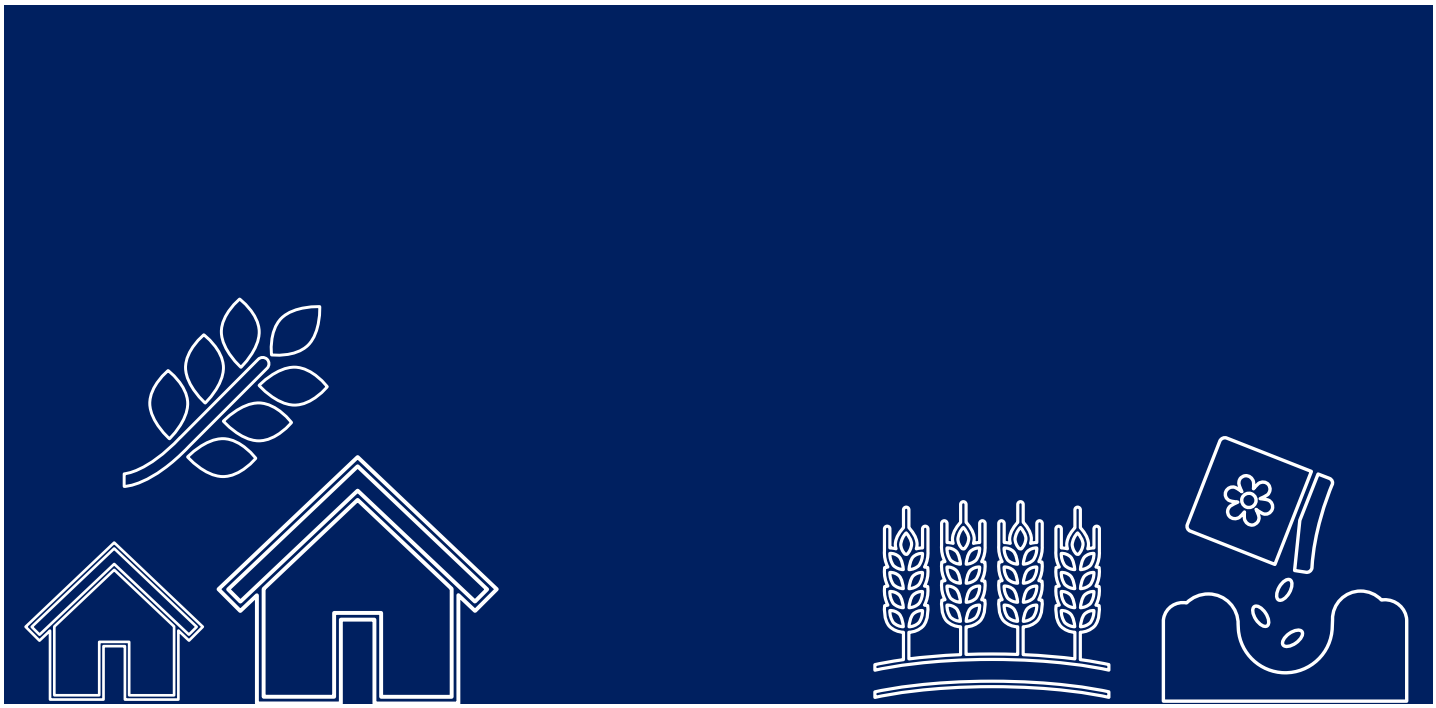
Social medicine as evolving norm in international public health



By Elise Emde

Social Medicine as emerging norm in international public health: A study into the hindrance of social prevention's norm evolvement in the League of Nations Health Organisation as result of the received criticism in the 1930s

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Abstract

Why is social prevention not a norm in international public health? While most view social prevention as a political issue today, it was an emerging norm in the Interbellum due to the social prevention programmes of the League of Nations. However, after World War II, the social prevention programmes were discontinued in the World Health Organisation (WHO). Most scholars have explained this transition by external factors of a changing international context. However, this research paper will argue the criticism the social prevention programmes received during its existence has been overlooked as contributory factor to its discontinuation in the WHO. This research paper will analyse minutes and correspondence of the League of Nations archives to explain what significant criticisms the social prevention programmes have received and what their likely impact was for the lack of social prevention's norm evolvement. The purpose of this research is to open a new research agenda into the social prevention programmes of the League of Nations Health Organisation and the meaning of social prevention within public health.

Keywords: social prevention, international public health, history, the League of Nations Health Organisation

“A place in the sun”

Dr Rajchman in 1934 about the future of social prevention

Dr Rajchman: Director of the League of Nations Health Organisation between 1921 and 1939

Contents

List of abbreviations

FAO	Food and Agriculture Organisation
HC	Health Committee of the League of Nations
	Health Organisation – plenary session
ILO	International Labour Office
League	League of Nations
LNHO	League of Nations Health Organisation

Introduction

I Context

Not many people today would argue social prevention not to be political. Many would even argue it to be a left-wing political issue. However, this was not always the case. Even more, in the Interbellum, social prevention was starting to become a norm within international public health work. At the start of the 1930s, health gained a broader definition as it also considered the social and economic circumstances of health. A broad definition which has mostly disappeared in today's public health systems. Still, more people are starting to realise social prevention could be an important contributor to public health. To understand the potential impact of social prevention as norm in international public health, more research is needed regarding the former international social prevention programmes of the League of Nations Health Organisation (LNHO). These programmes could help us to understand what for impact social prevention could have internationally, as it was a groundbreaking experiment. However, if it was so groundbreaking, how come nobody seems to know about it? This research paper will try to explore the lack of norm evolvement to help to address that question.

The LNHO was one of the technical bodies of the League of Nations that was established in 1920. The League of Nations contained several subsidiary bodies which were established in the covenant of the League. Examples of these organisations were the Economic and Financial Organization, the Communication and Transit Organization, the Intellectual Cooperation Organization and thus the Health Organisation. The mandate of the LNHO was extraordinarily as it focused on social medicine which meant it adopted a broader definition of health, moving away from purely focusing on curing diseases while also considering social and economic contributors of health. Hereby, social medicine refers to social prevention, two terms which will be used interchangeably within this paper. The LNHO's focus on social medicine was neither coherent nor systematic until the 1930s, making social prevention seem to be an odd collection of several fields of work.[1] At the beginning of the 1930s, in response to the Great Depression starting in 1929, the Health Committee (HC) decided to focus more on social medicine. Hereby, the HC refers to the plenary committee within the LNHO where all state representatives and the LNHO staff discussed and voted on all LNHO operations. It was open to all members and met twice per year. They approved the new social medicine programmes at

[1] Iris Borowy, 'The League of Nations Health Organisation: From European to Global Health Concerns?', 2010, https://www.academia.edu/798208/The_League_of_Nations_Health_Organisation_from_European_to_Global_Health_Concerns.

the start of the 1930s, which pushed the broader definition of health,[2] making social prevention an evolving norm over the 1930s within the international community. By the end of the 1930s, social prevention programmes had been established over rural hygiene, housing, nutrition, health during economic depressions and fitness. Unfortunately, the LNHO's activities stopped at the outbreak of World War II (WWII). After the war, the new international health organisation: the World Health Organisation, was established in which the strong emphasis on social prevention had disappeared. Social prevention was not an evolving norm anymore and since then has never properly returned within international public health.

Even though, the strong emphasis on social prevention had disappeared post-WWII, social prevention was still on the agenda of the first couple of World Health Assemblies organised by the WHO. The strong emphasis on social prevention had disappeared as the social prevention programmes were not re-established, however, economic and social circumstances were still considered to be a subset of health.[3] Nonetheless, as the social prevention programmes were not re-established post-WWII, the strong emphasis on social prevention had disappeared, which fully changed the debate over public health. Scholars have proposed several reasons for this shift whereby explanations generally consider the influence of WWII to be the largest variable. Existing literature argues WWII spurred several developments such as a larger need for separation between the political and technical, whereby the functionalist agencies of the newly established United Nations (UN) were supposed to adopt more limited and technical solutions. Historian John Farley has described this technocratic shift as "functionalist experiments – an attempt to separate, if possible, political from functional issues."[4] Otherwise, the fear of many public health professionals was that if a new war broke out, public health work might collapse again. This explanation would assume social prevention had too many political elements, which made a more limited and technical approach impossible.[5] Other examples by academics of explanations for the discontinuation consist of a renewed focus towards cost-

[2] Patricia Anne Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health' (Ohio State University, 2011).
[3] Department of Political Affairs, 'World Health Organization', Item, 31 December 1952, United Nations Archives, https://search.archives.un.org/world-health-organization-14.
[4] S William A Gunn, 'Brock Chisholm, the World Health Organization, and the Cold War', *Bulletin of the World Health Organization* 87, no. 1 (January 2009): 5, https://doi.org/10.2471/BLT.08.057562.
[5] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health', 330.

saving technologies;[6] the lack of legitimacy of social prevention due to fast expansion;[7] and the lack of research funding for social prevention due to adverse incentives.[8]

In sum, a large variety of explanations for the lack of norm evolvement regarding social prevention exist, even while it remains unclear why the programmes were discontinued in the WHO. A likely explanation for the lack of consensus could be the large focus on external circumstances, as the focus in literature was put too often on 'what did not happen', such as a lack of research funding,[9] instead of 'what did happen'. This research paper would suggest the lack of academic literature to focus on the social prevention programmes themselves, thus internal circumstances, to present a clear gap in the literature. Hereby, this paper suggests a crucial dimension of the social prevention programmes has been overlooked, namely: the criticism the social prevention programmes received during its existence. Could this help to explain the discontinuation?

To understand what criticisms of the social prevention programmes could have played a role regarding its discontinuation, a series of letters over the possibility of establishing a new international health organisation near the end of WWII will be used for discussion. The letters are mostly written by Biraud, who was a LNHO statistician, and send to other LNHO officials. These letters provide a unique insight into how the social prevention programmes were perceived at that time, and thus will be incorporated throughout this research. These letters are especially interesting as Biraud later became a founding member of the WHO. In the letters, Biraud also criticises the social prevention programmes, which criticism will be further analysed within this paper.

