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TITLE: The Idea of a ‘Health System’ and the Coming of Comparative Health Systems Research, 1891-1969

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ABSTRACT

Context: In recent decades health systems research has become established as an academic field and resource for policy-learning. This article accounts for the emergence of the concept of a ‘health system’ and its adoption as a subject of comparative research. Its focus is on English-language intellectual discourse both in the academy and international health organisations. It seeks to raise critical awareness amongst scholars and students about the values and controversies that surrounded the field’s emergence.

Method: The method is documentary analysis of several types of primary source including academic and professional studies of health services, and journals and technical publications.

Findings: The early usage of ‘system’ in writing about health policy was both descriptive and inflected with positive sentiment by those favouring public action. The 1950s and 1960s saw the conceptual and methodological groundwork of today’s field being laid, with seminal works by Odin Anderson, Milton Roemer and Brian Abel-Smith. Several intellectual trajectories converged here: interwar social medicine, epidemiology, health services research and medical sociology, though ‘system’ was still inconsistently conceptualised. The International Labour Organisation and League of Nations Health Organisation were instrumental in comparative study of health services and insurance programmes. This work was taken forward by the post-war ILO and the World Health Organisation, whose programme of technical assistance and dissemination was rooted in its Constitution. However, WHO’s position was initially highly contentious, particularly for the USA.

Conclusions: Today comparative health systems research aspires to defuse ideological debate by providing robust comparative data for policy-makers. However, its genealogy suggests it was also a project of social democratic thinkers, infused with a progressive vision. This prompts critical reflection on whether technical questions about health systems, can, or should, ever meaningfully be divorced from those of political philosophy. 289 words

KEYWORDS: Health Care Systems; World Health; History
The Idea of a ‘Health System’ and the Coming of Comparative Health Systems

Research, 1891-1969

In the last forty years the study of health systems has become firmly established as both a field of research and a resource for cross-national policy-learning. In the academy it is firmly embedded in schools of public health, management and public policy. As a research field, effort pours into the internal analysis of national systems and international comparison of their attributes and performance. At the level of supranational policy discourse it is an established feature of the work of the World Health Organisation (WHO), the World Bank and major NGOs, whose objectives span public health goals and economic development.

The WHO’s World Health Report 2000 is a characteristic, and classic, example, with its elaborate tabulations comparing national measures of equity, responsiveness and outcomes (WHO 2000).

Perhaps the first thing any student of the field learns is that there is no consensus definition of what constitutes a ‘health system’. Is it narrowly understood as the provision, financing and regulation of health services? Or is it broadly conceived to incorporate all aspects of policy bearing on health? If the former, what precisely are its constituent parts and their indicators? And if national systems are to be compared, what are the appropriate classificatory models (Nolte, McKee and Wait 2005)? The novice student will be only briefly detained by this, appreciating these uncertainties then moving quickly on to select the models and metrics which s/he will apply in research. However the historian is faced with a trickier problem.

This is to historicise the idea of a ‘health system’. For if it is to be used as a category in historical analysis then we need to learn something about how it emerged. Because it is a fairly recent concept, it would be dangerous to treat it as a neutral descriptor of some unproblematic external reality. Instead we need to understand how it was constructed and
thus to reflect on the work which it does for us. How does the label ‘health system’, with its associated connotations, shape the way we apprehend this slice of the social world? To explore these issues, this paper investigates the genealogy of the term and the concept. The ‘genealogical’ method derives from Nietzsche by way of Foucault, and it implies a particular approach to intellectual history. This is one in which there are no origins or linear evolution, and no essential elements waiting to be discovered. Rather, all systems of knowledge, whether moral philosophies or academic disciplines, are constructs, forged at particular moments and deriving from particular constellations of power which our task is to understand (Foucault 1977).

Figure 1: Ngram of occurrence of ‘health system’ in Google Books English language corpus, 1880-2000 Available at http://books.google.com/ngrams (Searched on 12th July 2013)

I start with a simple illustration showing the result of a N-Gram query for the frequency with which ‘health system’ appears in the electronic corpus of Google books (now some 12 million texts). This suggests that although the concept was occasionally deployed in the early 20th century, its usage only really began in the 1930s and 1940s, and only substantially escalated in the late 1960s and 1970s. I will begin by substantiating this picture, exploring the narrow etymology of ‘health system’, then the arrival of its core concepts in academic and in international health policy discourse. Next I will identify three key
individuals, Odin Anderson, Brian Abel-Smith and Milton Roemer, who I call ‘early
articulators’ (as opposed to ‘originators’ or ‘pioneers’) to denote that they shaped the field by
developing certain existing currents of thought. I then turn to the intellectual and institutional
contexts in which this happened. I bring into view the influential ideas informing social
medicine and the nascent health services research of the period, then discuss the history of
political conflict surrounding health systems policy in three international bodies, the
International Labour Organisation (ILO), the League of Nations Health Organisation
(LNHO), and its successor the WHO. As a preliminary caveat, I stress that a current
limitation of this work is its reliance on a principally English-language literature, and I
welcome correctives to the inevitable bias this creates.

