6 Social Medicine in Social Democracy

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The concept of social medicine, pioneered by activists and leftist medical professionals in Denmark, Norway, and Sweden during the 1930s, played a significant role in reshaping the Scandinavian societies. Initially characterized by its political radicalism, social medicine's principles were integrated after the war into the prevailing social democratic ideology. Many of its early proponents assumed influential positions within the state medical apparatus, thus wielding considerable influence in crafting national health policies during the "golden age" of the Scandinavian welfare states (1940s–1970s), as well as playing important roles on the international scene.

This chapter explores the emergence and evolution of social medicine within the context of the Scandinavian welfare states, tracing its transition from being a catalyst for revolutionary change to a discipline instrumental in bolstering the foundations of the burgeoning welfare state. What happened to social medicine's ambitions to disrupt the current power balances in society when the persons proposing them were themselves in hegemonic positions? The chapter examines the trajectory of social medicine in late twentieth-century health policy, research, and clinical practice, while shedding light on some of its inherent limitations and subsequent demise.

Although the historiography of social medicine has been predominantly Eurocentric, it has been Eurocentric in a particularly narrow way. As Timmermann relates in Chapter 1 in this book, it is the narrative of social medicine that George Rosen found it appropriate to tell that has formed the history of social medicine that we know. Hence the history we have told our colleagues and students has started with Virchow in Germany and discussed

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some of the UK histories. However, his narrative not only fails to adequately acknowledge the broader global context, as the contributions to this volume show to the full extent, it also omits large parts of what happened within non-anglophone parts of Europe. The history of social medicine in Scandinavia is in many ways different from what we are told by Rosen and later authors.[1] It is more sharply grounded in social theory, at least in the 1930s (in contrast to Latin America, where social theory becomes important in the 1970s, as we learn in Chapters 3, 8, and 11), it becomes a proper medical specialty and is tightly involved in the welfare state, both as theory and field of practice. It also offers an important counterpoint to traditional chronologies, for instance by revealing how social medicine, evolving within the framework of social democracy, achieved its greatest impact in the 1950s and 1960s, at a time when social medicine was struggling in the Americas.

Social Medicine in the Interwar Years

Concerns about the social dimensions of health and disease had been raised and approaches discussed during the nineteenth and early twentieth centuries in Scandinavia. People's living conditions, like housing and nutrition, were increasingly becoming an object of medical interest.[2] Different professional and voluntary organizations made efforts to improve the overall health and well-being of the population, termed "folkhälsan" or "folkehelse" (there is no real equivalent to public health in the Scandinavian languages).[3] The emergence of social medicine as a pivotal concept in the region first occurred in 1923. Then, the Swedish Medical Association replaced the term "state medicine" with "social medicine." The subsequent year, in 1924, marked the release of the inaugural issue of the *Journal of Social Medicine* in Sweden, enabling a dedicated scholarly platform for the exploration of social medicine.

During the early decades of the twentieth century, the first women physicians across Scandinavia pioneered new and socially pertinent realms of medicine. They championed initiatives such as assistance for unmarried women, support for vulnerable children, sexual education, and guidance on contraception.

[1] See, for example, Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (San Francisco: University of California Health Humanities Press, 2011).

[2] Aina Schiøtz, Maren Skaset, and Una Thoresen Dimola, *Folkets helse – landets styrke 1850–2003*, vol. B. 2 (Oslo: Universitetsforl, 2003), 38 ff.

[3] On the term "the health of the people," see Annika Berg and Teemu Ryymin, "The Peoples' Health, the Nations' Health, the World's Health: Folkhälsa and Folkehelse in the Writings of Axel Höjer and Karl Evang," in Sophy Bergenheim, Johannes Kananen, and Merle Wesse (eds.), *Conceptualising Public Health: Historical and Contemporary Struggles over Key Concepts* (London and New York, NY: Routledge, 2018), 76–100. See also Motzi Eklöf, *Läkarens Ethos: Studier i den svenska läkarkårens identiteter, intressen och ideal 1890–1960* (Malmköping: Exempla, 2018), 33.

Moreover, they actively engaged in political endeavors aimed at reshaping the societal structures contributing to poor health outcomes.[4] Ideologically, most of these physicians aligned themselves in the tradition of social hygiene and social medicine.[5] One notable figure was the Norwegian pediatrician Kirsten Utheim Toverud. She utilized her research on child nutrition and her leadership position within the Norwegian pediatric association to advocate for the establishment of guidance stations tailored to pregnant women and single mothers.[6] Through her multifaceted approach, Toverud not only addressed immediate medical needs but also sought to address systemic issues underlying public health challenges.

Socialist Physicians and Social Medicine

In the context of economic and social crisis of the 1920s and 1930s, young leftist physicians across Scandinavia started arguing for social medicine as an approach grounded in social theory based on readings of Marx and Freud. For them, social medicine by necessity implied not only describing and mapping inequity but also working for societal change. They took a critical stance on what they described as the technical and reductionist character of medicine (including hygiene, which they described a "bourgeois ideology"), which neglected the social and economic influences on health. In a decade characterized by unemployment, poverty, and social unrest, the socialist doctors set themselves the goal of developing a kind of medicine that included the economic and social aspects of sickness, prevention, and treatment, anchored in a socialist ideology of social reform.[7] They wanted to disrupt the system of power balances and transform the capitalist society into a socialist society.

Many of them became active members of the International Federation of Socialist Physicians, which inspired the creation of socialist medical associations in all three countries.[8] Together, these Scandinavian socialist medical

[4] Cecilie Arentz-Hansen, *"Kvinder med begavelse for lægevirksomhed": Norges første kvinnelige leger, og tiden de virket i* (Oslo: Cappelen Damm, 2018): 105–214.

[5] Aina Schiøtz, "'Gjør deres plikt- Men la all ting skje i stillhet': kvinner i folkehelsearbeidets tjeneste," *Michael* 11, no. 1 (2014): 28–44.

[6] Aina Schiøtz, "'Gjør deres plikt- Men la all ting skje i stillhet'," 37–8.

[7] Axel Strøm, "En sosialmedisiner ser tilbake," *Tidsskrift for den Norske Lægeforening* 91, no. 31 (1971): 2239–44; Siv Frøydis Berg, *Den unge Karl Evang og utvidelsen av helsebegrepet: en idéhistorisk fortelling om sosialmedisinens fremvekst i norsk mellomkrigstid* (Oslo: Solum, 2002), 33–83; Trond Nordby, *Karl Evang: en biografi* (Oslo: Aschehoug, 1989), 38–42 and 54–9; Niels Brimnes, "Mahler before India," unpublished manuscript, 2024; Annika Berg, *Den gränslösa hälsan: Signe och Axel Höjer, folkhälsan och expertisen* (Uppsala: Uppsala University, 2009).

