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

AUTHOR: Martin Gorsky, PhD, B.Ed., BA Hons.

AFFILIATION: Centre for History in Public Health,

London School of Hygiene and Tropical Medicine,

15-17 Tavistock Place,

London, WC1H9SH.

United Kingdom

Tel: 00 44 (0)207 927 2700

Email: martin.gorsky@lshtm.ac.uk

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

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

26 thus to reflect on the work which it does for us. How does the label ‘health system’, with its

27 associated connotations, shape the way we apprehend this slice of the social world? To

28 explore these issues, this paper investigates the genealogy of the term and the concept. The

29 ‘genealogical’ method derives from Nietzsche by way of Foucault, and it implies a particular

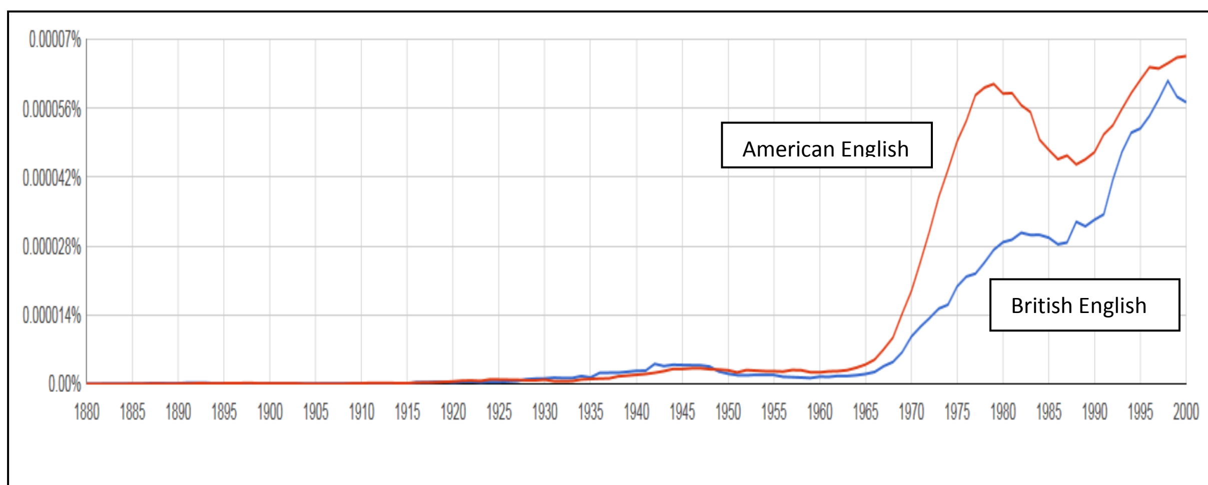
30 approach to intellectual history. This is one in which there are no origins or linear evolution,

31 and no essential elements waiting to be discovered. Rather, all systems of knowledge,

32 whether moral philosophies or academic disciplines, are constructs, forged at particular

33 moments and deriving from particular constellations of power which our task is to understand

34 (Foucault 1977).



35

36 Figure 1: Ngram of occurrence of ‘health system’ in Google Books English language corpus,

37 1880-2000 Available at http://books.google.com/ngrams (Searched on 12th July 2013)

38 I start with a simple illustration showing the result of a N-Gram query for the

39 frequency with which ‘health system’ appears in the electronic corpus of Google books (now

40 some 12 million texts). This suggests that although the concept was occasionally deployed in

41 the early 20th century, its usage only really began in the 1930s and 1940s, and only

42 substantially escalated in the late 1960s and 1970s. I will begin by substantiating this picture,

43 exploring the narrow etymology of ‘health system’, then the arrival of its core concepts in

44 academic and in international health policy discourse. Next I will identify three key