1. Constructing the term and concepts

In the medical sphere the usage of ‘system’ to denote interconnectedness of bodily
organs - ‘nervous system’, vascular system’ etc. - is evident in the 18th century (MacBride
1772). Early applications of this organic metaphor to governance and administration are
traceable at least to the 1860s, when they were used in the context of education or sanitation.
Here they both described interrelated parts, whether buildings, staff or activities, and implied
a delimited sphere of public policy: thus the ‘system’ maps onto the area in which the
political writ of a given local, municipal or regional government runs (Griscom 1861, 32).
The word was used liberally in the first major attempt at a global survey, Henry Burdett’s
multi-volume *Hospitals and Asylums of the World*, 1891-3; a text analytics scan of the
volume on hospitals, finds 436 uses to denote different aspects of national arrangements,
most typically ‘hospital/hospitals system’ (222 times) but also ‘nursing system’,
administration system’ and so on (Burdett 1893). The earliest use I located of the bi-gram
‘health system’ itself dates from 1896, in a US text which argued other national models of ‘practical sanitation’ could be adopted by American county boards (Suiter 1896, 135).

In the early twentieth century these descriptive and politico-spatial attributes were augmented by something else. ‘System’ began to carry a positive sentiment when used by advocates of greater state agency in the health field, who aligned this with improved functioning. Thus Arthur Newsholme, who later wrote a 3-volume, 17-country comparative survey of the Private and Official Practice of Medicine in Europe, argued in 1919 that:

‘there is always present .. a large mass of illness which might have been avoided or curtailed had there been an organized system of state medicine’ (Newsholme 1919, 918)

In the same year a report for Britain’s newly created Ministry of Health proposed a structured reorganisation of health services, introducing the ideas of primary and secondary care, and envisaging these linked spatially in hierarchies of medical expertise. This vision of an integrated system did not come about in the 1920s and 1930s, because politicians preferred to retain Britain’s pluralistic mix of independent voluntary institutions and municipal governments rather than empowering the central state, but the grail of rational planning regularly resurfaced. In America a major focus for debate about the desirability of state intervention was the Committee on the Costs of Medical Care (CCMC), whose usage in 1932 inflected the descriptive with the idealistic:

‘European countries may not have proceeded with the greatest wisdom, but they have acted. Most of them have developed organized systems of medical care. We in the United States ... are now in a position to go forward intelligently’ (CCMC 1932, 3, 128, 131, 149).

The period of formation of Britain’s National Health Service (NHS) saw ‘system’ become synonymous with a ‘tightening of the bonds’ and ‘co-ordination’, which was
contrasted unadmiringly with ‘confusion and overlapping’, ‘sectional pride and prejudice ...

misunderstanding and fear’ of unreformed health provision (PEP 1937, 16, 25, 230; 1941, 1).

The NHS’s founder, Aneurin Bevan, preferred the word ‘service’ to ‘system’, with its
connotation of serving the ordinary citizen, but he similarly conceived of the NHS as a
‘rational relationship between all parts’, rather than ‘a patch-quilt of local paternalisms’
(Bevan 1952, 79). A LNHO article of 1933 provides the earliest example traced in
international health policy discourse, where the phrase ‘single national health system’ was
used in a similar sense, in a discussion about British reform proposals (LNHO 1933, 326).

The mid-century backdrop of debate about health services reform therefore ushered in
the deployment of ‘health system’ in research and policy discourse, usually with both
descriptive intent and positive connotations. By the time of accelerated usage in the late-
1960s and early 1970s this ferment of debate had partly settled, as the advanced industrial
nations moved towards universal coverage and comprehensive provision, either using
funding models of social insurance (eg. France, Germany, Japan) or taxation (eg. Britain,
Scandinavia), which became known (inaccurately) as the Bismarck and Beveridge systems;
the more hesitant US had initiated Medicare and Medicaid to protect older and impoverished
people. Thus when books began to appear with titles such as Development of the Swedish
Health System (1968) or The Health System of Iceland (1971), the object had been reified to
the extent that a consensual meaning was assumed, and the earlier connotations of approval
had been incorporated and effaced (Engel 1968; Wren 1971). This period also saw the
foundational problems of comparative analysis first crystallised. These were the
classifications of different systems, the generic nature and composition of a system, and the
common criteria by which these could be measured. The next section brings into view three
scholars who led the field in addressing these challenges.
2. Early articulators of comparative health systems analysis

The first early articulator is Odin Anderson (1914-2003), an American medical sociologist whose academic base was as director of the Center for Health Administration Studies in the University of Chicago’s Business School. Earlier in his career (1949) he had been one of the first sociologists to work in a medical school, at the University of Western Ontario, and while there he had been funded by WHO to travel to Scandinavia and the UK to study their health services. This had sparked a lifelong fascination, taken forward in his next post (1952) at the Health Information Foundation, a research charity funded by the pharmaceutical industry (Anderson 1991).