"The S.G. and myself fully agree that it would be vain to undertake anything without first ascertaining the views of the British authority – Ministry of Health, Ministry of Reconstruction and Town Planning – with regard to the sharing documents and experience with the International Housing Commission or with the National Housing committees through the League Secretariat. We also agreed it would be vain to try and convene the League Health Committee without first ascertaining from its British members their position with regard to the revival of that body and the desirability of taking initiatives to deal with an

[6] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health'.
[7] Jane Lewis, 'The Public's Health: Philosophy and Practice in Britain in the Twentieth Century', ed. Fee Elizabeth and Acheson RM, *A History of Education in Public Health: Health That Mocks the Doctors' Rules*, 1991, 197.
[8] John Duffy, *The Sanitarians: A History of American Public Health* (University of Illinois Press, 1992), 30.
[9] Ibid, 30.

urgent problem – housing- and safeguard the field of international health against encroachments – social medicine."[10]

In the former fragment, Biraud expresses himself negatively over social medicine. First, he terms social medicine as 'encroachments' that international health needs to be safeguarded of. Second, he puts a lot of emphasis on the need to ascertain the views of the British regarding the re-establishment of the Housing Commission and the rest of the social prevention programmes. Third, it is interesting he feels the need to separate the issue of housing from the other social medicine programmes, even though housing also falls under social prevention. How can we explain these three factors? This research paper will further address these questions.

II Research question

This research paper will address how the criticisms of social prevention contributed to its lack of norm evolvement. This leads to the following research question:

> *How can the hindering of social prevention as an international norm be explained by the criticisms the social prevention programmes received during the 1930s as suggested by Biraud, when analysing correspondence and Health Commission minutes of the League of Nations Health Organisation in the 1930s?*

To answer this research question, the following subsidiary questions will be answered:

1) *In what context did the social prevention programmes expand and how was this received within the international community between 1933 and 1939?*
2) *What did the critique of encroachments of the social prevention programmes consist of and what importance can be assigned to the criticism when analysing Biraud's letters?*
3) *In what way could the criticisms discussed in the previous chapters help to understand the hindering of the evolvement of social prevention as international norm, when making use of the norm life cycle model?*

The expectation is that this research will provide an insight into the criticism's the LNHO has received and what role they played in the hindering of social prevention as evolving norm,

[10] United Nations Geneva, 'Health Committee - 32nd Session - Arrangements.', File (United Nations Library & Archives Geneva, 1946), 4, R6029/8A/42877/391, https://archives.ungeneva.org/health-committee-32nd-session-arrangements.

which likely contributed to its discontinuation in the WHO. This thesis will not be able to provide definite answers into why the social prevention programmes were discontinued within the WHO, as that would require further research into the founding of the WHO. Therefore, this research is more exploratory towards establishing a new narrative on why social prevention did not become a norm.

Additionally, this is not a study into the LNHO's intentions regarding the social prevention programmes. Some researchers, such as Sealey,[11] have argued the LNHO to have been politically and ideologically oriented. They argue the 'technical' presentation of the LNHO was merely a tool to legitimise its social prevention agenda. Although, this thesis will not set out to reject the research, it should be noted that the research referred to is based on very little theoretically-sound evidence. Evidence for the claim's rests on research of Patricia Clavin and Jens-Wilhelm Wessels who wrote *"while League officials sought to hide behind the distinction they certainly didn't believe in it",*[12] referring to the distinction between the political and technical. However, Clavin and Wessels research was only conducted on the work of the Economic and Financial Organisation, whereby other scholars provided no evidence for why it would be the same case for the LNHO. Still, as this is a topic deserving of more attention, this thesis will refrain of making comments about intent and focus at what has occurred.

II Historiography

So far, little research has been done regarding the LNHO and its social prevention programmes. An explanation for this is that League's archives were only fully digitised as of October 2022. Before this digitisation project, sources could only be found in hard copy in the Geneva archives. Therewith, the archives are multilingual whereby sometimes no English translation is included, making research harder for some researchers to conduct. This section will discuss existing research on possible factors that influenced the discontinuation of the social prevention programmes within the WHO. As the decision over the discontinuation of the social prevention programmes is used as indication of failed norm evolvement within this paper, the current scholarly debate on the discontinuation is highly relevant.

A common agreement among scholars is the impression that the norm change post-WWII is not a single-factor occurrence but a multi-faceted transition. Therefore, some researchers such

[11] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health'.
[12] Patricia Clavin and Jens-Wilhelm Wessels, 'Transnationalism and the League of Nations: Understanding the Work of Its Economic and Financial Organisation', *Contemporary European History* 14, no. 4 (2005): 482.

as Patricia Anne Sealey, who has done the most extensive research regarding the discontinuation, discusses multiple factors in her dissertation that likely had an influence. For the simplicity of the discussion, the next chapter will discuss several factors separately to understand their rhetoric and likely impact. Hereby, it is important to note that scholars as Sealey will be referred to more often due to her extensive research and as little other academic material is available. The following section will discuss the most explanatory factors so far researched: the influence of WWII; new ways of disease control; the fast expansion of the programmes and the lack of research funding.

After WWII context: towards functionalist organisations

A first explanation refers to the general shift towards functionalist organisations post-WWII. After WWII, a new constellation of United Nations "specialised agencies" was established, where the WHO belonged to, to divide political from functional issues as far as possible.[13] According to Paul Kennedy, these organisations were meant to be *"a multi-legged stool co-equal to prop up international relations without intertwining security and economic concerns."*[14] A similar argument is provided by Sealey. Sealey has argued that the implied shift towards more functionalist agencies was due to frustrations over political interference during the start of WWII. She argues that even though the LNHO had tried to be a 'technical' platform next to the politically struggling League at the end of the 1930s, this pretence had become impossible to uphold. States were withdrawing from the League and its technical subsidiaries; epidemic intelligence was considered as a military secret and the Office International d'Hygiène Publique was charged with a Nazi observer. All this led to public health workers advocating for a separation of their work from politics, which sentiment stayed after WWII and according to Sealey stimulated the shift towards a more functionalist approach in the WHO.[15]

The newfound ability to control disease' through magic bullets

Another explanation for the disappearance of the focus on social prevention could be the shift to faster and cheaper ways of disease eradication. Sealey argues the newfound ability to control diseases through 'magic bullets' could partly explain the shift from preventive measures towards more limited technical solutions. Suddenly, after WWII, single

[13] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health', 298.
[14] Paul M. Kennedy, *The Parliament of Man: The Past, Present, and Future of the United Nations* (Random House, 2006), 32.
[15] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health', iii.

technologies as DDT, antibiotics and the smallpox vaccine could cure, prevent and eradicate diseases. In this way, diseases could be cured faster and cheaper, turning away attention of the more expensive method of social prevention while moving to a more technical and limited definition of health.[16]

A fast-expanding project

Others argue that public health efforts tend to collapse whenever claims of expertise are stretched too far. In the case of the LNHO, they vastly expanded their social prevention programmes at the beginning of the 1930s in response to the difficult social and economic circumstances caused by the Great Depression. In a couple of years, the LNHO had gone from a social prevention focus on rural hygiene to more extensive programmes also focusing on nutrition, the consequences of the Great Depression on living conditions, fitness and housing. The social prevention programmes were created next to the work done on disease control, biological standardisation and even mother-and-child-welfare. The vast expansion of programmes possibly made it hard to claim any legitimacy at all.[17] While this theory provides a logical argumentation of why the LNHO could not have had legitimacy regarding social prevention, it still only provides us with a broad characterisation of a common issue in public health work. To test such theory, more solid research would need to have been done regarding the LNHO and its social prevention programmes.

A focus on externalities

Other researched factors with a likely effect are the general lack of organisational power post-WWII in public health and the medical research funding that would only go to measurable projects, as argued by Duffy.[18] While all the factors above could certainly explain parts of the lack of social prevention evolvement, they share a commonality: most research only discusses possible external influences on the discontinuation of the social prevention programmes. Thus, most explanations focus on what did not happen instead of what did happen (and what possibly went wrong) within the social prevention programmes. Furthermore, research suggesting internal affairs of the programmes to have played a role are often not well substantiated with evidence, such as the claim of social prevention as political endeavour.[19] Meanwhile, this research paper will argue that not only external influences

[16] Ibid.
[17] Jane Lewis, 'The Public's Health: Philosophy and Practice in Britain in the Twentieth Century', 197.
[18] Duffy, *The Sanitarians*, 294.
[19] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health'.

contributed to the end of the social prevention programmes, but that the decision was also likely influenced by the internal affairs of the programme, namely the criticism it received. Suggesting the development was more of a conscious decision by international public health professionals than suggested by scholarly literature.

III Methodology and sources

To answer the research question, I have analysed all minutes of the Health Commission (HC) plenary meetings and bureau meetings between October 1932 (19th HC session) till the last emergency meeting in March 1940. In total, I have analysed the minutes and reports of thirteen HC plenary meetings, seven bureau meetings and one emergency HC meeting right after the start of WWII. In the same primary source collection, I have also analysed the preparations for the 32nd session, containing the letters of Biraud in 1945. All these documents can be found in the online United Nations Library & Archives Geneva, under collection number R6015-R6029/8A/391. These documents have proven very insightful for understanding the dynamic of the committee and to provide more comprehensive examples for the criticisms portrayed by Biraud. Further, to understand the dynamic between the LNHO and individual national health administrations, I have also analysed correspondences between the LNHO with National Health Offices. These can also be found online in the United Nations Library & Archives Geneva under catalogue number R6069/8A/1263. To limit my research, I have only fully read the correspondences with the European health administrations. This would be justified for my research for two reasons. First, the HC minutes have illustrated pre-dominantly the European countries played a large role during the minutes, also confirming other scholars that the League of Nations was quite Eurocentric.[20] Second, after reading twenty correspondence series (France, Belgium, Bulgaria, Germany, Czecho-Slovak (pre-1939), Slovakia (after April 1939), Denmark, The Netherlands, Greece, Italy, Norway, Poland, Romania, Scotland, Spain, Sweden, the United Kingdom, Hungary, Switzerland and Yugoslavia) it became clear that the correspondence series were in general not very insightful. The only interesting findings provided more information over issues already discussed during plenary meetings. Thus, as general rule, if there was nothing interesting during a plenary meeting, there was also nothing interesting in the correspondence.

[20] Klaas Dykmann, 'How International Was the Secretariat of the League of Nations?', *The International History Review* 37, no. 4 (2015): 721–44.

The correspondence was both in English and French. As I can read English well and can also understand French well, sometimes with the use of a dictionary, I was able to do the research. Two remarks should be made about my sources. First, some quoted fragments in this research paper are translated from French to English. As, I have translated them myself, I have added the original texts in the footnotes. Second, while my document series are quite large in terms of pages, it should be noted that often minutes or reports had multiple translations in one data set. Thus, often it occurred that one set of minutes of for example, 30 pages, would be put as English draft, French draft, English official version, and French official version in one PDF, which makes up for 120 pages even when I only needed to read 30. Further, I only scanned the documents for all relevant information regarding social prevention as my research does not focus on the rest of the LNHO's activities.