[8] The International Federation was founded in Karlovy Vary (Karlsbad) in Czechoslovakia in 1931, on the initiative of the Verein sozialistischer Ärzte (Federation of Socialist Physicians). Jonathan Høegh Leunbach from Denmark and Karl Evang from Norway were elected to the new federation's international bureau. "Karlsbader Tagungen der sozialistischen Ärzte," *Der Sozialistische Arzt. Monatszeitschrift des Vereins Sozialistischer Ärzte* 7, no. 7 (1931): 197.

associations engaged in the "culture wars" against fascism and Nazism, partly by building on a common platform. The journal of the Norwegian Socialist Medical Association, *Socialistisk Medisinsk Tidsskrift* (1932–9) soon developed into a journal for the Scandinavian section of the International Federation of Socialist Physicians.[9] By joining the international federation, the organized left-wing doctors in Scandinavia affiliated to a global movement for a social medicine that professed "socialism and class struggle."[10]

To the young Norwegian physician Karl Evang and his progressive Scandinavian colleagues, social medicine was a crucial advance forward in the development of academic medicine. "The wildest confusion" prevailed, Evang argued, regarding the concept "social."[11] First of all, social medicine was not the same as socialized medicine. Social medicine was destined to study the conditions of health under a capitalist world order (as an object of critique). Social medicine, he continued, did not mean a health system financed by the state, nor was it merely a term for the health of a population. Finally, although social medicine took a special interest in conditions caused by society, such as alcoholism, poverty, or criminality, this was only a part of the field. Rather, social medicine was dedicated to (a) understanding the socioeconomic causes of ill health, (b) criticize and change the individualistic and reductionistic modern healthcare, and (c) change how society organized healthcare.

Paraphrasing the first German professor in social hygiene Alfred Grotjahn, whose book *Social Hygiene* he read when imprisoned for conscientious objection in 1930, Evang contended that the organization of society played a crucial role in determining how external factors which can be detrimental to health, affect individuals.[12] Illness was not a random occurrence; rather, it was heavily influenced by the socioeconomic factors humans were exposed to. Acting for change was a crucial part of social medicine and social medicine as a field could provide the tools for doing so.

In Denmark, Mogens Fog, the first chairman of the Danish socialist medical association, commented that doctors "often encounter conditions, which lies beyond our narrow field, but nevertheless touches on our profession. We encounter housing conditions, states of nutrition and environments, which make our prescriptions illusory." In conclusion, he asked: "Can we simply close our door and wash our hands?"[13]

[9] "Aus der sozialistischen Ärztebewegung," in *Internationales Ärztliches Bulletin. Zentralorgan der Internationalen Vereinigung Sozialistischer Ärzte* 1 (January 1934): 20.
[10] "Karlsbader Tagungen der sozialistischen Ärzte."
[11] Karl Evang, "Av en innledning til en studiecirkel i sosialmedicin," *Æskulap* 12 (1931): 2–8.
[12] Karl Evang, "Socialmedisinske fremtidsperspektiver," in S. Kjølstad (ed.), *Socialhygiene og folkehelse* (Oslo: Stenersen, 1938), 69–71.
[13] Quoted from Brimnes, "Mahler before India," 8–9.

Sex Education and Reproductive Rights

Freud's ideas greatly influenced young socialist physicians across Scandinavia.[14] They actively advocated for sexual education and the decriminalization of abortion, aligning themselves with the radical women's movements and collaborating with reproductive rights activists.[15] Notable examples include Elise Ottesen-Jensen in Sweden and Katti Anker Møller in Norway, who left indelible marks on the sociomedical landscape of Scandinavia.

Ottesen-Jensen, along with Gunnar Inghe (who in the 1960s became professor of social medicine) founded the Swedish Association for Sexuality Education (RFSU), an organization that continues to advocate for sexual health and LGBT rights.[16] Similarly, Møller advocated for single mothers and campaigned for the legalization of abortion. She also established Norway's first women's health center, laying the foundation for the establishment of similar centers across the country, and influenced the social medical physicians with her thinking.[17] In Denmark, Jonathan Leunbach was a co-founder of the World Liga for Sexual Reform and fought for the right to induced abortion.[18]

Building on their work, proponents of social medicine published a *Popular Journal for Sex Education* in the three Scandinavian countries from 1932 to 1935, reaching diverse audiences. Its content ranged from advocating for women's unfettered access to abortion services to promoting sexual pleasure, while emphasizing the importance of using contraceptive methods such as condoms and pessaries to alleviate women's concerns about unwanted pregnancies. According to Evang, the Norwegian edition alone sold an impressive 120 000 copies of one of its first issues and the editorial team were inundated with 3,000 letters within a two-year span, underscoring its profound impact on public discourse and awareness.[19]

Eugenics and Sterilization in Scandinavia

In the 1990s, a major public upheaval was caused by the fact that the Scandinavian welfare states, which were supposed to protect the marginalized, had engaged in eugenics from the interwar years. In Scandinavia, laws permitting sterilization for eugenic and social reasons were introduced in Denmark,

[14] Nordby, *Karl Evang: en biografi*, 35–53.
[15] Kari Tove Elvbakken, *Abortspørsmålets politiske historie: 1900–2020* (Oslo: Universitetsforlaget, 2021): 78–9.
[16] Lena Lennerhed, "Sex Reform in the 1930s and 1940s: RFSU, the Swedish Association for Sex Education," in Lars-Göran Tedebrand (ed.), *Sex, State and Society: Comparative Perspectives on the History of Sexuality* (Umeå: Nyheternas tryckeri KB, 2000): 403–7. The organization had 33,000 members in 1933 and 65,000 members in 1940.
[17] Schiøtz, "Gjør deres plikt- Men la all ting skje i stillhet."
[18] Elvbakken, *Abortspørsmålets politiske historie*, 38.
[19] Karl Evang, *Fred er å skape*. (Oslo: Pax, 1964): 68. Kari Hernæs Nordberg, "Ansvarlig seksualitet: Seksualundervisning i Norge 1933–1935," PhD, University of Oslo, 2013.

Norway, and Sweden between 1929 and 1941. Sterilizations for eugenic and/or social reasons,[20] mainly of women, peaked from the 1930s to the 1950s. By the mid 1950s, a shift occurred toward voluntary sterilization for contraceptive purposes, moving away from coercive measures.

