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1 **First Time Around: The Rise and Fall of ‘Universal Health Coverage’ as a Goal of**
2 **International Health Politics, 1925-52**

3

4 **Introduction**

5 In September 2015, the Sustainable Development Goals (SDGs) were announced at a
6 summit of the United Nations (UN) in New York.¹ Comprising numerous social, economic
7 and environmental policy objectives, these followed the Millennium Development Goals of
8 2000-2015, in which public health targets had figured prominently. While continuing earlier
9 concerns with reducing infectious diseases and child mortality, a novel feature of the SDGs
10 was Target 3.8:

11 ‘Achieve universal health coverage, including financial risk protection, access to
12 quality essential health-care services and access to safe, effective, quality and
13 affordable essential medicines and vaccines for all.’²

14 Not only did this prioritize health systems on the UN agenda, it also emphasized
15 universalism, in a way rarely seen since the ‘Health For All’ drive of the World Health
16 Organization (WHO) in the 1970s.³

17

18 What exactly does the target of universal health coverage (UHC) imply? ‘Coverage’ is a term
19 deriving from the insurance industry, but proponents of UHC stress that it may also refer to
20 tax-based health security.⁴ Equally, ‘universal’ has never straightforwardly signified the
21 whole population. For example, an early usage, from Germany in 1882, referred to the
22 ‘universal adoption of sickness insurance’ in respect of Bismarck’s scheme to compel only
23 the industrial workforce to join sick funds.⁵ Such definitional ambiguities have cued an
24 impassioned debate amongst today’s global health community about how UHC should be
25 operationalized in low and middle income countries. Latin America is a particular focus of
26 controversy. Some advocate the approach of ‘structured pluralism’, with insurance as the
27 main medium of cover, and the state’s role as regulator rather than provider. Others argue
28 that the priority must be universal health *care* as a basic human right, and that single-
29 payer systems are best placed to deliver this.⁶

30

31 This is not the first time that the issue of universal rights to health services has generated
32 debate in the international arena. This article discusses an earlier episode, centered on the

33 Philadelphia Declaration of the International Labour Organization (ILO) in 1944. The ILO was
34 originally an autonomous agency of the League of Nations, founded in the aftermath of
35 World War I with the ‘protection of the worker against sickness, disease and injury arising
36 out of his employment’ amongst its constitutional goals.⁷ The ILO’s methods included an
37 annual conference at which optimal standards, initially drafted by its officials, were debated
38 and agreed. These were written into Conventions, which states were asked to ratify, or
39 Recommendations, which were advisory and non-binding. States were then offered advice
40 and information on how to develop appropriate legislation.⁸

41

42 The Philadelphia Declaration was propounded in the latter stages of World War II, when the
43 ILO had fled Geneva for the safety of Montreal, Canada. It set out a vision of basic political
44 and economic rights for working people in the postwar settlement. These encompassed the
45 full gamut of social security arrangements available in more advanced welfare states,
46 including the right to sickness benefit and ‘comprehensive medical care’.⁹ In the
47 Recommendation that elaborated the main text, a universalist intent was specified. Health
48 services were for ‘all members of the community, whether or not they are gainfully
49 occupied’; if under a social insurance system, the uninsured would have the same right to
50 care ‘pending their inclusion’; if under a state public health service, then ‘all beneficiaries
51 should have an equal right’ to care, without qualifying conditions or means-testing.¹⁰ Once
52 peace was achieved, debate began on how these ideals could be translated into a
53 Convention and hence into action by member states. The outcome, in 1952, was a bitter
54 disappointment to champions of the Declaration, for the text that was finally agreed had so
55 diluted the standards required for ratification that the original goals were lost.