45 individuals, Odin Anderson, Brian Abel-Smith and Milton Roemer, who I call ‘early
46 articulators’ (as opposed to ‘originators’ or ‘pioneers’) to denote that they shaped the field by
47 developing certain existing currents of thought. I then turn to the intellectual and institutional
48 contexts in which this happened. I bring into view the influential ideas informing social
49 medicine and the nascent health services research of the period, then discuss the history of
50 political conflict surrounding health systems policy in three international bodies, the
51 International Labour Organisation (ILO), the League of Nations Health Organisation
52 (LNHO), and its successor the WHO. As a preliminary caveat, I stress that a current
53 limitation of this work is its reliance on a principally English-language literature, and I
54 welcome correctives to the inevitable bias this creates.
55
56 **1. Constructing the term and concepts**
57 In the medical sphere the usage of ‘system’ to denote interconnectedness of bodily
58 organs - ‘nervous system’, vascular system’ etc. - is evident in the 18th century (MacBride
59 1772). Early applications of this organic metaphor to governance and administration are
60 traceable at least to the 1860s, when they were used in the context of education or sanitation.
61 Here they both described interrelated parts, whether buildings, staff or activities, and implied
62 a delimited sphere of public policy: thus the ‘system’ maps onto the area in which the
63 political writ of a given local, municipal or regional government runs (Griscom 1861, 32).
64 The word was used liberally in the first major attempt at a global survey, Henry Burdett’s
65 multi-volume *Hospitals and Asylums of the World*, 1891-3; a text analytics scan of the
66 volume on hospitals, finds 436 uses to denote different aspects of national arrangements,
67 most typically ‘hospital/hospitals system’ (222 times) but also ‘nursing system’,
68 administration system’ and so on (Burdett 1893). The earliest use I located of the bi-gram

69 ‘health system’ itself dates from 1896, in a US text which argued other national models of
70 ‘practical sanitation’ could be adopted by American county boards (Suiter 1896, 135).
71 In the early twentieth century these descriptive and politico-spatial attributes were
72 augmented by something else. ‘System’ began to carry a positive sentiment when used by
73 advocates of greater state agency in the health field, who aligned this with improved
74 functioning. Thus Arthur Newsholme, who later wrote a 3-volume, 17-country comparative
75 survey of the *Private and Official Practice of Medicine* in Europe, argued in 1919 that:
76 ‘there is always present .. a large mass of illness which might have been avoided or
77 curtailed had there been an organized system of state medicine’ (Newsholme 1919,
78 918)
79 In the same year a report for Britain’s newly created Ministry of Health proposed a structured
80 reorganisation of health services, introducing the ideas of primary and secondary care, and
81 envisaging these linked spatially in hierarchies of medical expertise. This vision of an
82 integrated system did not come about in the 1920s and 1930s, because politicians preferred to
83 retain Britain’s pluralistic mix of independent voluntary institutions and municipal
84 governments rather than empowering the central state, but the grail of rational planning
85 regularly resurfaced. In America a major focus for debate about the desirability of state
86 intervention was the Committee on the Costs of Medical Care (CCMC), whose usage in 1932
87 inflected the descriptive with the idealistic:
88 ‘European countries may not have proceeded with the greatest wisdom, but they have
89 acted. Most of them have developed organized systems of medical care. We in the
90 United States ... are now in a position to go forward intelligently’ (CCMC 1932, 3,
91 128, 131, 149).
92 The period of formation of Britain’s National Health Service (NHS) saw ‘system’
93 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.

119 **2. Early articulators of comparative health systems analysis**

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

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

142 The next key figure is Brian Abel-Smith (1926-1996), a British health economist \nd
143 international expert adviser, whose institutional base was the Department of Social

144 Administration at the London School of Economics, where he became Professor in 1965
145 (Sheard 2013). He had made his name on the Guillebaud Enquiry (1953) into the costs of the
146 NHS, when, in addition to persuading the UK Treasury that the NHS was not a drain on the
147 taxpayer, he also developed new methods of national health accounting (Abel-Smith and
148 Titmuss 1956). These skills led to a commission from WHO to lead a major cross-national
149 study of health financing, beginning with a six-country pilot (Abel-Smith 1963). This was
150 followed by a full 33-country study, presenting data from high, middle and low-income
151 nations on the same footing (Abel-Smith 1967). Meanwhile in a paper complementing
152 Anderson's, he provided a historical and political overview of the 'major pattern of financing
153 and organisation of medical service' (Abel-Smith 1965).

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

165 The third early articulator was Milton Roemer (1916-2001), an American public
166 health doctor, also trained as a sociologist, whose varied career culminated in tenure from
167 1962 of a chair in Health Administration at UCLA School of Public Health. Before academia
168 Roemer worked in the public health service at municipal level (New Jersey), and at federal

169 and state levels (including for the Farm Security Administration, West Virginia) and then
170 internationally, in Canada (implementing the first North American social health insurance
171 programme, in Saskatchewan) and for WHO. He is best known in the field for the two-
172 volume compendium, *National Health Systems of the World*, spanning 68 countries (Roemer
173 1991, 1993). This was the culmination of a research interest which began in 1948, with a 17-
174 country study of rural health care (Roemer 1948). Like Abel-Smith, it was the WHO, and in
175 his case also the ILO, which nurtured his ideas, crucially in his ILO study of *Medical Care*
176 *under Social Security* (Roemer 1969). This was followed by the 21-country survey *Health*
177 *Care Systems in World Perspective*, the precursor to his magnum opus (Roemer 1976).