The development of eugenics in Scandinavia is an example of the well-established links between eugenics and progressive social thought.[21] How did social medicine in Scandinavia relate to these practices? Alfred Grotjahn was a major source of inspiration in Scandinavian social medicine. He had introduced eugenics as one way to solve what he called "social pathologies" and the members of the International Federation of Socialist Physicians did not distance themselves from eugenics.[22] Scandinavian advocates of social medicine, particularly those with radical socialist leanings, however, vehemently opposed the interpretation of eugenics propagated by the radical right and the Nazis as well as its endorsement by "bourgeois scientists." They criticized the unscientific, "race-chauvinistic," and "reactionary" literature associated with eugenics.[23] However, they did not outright reject eugenics itself. Axel Höjer, the Swedish General Director of Health, and prominent public figures Alva and Gunnar Myrdal in Sweden supported the Swedish sterilization laws. The Norwegian Karl Evang viewed the concept of eugenics as – in principle – fundamentally rational. Since the primary cause of intergenerational suffering in his view lay in socioeconomic inequality, however, eugenics would only be justifiable in a society devoid of class distinctions, where socioeconomic disparities had been eradicated.[24] Upon assuming the position of General Director of Health in 1938, Evang, alongside his Swedish counterpart Axel

[20] See Gunnar Broberg and Nils Roll-Hansen, *Eugenics and the Welfare State: Sterilization Policy in Denmark, Sweden, Norway and Finland*, 2nd ed. (East Lansing, MI: Michigan State University Press, 2005), 265. Mattias Tydén, *Från politik till praktik: de svenska steriliseringslagarna 1935–1975* (Stockholm: Almqvist & Wiksell International, 2002); Lene Koch, "The Meaning of Eugenics: Reflections on the Government of Genetic Knowledge in the Past and the Present," *Science in Context* 17, no. 3 (2004), at: doi.org/10.1017/S0269889704000158; Lene Koch, *Racehygiene i Danmark 1920–56* (Copenhagen: Gyldendal, 1996); Lene Koch, *Tvangssterilisation i Danmark 1929–67* (København: Gyldendal, 2000); Per Haave, *Sterilisering av tatere 1934–1977: en historisk undersøkelse av lov og praksis* (Oslo: Norges forskningsråd, 2000).

[21] Paul Weindling, "International Eugenics: Swedish Sterilization in Context," *Scandinavian Journal of History* 24, no. 2 (1999), doi.org/10.1080/03468759950115791; Paul Weindling, *Health, Race, and German Politics between National Unification and Nazism, 1870–1945* (Cambridge; New York: Cambridge University Press, 1989).

[22] See Michael Schwartz, *Sozialistische Eugenik. Eugenische Sozialtechnologien in Debatten und Politik der deutschen Sozialdemokratie 1890–1933* (Bonn: Dietz, 1995).

[23] Karl Evang and Ebbe Linde, *Raslära, raspolitik, reaktion* (Stockholm: Clartés förlag, 1935): e.g., 17, 47, 88.

[24] Karl Evang, "Rassenhygiene und Sozialismus," in *Internationales Ärztliches Bulletin. Zentralorgan der Internationalen Vereinigung Sozialistischer Ärzte* 1, no. 9 (1934): 130–5. Evang and Linde, *Raslära, raspolitik, reaktion*; Karl Evang, *Rasepolitikk og reaksjon* (Oslo: Fram forlag, 1934).

Höjer, nevertheless found themselves intricately involved in the implementation of sterilization laws. This involvement was unavoidable given their roles as directors of their respective countries' national public health services, regardless of their personal endorsements.[25]

Nonetheless, in the broader context of social reform, eugenics and sterilization remained relatively minor issues within Scandinavian social medicine. The primary focus remained on the prevention of unjust disparities in morbidity and mortality through socioeconomic and political measures.[26]

Social Medicine and the Post-war Welfare State: The Expanded Concept of Health

During the interwar years, leading intellectuals like Alva and Gunnar Myrdal in Sweden, along with radical physicians across Scandinavia, saw medicine as having a political role in reshaping industrial society. They pushed for the welfare state's construction through science, with social medicine as a key tool.[27]

After the Second World War, social medicine proponents from the 1930s rose to influential positions in Scandinavian welfare states.[28] For instance, Karl Evang became Norway's General Director of Health from 1938 until 1972, interrupted by wartime exile. In Denmark, Johannes Frandsen led the national board of health from 1928 to 1961, and Axel Höjer served as Sweden's General Director of Health from 1935 to 1952. All of them anchored their social medicine in socialist ideology of social reform.[29]

One crucial component of social medicine as a normative and practical field was the expanded concept of health, which was clearly rooted in the politically radical social medicine that the Scandinavian social medicine advocates had championed since the 1930s,[30] rejecting what they deemed a reductionist and "primitive" view in contemporary medicine. While in exile during the war, Karl Evang built a broad network of social medicine allies in the US and Europe, who shared this vision. He participated in the technical preparatory committee for the International Health Conference in Paris in 1946, working on the draft with the preamble for the new World Health Organization (WHO), which contained the definition of the expanded concept of health. When the conference took place in New York in June, he was appointed chair

[25] Tydén, "Från politik till praktik." [26] Berg, *Den gränslösa hälsan*, 269.
[27] Alva Myrdal and Gunnar Myrdal, *Kris i befolkningsfrågan* (Stockholm: Albert Bonniers Förlag, 1934).
[28] Berg, *Den unge Karl Evang og utvidelsen av helsebegrepet*; Berg, *Den gränslösa hälsan*.
[29] Berg and Ryymin, "The Peoples' Health"; Haave Per, "The Winding Road of the Norwegian 'Welfare State,'" in Nils Edling (ed.), *The Changing Meanings of the Welfare State: Histories of a Key Concept in the Nordic Countries* (New York, NY: Berghahn Books, 2019), 179–224.
[30] Berg, *Den unge Karl Evang og utvidelsen av helsebegrepet*.

of the subcommittee tasked with finishing the constitution for the WHO.[31] Throughout his tenure as General Director of Health and at the WHO, Evang viewed the expanded concept of health not as empty rhetoric but as a catalyst for health policy action, advocating for its implementation beyond hospitals.

Evang remained committed to the expanded concept of health that throughout his life, both in his role as General Director of Health and in that at the WHO. He did not regard it as an empty concept but as a powerful source of health policy action,[32] and wanted the health service outside of hospitals to be organized and filled with content that involved a realization of the extended concept of health.[33]

The sociomedical thinking expressed in the expanded concept of health fitted the intention of the ruling Labour Party in the three countries to secure lives from the cradle to the grave. In varying degrees drawing on the Beveridge Report,[34] the healthcare systems in Scandinavia rose within a welfare model, which would later become known as the Scandinavian or Nordic welfare model.[35] Social medicine helped to form the theoretical basis for health and social policy and the public administration of health was reorganized to construct all those procedures, techniques, institutions, and knowledges that together could empower the application of social medicine.[36]

While rooted in socialist ideology, proponents of social medicine transitioned from revolutionary figures to empowered experts advocating for social integration and justice within the state apparatus. Figures like Karl Evang shifted their focus to using the state to ensure public health rather than viewing it as a repressive entity.[37] The former revolutionary doctors had become nation-builders; a medical expertise in the making of "the good society," and the capital invested to "safeguard the health of the people" was not unproductive, rather "in the truest sense productive capital."[38]

[31] Nordby, *Karl Evang*, 138.
[32] Kari Martinsen, *Omsorg, sykepleie og medisin: historisk-filosofiske essays* (Oslo: TANO, 1989), 239.
[33] Seip, *Veiene til velferdsstaten*, 351.
[34] Aina Schiøtz and Maren Skaset, *Folkets helse – landets styrke 1850–2003* (Oslo: Universitetsforlaget, 2003), 314–15; Nordby, *Karl Evang*, 118; Brimnes, "Mahler before India."
[35] P. Kettunen and Klaus Petersen, "Images of the Nordic Welfare Model: Historical Layers and Ambiguities," in Haldor Byrkjeflot, Lars Mjøset, Mads Mordhorst, and Klaus Petersen (eds.), *The Making and Circulation of Nordic Models, Ideas and Images* (London: Routledge, 2021), 13–33.
[36] Aina Schiøtz and Maren Skaset, *Folkets helse – landets styrke 1850–2003* (Oslo: Universitetsforlaget, 2003), 344–7; Anne-Lise Seip, *Veiene til velferdsstaten: norsk sosialpolitikk 1920–75* (Oslo: Gyldendal, 1994), 313–56.
[37] Engh, "The complexities of postcolonial international health," 28.
[38] K. Evang, "Det norske forslag til folketrygd," public speech, 194, Ra/Pa-386/J/L0082; Anne Lise Ellingsæter, Aksel Hatland, Per Haave, and Aksel Hatland (eds.), *Den nye velferdsstatens historie: ekspansjon og omdanning etter 1966* (Oslo: Gyldendal, 2020), 79.