56

57 The aim in what follows is to describe and explain this earlier rise and fall of UHC as a goal in
58 international health policy. How and why did it come onto the agenda, and why was it
59 ultimately unsuccessful? Conceptually, we follow scholars of international organizations
60 (IOs) who find the key to understanding change in the tensions between the authority of the
61 member states and the autonomous actions of the agencies themselves.¹¹ Within this
62 literature is a spectrum of emphasis. Some argue that the interests of the most powerful
63 nations are always the dominant forces in international engagement, and that IOs exert no
64 supra-national authority over the anarchic behavior of individual states, each in ‘a struggle

65 for power'.¹² Others stress the global issues that compel states towards interdependence,
66 fostering independent bureaucracies and transnational networks of expertise through which
67 IOs formulated and shaped policy distinct from the goals of national actors.¹³

68

69 Our explanation falls somewhere between these poles. The powers delegated to the ILO's
70 bureaucracy at its foundation, and the internationalist nature of early welfare state
71 development, encouraged its increasing advocacy of health coverage under social
72 insurance. However, the weakness of the League of Nations system meant that the ILO
73 lacked authority, and its early work in this field was Eurocentric and of limited achievement.
74 In the late 1930s and 1940s a temporary concordance between ILO experts and policy-
75 makers in Britain and America informed planning for more comprehensive health cover
76 under social security. However, with the advent of peace, the Cold War, and the impending
77 end of colonialism the positions of the member states became too divided to sustain the
78 ILO's ambitious vision.

79

80 First, we focus on the interwar period, establishing the international context of
81 health policy-making within incipient state welfare schemes, then identifying the themes,
82 networks and individuals whose intellectual groundwork underlay the Philadelphia
83 Declaration's medical sections. We next describe the debates between officials and
84 member states prior to, and following, the Declaration, then advance our explanation for its
85 failure, blending issues of ideology, practicality and *realpolitik*. We close with reflection on
86 how this history speaks to the present juncture. Our method is documentary research in
87 the Geneva archives of the ILO, the League of Nations Health Organization and the WHO,
88 including conference proceedings, journals, committee records, correspondence and office
89 files.

90

91 **Towards Philadelphia: the interwar context**

92 The circumstances of the ILO's establishment at the Paris Peace Conference in 1919 were
93 conducive to innovative thought about social security. Britain, France and the United States
94 took the leading role in its creation, at a time when each was preoccupied with labour
95 unrest at home and abroad. In particular, the Russian Revolution encouraged politicians to
96 create a Western foil to Bolshevism, in which representatives of workers, employers and

97 governments would convene to address the injustices that otherwise provoked conflict.¹⁴
98 The delegation of responsibilities for social goals to the ILO therefore had a legitimization
99 function, but it also responded to the spread of socialist or social democratic ideas, and the
100 softening of laissez-faire principles within liberalism, as in French *solidarisme*, British New
101 Liberalism and American Progressivism.

102

103 The context in which the ILO's thinking occurred was one of expanding entitlements to
104 health services within prominent nation states. Prior to the 1880s, individuals outside the
105 medical marketplace resorted either to poor laws or charity, or joined mutual sickness
106 funds, sometimes regulated or subsidized by governments. A fundamental break came in
107 Germany, with Bismarckian social insurance against sickness (1883), accidents (1884) old
108 age and disability (1889). This mandated employer contribution to sick funds; it compelled
109 participation of substantial sections of the working class, thus creating large general risk
110 pools; and it introduced (initially through accident insurance) the principle of no-fault
111 liability, so that risk was removed from the individual and managed collectively using
112 actuarial mathematics.¹⁵ The national health insurance (NHI) approach was taken up in the
113 territories of Austria-Hungary, whose constituent nations retained and extended it on
114 gaining independence following World War One. Britain adopted a variant in 1911, and
115 France in 1930. The Soviet Union's Constitution enshrined a public health system in 1917,
116 though implementation awaited stability in the 1920s.¹⁶ In the liberal democracies, the first
117 constitution pledging 'a comprehensive system of insurance ... to maintain health' as a right
118 of citizenship was that of Germany's Weimar Republic (1919).¹⁷ The United States
119 considered, then rejected, NHI proposals placed before state legislatures in the 1910s, and
120 did so again when mooted by New Dealers for the Social Security Bill in 1934-5, though
121 some Latin American nations, such as Chile adopted it (1924).¹⁸ More radically, New
122 Zealand's Labour government pioneered a state national health service in 1938.¹⁹