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

191

192 **3. Intellectual and institutional descents:**

193 *i) Interwar social medicine*

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

198 'Social medicine' is a hard term to define precisely, or to date. The earliest European
199 usage stretches back to in 1848, when champions of liberal revolution urged that medical
200 doctors had a role in improving the lot of the poor (Guerin 1848). In its modern sense it
201 implies three things: making the profession aware that diseases have a 'social pathology', and
202 hence could never be treated only at the singular level of the doctor/patient encounter.
203 Second, if causation was to be understood fully, then the social sciences had to supplement
204 biological and clinical training. Third, there was inevitably a political dimension to this,
205 'social conscience as well as scientific intent' in the words of John Ryle (Porter 1992;
206 Zylberman 2004). Academic recognition as a disciplinary approach may be traced through
207 the establishment of university chairs in the subject (eg. Germany, France 1920, Belgium
208 1936, UK 1942), and through the foundation of specialist journals (eg. *British Journal of*
209 *Social Medicine* 1949). Within this field the place of health services as 'social prophylaxis'
210 was well established, and included insurance and public health services (Rosen 1947). Within
211 the policy arena social medical thought was influential in different ways. In Eastern Europe
212 it galvanised programmes of health education and health centre provision, while in the West
213 it directed attention to the relationship between poverty, occupation and health, and in the
214 United States influenced those members of the CCMC who favoured extending social
215 insurance.

216 Anderson, Abel Smith and Roemer all had direct links to interwar luminaries of social
217 medicine. Abel-Smith's academic mentor and patron was Richard Titmuss, whose reputation
218 was built on demonstrating the relationship between poverty and ill health in Britain during

219 the Depression, and whose history of wartime social policy had powerfully justified the
220 expanded Beveridge welfare state. One of Anderson's early influences was Edgar
221 Sydenstricker, whose 1933 text *Health and Environment* similarly explored for the US the
222 health impacts of the slump. Both Anderson and Roemer had been trained by Nathan Sinai,
223 who had conducted the core research that underpinned the report of the CCMC (on which
224 Sydenstricker also sat). Roemer had also studied at Johns Hopkins under Henry Sigerist, the
225 Swiss historian of medicine, whose *Socialised Medicine in the Soviet Union* was both an
226 early example of a national health system study and an admiring analysis of a fully public
227 service. Finally, Roemer's 1976 survey carried a preface by Karl Evang, Norway's Chief
228 Medical Officer and one of the founders of the Scandinavian model of welfare, who, along
229 with Sigerist was a framer (or at least supporter) of the famous WHO definition of health as:
230 'a state of complete physical, mental and social well-being and not merely the absence of
231 disease' (Ringen 1990; Terris 1975).
232 In addition to these broad themes of internationalism in outlook, an emphasis on
233 social epidemiology, and a commitment to welfare states, social medicine made one other
234 key conceptual contribution. This was to imbue the history of health services with a sense of
235 progressive evolution. A key work is René Sand's tellingly entitled *The Advance to Social*
236 *Medicine* (1952), which was an early global historical survey. Its starting premise was
237 medicine's 'evolution' since the nineteenth century 'from impotence to efficacy', and the
238 similar transformation marking the different fields of social medicine (which included
239 hospitals and 'social hygiene' - mutual insurance, public health law and municipal services).
240 Thus public health had experienced a 'true renaissance' thanks to bacteriological science, and
241 social assistance had seen a 'dawn of progress' in early welfare states. As the language
242 implies, this history suggested to Sand that social medicine's '... grip is as inescapable as that
243 of the forces of which it is the expression' (Sand 1952, 37, 55, 99, 137, 167, 185, 252, 298,

345, 512). 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

294 (Field 1973). For epidemiologists and organisational researchers it signalled rather a set of
295 interrelated elements that could be conceptualised as a model, crudely consisting of 'input',
296 'throughput' and 'output'. Different parts of the model could be quantified, and the
297 relationships between the elements thus explored (Bice and White 1971). But, to re-
298 emphasize, these understandings of 'system' came after the term had entered the discourse as
299 a means of conceptualising health services in place.

