constructed hospitals and *unidades sanitarias* for a total of 18,130 beds. In addition, in August 1951 and again in 1953 the FEP sponsored a *tren sanitario* (medical train) to take health care to the underserved interior (specifically, the provinces of Santa Fe, Córdoba, Tucumán, Salta, Jujuy, and Formosa). The train included nine cars dedicated to gynecology, obstetrics, dentistry, general practice, a laboratory, cardiology, sleeping accommodations, food preparation and eating, and movie presentations to the public via a theater car (Campins, Gaggero, & Garro, 1992, p.83).

The FEP thought of itself as an outgrowth of worker solidarity and social assistance, and as a consequence contributions by workers significantly funded the Fundación's activities. Mariano Plotkin argues that in spite of its funding sources, the FEP was an effort by Peronism to counterbalance the strength of the labor unions. The provision of social services was a vital part of constructing the consent of people, and Plotkin remarks:

The FEP provided concrete benefits to the poor, but at the same time it was instrumental in the creation of some aspects of the Peronist political imagery. The FEP was perhaps the most visible evidence of the accessible and dedicated nature of the government. Moreover, the FEP contributed to the process of the politicization of everyday life. Going to an FEP hospital... could be seen as an act of – if not support for – at least benevolent neutrality toward the regime... In the context of a society profoundly polarized along the lines of "Peronism" and "anti-Peronism," this was an important achievement (2002, p.192).

In addition to supporting the FEP's projects, many labor unions also undertook their own construction programs. One major example highlights Perón's involvement in supporting the efforts of organized labor. The

Unión Ferroviaria (UF, the railway workers' union) began a significant investment in medical facilities for its members in 1944. Perón understood that the working class represented the core of his support, and he in turn supported their efforts to take control of their own health care needs. At the ground-breaking for the union's new hospital in Puerto Nuevo (suburban Buenos Aires) in 1944, Perón was quite direct about his relationship with labor: "To me, the railway workers deserve this [hospital] and much more. They have been loyal to us and we understand that loyalty is not one-sided: loyalty is mutual or stops being loyalty" (1944b). Later, in 1954, he revealed a much more nuanced understanding of the union's undertaking:

We understand that health is the supreme good of life, and as a consequence we dedicate to the people's health our principal programs. It was for this that, in 1944, we thought the enormous mass of Argentine railway workers – covering the entire Republic – was found defenseless before illness or threats to their own health... In this manner the idea was born whose realization we see crystallized today through the sixty facilities for the medical care of members of the Unión Ferroviaria. Equally, we see erected today in the port of Buenos Aires one of the best hospitals in the country, placed at the service of the valuable health of our people in the sector of the family of the railway workers (1954).

Perón, when speaking as "we", clearly did not address members of the UF as the head of the Argentine state, president of the federal government, or proxy for Carrillo's MSP. The Peronist state had not directly financed the immense and comprehensive construction of hospitals and *unidades sanitarias* undertaken by the UF. Instead, Perón enacted multiple identities: the leader of the Peronist movement, a sympathetic member of the working class for whom the union's medical facilities were intended, and the ultimate guiding force that made these new hospitals possible. The manner in which Perón recognized and aided hospital construction by the UF reflected the personal and populist approach so important to the cultivation and maintenance of his political support. Perón's rhetoric underscored everyone's understanding that railway workers enjoyed their own hospitals primarily because of Perón's personal will. In this way, Perón could promote the conception of the UF's hospitals as "homes" exclusively set aside by his own determination and resolve to achieve the appropriate level of health care for Argentine workers:

We have asked, as well, that this hospital be purely and exclusively for railway workers... We want the same concept to reign in this hospital that commands the other union hospitals that are being built in the territory of the Republic. We don't want medical care in public hospitals for our workers; we want them to have their own hospitals because seeking shelter in a charity hospital isn't the same as being treated in your own home. We want this to be a railway workers' hospital directed and managed by railway workers and at the service of railway workers (1954).

## V. Conclusion

Through his insistence on casting hospitals as homes for specific social groups within Argentine society, Perón and Peronism were clearly complicit in the continued strength and autonomy of social groups with clear sub-national identities within the Argentine health care infrastructure. The expansion of provincial public health and hospital networks belied an emphasis on local control and action within Argentina's federal system. The success of the FEP's hospital construction program demonstrated Perón's willingness to sacrifice the MSP's stated goals of nationalization and public health for all members of Argentine society in order to deliver directly to the working class concrete examples of Peronist largesse and social justice. Finally, the ability of labor unions such as the UF to implement a vast scheme for hospitals and *unidades sanitarias* for its members with the full-fledged and spirited

support of Perón unmistakably highlighted the tendency within Peronism to favor its political base while also cultivating a diverse set of autonomous social and class-based identities within Argentine society.