Anderson made two major contributions to the field. One was an article in the New England Journal of Medicine that provided the first comparative health systems discussion (Anderson 1963). This included a suggestion for classification, where he argued for a ‘spectrum’ between ideal polar types of ‘governmental system’ and ‘purely private’, and an identification of generic categories which might be subjected to comparison: equity, satisfaction, utilization, productivity and quality (‘efficiency and effectiveness’). The other was his monograph, Health Care: can there be equity? The United States, Sweden, and England (Anderson 1972). This was the first depth comparison of three national systems, incorporating history and political theory, and operationalizing his comparator concepts through a variety of metrics. Anderson and his research team were also amongst the first to conceptualise a ‘system’ as something more than a collection of interconnected parts. Instead these connections were formalised to identify four discrete elements: a population demand/utilisation input, a resourcing and service core of the system, and then its outcomes expressed through different health indicators.

The next key figure is Brian Abel-Smith (1926-1996), a British health economist and international expert adviser, whose institutional base was the Department of Social
Administration at the London School of Economics, where he became Professor in 1965 (Sheard 2013). He had made his name on the Guillebaud Enquiry (1953) into the costs of the NHS, when, in addition to persuading the UK Treasury that the NHS was not a drain on the taxpayer, he also developed new methods of national health accounting (Abel-Smith and Titmuss 1956). These skills led to a commission from WHO to lead a major cross-national study of health financing, beginning with a six-country pilot (Abel-Smith 1963). This was followed by a full 33-country study, presenting data from high, middle and low-income nations on the same footing (Abel-Smith 1967). Meanwhile in a paper complementing Anderson’s, he provided a historical and political overview of the ‘major pattern of financing and organisation of medical service’ (Abel-Smith 1965).

The principal contribution arising from this was to establish a common language for comparative health accounting, using the authority of WHO to encourage nation states to adopt these practices. Abel-Smith and his committee identified and legitimised a set of key categories, including harmonised definitions of concepts like ‘hospital’, or ‘health expenditure’, and practical cross-national measures, such as health expenditures as % of GNP. The final study delivered a detailed picture of variations in performance across place and time, and though it did not attempt a comparison of outcomes it laid the groundwork for this, much as Anderson was doing in his depth studies. Finally he proposed a rather cruder classification scheme than Anderson’s, identifying an ‘American system’, ‘West European system’ and ‘East European System’ of provision, and just two systems of financing: European ‘collective responsibility’ versus American individualism.

The third early articulator was Milton Roemer (1916-2001), an American public health doctor, also trained as a sociologist, whose varied career culminated in tenure from 1962 of a chair in Health Administration at UCLA School of Public Health. Before academia Roemer worked in the public health service at municipal level (New Jersey), and at federal
and state levels (including for the Farm Security Administration, West Virginia) and then
internationally, in Canada (implementing the first North American social health insurance
programme, in Saskatchewan) and for WHO. He is best known in the field for the two-
volume compendium, *National Health Systems of the World*, spanning 68 countries (Roemer
1991, 1993). This was the culmination of a research interest which began in 1948, with a 17-
country study of rural health care (Roemer 1948). Like Abel-Smith, it was the WHO, and in
his case also the ILO, which nurtured his ideas, crucially in his ILO study of *Medical Care
under Social Security* (Roemer 1969). This was followed by the 21-country survey *Health
Care Systems in World Perspective*, the precursor to his magnum opus (Roemer 1976).

Roemer’s importance was arguably more as a populariser, contributing to the
conceptual and descriptive development of the field, in contrast to the empirical and
evaluative work of the other two. He brought considerable global ambition to his writing,
from the outset spanning continents and income scale: the 1948 survey included Norway,
Sweden, Denmark, the Netherlands, Canada, Italy, Chile, China, Scotland, Mexico, the
Soviet Union, Peru, South Africa, Turkey, New Zealand, Yugoslavia and Britain. He also
posited different classification schemes, beginning in 1956 with the typology ‘private
initiative; social assistance; social insurance and public service’, and culminating in 1991
with the ‘entrepreneurial’, ‘welfare-oriented’, ‘comprehensive’ and ‘socialist’ types in
‘industrialised’, ‘transitional’, ‘very poor’ countries. He was also relatively explicit about the
political agenda firing his comparative study, both to aid development and to encourage
Western nations towards the type of system he considered optimal - an issue I will amplify
below.

3. Intellectual and institutional descents:

i) *Interwar social medicine*
The role of international organisations in encouraging these developments has been hinted at in the three biographies. However, before exploring this I want to bring into view the intellectual context in which the early articulators worked, and which provided networks and linkages between them. The first shaping area is that of interwar social medicine.