For methodology, I used discourse analysis to analyse all documents. While reading, I looked for critical (negative), enthusiastic (positive) and/or neutral language regarding the social prevention programmes. Next, I grouped all criticising language on the social prevention programmes while trying to contextualise. This left me with two large criticisms (British position and encroachments) that I later found were also discussed in Biraud's letter in March 1945. Further, I also collected all the positive language regarding the social prevention programmes which I have also incorporated in my chapters to nuance the research and present a more just image.

For my research, I consciously choose not to go too much in depth regarding specific programmes. The intention of this research paper is solely to outline the broader trends of the social prevention programmes to understand what has happened and what went wrong. Therefore, I decided to discuss the social prevention programmes but more regarding their general mistakes and differences. Lastly, should be noted that while I have analysed a lot of primary sources, little sources went in depth over the criticisms researched. Even though, I would have liked to have provided more examples of encroachments, British critiques, etc. These simply did not exist in the sources. Thus, the research has become more exploratory to try to understand what happened with often little information available.

IV Structure

The first chapter will discuss the expansion of the social prevention programmes during the 1930s, whereby social prevention became an evolving norm. It will discuss the British criticism in response to social prevention as evolving norm and balance it against the general

positive opinion of the HC. The second chapter will discuss and contextualise the criticism of encroachments. It will suggest Biraud's reference to 'encroachments' implies the encroachments by the LNHO upon other international institution's responsibilities. The criticism of encroachment leaves a breadcrumb trail throughout the HC minutes and are likely the largest critique to social prevention. This critique will be contextualised and nuanced by using Biraud's letters. Chapter three starts by discussing a model of norm evolvement: the norm life cycle, by Finnemore and Sikkink. Consecutively, the chapter will place the critique of the British and encroachments within the norm life cycle model to determine their likely significance. It will argue the critique of encroachments, as part of miscoordination, to have likely led to a loss of credibility of social prevention as norm, which has led to the selective adoption of social preventive measures by other institutions. Lastly, a new research agenda will be proposed.

1. Social prevention as evolving norm

This chapter discusses in what context social prevention became an emerging norm in the 1930s and how this was received and possibly criticised within the international community. It should be noted that the following chapter highlights the HC member's opinions as predominantly HC plenary session minutes will be used as primary sources. The chapter will also highlight the role of the British as mentioned in Biraud's letters.

1.1 A broader definition of health

To explain the norm emergence of social prevention, it is important to consider how the social prevention programmes started. The social prevention mandate of the LNHO was created at the establishment of the League's Health Section in 1921 by the LNHO director, Dr Rajchman. Rajchman established social preventive measures as he tried to establish a gradual change in public opinion regarding medico-social protection. Especially, during those beginning years, the studies conducted were seen to be quite ineffective and limited. The limited scope of the social prevention programmes was explained by Rajchman during the 30th session as a consequence of the little interest by states at that time in preventive measures, as the public opinion did not consider its benefits yet.[21] During the 1920s, the only promising study regarding social prevention had been on Rural Hygiene.

Nonetheless, at the beginning of the 1930s, a proposal followed for the expansion of the social prevention programmes. A variable proposed for this change by the LNHO itself was the shock of the Great Depression. The economic shock of the Great Depression started in 1929 in the United States and spread throughout the rest of the world, especially greatly affecting the rest of the industrialised world. The economic downturn that arose due to the Great Depression lasted throughout the 1930s, until the outbreak of WWII. The new worsened economic reality led to the fear in the board of the Health Committee that health would be greatly affected by the depression. This led to the proposal of a study into the conditions of health during an economic depression by M. Cahen Salvador who was the President of the Conference of Experts within the LNHO and M. Tixier who was the representative of the ILO, during the 20th session in 1933. The study presented a new

[21] United Nations Geneva, 'Health Committee - 30th Session, 4 to 6 May 1939 - Minutes.', File (United Nations Library & Archives Geneva, 1939), 55–56, R6028/8A/38097/391, https://archives.ungeneva.org/comite-dhygiene-30eme-session-4-au-6-mai-1939-proces-verbaux.

collaboration between the LNHO and ILO and highlighted as well curative as preventive medicine. Salvador stated that he wanted to take more direct action in the field of social prevention due to the ongoing economic pushback of the Great Depression, while he suggested a direct correlation between the Great Depression and health. He argued the study into the effects of the Great Depression on living conditions would 'retain its topicality' but there was too little time to wait for public opinion to change in its favour, it needed to be implemented now. His idea was to think of very practical ways of improving living conditions.[22] Experts would then create recommendations for improving living conditions and countries were able to choose whether to implement them or not. One of these practical solutions was for example sickness insurance, which was also an issue of great importance to the ILO.[23]

Nonetheless, the discussion also hinted towards a more philosophical discussion over what health should be. Léon Bernard as representative of France replied to Salvador's plea by stating that in France, the crisis had so far not led to a reduction in public expenditure and thus to a deterioration of health. He questioned whether the need for social prevention was not rather a social evolution of humanity. While highlighting the voluntary character of states to comply to the study, he stated that it was the moral obligation of the HC to help when countries desired it.[24] He continued to argue that while the development of social medicine had started in the United States, awareness had now finally been created in France. He phrased the new development of preventive medicine as: *"if we want to inspire the physician of the future with the spirit of preventive medicine, this spirit must be taught to him in all forms."*[25]

The study into the worsening of living conditions due to the Great Depression also highlighted the importance of other social factors such as housing and nutrition, as the study considered all these factors. For example, the report on the changed living conditions in times of depression started by highlighting the tuberculosis case, which was considered a social disease. Epidemiology and statistics suggested the mortality rate of tuberculosis started to decline in European countries even before it could be scientifically cured. Advances in social

[22] United Nations Geneva, 'Health Committee - 20th Session, 10-15 October 1933: Documentation.', File (United Nations Library & Archives Geneva, 1933), 34–37, R6015/8A/7256/391/Jacket1, https://archives.ungeneva.org/health-committee-20th-session-10-15-october-1933-documentation.
[23] Ibid, 39.
[24] Ibid, 43-44.
[25] Ibid, 18. Original text (French): *Si l'on veut imprégner le médicin de l'avenir de l'esprit de la médicine préventive, il faut que cet esprit lui soit enseigné dans toutes les chaires.*

medicine and hygiene had accelerated this decline. Therefore, the report argued we should not lose sight of social factors such as food, housing and education.[26] In this way, the report on the living conditions caused by the Great Depression spurred interest in housing and nutrition programmes as its relevance was clearly suggested. This increased interest led to the creation of a programme in nutrition, housing and fitness in 1933. The goal of these programmes was to deliver practical and objective suggestions to states. The establishment of these new programmes will be considered the start of social prevention's norm evolvement in the international community, as the establishment of the new programmes portrays an increased interest in social prevention within the Health Committee.

1.2. Shouting into the wind: United Kingdom

So far, a relatively positive image has been provided on the rise of the social prevention programmes. However, the expansion of the social prevention programmes was also criticised, predominantly by the United Kingdom. While the position of the British was also highlighted in the letters of Biraud, it is important to understand the British critique and the support it received. The British critique on the social prevention programmes mainly concerned the HC's proposal during the 20th HC session over the studies on the improvement of living conditions during the Great Depression. While most member states had expressed their content to the study on living conditions during a depression, Sir George Buchanan as representative of the UK disagreed. Buchanan held a speech stating that he felt the economic depression to be a false preconception by the LNHO to establish new social prevention studies.[27]

Buchanan argued that while the UK had always been supportive during the 1920s over social prevention, while they participated in the exchange of information regarding social prevention, the UK was not supportive of the expansion of the social prevention programmes. They viewed the current request of the LNHO for the expansion of research into health and the economic depression as illegitimate. Buchanan believed it to be a study into the healthcare systems of the future, falsely presented on economic grounds.[28] He continued his speech by stating that he viewed the participants of the committee to be *'practical spirits'*, whereby he meant that their practicality made them willing to help people even if it meant they did not have the legitimacy to do so. Ultimately, the depression had offered the

[26] Ibid, 678.
[27] Ibid, 48.
[28] Ibid, 48.

'practical spirits' a pretext for expansion. If the committee was indeed concerned with the mapping of future health systems and used the economic circumstances as an excuse, he would never have agreed with the studies initially.[29]

To support his argumentation, Buchanan used the UK as a case study to illustrate the economic depression did not greatly affect health as stated by reports in the UK, which undermined the LNHO's expansion in his eyes. These reports showed that while the national health administration in the UK had shrunk, it did not lead to a worsening of healthcare. The economic depression could according to him be in no way linked to bad health. Even the suggestion of the linkage between health and the economy had angered diverse administrations in the UK. The Italian and Belgian health administration representatives agreed. They stated during the HC session that health also did not seem to be directly related to bad economic circumstances in their countries. Thus, they agreed with the UK that the use of the Great Depression as legitimisation for new social prevention studies was regrettable.[30]

However, while Buchanan briefly enjoyed the support of Italy and Belgium during his speech, the support appeared to have been out of place. Buchanan continued to offer critique on the social prevention programmes and questioned whether the LNHO was able to determine the appropriate course of action regarding healthcare implementations. He even suggested another (national/international) institution could support the LNHO to determine an appropriate course of action. Lastly, he questioned whether the technical reports written by experts had been open to political views instead of technical ones, as he was not sure whether other states had the opportunity to critique the reports. As Buchanan's statements became more distrustful, Italy and Belgium quickly withdrew their support to him. The Italian and Belgium representative observed they only had agreed to the suggestion that health in their respective countries was not worsened yet by the economic circumstances. Besides this observation, they fully agreed to the work of the medical director and the establishment of the new social prevention programmes. They felt Buchanan had misallocated their statement before.[31]

The strong accusations of Buchanan regarding social prevention had by that moment irritated the director of the LNHO who started to openly criticise Buchanan for his insinuations. The LNHO director stated the UK had supported other similar studies into the relationship

[29] Ibid, 48.
[30] Ibid, 49.
[31] Ibid, 49-52.

between the economy and living condition within the ILO in 1927. The only difference now was that the study focused on the Great Depression. Still, the director argued the UK to be inconsistent as they did not have any complaints back in 1927.[32] Accordingly, the director argued that in response to Buchanan's earlier request to withdraw the report on the relationship between health and the economic consequences of the Great Depression, the board of the HC had seriously considered doing so. The board of the HC believed that if the committee did not agree to the study, it would be important not to distribute the report any further. The HC board agreed to conduct a vote during the next plenary session. If a unanimous vote was conducted during the plenary session stating the report should be withdrawn, the report would indeed be withdrawn by the board. However, during the plenary session, the UK had clearly been the only member opposing the report. Thus, the report would be circulated. The director's words soothed Buchanan's expressed irritation. Buchanan closed off by saying that he did not have uncertainty over the intentions of the committee or its capabilities, this had also not been his intention with his speech. He argued he had tried to caution the committee on starting work they were not equipped for, thus social prevention.[33]

After the incident, Buchanan remained a respected member of the committee. During the rest of the 20th session, other states offered their sympathy to the social prevention endeavours of the LNHO and discussed their importance. For example, the French argued they would be able to learn in terms of social security and the Germans could learn what social preventive measures could benefit them.[34] Did this imply social prevention further evolved as a norm?