Nevertheless, this support of state-, quasi-state-, and union-led interventions into the health care sector clearly undermined the goal of a national hospital infrastructure. After only a few years, it became clear to the Perón administration that the implementation of a centralized apparatus for delivering social services to the Argentine people potentially jeopardized Perón's ability to maintain union support (Plotkin, 2002). At the same time, organized labor seized the opportunity to obtain medical care that was private, neither state-sponsored nor subordinated to the state, and therefore similar to the health care via physicians' private offices that the upper classes and elites in Argentina had always enjoyed (Neri, 1976). In the end, each different sub-national identity, or cell, in Argentine society wanted control over its individual portion of the health care sector, and Perón aided in the development of such a fractured system despite Peronist rhetoric – via Carrillo and the MSP – concerning a united, national approach to health care.

Two currents explain this seeming contradiction. First, the pragmatics of Peronist rule meant that the cost of labor union support was the concession of social and medical services to organized labor. What's more important, the tensions within Peronism also reflected opposing forces at work in Argentine society; and Carrillo's universalizing plans for centralized, state-led medicine and the creation of a national hospital infrastructure ultimately yielded to the inertia of Argentine society's cellular organization.

This conclusion depends upon recognizing the development of autonomous social groups within Argentine society. This process had roots that predated the arrival of Peronism, but it was under its supervision that the fragmentation of Argentine society into distinct sub-national identities solidified – at least in the realm of the health care sector. In this context, autonomy meant the ability of a social group to deliver a comprehensive portfolio of health care services to members with neither the daily involvement of the state (as an “employer” of physicians or other medical professionals, “owner” of medical facilities, or “single-payer” of health care fees) nor any explicit institutional connections between the group's health care system and the state's public health apparatus.

To be sure, even with the MSP's minimally-coordinating role, which held true for several decades after Perón's exit from power in 1955, the health care systems of the provinces, municipalities, and *mutualidades* still interacted in important and sometimes pernicious ways with the state. However, the coincidence of Perón's support for union-owned and managed health care systems and his status as political leader of the Argentine state subordinated the *mutualidades* to Peronism – and, therefore, the state – at the time, but Perón's ouster untethered these cellular health care systems from the state. After Perón left, the health care infrastructures and practices put into place by social groups under Peronism realized their full potential for autonomy.

Along with many other historians, Carlos Waisman (1987) argues that members of the working class were content with Peronism only so long as their overall welfare improved and the resulting economic surplus could be redistributed to them. Indeed, Perón found all of the necessary pieces in the financial strength of Argentina following the industrialization of the 1930s and 1940s and its economic success during the Second World War. This agreement broke down when the economy stagnated first in 1949 and again in the early 1950s, and because the labor unions had been able to maintain control over social services that otherwise could have been under state control, labor emerged from the Peronist years as a largely autonomous social group ironically less dependent upon the state than before Perón's project of labor incorporation.

This interpretation contrasts with that of scholars such as Joel Horowitz (1990), who asserts that unions lost autonomy due to Peronist policies. It is certainly true that in the realms of economics and politics, organized labor was profoundly subservient to the dictates of Perón. That is not to say that labor blindly followed orders from above; Perón and labor unions negotiated systems of power and the relationship between the working class and the state.

While organized labor unquestionably lost a certain measure of autonomy in the midst of union collaboration with Perón, Horowitz ignores the success of labor unions to maintain, expand, and improve their hegemony over social services for members. For example, union *mutualidades* successfully rebuffed efforts by the state to change their pension systems dramatically, and in the health care sector *mutualidades* built vast networks of hospitals while reconfiguring the economic position of medical professionals so that the physician's private office declined in the face of employment at facilities owned and operated by *mutualidades*. As a result, through the late 1940s and early 1950s labor unions gradually obtained a measure of autonomy in relation to social services and the health care sector that became invaluable once the relationship between the working class and the state changed significantly after 1955.

While this autonomy may seem antithetical to Peronism's project to integrate the working class into Argentine society, it nonetheless reveals the subtleties of Perón's redefinition of citizenship. His emphasis on the "social dimension of citizenship" necessarily drew attention to issues of health and the provision of medical services while also opening the door to the state's responsibility to organize and centralize the delivery and management of such services. That said, although Peronism did recognize the need for social rights and reform, Perón's support of hospital construction and the provision of social services by labor unions is an example of how the Peronist state willingly ceded social rights and responsibilities to autonomous social groups with clearly articulated sub-national identities – of which labor unions are the best examples. While the rhetoric and policies of Peronism reframed citizenship and membership in Argentine society as a bundle of political, social, and economic rights, Peronism nevertheless frequently withheld or toned down state involvement in addressing some of the features of this newly-conceived vision. As a result, the true legacy of Perón's vision of Argentine identity was its articulation as membership in an autonomous social group rather than citizenship in a social welfare state where the nation-state delivers such services itself.

