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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.<sup>1</sup> 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.’<sup>2</sup>

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.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup> 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.<sup>6</sup>

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.<sup>7</sup> 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.<sup>8</sup>

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’.<sup>9</sup> 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.<sup>10</sup> 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.<sup>11</sup> 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'.<sup>12</sup> 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.<sup>13</sup>

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.<sup>14</sup>  
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.<sup>15</sup> 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.<sup>16</sup> 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).<sup>17</sup> 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).<sup>18</sup> More radically, New  
122 Zealand's Labour government pioneered a state national health service in 1938.<sup>19</sup>

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.<sup>20</sup> American Progressives  
128 reported on England and Germany and deployed international comparison in reform

129 propaganda.<sup>21</sup> 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.<sup>22</sup> 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.<sup>23</sup> 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?<sup>24</sup> 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.<sup>25</sup>

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.<sup>26</sup> 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).<sup>27</sup>

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.<sup>28</sup> 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.<sup>29</sup> 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.<sup>30</sup> 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.<sup>31</sup>

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.<sup>32</sup> 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.<sup>33</sup> 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...'.<sup>34</sup> 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'.<sup>35</sup> 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.<sup>36</sup> 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.<sup>37</sup> 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.<sup>38</sup> In North America, the  
205 National Resources Planning Board report, *Security, Work and Relief Policies*, was also  
206 significant for broaching a universalist language.<sup>39</sup> 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'.<sup>40</sup>

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.<sup>41</sup> 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.<sup>42</sup> 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.<sup>43</sup>

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'.<sup>44</sup>  
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 Edgardo 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'.<sup>45</sup> 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.<sup>46</sup> 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'.<sup>47</sup> 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.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup> 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.<sup>51</sup>

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...'.<sup>52</sup> 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.<sup>53</sup> 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.<sup>54</sup> 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.<sup>55</sup> 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.<sup>56</sup>

290

291 Third, was the well-documented marginalization of social medicine in postwar international  
292 health.<sup>57</sup> 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'.<sup>58</sup> 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.<sup>59</sup> The WHO's Executive Board immediately  
301 distanced itself from this, while the WMA claimed the 'vast majority' of physicians  
302 disagreed.<sup>60</sup> 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.<sup>61</sup> 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).<sup>62</sup> 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.<sup>63</sup> 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?<sup>64</sup> 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?<sup>65</sup>  
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:**

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365

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<sup>1</sup> “Breakdown of U.N. Sustainable Development Goals”, New York Times, September 26, 2015.

<sup>2</sup> United Nations Sustainable Development Platform, Goal 3.8, URL:  
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<sup>7</sup> "Appendix II Constitution of the International Labour Organization: Preamble, 1919", in Gerry Rodgers et al. *The International Labour Organization and the Quest for Social Justice, 1919-2009*, (Geneva: ILO, 2009), 249.

<sup>8</sup> Rodgers et al., *International Labour Organization*, ~~Rodgers et al.~~, 19-20.

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