1.3. An evolving norm of social prevention

After the 20th session in October 1933, the expansion of the social prevention programmes was further discussed, in which a growing positive sentiment existed on social prevention. What did this positive sentiment consist of? This section will discuss the norm evolution of social prevention during the 1930s after the 20th session. To explain the norm emergence of social prevention, it is important to discuss: the ongoing changing definition of health; the normalisation of social prevention as practice; and social prevention when the League fell apart.

First, after the 20th session over the expansion of the programmes, social prevention got more accepted and integrated into the international political community's definition of health. No

[32] Ibid, 53.
[33] Ibid, 48-55.
[34] Ibid, 48-55.

large discussion on the desirability of the broader definition of health, which included social prevention, occurred after the 20th HC plenary session in 1933. Even more, the support for the social prevention programmes grew stronger. The growing support for the programmes could be seen in two developments. First, while the linkage between the economic backlash of the Great Depression and health had been disputed by the UK, Italy and Belgium in 1933, two years later the narrative had changed. In October 1935 during the 22nd session of the committee: Denmark, France, Hungary, Mexico, Poland, Venezuela and even Italy had drawn attention to the close interrelation between health and the economy whereby they emphasised the importance of the studies done on these issues, especially regarding nutrition and housing.[35] The acceptance of social prevention as an approach to health in uncertain times seemed to have been caused by a growing awareness of states that investing in health in times of economic depression was important. Second, sometimes members of the HC even had asked the committee to expand its number of social prevention programmes, to tackle more issues regarding social prevention. For example, at the 21st session in May 1934, Dr Husamettin, who was the state secretary of Turkey, thanked the committee for the invaluable work on social prevention it had offered. While he understood the primary focus on rural areas[36], he still asked whether the preventive work could be expanded to trachoma.[37] Even though, work on this was already being done in the Netherlands meaning a LNHO's programme was not desired, it is a clear example of the desirability of social prevention at that time and the renewed definition of health.

Second, notable after the 20th session of the HC, is a normalisation of social prevention that occurred, which contributed to social prevention becoming an emerging norm. Two examples of this normalisation can be provided. A first example of normalisation can be seen in the 23rd HC session minutes in April/May 1936 whereby Dr Parisot, as president of the HC, had made an interesting reference as he had observed teachers started to normalise social medicine. He stated that besides professors in rural hygiene, professors from other fields of study also showed an increased interest in social prevention, whereby they started to include

[35] United Nations Geneva, 'Health General - Hygiene Committee - 22nd Session, October 1935, Documentation (English Texts).', File (Geneva: United Nations Library & Archives Geneva, 1935), 592, R6018/8A/19264/391/Jacket3, https://archives.ungeneva.org/health-general-comite-dhygiene-22eme-session-octobre-1935-documentation-textes-anglais.

[36] During the 1920s the focus of social prevention within the LNHO had been hygiene within rural areas, which was before the expansion of social prevention programmes.

[37] United Nations Geneva, 'Health Committee - 21st Session, 11-14 May 1934: Documentation and P.V.', File (United Nations Library & Archives Geneva, 1934), 53, R6016/8A/10469/391/Jacket1, https://archives.ungeneva.org/health-committee-21st-session-11-14-may-1934-documentation-and-p-v.

social medicine more in their teachings. He also observed teachers of hygiene would cooperate more often with teachers of other fields of study, which suggested joint efforts could be achieved.[38] In reaction to Parisot's observation, Sir George Newman (UK) even stated that "*the spirit of social prevention should penetrate into all medical studies".*[39] A second example, occurred on the 26th of April 1937 in the 25th session during the discussion about a collaboration agreement between the LNHO and the ILO. The president of the HC committee stated that *"it becomes increasingly recognised that the general health in a country depends on its economic and social circumstances",* which statement was supported by all parties present.[40] These are only two examples of a broad trend in the HC plenary session minutes of increasing positive and normalising language regarding social prevention. This would suggest social prevention enjoyed broadening support and normalisation, which suggests socialisation and growing acceptance of an emerging norm.

Third, while the League went into decay due to rising global political tensions, the support for social prevention and the technical LNHO as a non-political meeting ground remained. This underlines social prevention and other programmes of the LNHO to have enjoyed more support than the League received in those years, disassociating its success from that of the League. Over the 1930s, the League had grown weaker as it became more susceptible to global tensions that would lead to WWII in September 1939. The decay of the League could be noticed in HC minutes over the 1930s, as representatives needed to withdraw from the LNHO as their states had already withdrawn themselves from the League. Some representatives stayed with the LNHO even though their states had already withdrawn themselves from the League, as the LNHO was considered an ideal and technical meeting ground away from the political League. For example, Japan already had withdrawn itself from the League in March 1933, while they remained a member of the LNHO due to their value for the technical work done, especially regarding social prevention. Nonetheless, by May 1939 during the 30th session, Dr Tsurumi who was the representative of Japan had to

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[38] United Nations Geneva, 'Health Committee - 23rd Session (29 April - 2 May 1936) - P.V. [Proces-Verbaux] Texts.', File (United Nations Library & Archives Geneva, 1936), 28, R6020/8A/24142/391, https://archives.ungeneva.org/health-general-health-committee-23rd-session-29-iv-2-v-36-p-v-proces-verbaux-texts.

[39] Ibid, 28. Original text in French: *"Comme le disait Sir George Newman, l'esprit de la medicine préventive doit pénétrer tout l'enseignement de la médicine."*

[40] United Nations Geneva, 'Health General - Health Committee - 25th Session, 26th April 1937 - P.V. [Proces-Verbal] Texts.' (United Nations Library & Archives Geneva, 1937), 138, R6023/8A/30054/391, https://archives.ungeneva.org/health-general-health-committee-25th-session-26th-april-1937-p-v-proces-verbal-texts. Original text in French: "On reconnaît de plus en plus que l'état sanitaire d'un people depend de ses conditions économiques et sociales."

withdraw from the LNHO under Japan's pressure. He expressed his remorse for leaving, especially as he had initially wanted to develop the social prevention programmes further.[41] Tsurumi's remorse was not a unique case as many representatives obliged to leave the LNHO had expressed such sentiment. Most often, social prevention was mentioned as regret not to be able to continue.

The moment Tsurumi resigned, Jacques Parisot the sitting president of the committee, held a speech on the suffering of the LNHO as a technical meeting ground for states. Parisot observes: "*without doubt the League of Nations was traversing a difficult period; although the Health Organisation was above party and, because of its technical character and its objects, should have continued to provide an ideal meeting ground, nevertheless it had suffered."*[42] By the former statement, Parisot confirms the suggestion that the LNHO held another, more technical, position compared to the League. He continues: *"The committee had lost some of its members, who found themselves compelled, or felt themselves bound, to cease their collaboration; yet it was an interesting fact, which deserved notice, that the four countries that had most recently withdrawn from the League had all explicitly stated their intention of continuing to participate as fully as in the past in the work of the League's technical organisations."*[43] This observation of Parisot on LNHO as technical and ideal meeting ground for states, supports the belief that the LNHO, and also its social prevention programmes, were seen as technical and valuable programmes by many independently of the League's success.

Thus, this section has illustrated the social prevention programmes to become more normalised in the international community whereby its norm evolvement stood relatively independently of the League's success.

[41] United Nations Geneva, 'Health Committee - 30th Session, 4 to 6 May 1939 - Minutes.', 54.
[42] Ibid, 56–57.
[43] Ibid, 56-57.

2. Encroachments upon other institution's responsibilities

This chapter will discuss what the critique of encroachments existed of and what importance can be assigned to them in the context of Biraud's letters. For primary sources, use will be made of LNHO correspondence series with national health administrations, HC plenary session minutes and Biraud's letters of the 1930s.

Biraud's letter have proposed 'encroachments' as a criticism to social medicine as he states in a letter to Gautier of the LNHO on the 15th of March 1945 they need to *"safeguard the field of international health against encroachments – social medicine*."[44] Another letter of Biraud provides an insight into the nature of the encroachments as he states: *"It is not sufficient either, to ensure that the field of activity of the future international health organisation is preserved from undue encroachments; proper allotment of work or collaborations with other organisations should be established."*[45] This statement would suggest encroachments likely followed from the lack of proper collaborations with other organisations.

This chapter will explain Biraud's critique of encroachments as encroachments upon other international institutions responsibilities. It will argue that overlapping responsibilities combined with miscoordination led to encroachments that were worrisome for the international community. While the issue of encroachments had not been unique to social prevention, the social prevention programmes seemed the most susceptible to encroachments which led to large critique, especially regarding nutrition. The chapter will start by contextualising the overlapping responsibilities; explain how overlapping responsibilities led to encroachments; explain what type of encroachments occurred and close off by contextualising their significance. Use will be made of Biraud's letters, HC session minutes and correspondence between the LNHO and national health administrations.

2.1 The need for coordination due to a broader definition of health

It is important to understand the context wherein the criticism of encroachments developed. As this section will argue encroachments were possible due to overlapping responsibilities, it is first important to explain the context of overlapping responsibilities. Overlapping responsibilities existed between the LNHO and other international institutions, especially regarding social prevention. The existence of overlapping responsibilities with other

[44] United Nations Geneva, 'Health Committee - 32nd Session - Arrangements.', 4.
[45] Ibid, 7.

international institutions can directly be traced to the broader definition of health the LNHO adopted during the expansion of the social prevention programmes.

The broader definition of health had made cooperation with other institutions inevitable, as social and economic issues crossed with other international institution's responsibilities. Parisot the chair of the HC explained at the 28th session of the HC that the newly adopted definition of health led to the necessity of the LNHO to stay in close contact with other international institutions. He observed the broader definition of health, whereby the medical and social aspects of health could no longer be disassociated – led to a broader focus of the HC to improving the environment of people. A focus on improving the environment meant to also consider improving economic, social and labour conditions. This broader definition, according to Parisot, led to the steps taken by the Health Organisation to remain in close contact with both the competent technical sections of the League and the ILO.[46] Later, cooperation would also be extended to other institutions such as the FAO.