123

124 This early welfare state building was inherently internationalist, for contemporary policy-
125 makers frequently employed foreign comparison and borrowing. Bismarck had been
126 inspired by French Emperor Louis Napoleon's regulation of mutual funds, while both Britain
127 and France borrowed from Germany, their upstart competitor.²⁰ American Progressives
128 reported on England and Germany and deployed international comparison in reform

129 propaganda.²¹ New Zealanders sought to surpass British NHI, while the Soviet Union (which
130 joined the ILO in 1934) attracted much observer interest as an ideal type.²² In sum, then,
131 the officials of League organizations and their constituent representatives would have been
132 well aware of health policy-making as a common and active endeavor across the member
133 states, albeit with much national variation.

134

135 Within this context, discussion of access to health services came formally onto the ILO's
136 agenda in 1927. One route was through the League of Nations Health Organization (LNHO).
137 This separate agency of the League had originated as its Provisional Health Committee
138 (1921), to address its Covenant obligations for the control and prevention of disease. Its
139 activities included establishing a global surveillance network, collating comparative health
140 metrics, developing the International Classification of Diseases, and providing technical
141 assistance, for example in Greece and China.²³ Several of its leading figures were from
142 Central European countries and advocates of social medicine, such as the Polish
143 bacteriologist Ludwik Rajchman, and the Yugoslav professor of hygiene, Andrija Stampar. It
144 was another successor state, Czechoslovakia, that first requested the LNHO to advise on a
145 problem common to nations developing social health insurance. How should this work
146 alongside public health agencies, that were typically funded by the local state to deal with
147 tuberculosis and infant health?²⁴ Behind this question lay issues of entitlement and the
148 irrationality of systems relying partly on general taxation and partly on individual insurance.
149 A Joint LNHO/ILO committee was convened to consider this, chaired by Sir George Newman,
150 the British Chief Medical Officer, a mainstream liberal. Unsurprisingly it backed away from
151 recommending formal integration, in favor of less rigid consultative councils.²⁵

152

153 The second area of action was the ILO's Sickness Insurance (Industry) Convention of 1927.
154 Ratifying nations agreed to establish compulsory sickness insurance for workers in industry
155 and commerce, principally through self-governing non-profit institutions funded by
156 employees and employers.²⁶ Various exceptions were permitted to the occupations
157 covered, deductibles and qualifying periods were allowed, and the state's contribution was
158 determined nationally. Ten years on only fifteen member states had ratified: Germany,
159 Hungary, Luxembourg (1928); Austria, Czechoslovakia, Yugoslavia, Romania, Latvia (1929);

160 Bulgaria (1930); Great Britain, Chile, Lithuania (1931); Spain (1932); Uruguay and Colombia
161 (1933).²⁷

162

163 The nature of the Convention, and the predominance of Central European states amongst
164 the early signatories illuminates the proactive role of key ILO staff, who now keenly
165 advocated a German, Bismarckian, model of NHI. This arose partly from the 'privileged
166 representation' of German experts in the ILO's Correspondence Committee on Social
167 Security.²⁸ Also important were two ILO officials, Adrien Tixier, a disabled French war
168 veteran who headed the Social Insurance Section, and his Czech deputy, Osvald Stein, who
169 had earlier overseen unemployment insurance in Austria.²⁹ Both were prominent in
170 establishing the International Conference of National Unions of Mutual Benefit Societies
171 and Sickness Insurance Funds (predecessor of the International Social Security Association),
172 whose title acknowledged the differing French and German approaches.³⁰ Chaired by a
173 Czech politician and ILO official, Leo Winter, they used this as a 'propaganda tool' in the
174 international promotion of social insurance.³¹