The advocates of social democracy wanted to create systems aiming to "make life worth living for us all," with healthcare as a crucial element.[39] All citizens, regardless of social class or geographical location, were supposed to get the same chances of being included as citizens in the welfare state.[40] The provision of equal access to health services was a crucial policy goal from the immediate afterwar years.[41] An important aspect was that people should not be humble applicants of social and health services but have their rights defined – in terms of services in kind and of financial support. The welfare state rested on a redistribution of money by direct and indirect taxation and improving the people's health was an integral part of social democratic policy to play down social differences.[42] Universalism was the underlying principle – in theory at least, all citizens of the welfare state should have the same rights and the state was given the responsibility to ensure their well-being.[43]

The work of social medicine proponents within the frames of the expansive social and work policy of the Scandinavian welfare states implied that these goals to a certain extent were reached: social medicine actors were important both for the normative reform work and its practical implementation in the Scandinavian welfare states from the end of the war to the 1970s. As Ida Rosenstam has argued, the postwar years were the golden age of social medicine, when the influence of social medicine on the sociopolitical debate and practice was considerable.[44]

Building a Health System: The Example of Norway

The plan for the restructuring of the health system after the war was built on the Norwegian Public Health Act of 1860, which had located the responsibility for the health of the people to Health Councils in the municipalities. These councils consisted of lay people and politicians and was headed by the respective district health officer, appointed by the state. The health officer and a locally appointed community nurse, constituted the core of primary healthcare in the municipality.[45] The attractiveness of this system was

[39] Nordby, *Karl Evang*, 156, 71–72; Rune Slagstad, *De nasjonale strateger* (Oslo: Pax, 2001), 209–12, 308–11.

[40] Teemu Ryymin and Astri Andresen, "Effecting Equality: Norwegian Health Policy in Finnmark, 1945–1970s," *Acta Borealia* 26, no. 1 (2009), doi.org/10.1080/08003830902951565. Seip, *Veiene til velferdsstaten*, 357–9; Slagstad, *De nasjonale strateger*, 210–11, 310–11.

[41] Schiøtz and Skaset, *Folkets helse*, 313–14.

[42] Karl Evang, *Gjenreisning av folkehelsa i Norge* (Oslo: Fabritius, 1947); Nordby, *Karl Evang*; Slagstad, *De nasjonale strateger*, 210–11, 310–11.

[43] Nordby, *Karl Evang*, 171–2; Slagstad, *De nasjonale strateger*, 209–10.

[44] Ida Ohlsson Al Fakir, *Nya rum för socialt medborgarskap: Om vetenskap och politik i "Zigenarundersökningen" – en socialmedicinsk studie av svenska romer 1962–1965* (Växjö: Linnaeus University Press, 2015), 97–8.

[45] Schiøtz and Skaset, *Folkets helse*, 332.

that it ensured decentralized and democratic control in matters of health but also a strong position for the central health administration in social matters. Explicitly drawing on inspiration from Andrija Štampar, Evang advocated participatory democracy at the district level, an idea rooted in the nineteenth-century educational tradition typical of the Scandinavian countries, which, in turn, had inspired Štampar's ideas of social pedagogy in the 1920s.[46]

When it came to primary healthcare within the municipalities, Norwegian health authorities considered publicly funded interdisciplinary health centers to be the best way to achieve an approach anchored in the expanded concept of health.[47] They were inspired by the *basic health services* approach in the WHO. Ideally, the health centers should have a fourfold task: carry out preventive work and curative activities, organize home-nursing care, be responsible for social provision in the municipalities, and be responsible for most of the public provision of health and social care.

However, in a system based on a considerable local political autonomy, this idea was never more than partially realized. Neither in the 1950s nor the 1960s did the health center idea gain traction with the county and municipal health authorities. The development of hospitals was given political priority, demanding the bulk of financial resources. Primary healthcare remained a functional periphery during the development of the welfare state in the post-war period.[48] The Hospital Act of 1969 reinforced the functional "distribution crisis" between the health service inside and outside the institution. In fact, during the post-war period, the Scandinavian healthcare system became more hospital-centered than healthcare systems in other Western countries.[49] In addition, both the Norwegian medical association as well as the municipalities preferred a system of mainly private family doctors to the system of health centers with publicly funded staff.

Although some interdisciplinary health centers emerged across the country over the next decade, shifting policy priorities gradually overshadowed their prominence, particularly the focus on curbing hospital expansion. In the health service reorganization planned in the latter part of the 1970s, the interdisciplinary health center lost its status as a pivotal institution. Simultaneously, the social medical vision integral to these centers faded

[46] Patrick Zylberman, "Fewer Parallels than Antitheses: René Sand and Andrija Štampar on Social Medicine, 1919–1955," *Social History of Medicine* 17, no. 1 (2004), doi.org/10.1093/shm/17.1.77.

[47] Martinsen, *Omsorg, sykepleie og medisin*, 240–1.

[48] Finn Henry Hansen, "Helsesektoren i velferdsstaten: kjempevekst og fordelingskrise," *Tidsskrift for samfunnsforskning* 20 (1979): 219–40.

[49] Per Haave, "The Hospital Sector: A Four-Country Comparison of Organisational and Political Development," in Niels Finn Christiansen, Klaus Petersen, Nils Edling, and Per Haave. (eds.), *The Nordic Model of Welfare. A Historical Reappraisal* (Charlottenlund: Museum Tusculanums Forlag, 2006), 215–42.

from health policy,[50] signaling a departure from the dominant social medical orientation of health policy since 1945.[51] Subsequently, in the 1990s, many of the health centers established in the 1970s and 1980s underwent privatization.[52]

Notwithstanding, Evang was content with the fact that they had managed to secure access to free healthcare to all. In 1964, he was taken on a tour of a hypermodern hospital at the University of California, Los Angeles, together with the sociologist, Milton Roemer. The director of the hospital, who was showing them around, halted in front of an advanced X-ray machine and asked Evang whether Norway had something similar. Evang praised the technology but added: "the advantage with our system is that we only need to take one image. Here you have to take two – one of the patient, and one of his wallet."[53]

Social medicine did not penetrate the medical system in a way that the socio-medically oriented health reformers across Scandinavia had wanted. The great paradox of Evang's career was that when he retired in 1972, close to 80 percent of health expenditures in Norway went to hospitals, even though he had been advancing prevention, rehabilitation, and primary care throughout his more than thirty years in office. Looking back, Evang argued that the majority of physicians were still practicing within an old and "outdated" reductionist biomedical mindset.[54] Throughout Scandinavia, in spite of the efforts of the leaders of the central health administration, social medicine became marginalized in a health service characterized by the growth of specialized hospitals, which developed into resource magnets – monopolizing investments, personnel, technology, and patients at the expense of primary healthcare.