‘Social medicine’ is a hard term to define precisely, or to date. The earliest European usage stretches back to in 1848, when champions of liberal revolution urged that medical doctors had a role in improving the lot of the poor (Guerin 1848). In its modern sense it implies three things: making the profession aware that diseases have a ‘social pathology’, and hence could never be treated only at the singular level of the doctor/patient encounter.

Second, if causation was to be understood fully, then the social sciences had to supplement biological and clinical training. Third, there was inevitably a political dimension to this, ‘social conscience as well as scientific intent’ in the words of John Ryle (Porter 1992; Zylberman 2004). Academic recognition as a disciplinary approach may be traced through the establishment of university chairs in the subject (eg. Germany, France 1920, Belgium 1936, UK 1942), and through the foundation of specialist journals (eg. *British Journal of Social Medicine* 1949). Within this field the place of health services as ‘social prophylaxis’ was well established, and included insurance and public health services (Rosen 1947). Within the policy arena social medical thought was influential in different ways. In Eastern Europe it galvanised programmes of health education and health centre provision, while in the West it directed attention to the relationship between poverty, occupation and health, and in the United States influenced those members of the CCMC who favoured extending social insurance.

Anderson, Abel Smith and Roemer all had direct links to interwar luminaries of social medicine. Abel-Smith’s academic mentor and patron was Richard Titmuss, whose reputation was built on demonstrating the relationship between poverty and ill health in Britain during
the Depression, and whose history of wartime social policy had powerfully justified the expanded Beveridge welfare state. One of Anderson’s early influences was Edgar Sydenstricker, whose 1933 text *Health and Environment* similarly explored for the US the health impacts of the slump. Both Anderson and Roemer had been trained by Nathan Sinai, who had conducted the core research that underpinned the report of the CCMC (on which Sydenstricker also sat). Roemer had also studied at Johns Hopkins under Henry Sigerist, the Swiss historian of medicine, whose *Socialised Medicine in the Soviet Union* was both an early example of a national health system study and an admiring analysis of a fully public service. Finally, Roemer’s 1976 survey carried a preface by Karl Evang, Norway’s Chief Medical Officer and one of the founders of the Scandinavian model of welfare, who, along with Sigerist was a framer (or at least supporter) of the famous WHO definition of health as: ‘a state of complete physical, mental and social well-being and not merely the absence of disease’ (Ringen 1990; Terris 1975).

In addition to these broad themes of internationalism in outlook, an emphasis on social epidemiology, and a commitment to welfare states, social medicine made one other key conceptual contribution. This was to imbue the history of health services with a sense of progressive evolution. A key work is René Sand’s tellingly entitled *The Advance to Social Medicine* (1952), which was an early global historical survey. Its starting premise was medicine’s ‘evolution’ since the nineteenth century ‘from impotence to efficacy’, and the similar transformation marking the different fields of social medicine (which included hospitals and ‘social hygiene’ - mutual insurance, public health law and municipal services). Thus public health had experienced a ‘true renaissance’ thanks to bacteriological science, and social assistance had seen a ‘dawn of progress’ in early welfare states. As the language implies, this history suggested to Sand that social medicine’s ‘... grip is as inescapable as that of the forces of which it is the expression’ (Sand 1952, 37, 55, 99, 137, 167, 185, 252, 298, 531).
The tendency to read into history an inexorable advance also runs through Sigerist’s work, where it is entwined with his leftist political sentiment. Thus the Soviet health system marked ‘... the beginning of a new period in the history of medicine ... a new era, the period of preventive medicine ...’. In 1943, shortly before the atmosphere in the US turned distinctly hostile towards him, he remarked that ‘... the more I study history, the more faith I have in the future ... The step will be taken from the competitive to the cooperative society, democratically ruled on scientific principles ... a new and better civilization’ (Terris 1975, 520-1). It was not until the 1980s, or later, that the embeddedness of such historicist assumptions began to be articulated and questioned (Fox 1983).

ii) Health Services Research

The second contextual point to make concerns the institutional and disciplinary locations from which health systems studies arose. These can be characterised under the umbrella term ‘Health Services Research’ (HSR), a new specialty whose emergence is usually dated to the early 1960s: in the US this was when earmarked HSR funding began and when dedicated conferences and journals (Medical Care, Health Services Research) launched (McCarthy and White 2000). Four developments in the academy had converged to bring this about. First, demand for hospital and social service administrators had led to the creation of university departments providing vocational training in these fields (Duke University’s 1936 course is claimed as the American pioneer). Second, research to inform public policy, including health policy, had taken off in the postwar period in schools of public health, social administration and business: when not researching international health systems, this was the field in which Anderson, Abel-Smith and Roemer laboured (Anderson 1966). Third, epidemiologists had started to turn their attention to health services, after London’s Jerry Morris blazed the trail in his seminal textbook, Uses of Epidemiology; Kerr White and Archie
Cochrane subsequently applied epidemiological methods to assess whether particular interventions worked and provided value for money (Cochrane 1972; Morris 1957). Finally, medical sociology had begun to attract interest, and its initial themes, such as the sociology of the health professions, fed into early HSR.