175

176 International advocacy for the expansion of NHI by ILO figures became more urgent during
177 the Depression. A LNHO memorandum of 1932 by German Health Section official Otto
178 Olsen argued this was a humanitarian and political necessity, for insecurity could foster the
179 extremism exemplified by Hitler.³² These themes were echoed in 1933, by a new ILO/LNHO
180 expert committee considering 'the best methods of safeguarding public health during the
181 depression'. Chaired by Georges Cahen-Salvador, an expert on Bismarckian insurance and
182 active promoter of NHI in France, the committee included other leaders of European social
183 medicine, such as Jacques Parisot, Franz Goldmann, Winter and Stampar.³³ Its conclusion
184 was that '...compulsory sickness insurance must be regarded as the most appropriate and
185 rational method of organizing the protection of the working classes...'.³⁴ Tixier too became
186 bolder, dismissing earlier objections that broadening entitlements to dependent family
187 members would damage private medicine, and frankly asserting the inadequacy of
188 'individual saving, public assistance, and voluntary insurance' for achieving social security.
189 Instead, 'compulsory social insurance ... is the most scientific and the most effective
190 means'.³⁵ While still hesitant about recommending a 'public medical service' for 'the whole
191 population of the country', he felt it 'fairly safe to say' that 'State intervention' in

192 combination with NHI made this direction inevitable.³⁶ Thus, by 1939 an ILO position was
193 discernible that yoked modernist tropes of science and rationality to a vision of progressive
194 advance.

195

196 **Towards the Philadelphia Declaration**

197 From this base, a more radical position was adopted in 1944. Why? Partly the answer lies
198 with the changing international context and the publication of two influential documents in
199 1942. One was Britain's Beveridge report. ILO officials had contributed evidence to this,
200 although they felt their influence was doubtful compared to the 'strong movement in the
201 trade unions and among the private "planners"' favoring the radical developments in New
202 Zealand.³⁷ Beveridge's vision of a universal, comprehensive social security system captured
203 the war-weary public imagination at home, inspired exiled French and Scandinavian
204 politicians in London, and quickly circulated the Anglophone world.³⁸ In North America, the
205 National Resources Planning Board report, *Security, Work and Relief Policies*, was also
206 significant for broaching a universalist language.³⁹ For example, both documents, and the
207 New Zealand innovations, shaped thinking in Canada, the ILO's temporary home, where the
208 Marsh Report (1943) proposed full employment, social security and health insurance against
209 'universal risks'.⁴⁰

210

211 The importance of British and American social thought also reflected changing networks of
212 expertise and influence that followed Europe's disintegration and the ILO's flight West in
213 1940.⁴¹ Advisers from the Roosevelt administration now came centre stage in the ILO's
214 consultative work, for having drawn heavily on European precedents in making New Deal
215 legislation they could now offer America's own experience.⁴² In addition, with the
216 introduction of the first Wagner-Murray-Dingell bill seeking to implement federal health
217 insurance in the United States (1943), new questions arose about how international
218 recommendations would accommodate an American model. Also to the fore came Latin
219 American officials, building on networks which Stein had developed through an Inter-
220 American conference and the Declaration of Santiago de Chile (1942), which outlined a
221 social security program and technical assistance arrangements.⁴³

222

223 The adoption of more radical elements of British policy also followed changes within the ILO
224 bureaucracy in 1943, following Stein's accidental death and Tixier's departure to the Free
225 French. Maurice Stack now headed the Social Insurance Section, but of more central
226 importance was Laura Bodmer. An Anglo-German economist with a PhD from Zurich in
227 British trade unionism, Bodmer joined the ILO as a statistician in 1925, moving to the
228 Section in 1932, where she increasingly specialized in 'des questions medico-sociales'.⁴⁴
229 She took main responsibility for drafting sections on medical aspects of social security for
230 the Declaration, creating then amending texts in a balancing act between ILO goals and
231 member state wishes.

232

233 This process began with a major consultation in July 1943, convening luminaries like
234 Britain's William Beveridge, American New Deal experts Isidore Falk, Arthur Altmeyer and
235 George Perrott, Canadian NHI planner Leonard Marsh, and Latin American politicians Miguel
236 Etchebarne (Chile) and Edgarde Rebagliati (Peru). Bodmer's draft proposed a health plan
237 covering 'all individuals whether or not gainfully occupied' and comprehensive in form,
238 providing 'all care required for the restoration, conservation and promotion of health'.⁴⁵ Her
239 preferred option was a 'public general service' financed by general or special taxation; the
240 alternative was contributory social insurance supported by taxation for individuals unable to
241 pay.⁴⁶ In the ensuing discussions, American delegates like Falk repositioned the 'general
242 medical service' as a longer-range 'ultimate objective' achievable incrementally through
243 different paths, rather than by forcing nations into a 'common mold'.⁴⁷ The agreed text was
244 debated at the International Labour Conference (ILC) in Philadelphia, where it was
245 embraced by a vote of 76 to 6.⁴⁸ Amongst abstainers ~~were~~was the US government, whose
246 employer delegates disapproved, and the UK government, resistant to intrusion into its
247 colonial sphere of influence.