In the beginning, the HC had expressed themselves positively over the new collaborations. Parisot continued to express his satisfaction during the 28th session on the committee's convincement over the importance of establishing close liaisons with other competent bodies. Nonetheless, Parisot emphasised that if results needed to be achieved, definite demarcated lines needed to be established between different institutions to prevent programmes from overlapping. For example, he referred to the firm agreement the ILO and the LNHO established and emphasised new collaborations would require a similar agreement. The rest of the HC agreed to Parisot his comments. Proper public health work seemed ensured by co-ordinating all services, whereby coordination between organisations was seen to be critical.[47]

What coordination was needed? Dr Rajchman as Director of the LNHO explained during the 28th session what coordination with other institutions was established on social prevention. The nutrition programme was considered to have a physiological, social and public health dimension. Research on nutrition occurred among different subsidiaries of the League, and further coordination of services was established with the FAO. The housing programme had tried to establish demarcated limits with other institutions. Research into housing was done by the Economic Organisation, the Financial Organisation, the ILO and to a certain extent by

[46] United Nations Geneva, 'Health Committee - 28th Session, 30 June to 4 July 1938 - P.V. Texts [Minutes].', File (United Nations Library & Archives Geneva, 1938), 26–28, R6026/8A/34747/391, https://archives.ungeneva.org/health-committee-28th-session-30-june-to-4-july-1938-p-v-texts-minutes.
[47] Ibid, 26-28.

the Social Questions Committee. When the studies would be completed, they would all be co-ordinated. Physical fitness was still in its preliminary stage, research into whether coordination was required still needed to be explored.[48]

A fear for overlapping responsibilities

The need for coordination between the overlapping responsibilities was often emphasised during HC plenary session by the LNHO staff as well as by the national representatives. Although parties agreed coordination was crucial, a growing fear developed for overlapping responsibilities and miscoordination. The Medical Director of the LNHO clearly expressed this fear during the 21st HC session between 11 and 17 May 1934. Buchanan of the UK had observed the LNHO's working programme for the coming years overlapped with other institution's programmes, especially regarding the ILO. In response to this statement, Dr Boudreau of the LNHO stated that the Medical Director was indeed concerned about overlapping responsibilities with other institutions as he stated to have *"constant anxiety to avoid any overlapping by means of close co-operation with international organisations"*.[49] This fear for overlapping responsibilities reemphasised the need for close co-operation between institutions and the demarcation of responsibilities in programmes for collaboration.

2.2 Miscoordination: from overlapping responsibilities towards encroachments

While the LNHO had clearly expressed the need to strongly demarcate responsibilities during close cooperation with other international institutions, this turned out to be harder than expected. Dr Rajchman observed during the 24th HC session in February 1937 that cooperation with the ILO had been more troubling than expected, whereby overlapping interests were seen to be at the root of the issue. In support of his observation, he provided the HC with an example of experienced difficulties during the Conference on Rural Hygiene. While the HC's expectation had been the conference to consider the labour conditions in agriculture, the ILO had reserved the right to study this question. The ILO had briefed the LNHO that they did not enjoy any rights to research the labour conditions in agriculture. Nonetheless, the ILO promised they would provide all necessary information to the LNHO after finishing their own research. The inability for the LNHO to study the labour conditions in agriculture even though it was desired, illustrates the existence of overlapping interests and

[48] Ibid, 26-28.
[49] United Nations Geneva, 'Health Committee - 21st Session, 11-14 May 1934: Documentation and P.V.', 85.

provides an insight into tensions over coordination.[50] Still, even though this case could help to understand the tensions over coordination, it is no example of an encroachment. In contrast, a couple of years later, it was perceived by HC members that too many encroachments had occurred. In the 30th session by May 1939, Surgeon-General Cumming as representative of the United States and vice-president of the HC had noted that *"any further encroachment upon the autonomy of the Health Organisation would be inexpedient and might perhaps create an unfavourable impression."* He then stated that the former statement *"was not only his personal view, but one shared by many others in his own country."* By these statements, Cumming tried to illustrate any further encroachments were not desirable in his eyes or in his country's eyes. What did this shift from overlapping responsibilities to a large number of encroachments look like?

Nutrition

An example of overlapping responsibilities towards encroachments can be found in the portfolio of nutrition. In the minutes of the 25th HC plenary session can be seen the LNHO staff believed the nutrition programme to be very susceptible to encroachments, as the records state: *"the problem of nutrition was a striking example",* referring to the number of encroachments.[51] Also, the letters of Biraud suggest nutrition to be a programme wherein many encroachments occurred, as suggested in the introduction. What do the minutes and correspondence between the LNHO, and national health administrations suggest on the occurred encroachments within the nutrition portfolio?

Before discussing the nature and type of encroachments in the field of nutrition, it is important to provide a brief disclaimer. While evidence suggests that the LNHO staff believed the nutrition portfolio had the largest number of encroachments, this is hard to prove due to limited examples provided within the HC minutes and correspondence. While no comprehensive documentation exists regarding the number of encroachments that occurred, this research has tried to use LNHO's staff quotes to support the argument that nutrition had the highest number of encroachments, whereof Biraud's letters and the minutes terming nutrition 'a striking example' are an example.

[50] United Nations Geneva, 'Health General - Health Committee - 25th Session, 26th April 1937 - P.V. [Proces-Verbal] Texts.', 333–35.
[51] Ibid, 333.

As an example of an encroachment on the nutrition portfolio, the issue of food fraud should be discussed. Minutes of the 30th session of the HC in May 1939 will be used for discussion. During the 30th session, a discussion started over the subject of fraudulent practices in connection with food, as part of the nutrition programme. Dr Gautier of the LNHO explained the Economic Committee had in June 1937 asked to do a study on fraudulent practices in connection with food. In 1938, the HC had adopted a resolution asking the Director of Health of the LNHO to collect documentary material about the different countries' regulations of force directed at the protection of public health against fraud and the actual efficacy of those regulations. The HC proposed based on those results what further steps, if any, might be taken. The HC consulted nineteen governments regarding their regulations, whereof eleven replied. However, the replies were too varied, making general conclusions impossible. It seemed necessary to limit the scope of the problem and to decide the extent to which such enquiry fell within the LNHO's scope. In response to the research, Dr Goodman, as representative of the UK, commented the initial lack of enthusiasm he had for this research was now shared by others. He observed national laws were adequate to deal with food fraud and suggested no compelling evidence for international action existed. The issue of food fraud was of great importance, but investigations of the LNHO never went further than the statistical stage, whereby no evidence suggested the research would contribute to less fraud. Ultimately, Goodman argued the question of food fraud fell outside the HC's scope and inside the scope of the Economic Committee. The HC's president and vice-president supported Dr Goodman's views and halted the study into food fraud, it would not be continued. Nonetheless, the study into food fraud could be seen as an example of an encroachment of the LNHO into the Economic Committee's responsibilities.[52]

2.3 The nature of the encroachments: miscalculations and the case of Belgium

Nonetheless, when considering a perceived pattern of encroachments by HC members, it is important to get a better sense of how they occurred. This research would suggest encroachments were likely due to failed planning and thus miscoordination. It would suggest the broader definition of health together with a lack of communication and well-communicated institutional demarcations led to a pattern of miscoordination. In that way, encroachments could be seen as a consequence of miscoordination.

[52] United Nations Geneva, 'Health Committee - 30th Session, 4 to 6 May 1939 - Minutes.', 71–72.

The previous example of food fraud presented an encroachment by the LNHO on the Economic Committee's responsibilities. Nonetheless, it is also important to consider a case where the LNHO was accused of encroaching upon other's responsibilities even while this was not directly the case. This case study concerns Belgium, where a political debate in the Senate had sparked due to a proposal for increased collaboration with the LNHO. To explain what happened, use will be made of the 27th HC session minutes and correspondence between the Belgian Ministry of Health and the LNHO.

By February 8th, 1938, during the 27th session, René Sand of Belgium presented a request. The Belgian Ministry of Public Health had recently been established since 1936 and was faced with a difficult task as for the first-time central health services in Belgium formed an autonomous administration. Meanwhile, the Belgian health administration was now concerned to deal with the principles of communal autonomy and subsidised liberty. The Ministry had no extensive national health services and was more concerned with the formation of necessary institutions, whereby it tried to coordinate public health work. Therewith, it was difficult to find health solutions that satisfied all parties in the country and thus the Ministry of Health in Belgium had decided they would be glad to receive help and data of the LNHO, especially regarding social medicine. Thus, the ministry requested to expand the cooperation between Belgium and the LNHO during the 27th session of the HC. During the HC session, the message of the Belgium proposal was received enthusiastically, whereby all parties emphasised the importance of the newly established Ministry of Public Health in Belgium. The member states present at the 27th HC session proposed to establish a commission that would be concerned with providing Belgium all the documentary material they needed to properly establish their health strategy. The HC drafted a document that summarised all the agreements for the proposed collaboration and send it to the Belgian ministry that shared the document with the Belgian senate. [53]

A couple of weeks later, a letter on 22 February 1938 by René Sand of Belgium to Rajchman stated that while the cooperation between Belgium and the LNHO was excellent in his eyes, the request of the League had caused a political debacle that morning in the Belgian senate. The approval of the cooperation on public health and social medicine between the LNHO and

[53] United Nations Geneva, 'Health Committee - 27th Session, February 1938 - P.V. Texts [Minutes].', File (United Nations Library & Archives Geneva, 1938), 27–29, R6025/8A/33894/391, https://archives.ungeneva.org/health-committee-27th-session-february-1938-p-v-texts-minutes.

the Belgian Ministry of Health had sparked a large debate.[54] A letter dated 25 February 1938 to Gautier of the LNHO clarifies that the political debate had been caused by a Senate member that fell over certain wording of the cooperation document of the LNHO with Belgium.[55] The letters of Sand provide the impression that the Senate member felt the LNHO was encroaching upon the national territory of the national government. While the political debate seemed to be a misunderstanding, the LNHO had sent a letter to M. Wauters who was the Minister of Health in Belgium at the time, for clarification.[56]

Over a week later, on the 2nd of March, Sand had sent a letter to Gautier stating the incident arising out of the proposed collaboration had been settled. The Senate had adopted a vote of confidence by a large majority, after which the interpellator himself had joined. In a later letter, Gautier wrote the Secretary General of the League that the settlement of the dispute was due to the LNHO's written clarification to Wauters, which apparently had been quite successful.[57] Nonetheless, even though the debate had been settled, the Belgian Senate still urged the LNHO to also include the ILO in the renewed collaboration. In reaction to this request, M. Tixier of the ILO send a letter to the LNHO that for a large part clarifies the discussion in the Belgian Senate.