HSR’s turn to cross-national analysis also came in the 1960s, and if an inception date for the academic study of comparative health systems is sought, then August 1969 is a good candidate. This was when the American Sociological Association held a ‘Workshop on International Studies of Medical Care’ in Monterey, California, which seems to be the first dedicated academic meeting on the subject, albeit with predominantly American attendees (Riedel 1971). Again though there were various precursors. The epidemiologists had already paved the way, forming an International Epidemiological Association in 1954, whose annual meeting of 1964 was themed on international comparison, and contained a ‘Medical Care’ strand (Acheson 1965). WHO was also instrumental as a research funder in encouraging detailed comparisons of hospital utilisation and its relationship with primary care (Btesh 1965). More generally, within the social sciences the same trend towards comparative research was manifested in the new journal *Comparative Studies in Society and History* (1958) and the foundation of an International Social Sciences Council in 1961 under the UNESCO umbrella, with attention focusing initially on political themes such as nation-building and democratisation.

In these early comparative health systems papers, which mostly seek to define key concepts, problems and metrics, we begin to see the term ‘system’ take on a more precise and theoretical meaning than hitherto. However the usage was not consistent. For sociologists of the Parsonian school ‘Health Care Systems’ were ‘one of the functional prerequisites for the survival of any nation or society’ (Mabry 1971, 194; Parsons 1951, 428-79). Like religion or education they were a fundamental ‘secondary system’ underpinning the whole social system.
(Field 1973). For epidemiologists and organisational researchers it signalled rather a set of interrelated elements that could be conceptualised as a model, crudely consisting of ‘input’, ‘throughput’ and ‘output’. Different parts of the model could be quantified, and the relationships between the elements thus explored (Bice and White 1971). But, to re-emphasize, these understandings of ‘system’ came after the term had entered the discourse as a means of conceptualising health services in place.

4. International Organisations and Comparative Health Systems

These intellectual trajectories within the academy were, however, secondary to the political work of building health services within welfare states. This was proceeding apace through the mid-twentieth century. To the extent that a comparative vision of these processes can be identified, it was from the international organisations who were their active advocates.

a) The Interwar period

The first of these is the International Labour Organisation. Founded in 1919 as a Western counterfoil to Bolshevism, the ILO was initially concerned to model consensual approaches to improvement for workers. It brokered joint agreements of employers, labour and governments, framed as conventions, whose ratification member states would then debate. At first though, health (other than occupational safety) was not on its radar. This changed in 1927 when a Social Insurance Section was set up, and a convention adopted obliging member states to establish sickness insurance. Behind this initiative were two Frenchmen, ILO director Albert Thomas and the Section’s head, Adrien Tixier, a disabled war veteran (Tixier 1927). In practical terms the Section issued a stream of publications monitoring the development of national social security structures, and provided technical assistance to member states considering legislation. During the Depression its focus on the issue intensified, and it moved from information source to active promoter of those insurance
structures which provided maximum security for workers. Thus they should be: compulsory; funded by joint employer/employee contributions; self-governing with workers’ representatives; and providing both cash income replacement and direct medical benefits.

Tixier explicitly opposed this ILO model of social health insurance to ‘la conception individualiste’ favoured by the USA. Here then we have an early articulation of the European social model, and the associated notions of compact between state and citizens which this entails (Kott 2010, 177-8).

The League of Nations Health Organisation also became progressively more focused on health services issues, after beginning with a predominantly biomedical agenda (infectious disease control, drug safety etc). Like the ILO it kept abreast of the development of health insurance, issuing 25 reports on the subject, 1925-31, but a fuller embrace of the social medicine agenda did not come until the 1930s with the arrival of thinkers like René Sand and Andrija Stampar on its Health Committee (Gillespie 2002). As the Depression worsened there was joint work with ILO on subjects like the health impacts of housing and nutrition, and a similar move to an advocacy position on health insurance. At the same time the LNHO pioneered advisory interventions, which its historian has called ‘establishing health systems’ (Borowy 2009). Examples are Greece (following a dengue fever outbreak there) where it helped develop a public health infrastructure of professional training and regional health centres, and China, where a school of public health and attached hospital was established in Nanjing, and work on infectious diseases, port sanitation, and community health services was taken forward. Though focused more on public health than health services, this nonetheless foreshadowed the WHO’s later technical assistance programme.