300

301 **4. International Organisations and Comparative Health Systems**

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

306 *a) The Interwar period*

307 The first of these is the International Labour Organisation. Founded in 1919 as a
308 Western counterfoil to Bolshevism, the ILO was initially concerned to model consensual
309 approaches to improvement for workers. It brokered joint agreements of employers, labour
310 and governments, framed as conventions, whose ratification member states would then
311 debate. At first though, health (other than occupational safety) was not on its radar. This
312 changed in 1927 when a Social Insurance Section was set up, and a convention adopted
313 obliging member states to establish sickness insurance. Behind this initiative were two
314 Frenchmen, ILO director Albert Thomas and the Section's head, Adrien Tixier, a disabled
315 war veteran (Tixier 1927). In practical terms the Section issued a stream of publications
316 monitoring the development of national social security structures, and provided technical
317 assistance to member states considering legislation. During the Depression its focus on the
318 issue intensified, and it moved from information source to active promoter of those insurance

319 structures which provided maximum security for workers. Thus they should be: compulsory;
320 funded by joint employer/employee contributions; self-governing with workers'
321 representatives; and providing both cash income replacement and direct medical benefits.
322 Tixier explicitly opposed this ILO model of social health insurance to 'la conception
323 individualiste' favoured by the USA. Here then we have an early articulation of the
324 European social model, and the associated notions of compact between state and citizens
325 which this entails (Kott 2010, 177-8).

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

341 It is also with the LNHO that we see the rudimentary precursor to Abel-Smith's
342 national health statistics work, in its *International Health Yearbook*, published annually
343 between 1925 and 1930 (Borowy 2004). The main purpose of this was to gather comparable

344 data on mortality and morbidity, based on returns from 37 countries, though some health
345 services data were also included (LNHO 1926 et seq). This was unsophisticated and
346 inconsistent, but it exposed the challenges of comparison and provided the first visual index
347 of national system components. When the WHO's statistical programme was launched, its
348 duty of recording 'health and medical personnel, institutions, and activities' was essentially a
349 resumption of this earlier effort (Anon 1954).

350 *b) The postwar period*

351 Given these precedents, it seemed probable that health system development would
352 assume a prominent position in the work of international organisations after 1945. This was
353 particularly the case in light of the optimism infusing plans for postwar recovery. The ILO,
354 which survived the war by relocating to the USA, set out its goals in the 1944 Philadelphia
355 Declaration. One of these was to assure the 'material well-being and ... economic security' of
356 workers, and this was to include 'comprehensive medical care' (General Conference of the
357 ILO 1944). In 1946 the ILO became the first Special Agency of the United Nations, and its
358 technical assistance programme resumed, but now with the remit broadened from a limited
359 focus on labour relations to include poverty reduction and advice on welfare policies (Alcock
360 1971). It was in 1952 however, with the fledgling WHO firmly established, that the ILO
361 revived its prewar goals of extending national health insurance plans through an international
362 convention. Together the WHO and ILO drafted the text of *Medical Aspects of Social*
363 *Security* which proposed that member states should adopt the funding and provision
364 arrangements considered most favourable to workers. This meant compulsion, non-means-
365 tested universal coverage, and services free at the point of use. The convention also stated
366 that a salaried medical service was optimal, and favoured unified national administration with
367 regional integration, rural health centres and so on (WHO 1952). This suggests both the
368 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 heath 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

419 governance of the interwar period, when the USA stood aloof from the League of Nations
420 while militarist powers grew unchecked. Thus it was better to accommodate American
421 preferences and prevent a return to isolationism.

422 Arguably then the momentum behind health systems development at the international
423 level was stalled after this controversy (Roemer 1994). The flagship efforts of the early WHO
424 went instead into high profile eradication campaigns, notably against smallpox, which was
425 ultimately successful, and malaria, which was not. Not until the Alma Ata Declaration of
426 1978, with its support for primary care services, could it be said that the interest of the WHO
427 in the field had fully revived, and this followed the growing prominence of low- and middle-
428 income nations in key committees. Nonetheless there were two areas in which the flame was
429 kept alive.