Tixier argued that he had received a request of the Belgian government to support the LNHO's study on the protection of Health in Belgium, whereby he referred to the disputed cooperation agreement. He states that *"indeed questions on mutuality and social security fall in Belgium under the authority of the Ministry of Labour and Welfare that is directly related to the ILO"*. He continues by stating that *"at the invitation of the Belgian government he would like to participate in the study".* Tixier also highlights in his letter "*that the Ministry of Labour and Welfare in cooperation with the ILO are responsible for all social questions and that it would be appreciated if the ILO can consult on all social questions that will arise of the study into Belgian health".*[58] This letter of Tixier to the LNHO suggests that the dispute in the Belgian Senate over the cooperation agreement was due to a perceived encroachment of

[54] United Nations Geneva, 'Various Correspondence with National Health Offices - Belgium.' (United Nations Library & Archives Geneva, 1940 1933), 43, R6069/8A/2568/1263, https://archives.ungeneva.org/national-health-organisations-various-correspondence-with-national-health-offices-belgium. *Original text: "notre requête à la S.D.N. (the League of Nations) a soulevé un orage politique qui a cause ce matin une interpellation de grand style au Sénat"*
[55] Ibid, p.51.
[56] Ibid, 46.
[57] Ibid, 43,46.
[58] Ibid, 41. Letter from Tixier of the ILO to Rajchman of the ILO on the 11th of March 1938.

the LNHO on the responsibilities of the Ministry of Labour and Welfare and the ILO, as the collaboration concerned social issues. While the dispute was quickly resolved and all parties were clearly convinced there was no conscious or intended encroachment upon others' responsibilities, it does show the difficulty of enforcing a broad definition of health and the miscommunication that often existed among stakeholders.

2.4 Ineffectiveness: A generalist critique

So far, a critique on the social prevention programmes has been expressed regarding miscoordination and overlapping responsibilities that sometimes led to encroachments on other's international institutions responsibilities. However, this section will argue that the critique of encroachments regarding social prevention fits into a more general critique on the LNHO regarding miscoordination, which makes the critique of miscoordination not exclusive to social prevention. Two examples will be given of critique over miscoordination concerning the entirety of the LNHO.

A first example of a critique on the LNHO regarding miscoordination can be found in the correspondence series between Spain and the LNHO. The Minister of Health in Spain criticised the LNHO in a decree he wrote on the 22nd of August 1938 as he stated the LNHO to be inefficiently organised. In the decree, he urged the LNHO to achieve a better coordination of the different services it offers as in his words: *"it could help to overcome the shortages and overlapping of the services offered"*.[59] An article in the official government newspaper a day after the minister's decree further explained the complaints on efficiency and overlapping services regarding the LNHO. The article stated that the lack of coordination between the different institutions demanded a rectification of the LNHO's structure.[60] Spain clearly expressed the need for a reorganisation of the LNHO structure, referring to the entirety of the LNHO's activities. Nonetheless, it should be noted Spain did not want to quit certain programmes, as no sources would indicate such position. Furthermore, correspondence between the LNHO and Spain show that the general miscoordination of the LNHO in Spain's eyes was the main criticism they had, for the rest Spain illustrated a lot of content with the LNHO's goals including social prevention.

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[59] United Nations Geneva, 'Correspondence between League of Nations Health Organisation and National Health Organisations - Spain.', File (United Nations Library & Archives Geneva, 1938 1933), 6, R6069/8A/1263/1263, https://archives.ungeneva.org/national-health-organisations-spain. Original text: "…de remédier aux lacunes et aux chevauchements de ces services".

[60] United Nations Geneva, 'Correspondence between League of Nations Health Organisation and National Health Organisations - Spain.' File: Official government newspaper Spain. 23rd of August.

During the 25th HC session in April 1937, another example of miscoordination was discussed. In a discussion on the possible extension of the social prevention programmes, Dr Morgan as representative of the UK argued new plans within the LNHO should be carefully considered. Dr. Morgan argued: *"…regrettable mistakes, of which there had been only too many in the past, would thus be avoided (it was well-known, for instance, that the Ministry of health had recently received a lengthy questionnaire on the effects of venereal diseases when it had already sent out a detailed reply on that subject four years ago)."*[61] His reference to the lengthy questionnaire on the effects of venereal diseases that had been sent out two times, illustrates issues of miscoordination. Dr Rajchman of the LNHO agreed with Dr Morgan of the UK and stated further overlapping during coordination should be avoided in the future, referring to the questionnaire on venereal diseases.[62] This example illustrates miscoordination was a more general issue, as venereal diseases presented a curative and not preventive issue.

2.5 A more nuanced view of Biraud's letters

Thus far, the chapter has illustrated the LNHO was problematised by a lot of miscoordination, whereof encroachments upon other's responsibilities followed. Within the LNHO, it was perceived that social prevention contained the highest number of encroachments, probably leading to its more negative view as portrayed in Biraud's letter. This section will draw again on Biraud's letters. While the chapter started with Biraud's negative perception on social prevention, his position should be nuanced. Therefore, a fragment of Biraud will be contextualised to illustrate he did not necessarily oppose social prevention even though he termed social medicine as encroachments.

For illustration, a fragment of Biraud's letter to Vigier of the LNHO on the 23rd of March 1945 should be considered:

"It is for the Health Committee to decide:

1. *On the revival with possible transformations of the International Housing Commission;*
2. *On the studies to be undertaken by the Health Section on social medicine with a possible revival, later, of its Committee on Social Medicine;*

[61] United Nations Geneva, 'Health General - Health Committee - 25th Session, 26th April 1937 - P.V. [Proces-Verbal] Texts.', 331–33.
[62] Ibid, 333.

3. *On the field of activity of the future international public health organisation and the means by which its own responsibilities, technical committees and secretariat could be transferred to and used by the successor organisation."*[63]

This fragment discusses the issues Biraud wishes to address during a meeting on the new international health organisation if he can reconvene the HC. The fragment also contains a lot of implicit information on Biraud's perception. To start, it should be noted that Biraud tried to distinguish the Housing Commission from the rest of the social prevention programmes, an occurrence wherefor an explanation will be considered in chapter three. Two things of the fragment should be noted for the purpose of this chapter's argumentation. First, the fragment suggests a very favourable perception of Biraud over the Housing Commission as it leaves no room open to debate over whether it should be re-established or not. His favourable view is also noticeable in the rest of the letters as he believed work on the Housing Commission should be established as soon as possible, whereby he uses firm language. Second, the fragment illustrates a less affirmative stance regarding to whether the rest of the social prevention programmes should be re-established. As he suggests the revival of social medicine to be 'possible', he leaves the question open to debate. Nonetheless, even though he leaves the question about re-establishment on the table, nowhere in his letters does he argue the social prevention programmes should not be continued in the WHO.

Also, while Biraud is more affirmative over the continuation of the Housing Commission than over the continuation of the other social prevention programmes, there is still no evidence he sets out to halt the other social prevention programmes. This finding would suggest a more nuanced view to Biraud's letters, as it illustrates Biraud's view would not directly explain the discontinuation of the social prevention programmes.

[63] United Nations Geneva, 'Health Committee - 32nd Session - Arrangements.', 8.

3. The significance of the social prevention programme's criticisms

This chapter will contextualise the significance of the criticism of the British as discussed in the first chapter and the criticism of encroachments upon other institutions responsibilities as discussed in the second chapter. To do so, it will make use of the theory of the norm life cycle by Finnemore and Sikkink. At first, the norm life cycle will be used to analyse in which phase social prevention's norm evolvement was in. By explaining in which phase of the norm life cycle social prevention was in, it could be analysed how the criticism of the British and of encroachments would fit into the lack of social prevention's norm evolvement. In that way, the criticisms likely significance can be contextualised.

This chapter analyses the norm life cycle of social prevention roughly between 1933 and the end of 1939, thus between the adoption of new social prevention programmes and the outbreak of WWII. While public health work stopped in WWII, making norm evolvement impossible, this period will not be considered. The chapter will only focus on norm evolvement within the HC as only LNHO sources are used due to the limited scope of the research.

3.1 The norm life cycle

Why is the norm life cycle of Finnemore and Sikkink used? The norm life cycle is a conceptual framework describing how norms emerge, cascade, become internalised and how they shape the interactions of states and other actors in the international system. The framework can be applied to different fields of study and is therefore a wide-applicable model.[64] Two reasons suggest why the framework should be used in the context of social prevention. First, the norm life cycle helps to better understand social prevention's norm evolvement and provides a framework to contextualise the criticisms within a process of norm evolvement. Second, a cycle's conception suggests the end of norm evolvement is more similar to a fading norm than an abrupt ending, which suits what has happened to social prevention as a norm. Even though the social prevention programmes had been discontinued in the new health organisation, the WHO still maintained a broader definition of health which included economic and social circumstances. A letter on the 27th of December 1950 from Wilfrid Benson, the Director of Non-Self-Governing Territories in the WHO, to the WHO

[64] Martha Finnemore and Kathryn Sikkink, 'International Norm Dynamics and Political Change', *International Organization* 52, no. 4 (1998): 890.

executive board also seemed optimistic as he stated "the subject of preventive medicine already be on the agenda of the World Health Assembly", while he still needed WHO assistance to draw up the documents for preventive medicine.[65] This rejects social prevention was fully lost in the new health organisation and would suggest a process of norm fading instead of an abrupt ending had occurred.

3.1.1 The stages of the norm life cycle

To start, it is important to explain the norm life cycle its stages. The norm life cycle model consists of three main stages: norm emergence, norm cascade and norm internalisation.

The first stage, norm emergence, involves the emergence of a new norm. In this stage, the norm is not widely accepted and there is often resistance and debate over its validity and appropriateness. The second stage, norm cascade, occurs when the norm gains more attention and support by states and international actors. A certain tipping point should be reached when entering norm cascade whereby a norm will gain traction and attention by itself. As more states and international actors adopt the norm, the norm becomes increasingly institutionalised by for example new treaties and conventions. The third stage, norm internalisation, is when the norm has become a common standard of behaviour whereby compliance with the norm is seen as a matter of self-interest. In this stage, the norm has merged into the identity of states and other actors. Non-compliance will be punished. These three stages compose the norm life cycle.[66] The next two sections will try to understand to what stage of norm emergence social prevention belonged.