It is also with the LNHO that we see the rudimentary precursor to Abel-Smith’s national health statistics work, in its International Health Yearbook, published annually between 1925 and 1930 (Borowy 2004). The main purpose of this was to gather comparable
data on mortality and morbidity, based on returns from 37 countries, though some health
services data were also included (LNHO 1926 et seq). This was unsophisticated and
inconsistent, but it exposed the challenges of comparison and provided the first visual index
of national system components. When the WHO’s statistical programme was launched, its
duty of recording ‘health and medical personnel, institutions, and activities’ was essentially a
resumption of this earlier effort (Anon 1954).

b) The postwar period

Given these precedents, it seemed probable that health system development would
assume a prominent position in the work of international organisations after 1945. This was
particularly the case in light of the optimism infusing plans for postwar recovery. The ILO,
which survived the war by relocating to the USA, set out its goals in the 1944 Philadelphia
Declaration. One of these was to assure the ‘material well-being and ... economic security’ of
workers, and this was to include ‘comprehensive medical care’ (General Conference of the
ILO 1944). In 1946 the ILO became the first Special Agency of the United Nations, and its
technical assistance programme resumed, but now with the remit broadened from a limited
focus on labour relations to include poverty reduction and advice on welfare policies (Alcock
1971). It was in 1952 however, with the fledgling WHO firmly established, that the ILO
revived its prewar goals of extending national health insurance plans through an international
convention. Together the WHO and ILO drafted the text of Medical Aspects of Social
Security which proposed that member states should adopt the funding and provision
arrangements considered most favourable to workers. This meant compulsion, non-means-
tested universal coverage, and services free at the point of use. The convention also stated
that a salaried medical service was optimal, and favoured unified national administration with
regional integration, rural health centres and so on (WHO 1952). This suggests both the
contemporary influence of radical system reform, as represented by New Zealand’s and
Britain’s newly launched NHSs, and also the persistence in the policy arena of ideals of social medicine.

At the time of the WHO’s foundation however, the Sand/Sigerist model of social medicine was only one shaping force. As noted, the stamp of these thinkers was imprinted on the aspirational statements in the 1946 Convention which framed health as a ‘fundamental right’, assumed ‘mental and social well-being’ as well as physical fitness, and asserted that governments had a duty of ‘provision of adequate health and social measures’ (WHO 1946).

Despite this, when discussion began on the place of health insurance policy in WHO’s remit consensus was hard to obtain. A rift opened between a European faction, including interwar champions of social medicine like Stampar and Ludwig Rajchman, the ex-director of the LNHO, which strongly favoured setting international standards, and an Anglo-American group that defended member-state autonomy in this realm. The issue was partially resolved by agreeing that there would be a ‘study and report’ function on ‘hospital services and social security’. From this compromise came the plan for the joint WHO/ILO Medical Aspects of Social Security convention just mentioned, whose social democratic characteristics become more explicable when we consider that its consultant group contained Sigerist and Sand (Gillespie 2002). Meanwhile, Sigerist’s protégé Milton Roemer was appointed head of WHO’s Social and Occupational Health Section. Thus in 1952, when the draft text went to the International Labour Conference for ratification, the social medicine faction was poised to place an egalitarian model health systems development at the heart of the UN’s activities.

This was not to be. The convention finally approved was considerably watered down, removing the crucial commitment to universal coverage, and incorporating features acceptable to the private health insurance industry, such as the use of co-payments in place of free services, time limited benefits in place of full comprehensive cover, and qualifying periods in place of a right to immediate access. This dilution was the doing of the American
delegation and driven by employers’ representatives, who had tried initially to have the medical elements downgraded to mere recommendations. Contemporary comment emphasized the explicitly ideological considerations informing this stance. Their’s was an ethic of liberal individualism, founded upon ‘savings, insurance and home ownership’, and philosophically inimical to European welfarism: ‘Man does things more effectively of his own volition ... instead of doing them from compulsion’ (Myers 1952).

America’s stance also needs to be understood in the context of its internal politics. Throughout the 1940s the US had undergone a turbulent period of debate about its own health system, with several bills (associated with Senators Wagner, Murray and Dingell) seeking to introduce a federal social insurance scheme. President Truman had put his own weight behind this drive in 1945. Each time the initiative had failed, thanks to a powerful campaign waged by oppositional interest groups like private insurers, employers and the American Medical Association. In addition to fervid anxiety about what was now branded ‘socialized medicine’, US political life was in the throes of MacCarthyism. This ‘Red Scare’ of the early 1950s is remembered now for its anti-Communist witch-hunts, but it also wounded progressive proponents of social insurance, who became the subject of fierce attacks. Sigerist, for example, left the country in despair (Derickson 1997; Fee 1996). There were ramifications too for the UN, when America demanded that the FBI be permitted to vet the loyalty of US employees. WHO consented, and one casualty was Milton Roemer, who refused on principle to sign the requisite loyalty oath, had his passport was revoked, and was forced to resign his post (Farley 2008).