430 First, the approved 'study and report' function continued, even though the first such
431 effort, a report produced in 1956 on commission by Milton Roemer, remained unpublished
432 due to internal WHO opposition from American interests (Roemer 1956). Instead it was again
433 the ILO that took the lead, publishing in 1959 *The Cost of Medical Care*, a study comparing
434 health costs from social security budgets across fourteen countries between 1945 and 1955
435 (ILO 1959). This was the 'missing link' between the early LNHO statistical work and the
436 Abel-Smith WHO project, and it also had a political agenda, in refuting charges of a rising
437 public burden of cost, and showing that comprehensive public systems provided good value
438 compared to private health care. Second, the technical assistance function, arising from
439 Article 2 of the convention (to 'assist governments ... in strengthening health services') also
440 necessitated work on health systems (WHO 1946). In the 1950s the focus was on hospital
441 planning in Latin America, South-East Asia and the Middle East, while in the 1960s
442 decolonization turned attention to Africa, with support for national plans, emergency aid in
443 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

469 inexorable forces. Thus in a 1945 essay on the state and medicine in the US, he urged that
470 there could be no going back to:

471 'laissez-faire economic and social policies' for it was now the 'Century of the
472 Common Man', in which the state acted as 'the most highly organised expression of
473 group action' (Roemer 1945, 166, 168).

474 Or in 1960, when he detected in health system politics:

475 'a trend from the free enterprise toward the universal service pattern', assuring readers
476 this was '... not an advocacy but an observation' (Roemer 1960).

477 Or in his 1976 grand survey, when he observed that the:

478 '... battles in the United States about various forms of health insurance are only minor
479 skirmishes that may retard the rate of this transformation, but can hardly affect its
480 final outcome.'

481 And from the same source, echoing the lofty ideals of the WHO Constitution, he urged that
482 progressive health politics reflected:

483 '... a value system in which life is the highest good and untimely death the greatest
484 evil. ...the worldwide trend toward social organization of health services is also
485 advancement toward a goal of world peace' (Roemer 1976, 13, 14, 283-4)

486 By contrast Odin Anderson's stance was proudly in the centre, and indeed he chided
487 Roemer for the dogmatic assumptions which constrained his social theory. Strategically
488 Anderson asserted the virtues of maintaining a 'low political profile', having seen the attacks
489 on his mentor, Nathan Sinai, by opponents of social insurance (Anderson 1991, 53, 99). For
490 his pains he suffered hostility from erstwhile colleagues when he attracted funding from big
491 pharma, but he weathered this. His argument was that whatever the qualms about one's
492 bedfellows, it was essential to remain squarely in the 'vital center'. Effective change lay in
493 this realm of consensus between liberal and conservative in America's pluralist polity.

494 Publicly Anderson described himself as an 'empirical conservative', in that (*contra* Roemer)
495 he anticipated the survival of a mixed health system in the United States (Anderson 1991, 76,
496 121-2, 131; 1977). For him, what mattered was what worked: there was no perfect system,
497 and the purpose of his research was to ensure that 'all countries can learn from each other'
498 (Anderson 1963, 898). All that said, a posthumous unpublished work reveals that Anderson's
499 conception of the 'vital center' in American politics was somewhat removed from its locus in
500 the Reagan/Bush years. Instead he revealed that his personal political philosophy had been
501 shaped by the liberal values of 1930s New Deal, with its still unmet promise that capitalism
502 'was to be given a "human face"' by the welfare state, and that '... all people should have
503 relatively equal access to health services regardless of financial status' (Anderson 2012, v).
504 Like the two Americans, Brian Abel-Smith was a twentieth-century man whose
505 political consciousness, though formed under postwar affluence, was tinged by an
506 understanding of the effects of poverty and unemployment in the 1930s. His creed was
507 Fabian socialism, that is a commitment to social democracy, to Keynesian economics and to a
508 strong welfare state. As an academic in public life his commitment may be gauged by his
509 refusal of a life peerage and by his long service as an adviser to Britain's Labour
510 governments (Townsend 1996). Prior to the mid-1980s Labour was a social democratic party
511 championing trade union and working-class interests, and Abel-Smith's influence in the late
512 1960s and 1970s lay behind pension, disability and child benefit reform; he also kick-started
513 the process that led to a more equitable resource distribution within the NHS. His later
514 writings suggest that his convictions remained intact, and he described the economic
515 retrenchment under Mrs Thatcher, with its concomitant unravelling of welfare, as a 'return to
516 the failed remedies of the pre-war era' (Abel-Smith 1996, 131). However, like Anderson he
517 had no *a priori* commitment to the superiority of any single health system; each had evolved
518 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 'system' 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