3.1.2. Broadening support as important indicator

To explain social prevention's stage of norm evolvement, the norm life cycle will be discussed from the start and in a chronological order, starting with the first phase of norm emergence. During the first stage of norm emergence, a norm is not widely accepted and often debate exists over its validity and inappropriateness. Signs of social prevention as emerging norm can be viewed by 1933, when the HC had agreed to take more decisive and promotive action regarding social prevention. At that time, social prevention was an emerging concept whereby its validity and legitimacy were often questioned, symbolising the first phase of norm emergence.[67] The contestation of social prevention as norm was the strongest during the first half of the 1930s, whereby mostly the British opposed the norm (chapter 1.2.).

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[65] Department of Political Affairs, 'World Health Organization'.
[66] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', 895.
[67] Ibid, 895.

However, over the second half of the 1930s, social medicine became more accepted and normalised among the HC (chapter 1.3.). This broadening support during the second half of the 1930s, is viewed by Finnemore and Sikkink as an important indicator for norm evolvement towards the second phase of norm cascade.[68]

3.1.3. Institutionalisation

Finnemore and Sikkink argue for a norm to enter the second stage of norm cascade, a certain 'tipping point' should be reached whereby states start to adopt a norm without pressure. While no specific criteria or thresholds are provided for when this tipping point occurs, Finnemore and Sikkink have a couple of suggestions. As previously mentioned, broadening support is one of these factors. Another important factor is the institutionalisation of a norm.[69] Could we observe signs of institutionalisation of social prevention in the second half of the 1930s?

Before proposing the necessary justification to answer such question, it should be addressed when institutionalisation could be observed regarding social prevention. While Finnemore and Sikkink offer no coherent definition of institutionalisation, they have embedded its concept throughout their work. They argue norm institutionalisation is the process whereby a norm gets formally embedded within the structures and practices of international organisations. However, the social prevention programmes consisted of commissions with a voluntary character. Thus, states could choose themselves whether they wanted to implement certain studies or not. The voluntary character would suggest new treaties or policies would not be formed at an international level, as implementation occurred on a national level. Therefore, institutionalisation of social prevention should be analysed at the state level. Thus, institutionalisation in this case should be defined as a process whereby a norm gets formally embedded into the structures and practices of individual member states of the LNHO.

In fact, social prevention did get formally embedded within national institutions between 1935 and 1939, as several countries adopted certain laws and resolutions into parliament about social prevention. Two examples will be provided, namely: Romania and Belgium. The first example is Romania. Romania informed the LNHO by the 3rd of September 1935 that their parliament had adopted a resolution to create the Academy of Medicine in Romania. This academy would be tasked with providing advice regarding social issues of health, such

[68] Ibid, 895.
[69] Ibid, 898, 901.

as: hygiene, social insurance and social assistance.[70] While it was only an advisory body, its intention was to explore policies on social prevention. The establishment of a national advisory body about social medicine is a clear example of a first step towards institutionalisation. The second example social prevention's institutionalisation is Belgium. Belgium had very little central health services until 1936. Around this time, the Belgian Ministry of Health authorised the local municipalities to facilitate healthcare while the municipalities were also already tasked with all social services. The national government had no role in social services nor social medicine up till that point. Nonetheless, by a decree in 1938, the Ministry of Health officially established a social medicine archive and a new institution concerned with social medicine: the Belgian Association of social medicine.[71] Similar to the academy in Romania, the Association was tasked with providing advice about social medicine. These two examples could be seen to illustrate signs of institutionalisation.

3.1.4. Norm emergence

So far, it has been argued social prevention as norm illustrated signs of broadening international support and first signs of institutionalisation. While it is clear that social prevention never reached the third phase of norm internalisation, as that would imply social prevention was becoming a standard in public health which it was not, the discussion between the first two phases remains. This leaves the question: was a certain tipping point reached to enter norm cascade or not?

While it is hard, according to Finnemore and Sikkink, to determine a norm's stage as it requires hard and careful consideration, it is unlikely the tipping point was reached. While social prevention did enjoy broadening support over the 1930s and started to show signs of institutionalisation, this was likely not enough. Finnemore and Sikkink argue that even though states would adopt a norm and thus institutionalise a norm, a critical mass would be needed to reach a tipping point. While it is hard to define such critical mass, normally about one third of all countries should adopt the norm before a tipping point is reached.[72] In the case of social prevention, it seems that less than one third of states had adopted national laws

[70] United Nations Geneva, 'Various Correspondence with National Health Offices - Romania.' (United Nations Library & Archives Geneva, 1938 1935), 52, R6069/8A/20202/1263, https://archives.ungeneva.org/national-health-organisations-various-correspondence-with-national-health-offices-romania. File: A letter of D. Danielopolo (secretary general of the Academy of Medicine in Bukarest) to the director of the LNHO.
[71] United Nations Geneva, 'Various Correspondence with National Health Offices - Belgium.', 13–20. File: A small report on 'les problems de la sante en Belgique'.
[72] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', 901.

to institutionalise social prevention. This finding would suggest social prevention was still in the first stage of norm emergence, even though, it was nearing the end of this stage.

However, what could social prevention's norm at the end of the stage of norm emergence explain about its inability to reach the tipping point? Did it have anything to do with the criticisms portrayed by Biraud? This will be analysed in the next section.

3.2. Applying the norm life cycle model

In this section, the critique of the British and of encroachments on other institution's responsibilities will be categorised within the norm life cycle. Similarly, to the previous sections, the criticisms will be discussed in a chronological matter. The section will first discuss the British as a resisting powerful actor. Second, encroachments will be characterised as miscoordination that likely led to a large loss of norm credibility, possibly leading to the need for the norm's separation. The chapter will end with a nuanced discussion on the found results and possible further ideas for a new research agenda.

3.2.1. The British: a factor of pushback and opposition

The first chapter has argued the British were negative over the expansion of the social prevention programmes from the start. In their eyes, the newly proposed social prevention studies initiated in reaction to the Great Depression were presented on false economic and social grounds and thus illegitimate. In the years after, even though more nuanced, the British remained a critical voice over the social prevention programmes, critiquing its lack of definition, lack of coherent plans, miscoordination and encroachments. The letters of Biraud also highlighted the British position: *"The S.G.[73] and myself fully agreed it would be vain to undertake anything without first ascertaining the view of the British authority"[74],* which would suggest the British to have been a powerful actor in the talks over a possible continuation of social prevention. This would suggest the British to have been a resisting powerful actor, which Finnemore and Sikkink suggest is a large threat to norm evolvement in the first phase of norm emergence.[75]

The norm life cycle views the resistance of powerful actors such as states or influential interest groups as a threat to norm entrepreneurs working on the advancement of a certain norm. This as powerful actors set out to undermine a norm's development. As a norm

[73] S.G. = Secretary General
[74] United Nations Geneva, 'Health Committee - 32nd Session - Arrangements.', 5.
[75] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', 899–900.

emerges, states might perceive the emerging norm as threat to their interests, whereby they feel threatened or disadvantaged. Therefore, these actors will deliberately challenge the norm's legitimacy and will try to undermine its acceptance.[76] The role of the British resembles the factor of a powerful actor's resistance for two reasons. First, they indeed felt social prevention to be an intrusion upon their rights, trying to build opposition to the norm, as illustrated in chapter one. Second, the British were a powerful actor within the HC. The British were one of the four permanent members of the Council of the League, which created a strong power base within the League. Academic literature also suggests the UK next to France and the US to have been one of the great liberal powers whom the League depended on.[77] The strong international position of the UK in the League could suggest the British opinion in the HC to have been more credible and important than in the case with other states. Another suggestion for the British power, is the large shrinkage of the number of HC members post-WWII. During the 1930s, many states had already withdrawn themselves from the League and the LNHO, lowering the level of representatives present in HC meetings. While during the 22nd session in October 1935, seventeen members had been present, by November 1939, only eleven members were present. Biraud's letters in March 1945 even mentioned only six members could be reconvened for the HC, which could be explained by many representatives dying in the war. The different composition of the HC could have skewed the balance of opinions during HC plenary sessions.

However, did the UK enjoy enough power to be able to halt the social prevention programmes? While the power of the UK cannot be denied, they were still just one member of the HC, which makes it unlikely they were able to halt the programmes without support. While they had enjoyed little support during the 20th session, when they had tried to halt the expansion of the social prevention programmes, their criticism to the broader definition of health also never gained traction after that session. Even with their powerful role. Therefore, the British critique on expansion would likely not have contributed to the decision over discontinuation. Nonetheless, over the 1930s, their criticism over social prevention had changed towards a critique over miscoordination and a lack of demarcated responsibilities, which we know led to encroachments. This sentiment had grown among the HC over the 1930s, which created a larger opposition to a better execution of certain parts of the social

[76] Finnemore and Sikkink, 906.
[77] Patricia Clavin, *Securing the World Economy: The Reinvention of the League of Nations, 1920-1946* (OUP Oxford, 2013), 107.

prevention programmes. In this way, it could be possible the British had been a powerful facilitator towards the critique of encroachments, which is deserving of more research. Even so, the research shows, the role of the British cannot be adequately addressed with the use of the sources in this paper. Their role should be further researched with the use of different sources.

3.2.2 Miscoordination and a loss of credibility

The most discussed critique regarding social prevention in the HC plenary session minutes has been the encroachments upon other's institutions responsibilities. This section will argue the perceived large presence of encroachments on social preventive measures to have led to a loss of social prevention's norm credibility, a likely significant factor for discontinuation.

3.2.2.1. The role of encroachments upon other's institutions responsibilities

First, the critique of encroachments should be contextualised within the norm life cycle model. Three things can be noted on the importance of the critique of encroachments, making it possibly the largest criticism. First, the criticism of encroachments was the criticism most discussed during plenary meetings of the HC, and therefore received the most attention. Second, every representative seemed to agree encroachments were a large issue, which contrasts with the British critique on the expanding definition of health. Third, Biraud's letters places the critique of encroachments in the direct context of the discussion on the possible reconvening of the HC to discuss the new international health organisation.

What can the norm life cycle explain about this critique? The norm life cycle theory argues coordination is critical to ensure the consistent adoption and implementation of the norm across various states. Especially, when the tipping point has not been reached yet, issues of coordination could be detrimental to norm evolvement. If a lack of or wrongful coordination occurs, states might interpret or apply the norm in a different way, which leads to inconsistency and potential loopholes.[78] It has been argued the encroachments on social prevention also derived out of issues of miscoordination as they were caused by a lack of communication and a lack of demarcations over responsibilities between institutions. This miscoordination could have caused the institutions to adopt certain social preventive measures in their own way. Thus, while encroachments seem to be a consequence of bad coordination, they presented a hindering factor to social prevention.