Why though did the WHO/ILO leadership accede to American demands? The answer is that pragmatism ruled. Though only one country among many, America had emerged from the war as the global superpower and was effectively paymaster to the United Nations and its special agencies. Moreover, all parties sought to avoid the failures of international
governance of the interwar period, when the USA stood aloof from the League of Nations while militarist powers grew unchecked. Thus it was better to accommodate American preferences and prevent a return to isolationism.

Arguably then the momentum behind health systems development at the international level was stalled after this controversy (Roemer 1994). The flagship efforts of the early WHO went instead into high profile eradication campaigns, notably against smallpox, which was ultimately successful, and malaria, which was not. Not until the Alma Ata Declaration of 1978, with its support for primary care services, could it be said that the interest of the WHO in the field had fully revived, and this followed the growing prominence of low- and middle-income nations in key committees. Nonetheless there were two areas in which the flame was kept alive.

First, the approved ‘study and report’ function continued, even though the first such effort, a report produced in 1956 on commission by Milton Roemer, remained unpublished due to internal WHO opposition from American interests (Roemer 1956). Instead it was again the ILO that took the lead, publishing in 1959 *The Cost of Medical Care*, a study comparing health costs from social security budgets across fourteen countries between 1945 and 1955 (ILO 1959). This was the ‘missing link’ between the early LNHO statistical work and the Abel-Smith WHO project, and it also had a political agenda, in refuting charges of a rising public burden of cost, and showing that comprehensive public systems provided good value compared to private health care. Second, the technical assistance function, arising from Article 2 of the convention (to ‘assist governments ... in strengthening health services’) also necessitated work on health systems (WHO 1946). In the 1950s the focus was on hospital planning in Latin America, South-East Asia and the Middle East, while in the 1960s decolonization turned attention to Africa, with support for national plans, emergency aid in conflict regions and so on (WHO 1958; WHO 1968). Thus Abel-Smith’s 1967 study
explicitly states that his new work on comparative health data sought to support health
planning for ‘national economic development’ (Abel-Smith 1967, 9).

Conclusions: ‘health systems’ as legacy of the Popular Front?

In one sense then, we can see WHO’s sponsorship of health systems research as a
rather minimal compensatory activity in the absence of a larger role. For the purposes of this
discussion however, the point I want to emphasize is the politicized atmosphere in which the
concept of health systems, and its related scholarly field, emerged. Indeed it might
reasonably be described as an intellectual legacy of the mid-twentieth century ‘popular front’.
In its strict sense this term alludes to the interwar political alliance between left-wing parties
in West European states (specifically France and Spain) to defend democracy against Fascism
and the right. In its looser meaning, as here, it connotes the realm of shared political interest
between centrist middle-class parties and socialist groupings, within a liberal democratic
framework. I will develop this point by returning to the three ‘early articulators’ and
exploring in more detail their own political positions.

First, Milton Roemer, who can confidently be placed towards the leftmost edge of the
spectrum. He had tangled with the MacCarthyites twice, in the 1953 WHO episode and in
West Virginia in 1948-9, as an outspoken champion of rural public health services. His
lifelong political position was affirmed by his obituary, which confirmed that he:

‘... viewed the Soviet Union as embodying a vision of the future, with a health system
... built on principles of equity. At Roemer’s memorial service in 2001, his son John
stunned the audience by saying that his father had believed in the Soviet Union to the
end’ (Abel, Fee and Brown 2008).

This hints at the enduring influence of Henry Sigerist on Roemer, whose writing, like his
mentor’s, yields plentiful glimpses of his progressive vision - history as the motion of
inexorable forces. Thus in a 1945 essay on the state and medicine in the US, he urged that
there could be no going back to:
‘laissez-faire economic and social policies’ for it was now the ‘Century of the
Common Man’, in which the state acted as ‘the most highly organised expression of
group action’ (Roemer 1945, 166, 168).
Or in 1960, when he detected in health system politics:
’a trend from the free enterprise toward the universal service pattern’, assuring readers
this was ‘... not an advocacy but an observation’ (Roemer 1960).
Or in his 1976 grand survey, when he observed that the:
‘... battles in the United States about various forms of health insurance are only minor
skirmishes that may retard the rate of this transformation, but can hardly affect its
final outcome.’
And from the same source, echoing the lofty ideals of the WHO Constitution, he urged that
progressive health politics reflected:
‘... a value system in which life is the highest good and untimely death the greatest
evil. ...the worldwide trend toward social organization of health services is also
advancement toward a goal of world peace’ (Roemer 1976, 13, 14, 283-4)
By contrast Odin Anderson’s stance was proudly in the centre, and indeed he chided
Roemer for the dogmatic assumptions which constrained his social theory. Strategically
Anderson asserted the virtues of maintaining a ‘low political profile’, having seen the attacks
on his mentor, Nathan Sinai, by opponents of social insurance (Anderson 1991, 53, 99). For
his pains he suffered hostility from erstwhile colleagues when he attracted funding from big
pharma, but he weathered this. His argument was that whatever the qualms about one’s
bedfellows, it was essential to remain squarely in the ‘vital center’. Effective change lay in
this realm of consensus between liberal and conservative in America’s pluralist polity.
Publicly Anderson described himself as an ‘empirical conservative’, in that (*contra* Roemer)
he anticipated the survival of a mixed health system in the United States (Anderson 1991, 76,
121-2, 131; 1977). For him, what mattered was what worked: there was no perfect system,
and the purpose of his research was to ensure that ‘all countries can learn from each other’
(Anderson 1963, 898). All that said, a posthumous unpublished work reveals that Anderson’s
conception of the ‘vital center’ in American politics was somewhat removed from its locus in
the Reagan/Bush years. Instead he revealed that his personal political philosophy had been
shaped by the liberal values of 1930s New Deal, with its still unmet promise that capitalism
‘was to be given a “human face”’ by the welfare state, and that ‘... all people should have
relatively equal access to health services regardless of financial status’ (Anderson 2012, v).