544 resources, and they sought to learn from each other to improve their responses, both at the
545 level of public policy and of practical administration. The desire to foster health services in
546 developing economies was also shared across the political spectrum, and in low-, middle- and
547 high-income countries. Yet it is striking to observe, at least through the prism of the English
548 language literature, that the field had a deeply political inception. This was evident in the
549 early articulators, the discourses through which they framed their ideas and the institutional
550 contexts in which they worked. Social medicine, a key shaping influence, was inherently
551 oppositional in the mid-twentieth century, its advocates situating health services development
552 within a narrative of history as a forward march towards equity and social justice. Such
553 historicism seems jejune in today's intellectual climate, but it was a product of its period, one
554 in which expansive welfare states were integral to the political and economic recovery from
555 world war. Before neo-liberalism this was an arena in which the left and the 'vital centre'
556 could cohere, in Europe and to some extent in America. However, when a global consensus
557 was sought to lift these issues above purely national argumentation it proved challenging.
558 Differing conceptions of the proper roles of state and market, and of the rights and duties of
559 the individual prevented this. Consideration of the discipline's lineage therefore prompts
560 reflection on whether technical questions about health systems, conceived as input, process
561 and outcome, can, or should, ever meaningfully be divorced from those of political
562 philosophy.
563
564 **References**

565 Abel, E.K., E.Fee, T. M. Brown. 2008. Milton I. Roemer, Advocate of Social Medicine,
566 International Health, and National Health Insurance. *American Journal of Public Health*
567 98(9):1596-7.

568 Abel-Smith, B., and R.M. Titmuss. 1956. *The Cost of the National Health Service in England*
569 *and Wales*. Cambridge: Cambridge University Press.
570 Abel-Smith, B. 1963. *Paying for Health Service*s: *a study of the Costs and Sources of*
571 *Finance in Six Countries.* Geneva: World Health Organization.
572 Abel-Smith, B. 1965. The Major Pattern of Financing and Organisation of Medical Services
573 that have Emerged in Other Countries', *Medical Care* 3(1):33-40.
574 Abel-Smith, B. 1967. *An International Study of Health Expenditure and its Relevance for*
575 *Health Planning.* Geneva: WHO.
576 Abel-Smith, B. 1985. Who Is the Odd Man Out?: The Experience of Western Europe in
577 Containing the Costs of Health Care. *Milbank Memorial Fund Quarterly* 63(1):1-17.
578 Abel-Smith, B. 1992. Health insurance in developing countries: lessons from experience.
579 *Health Policy and Planning* 7(3):215-226.
580 Abel-Smith, B. 1996. Poverty in Context – New Thoughts on Old Themes. In *LSE on Social*
581 *Science*, ed.H.Sasson and D.Diamond, 121-33. London: LSE Books.
582 Acheson, R.M. ed. 1965. Comparability in International Epidemiology. *The Milbank*
583 *Memorial Fund Quarterly*, 43(2, Part 2):11-18,261-316.
584 Alcock, A. 1971. *History of the International Labour Organisation*. London: Macmillan.
585 Anderson, O.W. 1963. Medical care: its social and organizational aspect. Health service
586 systems in the United States and other countries. *New England Journal of Medicine* Part I,
587 269(6):839-843; Part II, 269(17):896-900.
588 Anderson, O.W. 1966. Influence of Social and Economic Research on Public Policy in the
589 Health Field: A Review. *The Milbank Memorial Fund Quarterly* 44(3):11-51.
590 Anderson, O.W. 1972. *Health Care: can there be equity? The United States, Sweden, and*
591 *England.* New York: Wiley and Sons.

592 Anderson, O.W. 1977. Are National Health Services Systems Converging? Predictions for
593 the United States. *Annals of the American Academy of Political and Social Science*
594 434:24-38.
595 Anderson, O.W. 1991. *The Evolution of Health Services Research: Personal reflections on*
596 *Applied Social Science*. Oxford: Jossey Bass.
597 Anderson, O.W. 2012. The Politics of the Welfare State as Seen by Wilbur J Cohen. eds.
598 R.Andersen, A.Kohrman, C.Kohrman, American Sociological Association. Available at
599 http://www2.asanet.org/medicalsociology/images/anderson.pdf (Accessed Sept 4 2013)
600 Anon. 1954. The role of the World Health Organization in vital and health statistics. *Bulletin*
601 *of the World Health Organization* 11(1-2): 242–247.
602 Auden, W.H. 1940. September 1, 1939. *Another Time.* New York: Random House.
603 Bevan, A. 1952. *In Place of Fear.* London: Heinemann.
604 Bice, T.W and K.L. White. 1971. Cross-National Comparative Research on the Utilization of
605 Medical Services. *Medical Care* 9(3):253-271.
606 Borowy, I. 2009. *Coming to Terms with World Health, The League of Nations Health*
607 *Organization 1921-1946*. Frankfurt am Main: Peter Lang.
608 Borowy, I. 2004. World Health in a Book – the International Health Yearbooks. In *Facing*
609 *Illness in Troubled Times: Health in Europe in the Interwar Years 1918-1939*, ed. Iris
610 Borowy and Wolf Gruner, 85-127. Frankfurt: Peter Lang.
611 Btesh, S. 1965. International Research in the Organisation of Medical Care. *Medical Care*
612 3(1):41-46.
613 Burdett, H.C. 1893. *Hospitals and asylums of the world. Volume III Hospitals—History and*
614 *Administration*. London: Churchill.
615 Cochrane, A.L. 1972. *Effectiveness and Efficiency. Random Reflections on Health Services*.
616 London: Nuffield Provincial Hospitals Trust.