## VI. Epilogue

Developments in the health care sector under Peronism were part of a welfare state stage in the development of health care in Argentina. Some, like Belmartino (1991, 2005) and Tobar (2001) have labeled Peronist Argentina the "Compromise State" because its "predisposition to incorporate new actors in the debate over public policy" led to negotiation that required "the inclusion of modern technical models in the management of the state" (Tobar 2001, p.8). After 1955, the Argentine state focused on development, and a "policy of transfer" shifted state investment and management of health care from the federal government to the provinces (Belmartino 1991, p.18). Beginning in 1957, previously national networks of hospitals fell under the control of provincial governments, which, despite the effective withdrawal of the federal government from the health care sector, nevertheless oversaw a growth in bureaucracy and state involvement in health care through provinces and municipalities (Tobar 2001, Rossi & Rubilar 2007). When Perón returned to power in the early 1970s, he proposed a national health care system, and in the early 1980s President Raúl Alfonsín made a similar effort. Both proposals met fatal resistance from entrenched interests. In the 1990s, the policy prescriptions of the Washington Consensus led to a preference for further deregulation and decentralization (Perrone & Teixidó 2007, p.5).

Three main segments have constituted Argentina's health care sector since 1955: *obras sociales* (essentially the *mutualidades* of Peronist Argentina), private health plans, and public hospitals.

*Obras Sociales*: In 1956, the federal government reformed labor laws to require unions to create separate organizations for the provision of social services in an effort to restrict the unions' ability to use dues for political purposes, a reform that resulted in the creation of *obras sociales* as entities distinct from yet related to labor unions (Rossi & Rubilar 2007, p.11). In 1967, the Comisión Nacional de Obras Sociales was created to regulate these

organizations through the active involvement of state officials, union leaders, and beneficiaries. Subsequent reforms also shifted the flow of premiums from laborers to the *obras sociales* from the unions to the state.

*Private Health Plans:* Despite the changes in health care in Peronist Argentina, wealthy elites and members of the upper-middle class had continued to access health care by paying for it out of pocket. While these *puddientes* (those would, “could” pay) did not need group schemes like those of the Peronist-era *mutualidades*, a private sector initially configured as pre-payment soon emerged. These plans were – and continue to be – sold by the hospitals and clinics themselves. In 1955, the Centro Médico Pueyrredón started the first private health plan in Argentina. It was based upon U.S. models and covered medical care at its own facility in Buenos Aires. In 1963, Sanatorio Metropolitano introduced a similar private health care plan for patients seeking care at its medical facilities. Between 1961 and 1980, 60 private health plans linked to private hospitals and clinics entered the Argentine health care sector. Between 1981 and 1990, an additional 57 appeared in part as a result of financial crises that weakened the ability of the *obras sociales* to provide services for its members at the same level of care as in decades before (Tobar 2001, p.20). Since the 1980s, many people have supplemented their medical coverage through *obras sociales* with private plans.

*Public Hospitals:* As noted above, beginning in 1957 the federal government divested itself of its hospitals, and the provincial and municipal governments gradually embraced a decentralized approach to the provision of health to members of the public neither covered by *obras sociales* nor for whom the purchase of a private health plan was an option. The reforms of the 1990s instituted user fees for medical services at public hospitals, but these institutions continue to provide services not only to the uninsured but also to beneficiaries of *obras sociales* or private health plans. Indeed, insured people often make use of public hospitals for more complex and expensive treatments and surgeries. Cavagnero et al note that, “in principle, hospitals should be refunded by the *obras sociales* for these particular services, but in practice they are hardly reimbursed” (2006, 9).

One’s place in the current structure of Argentina’s health care sector depends partly upon sub-national and class identities – much as it would under Peronism. Today, *obras sociales* cover most of the employed, the private health plans insure elites and members of the upper-middle and working classes who can afford to do so, and the public hospitals serve everyone else. With the addition since 1955 of a large and diverse private sector, health care in Argentina is even more fragmented than it was under Peronism with no change in sight. As Perrone and Teixidó argue: “The fragmentation and inequity of the system are in place and are a challenge to the country’s institutions” (2007, p.46). Given its long-standing disjointed character, the history of Argentina’s health care sector reveals a cellular society in which sub-national identities continue to shape access to health care.

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