248

249 **Diluting the Convention, 1949-52**

250 Against the backdrop of reconstruction, and the creation of the UN, the ILO now worked
251 towards a Convention that would implement the vision of 1944. Formal decisions were
252 taken at its annual conferences, with consultations in the interim. Retreat from the
253 Recommendation that accompanied the Declaration was first obvious at the 1951 ILC. After
254 debating a draft convention, it was decided that ratification could be for either 'minimum'

255 or 'advanced' standards.⁴⁹ Dilution went further at the 1952 ILC when the Convention was
256 finally approved. Ratifying members needed only implement three out of the nine specified
257 branches of social security, and could thus omit medical insurance altogether.⁵⁰ In addition,
258 low-income nations could claim temporary exemptions to even these obligations. In place
259 of compulsion the place of voluntary insurance was accepted, and the principle of state
260 subsidy rejected. The notion of advanced standards to which richer ratifying nations should
261 subscribe was also dropped.⁵¹

262

263 Four explanations can be suggested for this outcome. First, was the pragmatic concern of
264 low-income countries about the requirements of the Declaration. The need to distinguish
265 minimum and advanced standards was evident to Latin American member states
266 contemplating the extension of social security to rural populations. Given their lack of
267 resources they would have to retreat from universalism and comprehensiveness, and
268 instead '...try to extend, as soon as possible, to the greatest number of persons, within the
269 possibilities of each country, social security medical services, or other appropriate
270 methods...'.⁵² It was newly independent India which proposed the idea of permitted
271 exclusions, considering even the 'minimum standards' too demanding for a country whose
272 population was highly dispersed and largely rural.⁵³ To some extent these difficulties arose
273 from the mostly Eurocentric precedents in ILO thinking about welfare, but they may also
274 reflect the fissures within the early UN over the nature of internationalism under late-
275 colonialism. Although representatives from Latin America, China, the USSR and India
276 envisaged the supervisory role of the UN system displacing colonial prerogatives, the
277 imperial powers, with some support from the United States, were broadly successful in
278 preserving 'a world safe for empire' in the new dispensation.⁵⁴ This was hardly conducive
279 to generalizing Western models of health security to poorer nations.

280

281 Second, opposition was articulated by hostile business and medical interest groups.
282 Employers' representatives inveighed against the proposals in intemperate language: it was
283 a 'monstrosity'; a 'Utopian' project; it augured 'socialisation ... destruction'; it would extend
284 the 'all-embracing tentacles' of the state. Above all it was beyond the ILO's sphere of
285 competence.⁵⁵ Physicians also expressed their discontent, following the launch in 1947 of
286 the World Medical Association (WMA), aided by funding from US pharmaceutical firms. As

287 in national debates, objections emphasized patients' freedom of choice, and doctors' rights
288 to diagnose, treat and charge as they saw fit. The underlying agenda though, was to defend
289 the profession's status and market position.⁵⁶

290

291 Third, was the well-documented marginalization of social medicine in postwar international
292 health.⁵⁷ The ILO had initially hoped that the newly created WHO would endorse and
293 support the proposals. Yet while its constitution proclaimed the human right to 'the highest
294 attainable standard of health', its founding article on 'strengthening health services'
295 pledged only assistance 'upon request'.⁵⁸ Nonetheless, in 1951 a joint WHO/ILO consultant
296 group was formed to address the draft convention, containing leading social medicine
297 exponents like Henry Sigerist and René Sand. Its statement backed the ILO position,
298 favoring *inter alia* universal coverage where possible, services free from means-testing or
299 cost-sharing, remuneration by salary as optimal, unified national administration and
300 regionally integrated hospitals and clinics.⁵⁹ The WHO's Executive Board immediately
301 distanced itself from this, while the WMA claimed the 'vast majority' of physicians
302 disagreed.⁶⁰ By now WHO policy was moving firmly towards big, 'vertical' interventions
303 against infectious diseases, due both to faith in biotechnical solutions like vaccines and
304 pesticides, and to baser geopolitical considerations.⁶¹ Health systems work merited only a
305 'study and report' brief.