Exploring the Margins of the Welfare State: Social Medicine As Academic Field

In 1967, the book, *The Unfinished Welfare* (*Den ofärdiga välfärden*), garnered widespread public attention in Sweden, to the dismay of the Minister of Social Welfare, who criticized it for undermining the welfare state. The authors argued that society tended to overlook silent suffering, which contradicted the welfare state's self-image. Utilizing statistics, they demonstrated how class disparities affected access to medical care, higher education, mental health, and mortality rates. Additionally, the book featured field descriptions and interviews with homeless individuals. The book was authored by Swedish

[50] Martinsen, *Omsorg, sykepleie og medisin*, 249; Seip, *Veiene til velferdsstaten*, 353.
[51] Seip, *Veiene til velferdsstaten*, 355. [52] Schiøtz and Skaset, *Folkets helse*, 357–8.
[53] Nordby, *Karl Evang*, 55.
[54] Karl Evang, *Helse og samfunn. Sosialmedisinsk almenkunnskap* (Oslo: Gyldendal, 1974).

Professor of Social Medicine at Karolinska Institutet in Stockholm Gunnar Inghe and his wife, social worker Maj-Britt Inghe. It drew partly on Gunnar Inghe's groundbreaking PhD thesis of 1958,[55] published in Swedish in 1960 under the title, *Poor in the People's Home* (*Fattiga i folkhemmet*). The book sought to understand and address the root causes of poverty, illness, and marginalization within the welfare society.[56] Whereas sociomedical professionals in the health administration contributed to the building of the welfare state and assumed hegemonic positions, professionals within the academic sociomedical field sought to illuminate the shadows of the welfare state and expose the ill health and lack of access to the welfare state among people in marginalized positions.

Social medicine research had been performed by left-wing doctors in the 1930s, drawing inspiration from international social medicine research activities to explore nutrition and housing related to poverty in Scandinavia, and on the health conditions of people from disadvantaged backgrounds.[57] After the Second World War, social medicine gained recognition as a separate subject within the medical curriculum, complete with its own professorship. This first occurred in Norway in 1952, followed by Sweden in 1958, and Denmark in 1969. Across all three countries, this establishment involved the separation of social medicine from hygiene within the medical field.

The professors in social medicine, like Gunnar Inghe in Sweden, Poul Bonnevie in Denmark, and Axel Strøm in Norway, formed a generation of sociomedical professionals with their teaching and textbooks in social medicine. They were also people with significant influence in their own societies. For example, Strøm had served as President of the Norwegian Medical Association (1948–51) when he accepted his professorship. Following his tenure, he assumed the role of Dean of the Medical Faculty at the University of Oslo for seven years, from 1956 to 1964.

In Sweden, a committee appointed by the government recommended in 1953 that social medicine should be based on research related to the social context of clinical practice and on heredity, environment, and social determinants of health and disease, based in interdisciplinary research centers.[58] The first two professorships in social medicine with attached sociomedical clinics were established in 1958 in Gothenburg and Lund, followed by

[55] G. Inghe, "Mental and Physical Illness among Paupers in Stockholm," *Acta Psychiatrica Neurol Scandinavica* 33, Suppl 121 (1958): 1–316.

[56] Ohlsson Al Fakir, *Nya rum för socialt medborgarskap: Om vetenskap och politik i "Zigenarundersökningen" – en socialmedicinsk studie av svenska romer 1962–1965*.

[57] Karl Evang and Otto Galtung Hansen, *Norsk kosthold i små hjem : virkelighet og fremtidsmål* (Oslo: Tiden, 1937), 7.

[58] *Swedish Government Official Reports* (*SOU*), 1953: 7 Läkarutbildningen (on Medical Education) (Stockholm: Ministry of Education, 1953), 253–4.

professorships in three other universities by 1963, and ultimately in Linköping in 1969.[59] One of the early Swedish professors in social medicine was before mentioned Gunnar Inghe, who like the first professor in social medicine in Norway, Axel Strøm, had been one of the pioneers of the radical social medicine movement in the 1930s and then above all, for the more social-political line of social medicine.[60] In Denmark, Paul Bonnevie was the driving force in separating hygiene and social medicine. He was Professor in Hygiene at the University of Copenhagen from 1948. He rapidly expanded the subject to also include social medicine, which he called "the ecology of human beings,"[61] taking the post as the first Professor in Social Medicine in 1969.[62] In Norway, Per Sundby researched somatic health problems among patients with alcohol dependence, whereas Berthold Grunfeld continued the tradition of sexual health and reproductive rights in social medicine from the 1930s. His doctoral thesis from 1973 focused on women and abortion in Norway,[63] and had significant implications for the breakthrough of the new Norwegian legislation on voluntary abortion, which came into effect when the "abortion law" of 1975 was amended in 1978.

Social medical research in Scandinavia centered mainly on underprivileged groups in society – for example, on access to abortion services, alcoholism, substance use problems, venereal diseases, and national minorities.[64] A defining feature of the research in this period was its interdisciplinary nature, incorporating both natural and social sciences. It employed biomedical approaches alongside methods derived from the social sciences, encompassing clinical practice, research directed at policy and clinical practice, and investigations conducted at both individual and population levels. Moreover, funding for this research came from governmental authorities, public institutions, and universities alike. Thus, it was the transboundary character of social medicine that enabled the expansion of social medicine as an academic field.

[59] Urban Janlert, Socialmedicinens väg till specialitet, *Socialmedicinsk tidskrift* 5 (2009): 402–9. Umeå, Uppsala and Stockholm and Linköping.

[60] Jan Halldin, "Gunnar Inghe – de fattigas advokat Sveriges förste socialläkare inspirerande lärofader," *Läkartidningen* 96 (1999): 2895–7. Other politically minded social medicine proponents were Gustav Jonsson and John Takman, whereas Ragnar Berfenstam, who was a professor in Uppsala argued for a more "descriptive" social medicine without normative dimensions.

[61] Steen Brock, *Folkesundhed. Perspektiver på dansk samfundsmedicin* (Aarhus: Philosophia), at: https://samples.pubhub.dk/9788793041189.pdf.

[62] Povl Riis, "Poul Bonnevie," in Den Store Danske lex.dk, at: https://denstoredanske.lex.dk/Poul_Bonnevie.