617 Committee on the Costs of Medical Care (CCMC). 1932. *Medical Care for the American*
618 *People: the Final Report of the Committee on the Costs of Medical Care*. Chicago:
619 University of Chicago Press.
620 Derickson, A. 1997. The House of Falk: the Paranoid Style in American Health Politics.
621 *American Journal of Public Health* 87(11):1836-43.
622 Engel, A. 1968. *Planning and Spontaneity in the Development of the Swedish Health System*.
623 Chicago: University of Chicago.
624 Farley, J. 2008. *Brock Chisholm, the World Health Organization, and the Cold War*.
625 Vancouver: UBC Press.
626 Fee, E. 1996. The Pleasures and Perils of Prophetic Advocacy: Henry E. Sigerist and the
627 Politics of Medical Reform. *American Journal of Public Health* 86(11):1637-1647.
628 Field, M.G. 1973. 'The Concept of the "Health System" at the Macrosociological Level',
629 *Social Science & Medicine*, 7, 763-785
630 Foucault, M. 1977. Niezsche, Genealogy, History. In *Language, Counter-Memory, Practice:*
631 *Selected Essays and Interviews*, ed. D.Bouchard, 139-64. Ithaca: Cornell University Press
632 Fox, D.M. 1983. The Decline of Historicism: The Case of Compulsory Health Insurance in
633 the United States. *Bulletin of the History of Medicine* 57(4):596-610.
634 General Conference of the ILO. 1944. Text of the "Declaration of Philadelphia".
635 *International Labour Review* 50(1):37-39.
636 Gillespie, J.A. 2002. Social Medicine, Social Security and International Health. In *The*
637 *Politics of the Healthy Life: an International Perspective*, ed. E.Rodríguez-Ocaña, 219-
638 39. Sheffield: EAHMH publications.
639 Griscom, J.H. 1861. *Sanitary legislation, past and future: the value of sanitary reform, and*
640 *the true principles for its attainment.* New York: E. Jones & Co.
641 Guérin, J. 1848. Médecine Sociale. *Gazette Médicale de Paris*, 3(11):183-5.

642 International Labour Office (ILO). 1959. *The Cost of Medical Care: Studies and Reports 51*.
643 Geneva: International Labour Office.
644 Kott, S. 2010. Constructing a European Social Model: the fight for social insurance in the
645 interwar period. In *ILO Histories: Essays on the International Labour Organization and*
646 *Its Impact on the World in the Twentieth Century*, ed. J.V. Daele, M. Rodriguez Garcia,
647 G.Van Goethem and M.van der Linden, 173-195. Bern: Peter Lang.
648 League of Nations. 1933. *Quarterly Bulletin of the Health Organisation, Volume II*. Geneva:
649 League of Nations.
650 League of Nations Health Organization. 1926. *International Health Year-Book 1925, Reports*
651 *on the Public Health Progress of Twenty-One Countries*, Geneva: League of Nations.
652 Mabry, J.H. 1971. International Studies of Health Care. *Medical Care* 9(3):193-202.
653 MacBride, D. 1772. *Methodical Introduction to the Theory and Practice of Physic*.
654 London:W.Strahan.
655 McCarthy, T., and K.L.White. 2000. Origins of Health Services Research. *Health Services*
656 *Research* 35(2):375-87.
657 Morris, J.N. 1957. *Uses of Epidemiology*, Edinburgh: Churchill Livingstone.
658 Myers, R.J. 1952. Minimum Standards of Social Security: New International Convention.
659 *Social Security Bulletin* 15(10):3-10.
660 Newsholme, A. 1919. The Historical Development of Public Health Work In England.
661 *American Journal of Public Health* 9(12):907–918.
662 E.Nolte, M.McKee and S.Wait. 2005. Describing and evaluating health systems. In
663 *Handbook of Health Research Methods: Investigation, measurement and analysis,* ed.
664 A.Bowling and S.Ebrahim, 2-43. Maidenhead: Open University Press.
665 Parsons, T. 1951. *The Social System*, New York: Free Press.