306

307 Finally, the position of the United States, as the key funder of the UN and now the leading
308 world power, was crucial. The attempts of the Truman administration to legislate for NHI
309 had been roundly defeated, not least due to a vituperative and well-funded campaign by the
310 American Medical Association (in which WMA council members Louis Bauer and Morris
311 Fishbein were prominent).⁶² As *AJPH* readers will know, moderate New Deal progressives
312 were then tarnished by character assassination, while more radical health internationalists
313 endured a McCarthyite purge.⁶³ Faced with this domestic context, it became impossible for
314 America to support a universalist health services agenda on the world stage. Such
315 considerations would remain matters for national jurisdiction.

316

317 **Conclusion**

318 This account of the early rise and fall of UHC illustrates the capacity of international
319 organizations to exercise some autonomous agency. Building health systems within proto-
320 welfare states was always a supra-national endeavor, since no country, even Bismarck's
321 Germany, was immune from the diffusion of ideas and policy-learning. National
322 experiences fostered communities of experts willing to serve in international bodies, though
323 external events could determine which regions and ideas dominated at different times, and
324 epistemic communities could be oppositional as well as supportive. Responsible officers
325 within organizations were similarly conditioned by prior experiences, but they also sought a
326 creative and proactive role in directing policy, beyond simply reacting to the perceived
327 position of member states.

328

329 In this case though, the arc of the story was determined by the willingness of powerful
330 member states to delegate authority to the ILO. Health system reform to universalize
331 single-payer or NHI models has never been uncontentious, touching as it does on the
332 material concerns of vested interests, and on core beliefs about equity and individualism.
333 Once the idealistic ardor of wartime cooled, national interests disrupted the apparent
334 consensus. Low-income countries sought acknowledgement that poverty drastically
335 constrained ambition, and into this breach it was easy for opponents to ride, depleting
336 commitments until they were worthless. Colonial calculations played some part in Britain's
337 reluctance, and Cold War polarities helped determine the American position, in which
338 'socialized' medicine was now anathema. The new global superpower would not endorse a
339 position unacceptable within its own national polity.

340

341 How might this history speak to the present? Of course, much has changed in the interim.
342 The movement for 'selective primary health care' from the 1980s narrowed the meaning of
343 universalism to entitlement to a limited number of services of proven cost-effectiveness. At
344 the same time, the constraints exercised by powerful member states have been offset by
345 the proliferation, since the 1990s, of philanthropic foundations and public/private actors
346 that can set agendas unfettered by national governments. However, some parallels remain.
347 Then as now, the goal of universalism was politically controversial, with today's 'structured
348 pluralism' bearing some affinity to the incremental advance that Americans like Falk
349 advocated between 1938 and 1950. Today's champions of universal health care may also

350 trace their genealogy to progressive social medicine advocates of the mid-century. The
351 recurrent nature of this debate prompts challenging questions. How far should idealists
352 stifle their objections and work with pragmatists to exploit opportunities which were missed
353 before? Where are the oppositional networks of today, and how can they be addressed, so
354 that vested interests do not impede the honoring of human rights? ⁶⁴ What examples of
355 best practice can be advanced, to better address the pragmatic objections of poor
356 countries, so that unlike in 1949-52, these do not become a wedge to forestall change? ⁶⁵
357 And what will be the leadership role of the United States, at a time when its own domestic
358 health politics, and the nationalist sentiments circulating amongst its electorate, also echo
359 the early-1950s?

360

361 **Word Length:**

362 **Text:** 4,018

363 **Endnotes:** 1,790

364 **Illustration captions:** 187

365

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