[63] Berthold Grünfeld, *Legal abort i Norge: legalt svangerskapsavbrudd i Norge i tidsrommet 1965–1971: en sosialmedisinsk og sosialpsykiatrisk undersøkelse* (Oslo: Universitetsforlaget, 1973).

[64] Ida Ohlsson Al Fakir, *Nya rum för socialt medborgarskap: Om vetenskap och politik i "Zigenarundersökningen" – en socialmedicinsk studie av svenska romer 1962–1965* (Växjö: Linnaeus University Press, 2015), 96.

Social Medicine As a Medical Specialty

Social medicine as a clinical practice in Scandinavia during the postwar years was directed toward the multifaceted origins of diseases and disabilities, the importance of interdisciplinary collaboration, and advocacy for social reforms and collective care across various sectors such as education, healthcare, and social insurance. In all three countries, specialties in social medicine were created but took different forms.

One significant common feature was the development of social medicine as an important field in the disability benefit policy. This led to a new and broader client group, including the elderly, children, and other persons outside the labor market. From now on, experts in social medicine dominated the growing field of disability benefit policy. The new laws on disability pensions stressed the need to exhaust all available measures before granting pensions, a concept hailed by the General Director of Health in Norway as a "truly revolutionary sociomedical breakthrough."[65] Sociomedical advocates asserted that social medicine should play a pivotal role in a holistic and socially conscious rehabilitation, distinct from the biomedical approach.[66] Clinics were established in certain state and regional hospitals and primarily catered to a select group of complex patients while also serving as training facilities. In Sweden, Professor Gunnar Inghe held the position of clinic head at the Karolinska Hospital, whereas Strøm was the clinic head at the social medicine clinic at Rikshospitalet.[67]

In 1959, Norway was the first country in Scandinavia to establish a specialty in social medicine.[68] However, the proposed sociomedical departments that were supposed to give these new specialists a job and secure their specialization failed to materialize adequately due to low prioritization by regional authorities and societal stigma surrounding the specialty and its patients.[69] Instead, more biomedically oriented rehabilitation services began to dominate the hospital landscape. Additionally, primary healthcare, predominantly composed of general practitioners in private solo practices, was tasked with the responsibility of sociomedical rehabilitation, effectively diminishing the necessity for dedicated departments of social medicine. In 1986, social medicine ceased to exist as a medical specialty. A new specialty of physical medicine and rehabilitation was supposed to continue "the individual aspect" of

[65] Evang, *Helse og samfunn: sosialmedisinsk almenkunnskap*.
[66] Marte Feiring, "Fra revalidering til rehabilitering – en dansk begrebshistorie," *Tidsskrift for Professionsstudier* 13, no. 24 (2017): 86–97.
[67] Evang, *Helse og samfunn: sosialmedisinsk almenkunnskap*.
[68] Per Haave, *I medisinens sentrum. Den norske legeforening og spesialistregimet gjennom hundre år* (Oslo: Unipub, 2011), 92. See also the proposition:
[69] Anders Chr Gogstad, "Klinisk sosialmedisin: lavstatusposisjon i helsevesenet?," *Tidsskrift for Den norske lægeforening* 102, no. 31 (1982): 1619–21.

social medicine. Another new specialty, community medicine, was supposed to harbor the "population aspect" of social medicine, in addition to public health work in the municipalities.[70] In contrast to what Anderson, Dunk, and Musolino show in Chapter 12 in this volume, the authorities considered these new tasks to be "too important" to be left to "economists, experts on health administration, statisticians, lawyers or health educators" and wanted doctors in top positions in the local health administration.[71] Social medicine was supposed to be one of several disciplines contained within community medicine but it remained marginal in the new specialty.

In Denmark, social medicine, while similar to Norway, was important for rehabilitation in the early postwar years and defined as a proper clinical practice, a specialty devoted to social medicine alone never developed. However, in 1989, a specialty in community medicine (established in 1987) was expanded to include social medicine as a proper subspecialty (health administration is the other subspecialty). The specialty has, in contrast to Norway, maintained the combination of individual and population level focus so characteristic of social medicine in Scandinavia in the early days. The subspecialty in social medicine mainly focuses on sociomedical problems in individual patients, drawing on theory and methods from public health, sociology, epidemiology, law, and clinical medicine.

In Sweden, social medicine was suggested as a specialty by the highly influential scholars Gunnar and Alva Myrdal already in 1934,[72] but although it was defined as a clinical area in the 1950s, the specialty was only formed 1974. Until the 1990s, social medicine in Sweden had a clinical basis which was mainly concerned with work and rehabilitation toward full employment and many of the specialists worked as social physicians in interdisciplinary teams at regional level. However, as a consequence of the restructuring of the health system and finances, social physicians could no longer be employed at a district level and the specialty stopped being anchored in a clinical field. From then on, the Swedish specialty social medicine has been predominantly oriented toward population-oriented health policy and management, health promotion, prevention, and social epidemiology. The specialty still exists,

[70] One reason for the establishment was that the more than 120-year history of the centrally appointed District Medical Officer came to an end as a result of the new Act and was replaced by a physician appointed by the local government who was given the responsibility for the provision of healthcare in the community.

[71] Per Haave, *I medisinens sentrum: Den norske legeforening og spesialistregimet gjennom hundre år* (Oslo: Unipub, 2011), 271–3.

[72] Alva Myrdal and Gunnar Myrdal, *Kris i befolkningsfrågan* (Stockholm: Albert Bonniers Förlag, 1934); James M. Nyce and Toomas Timpka, "The reformist triad and Institutional Forgetting of Culture: A Field Study into Twentieth-Century Swedish Social Medicine" *International Journal of Health Services* 42, no. 1 (2012): 95–107.

although it is struggling due to a lack of places for the young specializing physicians to practice,[73] and its existence has been threatened.

Scandinavian Social Medicine Actors on a Global Scene

Social medicine protagonists in Scandinavia sought inspiration among like-minded colleagues abroad, first and foremost in the activities at the WHO. For small countries such as the Scandinavian, global engagements offered means to reassert themselves in an era of emerging powers and geopolitical crises. By collaborating with each other on a common social democratic agenda and with the non-aligned countries on political reform in the 1970s, the Scandinavian countries were able to maintain their status as important international actors, despite their small size.