Like the two Americans, Brian Abel-Smith was a twentieth-century man whose
political consciousness, though formed under postwar affluence, was tinged by an
understanding of the effects of poverty and unemployment in the 1930s. His creed was
Fabian socialism, that is a commitment to social democracy, to Keynesian economics and to a
strong welfare state. As an academic in public life his commitment may be gauged by his
refusal of a life peerage and by his long service as an adviser to Britain’s Labour
governments (Townsend 1996). Prior to the mid-1980s Labour was a social democratic party
championing trade union and working-class interests, and Abel-Smith’s influence in the late
1960s and 1970s lay behind pension, disability and child benefit reform; he also kick-started
the process that led to a more equitable resource distribution within the NHS. His later
writings suggest that his convictions remained intact, and he described the economic
retrenchment under Mrs Thatcher, with its concomitant unravelling of welfare, as a ‘return to
the failed remedies of the pre-war era’ (Abel-Smith 1996, 131)  However, like Anderson he
had no *a priori* commitment to the superiority of any single health system; each had evolved
from existing administrative and cultural traditions, and thus there was ‘no right answer’
applicable everywhere (Abel-Smith 1992, 225). When in later life he turned his focus to
global trends in cost containment he readily conceded that provider competition and
consumer choice could enhance efficiency, and that there were circumstances in which a
public salaried service might disincentivize practitioners (Abel-Smith 1992). Nonetheless, he
retained deep and undisguised scepticism about the American model, not only from the
ethical standpoint of its disregard for the right to health, but also because it performed so
poorly. In a withering assault on the sclerosis of US health policy-making in 1985 he asked:
‘Why ... are pressures so strong on politicians of certain interest groups that what turn
out to be paper tigers come to be established? ... How necessary is it to continue to
subscribe to the illusion that regulation is the enemy of competition when in reality it
is essential to secure cost-containment, quality, and equity? ... How deeply felt is the
apparent distrust of government of the people, by the people, actually also being
government for the people?’ (Abel-Smith 1985, 16).

* * *

It would be reductionist, of course, to suggest that the concept of a health system and
the beginnings of comparative analysis were solely the work of political progressives. From
its earliest usages the couplet appears as a value-neutral term signalling the
interconnectedness of the different elements that financed, provided and regulated health
services. Yet at the same time the strength of those interconnections attracted positive
sentiment from proponents of greater intervention by states on behalf of their citizens. Where
‘syste’ denoted integration under benign agents of the people, then it moved beyond
neutrality to raise issues of redistribution and restraint of the unfettered medical marketplace.
Likewise the coming of health systems research in the 1960s represented a broad
confluence of interests in the academy and international organisations. All developed nations
confronted similar problems of rising costs, demand from aging populations and limited
resources, and they sought to learn from each other to improve their responses, both at the
level of public policy and of practical administration. The desire to foster health services in
developing economies was also shared across the political spectrum, and in low-, middle- and
high-income countries. Yet it is striking to observe, at least through the prism of the English
language literature, that the field had a deeply political inception. This was evident in the
early articulators, the discourses through which they framed their ideas and the institutional
contexts in which they worked. Social medicine, a key shaping influence, was inherently
oppositional in the mid-twentieth century, its advocates situating health services development
within a narrative of history as a forward march towards equity and social justice. Such
historicism seems jejune in today’s intellectual climate, but it was a product of its period, one
in which expansive welfare states were integral to the political and economic recovery from
world war. Before neo-liberalism this was an arena in which the left and the ‘vital centre’
could cohere, in Europe and to some extent in America. However, when a global consensus
was sought to lift these issues above purely national argumentation it proved challenging.
Differing conceptions of the proper roles of state and market, and of the rights and duties of
the individual prevented this. Consideration of the discipline’s lineage therefore prompts
reflection on whether technical questions about health systems, conceived as input, process
and outcome, can, or should, ever meaningfully be divorced from those of political
philosophy.

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