666 Political and Economic Planning (PEP). 1937. *Report on the British Health Services* London:
667 PEP.
668 PEP. 1941. Hospitals in War Time', *Planning*, 177.
669 Porter, D. 1992. Changing Disciplines: John Ryle and the Making of Social Medicine in
670 Britain in the 1940s. *History of Science* 30(2):137-164.
671 Riedel, D.C. ed. 1971. Papers from the Workshop on International Studies of Medical Care.
672 *Medical Care* 9(3):193-290.
673 Ringen, K. 1990. Karl Evang: a giant in public health. *Journal of Public Health Policy*
674 (11(3):360-7.
675 Roemer, M.I. 1945. Government's Role in American Medicine, A Brief Historical Survey.
676 *Bulletin of the History of Medicine* 18(2):146-168.
677 Roemer, M.I. 1948. Rural Health Programs in Different Nations. *The Milbank Memorial*
678 *Fund Quarterly* 26(1):58-89.
679 Roemer, M.I. 1956. Medical Care in Relation to Public Health: A Study of the Relationships
680 Between Preventive and Curative Health Services throughout the World. United Nations
681 WHO/OMC/25 & Addenda, Papers of Commission on Medical Care, Volume 2.
682 Roemer, M.I. 1960. Health Departments and Medical Care- A World Scanning. *American*
683 *Journal of Public Health* 50(2):154-60
684 Roemer, M.I. 1969. *The Organisation of Medical Care under Social Security; a study based*
685 *on the experience of eight countries*. Geneva: International Labour Office.
686 Roemer, M.I. 1976. *Health Care Systems in World Perspective.* Ann Arbor: Health
687 Administration Press.
688 Roemer, M.I. 1991. 1993. *National health systems of the world. Vol. I The countries; Vol. II*
689 *Issues.* New York and London, Oxford University Press.

690 Roemer, M.I. 1994. Internationalism in Medicine and Public Health. In *The History of*
691 *Public Health and the Modern State*, ed.D.Porter, 403-23. Amsterdam: Rodopi.
692 Rosen, G. 1947. What is Social Medicine? A genetic analysis of the concept. *Bulletin of the*
693 *History of Medicine* 21(5):674-733.
694 Sand, R. 1952. *The Advance to Social Medicine*. London: Staples Press.
695 Sheard, S. 2013. *The Passionate Economist: How Brian Abel-Smith Shaped Global Health*
696 *and Social Welfare.* Policy Press: Bristol.
697 Walter Suiter, A. 1896. Obiter Dicta Concerning Sanitary Organisation. *Public Health*
698 *Papers and Reports* 22:133–137.
699 Terris, M. 1975. The Contributions of Henry E. Sigerist to Health Service Organization.
700 *Milbank Memorial Fund Quarterly* 53(4):489-530.
701 Tixier, A. 1927. Sickness Insurance at the International Labour Conference. *International*
702 *Labour Review* 16(6):773-803.
703 Townsend, P. 1996. Obituary: Professor Brian Abel-Smith. *The Independent*' 9 April.
704 World Health Organization (WHO). 1946. Constitution of the World Health Organization.
705 Available at http://www.who.int/library/collections/historical/en/index3.html (Accessed
706 Sept 4 2013).
707 WHO. 1952. Medical Aspects of Social Security. *Chronicle of the World Health*
708 *Organization* 6(12):343-46.
709 WHO. 1958. *The First Ten Years of the World Health Organization*. Geneva:WHO.
710 WHO. 1968. *The Second Ten Years of the World Health Organization.* Geneva:WHO.
711 WHO. 2000. *World Health Report 2000. Health Systems: Improving Performance.* Geneva:
712 WHO.
713 Wren, G.R. 1971. *The Health System of Iceland: a brief description and some impressions*.
714 Atlanta: Georgia State University.

715 Zylberman, P. 2004. Fewer Parallels than Antitheses: René Sand and Andrija Stampar on
716 Social Medicine, 1919-1955. *Social History of Medicine* 17(1):77-92