As Sunniva Engh has shown, Norwegian Karl Evang played a more important role in the early process of the creation of the WHO than has been acknowledged in the anglophone literature on the WHO.[74] According to Szeming Sze, Evang was a driving force behind the proposal of the formation of a world health organization.[75] He continued to be an active member of the WHO and chaired all Norwegian delegations to the yearly assemblies until his retirement in 1972. Furthermore, he served as president and vice president at the second and fourth World Health Assemblies in 1949 and 1951, respectively, and as chairman of the Executive Board in two sessions.[76] In 1966, he received the Léon Bernard Foundation Prize for outstanding contribution to social medicine.[77]

While chairing the Panel on Public Health Administration, Evang, together with Andrija Štampar and others, formulated the Basic Health services idea in 1951. Carrying forward ideas from the Bandung Conference of 1937, they attempted to launch a new primary healthcare offensive, at a local level, with involvement of the local population and collaboration with different sectors of society.[78]

The most controversial field, however, was family planning and women's health. Partly relying on previous experiences with sex education and domestic

[73] Urban Janlert, Socialmedicinens väg till specialitet, *Socialmedicinsk tidskrift* 5 (2009): 402–9.
[74] Szeming Sze, "The Birth of WHO: Interview [with] Szeming Sze," *World Health*, May 1989. See also Sunniva Engh, "The Complexities of Postcolonial International Health: Karl Evang in India 1953," *Medical History* 67, no. 1 (2023): 29.
[75] Sunniva Engh and Niels Brimnes, "Scandinavian Entry Points to Social Medicine and Postcolonial Health: Karl Evang and Halfdan Mahler in India," *Medical History* 67, no. 1 (2023): 1–4.
[76] In the 36th and 37th session.
[77] https://apps.who.int/gb/awards/pdf_files/Bernard/Winners_en.pdf.
[78] Martin Gorsky and Christopher Sirrs, "From 'Planning' to 'Systems Analysis': Health Services Strengthening at the World Health Organization, 1952–1975," *Dynamis (Granada, Spain)* 39, no. 1 (2019), doi.org/10.30827/dynamis.v39i1.8672.

concern over child poverty and depopulation from the interwar period and forward, Norway and Sweden pushed an early maternal- and child-oriented agenda. In 1952, Evang suggested that an expert committee should investigate and deliver a report on the health aspect of birth control and family planning.[79] He received support from representatives from both Ceylon and India but had to withdraw the suggestion after heated debate.[80] In 1958, Sweden responded to a request from Ceylon and later Pakistan to provide development assistance for family planning.[81]

Both Höjer and Evang were impressed and inspired by the work of the Indian delegation during the first years of the WHO, an impression that also led both of them to develop projects with Indian collaborators. It was Sir Arcot Lakshmanaswami Mudaliar, a key figure both within the WHO and Indian health and education policy-making,[82] who convinced Axel Höjer to leave his post as General Director of Health in Sweden and instead help develop medical education in Kerala, India.[83]

As Niels Brimnes has recently shown, WHO Director General Halfdan Mahler's views on healthcare were formed by his experience of social medicine in India between 1951 and 1961, where he was inspired by indigenous traditions, community orientation, and a broad approach to health,[84] described by Baru in Chapter 11 in this volume. The election of Halfdan Mahler as Director-General of the WHO (1973–88) also led the push for a more radical international health agenda, based on equity and social justice and the emergence of a new health for all paradigm in the Alma-Ata Declaration of 1978.

[79] World Health Organisation (WHO). 1952. Fifth World Health Assembly, 8, 237–8, https://iris.who.int/bitstream/handle/10665/85641/Official_record42_eng.pdf

[80] According to Milton Roemer, this event was the reason why Evang had lost his chances of becoming the next Director-General of WHO: "He [Karl Evang] is, in my opinion, the best public health administrator in the world and would undoubtedly have been the next Director-General of W.H.O., had he not brought the Catholics down on him by being outspoken on birth control" (Letter from Roemer to Sigerist, Regina, January 29, 1955, at: www.img.unibe.ch/e40437/e40444/e153944/section154575/files154580/CorrespondenceHenryE.Sigerist-MiltonI.Roemer_ger.pdf). Vicente Navarro held Evang to be one of the most important persons he had met: "my professional life in the health area was most influenced at that time by Evang and Brotherston. It was they who, with Štampar from Yugoslavia, wrote the famous definition of health in the 1948 World Health Organization Constitution" (Vicente Navarro, "A Historical Review (1965–1997) of Studies on Class, Health and Quality of Life: A Personal Account," *International Journal of Health Services* 28, no. 3 (1998): 389–406).

[81] Sunniva Engh, "The Rockefeller Foundation, Scandinavian Aid Agencies and the 'Population Explosion,'" in Klaus Petersen, John Stewart, and Michael Kuur Sørensen (eds.), *American Foundations and the European Welfare States* (Odense: Syddansk Universitetsforlag, 2013), 181–202.

[82] Roger Jeffery, *The Politics of Health in India & London* (Berkeley: University of California Press, 1988).

[83] Berg, *Den gränslösa hälsan*.

[84] Niels Brimnes, "Negotiating Social Medicine in a Postcolonial Context: Halfdan Mahler in India 1951–61," *Medical History* 67, no. 1 (2023), doi.org/10.1017/mdh.2023.11.

More than fifty years after Karl Evang had taken part in the first general health assembly in the WHO, the Norwegian physician and politician Gro Harlem Brundtland became Director General of the WHO. "There is a very close connection between being a doctor and being a politician," Brundtland said in an interview with *Time* magazine in 2001. "The doctor first tries to prevent illness, then tries to treat it if it comes. It's exactly the same as what you try to do as a politician, but with regard to society."[85]

When the young and politically relatively inexperienced physician Gro Harlem Brundtland was called to be Minister of Environment in 1974, she felt competent because she compared environmental politics to health promotion. She had a Public Health degree from Harvard and had worked in the Social Medicine Department, first at the Norwegian Directorate of Health, then at the Oslo City Health Council (on the subject of school health). At the time when she got the call from the prime minister, she had started a PhD on the social determinants of health and had initiated her public life as an abortion activist, applying her medical experience to bring about political change. Her outspoken pro-choice lobbying brought her into the public eye in the early 1970s and to the attention of the power circles in the Labour Party.[86] After having served five successful years as a minister of the environment, she was prime minister first in 1981, then in 1986–9 and 1990–6. In 1984, she was asked by the United Nations Secretary General Perez de Cuellar to preside over the newly created World Commission on Environment and Development.

With more of a willingness to compromise on humanitarian idealism than Karl Evang, she brought what Simon Reid-Henry has called "a distinctly Nordic brand of humanitarian internationalism" to the emergent environmental politics of the time.[87] The commission's landmark report *Our Common Future*, also known as the Brundtland report, published in 1987, coined the value-based concept of sustainable development, defined as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs."[88] In the report, social, economic, and environmental concerns were inextricably linked and the policy solutions they suggested integrated social equity, economic growth, and environmental problems.

Although both the commission's extensive community engagement in the form of hearings and the report's call for "vigorous redistributive policies" in

[85] N. Gibbs, "Norway's Radical Daughter," *Time*, June 24, 2001.

[86] Steinar Hansson, *Makt og mannefall: historien om Gro Harlem Brundtland*, ed. Ingolf Håkon Teigene (Oslo: Cappelen, 1992).

[87] Simon Reid-Henry, "The Pragmatarian Style: Environmental Change, Global Health, and Gro Harlem Brundtland's Nordic Internationalism," in Antoine de Bengy Puyvallée and Kristian Bjørkdahl (eds.), *Do-Gooders at the End of Aid: Scandinavian Humanitarianism in the Twenty-First Century* (Cambridge: Cambridge University Press, 2021), 194–221.