[78] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', 893.

What is known over the significance of miscoordination as hindering factor? According to the norm life cycle, the impact of miscoordination during the norm cascade has a significant role for norm evolvement's success. The norm life cycle proposes miscoordination could be hindering the norm's progression, diminishing its overall impact, and offering new challenges to norm evolvement.[79] This research paper argues it is possible one of these new challenges that derived out of miscoordination was the loss of norm credibility.

3.2.2.2 The selective adoption of social preventive measures

Before continuing, it is important to discuss a development after WW-II that has not been contextualised yet within this research but was named in the second chapter. The development referred to is the adoption of social preventive measures post-WWII by other international institutions. For example, the Food and Agriculture Organisation received the nutrition portfolio, and the United Nations International Children's Emergency Fund took up many of the broader issues related to health.[80] Thus, even while the WHO did not establish social prevention programmes, some social preventive measures were to a much lesser extent continued for some time within other international organisations. The continuation of certain social preventive measures in other international organisations seems a contradictory finding to the discontinuation of the social prevention programmes, as researched within this paper. Nonetheless, this section will suggest the selective adoption of social preventive measures post-WWII could possibly be explained by social prevention's loss of credibility due to encroachments and the vacuum of coordination post-WWII as suggested by Biraud's letter.

3.2.2.3 A loss of credibility due to encroachments

How did the critique of encroachments likely contribute to the loss of norm credibility? It should be considered the high level of encroachments that were perceived regarding certain subsets of the social prevention programmes likely caused a general loss of norm credibility. For example, as argued in chapter two, the nutrition portfolio was seen as a striking example of its high level of encroachments, suggesting it was more contested than for example the Housing Commission. Differences such as these, seemingly contributed to a need for separation between social preventive measures by authorities, which undermined the credibility of social prevention as norm.

[79] Ibid, 893.

[80] Sealey, 'The League of Nations Health Organisation and the Evolution of Transnational Public Health'.

This observation is supported by Finnemore and Sikkink. Finnemore and Sikkink also argue differences between intrinsic characteristics of a norm to contribute to the undermining of a general norm's credibility, as actors often feel the desire to differentiate between subsets of a norm that are considered as better or worse.[81] Meanwhile, this differentiation between the different social prevention programmes can also be seen in the HC plenary session minutes over the 1930s. In the minutes, less and less mention is made during the 1930s of the general social prevention programmes. By the end of the 1930s, the different portfolios were discussed more separately than at the beginning, thus: 'housing', 'nutrition', 'rural hygiene', were mentioned separately and little mention was made of 'social prevention'. In contrast, during the 20th session in 1933, little mention had been made of the individual programmes, as most reference was made to 'social medicine' or 'social prevention'.[82] This could suggest a more individual approach was adopted to the different social prevention programmes, which could imply social prevention as norm had lost credibility. This could also help to explain the selective adoption post-WWII of social preventive measures.

3.2.2.4. A vacuum of coordination

A loss of social prevention's credibility as norm, could help to understand the need for a more individualist approach for adopting social preventive measures by other international institutions. However, how was the adoption of social preventive measures by other international institutions even possible? Biraud's letters provide an insight into how this might have occurred.

"It is not sufficient, either, to ensure that the field of activity of the future international health organisation is preserved from undue encroachments; proper allotment of work or collaborations with other organisations should be established. This is most obviously needed with regard to the medical and health aspects of nutrition, the sanitary aspects of food with the Organisation for Food and Agriculture and with regard to organisation of medical care, preventive and curative medicine - a field which the International Labour Organisation has recently taken up without consultation or warning and which properly belongs to the organisation in charge of public health rather than labour protection. (Letter to M. Vigier on 23rd of March 1945)"[83]

[81] Finnemore and Sikkink, 'International Norm Dynamics and Political Change', 906.
[82] United Nations Geneva, 'Health Committee - 20th Session, 10-15 October 1933: Documentation.'
[83] United Nations Geneva, 'Health Committee - 32nd Session - Arrangements.', 8.

While the former fragment reaffirms the international community's annoyance towards encroachments, and highlights the need for better collaborations, it also suggests a vacuum of coordination post-WWII. The sentence "*a field… labour protection*", illustrates this lack of coordination regarding social preventive measures. Initially, this sentence is difficult to grasp as it remains unclear what type of work the ILO has taken up without consultation, which also cannot be found in other LNHO sources. Nonetheless, the sentence confirms that even during the discussions over the new UN-specialised agencies post-WWII, very little was coordinated between international institutions regarding their responsibilities. The lack of coordination and communication implied by Biraud's quote would suggest a vacuum to have existed post-WWII, wherein other international institutions were able to adopt measures without consent. In the end, this vacuum of coordination, made selective adoption possible.

3.2.2.5. Miscoordination as facilitator

The previous section has suggested the perceived large number of encroachments within social medicine likely contributed to a loss of credibility, which facilitated the selective adoption of social preventive measures. However, it should be noted that more research would be needed to establish such a claim, as the scope of this research paper is too limited. Further research should preferably resort to the use of other sources such as testimonies, interviews, etc. around that time.

Nonetheless, even while no strong claims can be made in this research paper, the sources used within this paper would suggest the implied loss of credibility and thus the need to separate between the different programmes, would provide a logical explanation for the discontinuation as well as for the selective adoption by other institutions. This loss of credibility and the difficulties of enforcing a broad definition of health with the social prevention programmes, could also explain why the WHO maintained a broader definition of health but decided not to establish new social prevention programmes. This as a broader definition of health could provide the benefits but not the difficulties of coordination. In this way, the WHO could also selectively adopt what side of the broader definition suited their best interest.

3.4. A new research agenda

Further research is needed into the discontinuation of the social prevention programmes. While the scope of this research paper is too limited in scope to make any claims, it is important further research will approach the issue from new dimensions and sources. As this

research has used al minutes of HC meetings and relevant correspondence series, it is likely new sources should be found outside of the LNHO archives. An analysis into the beginning years of the WHO archives, although these sources seem to be scarce or difficult to access, would be an option for further research. Another highly valuable option would be to find testimonies or first-hand accounts of LNHO staff that later had a role in the WHO, such as Biraud's letters but more extensive. However, I was not able to find anything as such and it is unclear whether those people are still alive to share information.

Examples for further research as proposed in this paper could be:

- The role of the British as powerful actor in halting social prevention's norm evolvement;
- The role of the perceived high level of encroachments towards less credibility of social prevention as norm;
- The differences between the Housing Commission and the Nutrition Commission in terms of desirability and encroachments;
- The ability of institutions to enforce multi-dimensional concepts such as social prevention;
- The desirability of social prevention within public health.

4. Conclusion

In brief, this paper has considered how the hindrance of social prevention as international norm could be explained by the criticism the social prevention programmes within the LNHO received, as formulated by Biraud in his letters in March 1945. This research paper suggested the internal affairs of the social prevention programmes, thus the criticism it received, contributed to the discontinuation of the programmes within the WHO. The focus on internal affairs contrasts with the dominant academic debate that focuses on the external affairs such as a changed political context. By focusing on what happened in the social prevention programmes instead of what did not happen (external factors), this research would make a valuable contribution to the research field.

To research this issue, the paper has analysed correspondence and HC plenary session minutes of the LNHO in the 1930s. It has used discourse analysis to outline all the negative, positive and neutral language over the social prevention programmes. Then, it has grouped all negative and positive language over the social prevention programmes and found two large criticisms occurred: that of the British on the broader definition of health and that of encroachments upon other institution's responsibilities. As these were the same criticisms found in Biraud's letters, his letters make a breadcrumb trail throughout this research paper.

It should be noted that this research will not provide a definite answer of how and why the social prevention programmes were discontinued in the new international health organisation. Briefly, this was also not the purpose of this research as the scope was too limited. This research paper was more interested in understanding the criticisms the LNHO received regarding social prevention and their impact on the lack of social prevention's norm evolvement. Hereby, the paper used the discontinuation of social prevention within the new international health organisation as indicator of the end of social prevention's norm evolvement.

To answer the research question, the paper has addressed the following. First, the context wherein the social prevention programmes expanded and how this was received in the international community is discussed. The first chapter highlights the process of social prevention's norm evolvement and discusses the British criticism on the expansion. Nonetheless, the chapter also highlights most states were positive over the expansion, which nuances the debate. To do so, the first chapter has used HC plenary session minutes and correspondence between the LNHO and national health administrations to support its

argumentation. Second, the next chapter explains the criticism of encroachments upon other institution's responsibilities, likely the largest critique on social prevention. It argues encroachments derived out of miscoordination and overlapping responsibilities. While the critique of miscoordination was not unique to the social prevention programmes, the social prevention programmes were perceived to be the most susceptible to miscoordination and encroachments due to its multi-faceted dimension. Hereby, nutrition was seen as a striking example. The chapter closes off by nuancing the debate on encroachments and suggesting there was still an interest in social prevention even though encroachments occurred. Third, the last chapter places the two expressed criticisms in the norm life cycle of Finnemore and Sikkink to discuss their likely significance. It argues the effect of the British critique on the broader definition of health was likely limited due to their limited support over the 1930s. Nonetheless, their role should deserve more attention in future research, as this research poses many questions regarding their role. Further, the chapter argues the criticism of encroachments was likely the most significant as it probably led a loss of norm credibility, leading to other international institutions to selectively adopt social preventive measures in their best interest. In this way, the perceived level of encroachments could have served as a facilitator to the end of social prevention's norm evolvement.

Nonetheless, more research would be needed before making definite claims. This research paper calls to open the research agenda to further explore the discontinuation of the social prevention programmes. Research into the issue is interesting as social prevention as emerging international norm was an extraordinary case. Today, few can imagine social prevention was an emerging norm in the international community in the Interbellum. After the discontinuation of the social prevention programmes in the WHO, the broader definition of health faded further. The social preventive measures adopted by for example the FAO, also disappeared over time.

Nonetheless, global awareness over social prevention's benefits is growing again as public health studies seem to realise curative medicine are not sufficient for a sustainable public health system. This should open the debate for new studies in (social) prevention studies to question its desirability and appropriateness. Or as Rajchman stated *"social prevention is a younger generation's desire for a place under the sun,"*[84] which refers to the need to rethink a future public health system for all.

[84] United Nations Geneva, 'Health Committee - 30th Session, 4 to 6 May 1939 - Minutes.', 263.

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