[88] World Commission on Environment and Development, *Our Common Future* (Oxford: Oxford University Press, 1987), 43.

economic growth,[89] were completely in balance with Brundtland's own egalitarian and social democratic ideas as Iris Borowy has shown,[90] it opened up a path for addressing structural problems via market logics and instruments. Therefore, although it initially had quite a radical agenda, it has been criticized for having made change dependent not upon solidarity but on self-interest.[91] However, it is hard to overestimate the impact the value-based concept of sustainable development has had and there is certainly important social medicine elements in the Commission's early work on popular engagement.

After returning to Norway to serve as prime minister once more – first from 1986 to 1989 and again from 1990 to 1996 – Brundtland later reemerged on the global stage when she was elected as the new Director-General of the WHO in 1998, a post she had until she resigned when term ended in 2003. When taking office, one of her two announced priorities was tobacco control and, in 2003, the World Health Assembly adopted the WHO Framework Convention on Tobacco Control. This landmark agreement introduced regulations governing tobacco production, sale, distribution, advertisement, and taxation, marking a watershed moment for international public health.[92]

During her leadership, WHO projects moved away from the health systems approach of Mahler. She was determined to reposition WHO as an important global player and strengthen the organizations position in an era with a growing dominance of neoliberal globalization and the entry of a whole series of new actors on the global arena, in the fragmented and complex landscape characterizing this transition from international health to global health.[93] Building on her extensive political experience, she contributed to a more political approach to health within the WHO. She also sought to strengthen the difficult financial situation of the WHO by opening it up for private–public partnership, thereby increasing the number of actors within global health, but also address the lack of governance.

Social Medicine: Still in Search of a Lost Discipline?

In the first decades of the post-war society, what had been radical left-wing social medicine became close to self-evident policies and the 1930s pioneer

[89] World Commission on Environment and Development, *Our Common Future*, 50.
[90] Iris Borowy, *Defining Sustainable Development for Our Common Future: A History of the World Commission on Environment and Development (Brundtland Commission)* (London: Routledge, 2014).
[91] Reid-Henry, "The Pragmatarian Style."
[92] R. Roemer, A. Taylor, and J. Lariviere, "Origins of the WHO Framework Convention on Tobacco Control," *American Journal of Public Health* 95, no. 6 (June 2005), doi.org/10.2105/ajph.2003.025908.
[93] Theodore Brown, Marcos Cueto, and Elizabeth Fee, "The World Health Organization and the Transition from 'International' to 'Global' Public Health," *American Journal of Public Health* 96, no. 1 (2006): 62–72, doi: 10.2105/AJPH.2004.050831.

generation saw many of their central ambitions fulfilled and important tasks solved, both in academia (professorships in social medicine) and in bedside medicine (social medicine clinics), in a growing welfare state that built on the expanded notion of health. The political radicalism of social medicine receded to the background and practitioners of social medicine as well as academics focused increasingly on vulnerable groups and their precarious position within the health and welfare services and most of its practitioners left its revolutionary ambitions.

During the 1980s and 1990s, social medicine experienced a notable decline, which was particularly evident in Norway. This period saw the closure of social medicine departments in regional hospitals and the discontinuation of the medical specialty in social medicine in 1986. Instead of being housed in hospital departments, academic social medicine became based in university departments, without any real connection to clinical practice. Reflecting the shift from the hospital sector to primary healthcare within community medicine, professors of social medicine during the 1990s were recruited mostly from academic general practice, rather than from psychiatry.[94]

For example, Per Fugelli assumed the position of professor in Social Medicine at the University of Oslo in 1992, after having established an academic department of general practice in Bergen. In Oslo, he embarked on a lengthy career as a public intellectual, addressing topics such as medicalization, social justice, and death and dying.

To a lesser extent, he focused on cultivating a new generation of researchers and did not succeed in building an academic field in the same way as he had done for general practice a decade earlier.[95] However, during the 1990s, he established an interest group for medical students called "The Patient Earth," which attracted many students who would later play significant roles in the Norwegian medical community. This group aligned with his passion for ecology and the environment at the time. In 1993, before the concept of planetary health emerged, he wrote an article about "the patient Earth," urging doctors to diagnose the diseases of the planet and recommend treatment.[96] Fugelli's influence extended to a broad public audience, as evidenced by the front-page coverage of his death in 2017 by all major newspapers.

In Sweden and Norway, the reorganization of academic departments in the latter part of the twentieth century ultimately diminished the status of social medicine as an independent discipline. It was consolidated with other fields

[94] K. Haug, P. Fugelli, G. Høyer, and S. Westin, "Sosialmedisin – på sporet av det tapte fag," *Tidsskrift for Den norske lægeforening* 120 (2000): 3057–61.

[95] K. Malterud and S. Hunskår, "Per Fugelli – en allmennmedisinsk biografi. I: S. Hunskår (red.)," *Akademisk allmennmedsin i Bergen 50 år: 1972–2022*, *Michael* 19, suppl 29 (2022): S61–8.

[96] Per Fugelli, "In Search of a Global Social Medicine," *Forum for Development Studies* 20, no. 1 (1993/01/01 1993), https://doi.org/10.1080/08039410.1993.9665937, https://doi.org/10.1080/08039410.1993.9665937.

into larger units, where various subjects were merged under a single umbrella, both in research and teaching.[97] In 1999, the *Nordic Journal of Social Medicine* was rebranded as the *Scandinavian Journal of Public Health*, reflecting the fading prominence of the term "social medicine." According to the editors, it had been concluded that "despite the strong sentiments attached to the historical, ideological and professional connotations of 'social medicine', … the broader term 'public health' would better convey the Journal's scientific orientation and sphere of interest."[98]

In the 2000s, research on social inequality in health surged, partly influenced by the Marmot Report. However, this research, mainly register-based and population studies, focused on the overall gradient of inequality in the population rather than addressing the sociomedical concerns of marginalized groups and the pathology of poverty. Furthermore, new dynamic research groups in international health, medical anthropology, and general practice, often adopting a social medicine perspective, opted against associating themselves with the label. The decline of the academic core environments for social medicine was partly due to the emergence of these new, vibrant research groups but also to a clear shift of research toward epidemiology and population-wide studies, where methodological challenges often took precedence and statistically trained researchers took the lead.

Today, the presence of academic chairs in social medicine has dwindled notably across Scandinavia, with Denmark showing a slightly more favorable situation compared to the other two countries. The calls for social medicine that became evident during the Covid-19 pandemic in other parts of the world remained almost silent in Scandinavia, despite its once prominent role as a core element of the welfare state. Consequently, social medicine, rooted in principles of social justice and the social determinants of health, has receded to the background.

[97] John Gunnar Mæland, "Samfunnsmedisin og folkehelsearbeid," *Michael* 13 (2016); John Gunnar Mæland, "Den norske akademiske sosialmedisins fall 1990–2024," unpublished manuscript, 2024.

[98] "From *Scandinavian Journal of Social Medicine* to *Scandinavian Journal of Public Health*: A Change of Name but Not of Vision," *Scandinavian Journal of Public Health* 27, no. 1 (1999): 1–2.