

THE WORKERS' HEALTH IN WAR AND PEACE

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I intend to examine the way in which the health of people *as workers* has been regarded in the course of the 20th century. I hope to show that workers' health has really only been a central concern of governments in war-time. In peace-time, the 1920s, 1930s and the period since the second world war, improvements in working conditions, and research into the hazards of work, have been left largely to private or non-central government efforts.

From the outbreak of war in August 1914 civilian production was intertwined with military strategy. Britain had to manufacture munitions for its fighting forces and manufacture exports to pay for imports of munitions, raw materials and food in order to maintain the military and civilian populations. Only by doing this could Britain win the war. Production was to be the guiding strategic tenet on the Home Front. Developing ways of increasing production by, for instance, improving industrial efficiency through safety, health and welfare measures was, therefore, central to the war effort. It was for this reason that the Home Office, and the Ministry of Munitions from its establishment by Lloyd George in 1915, increasingly intervened in industry to boost production.

The Ministry's best remembered effort was the creation of a Health of Mmunition Workers' Committee (H.M.W.C.) in 1915 to 'consider and advise on questions of industrial fatigue, hours of labour, and other matters affecting the personal health and physical efficiency of workers in munitions factories and workshops'. It produced reports on workers' health which led to improvements in munitions factories.

As the labour shortage worsened in 1917-18, attempts to increase industrial efficiency through safety, health and welfare at work intensified. The Ministry of Munitions and the Home Office both attempted to raise standards in industry, and the courts, which at the beginning of war had taken a 'soft' view of cases brought before them, toughened their sentences as the war dragged on.

But, at the end of the war, munitions factories shut down, women were laid-off and governments no longer saw occupational health as central to their policies. In the immediate post-war years, as war-time requirements for welfare in munitions factories came to an end, welfare provision declined; it continued at a low level in the early 1920s, but picked up again as the decade progressed. Significantly, even in the early 1930s, in the depths of depression, when British industry was shedding thousands of workers and profits were hardest to make, some firms chose to spend money on new welfare schemes. As the economy gradually picked up in the mid-1930s so welfare rapidly developed. Provisions continued to increase into the late 1930s.

From the First World War onwards a variety of new, private, national, employer-oriented organisations promoted industrial welfare. The Industrial Welfare Society (IWS), National Institute of Industrial Psychology (NIIP) and Institute of Labour Management (ILM) presented themselves as philanthropic bodies supporting the interests of both sides of industry. Improvements in occupational health were a central part of their message.

The appointment of works' doctors, or industrial medical officers as they were formally known, was the most direct application of medicine to industry, but the least common aspect of health promotion. Medical practitioners were only employed in industry to a limited extent before the Second World War; there were 20 founding members of the Association of Industrial Medical Officers (AIMO) in 1935 and by 1939, 70 members. They were mainly located in London, followed by Birmingham and then York, and were concentrated in particular firms (ICI employed more than any other firm). Despite pressure on Governments in the 1920s and 1930s from these organisations and from trade unionists, Governments took little interest in the workers' health - not so once war broke out.

Ernest Bevin, as Minister of Labour from May 1940, saw as a contributory factor to the successful handling of manpower, the expansion of the Ministry's work to include safety, health and welfare in factories, and compensation for injury at work. Safety, health and welfare changed from being an independent issue to an integral and explicit part of the Government's industrial relations strategy.

The war intensified the hazards of industry. The introduction of workers new to a process increased the risks of a process; longer hours and night work meant greater fatigue, in addition to which transport difficulties caused by congestion or enemy action lengthened the time spent away from home. As in the First World War, it was during the initial stages of war that the hazards of work were greatest, and in addition industry operated in almost total ignorance of the research undertaken between the wars. Yet, good health was especially important in war-time because it could affect production. The lessons of the First World War may have been lost on many employers in the early stages of the war, but the war nevertheless gave a spur to advocates of industrial medicine.

The key motive behind much of the war-time activity was the effect absenteeism was thought to be having on production. Time and time again ill-health, absenteeism and production were linked together. Fears about production were well-founded. The British aircraft industry's output per man-day was well below both those in Germany and the U.S.A. During 1942-3 absenteeism was double the American rate.

The manpower shortage prompted more effective action for the rehabilitation of injured workers. Before the war few rehabilitation units existed. Outside pressure was responded to by Ernest Bevin at the Ministry of Labour, rather than a health minister, and in 1941 Bevin set up an Interim Scheme for rehabilitation. Whitehall's support for rehabilitation was based solely on war-time production requirements. One Treasury official wrote, 'I'm not clear facilities should be provided expressly for training disabled men unless their services are required for war purposes' (PRO LAB 20/2 J.A. Barlow to F.N. Tribe, 3 March 1941). Following the recommendations of the 1942 inter-departmental Committee on the rehabilitation and resettlement of persons injured by accidents, a permanent scheme was established.

A variety of schemes to prevent deterioration to the point of disablement were instituted during the war. In the Clyde Basin (and later in the whole of Scotland) a preventative medicine scheme was aimed at young war workers. Panel doctors kept a close watch on workers between the ages of 15 and 25 for signs of a possible breakdown in health. These were referred to the Regional Medical Officer of the Department of Health for Scotland, who

arranged for a consultant opinion and admission to hospital, if necessary. Where only a short period of rest was required, patients were sent direct to a convalescent home. A systematic follow-up was also provided. A further experiment was set up by the Ministry of Labour for a special centre in the Manchester docks so that dock workers suffering from minor physical ailments could receive medical advice and treatment and then return to work as soon as possible. The centre worked closely with local hospitals and the scheme, financed by the Merseyside Dock Labour Scheme, included provision for the payment of a maintenance allowance during any period when a docker was certified as unfit for work.

Once the war ended, however, Governments' interest in occupational health again evaporated. Almost as soon as the National Health Service (N.H.S.) came into operation initial assumptions about its costs were undermined. When physical planning and controls formed the basis of economic management, the industrial relations strategy of the Ministry of Labour, which included promoting health and safety at work, received high priority in overall government strategy. When Keynesianism came to dominate economic management, industrial health was no longer of very great importance. As there were no strong economic arguments for incorporating occupational health into the NHS, the institutional structures already in existence had an inbuilt advantage. Employers were strongly opposed to further interference. In 1948 the British Employers Confederation (forerunner of the CBI) stated that it totally opposed any compulsory medical supervision in factories, irrespective of their size or the nature of work carried out there. Governments received ample criticism for trying to encourage employers to limit their pay settlements, and as industrial health was no longer an important part of governmental strategy, it was not worth exacerbating tensions which already existed with employers. Changes which were introduced came within the traditional ambit of government responsibility for working conditions, reform of the workmen's compensation system and a new Factory Act.

Occupational, medical and nursing services in the post-war years developed, for the most part, along lines laid down in the 1930s. The two new departures which occurred were both funded by the Nuffield Foundation. The first one, which grew from a new conception of the nature of industrial health, was the funding of research and teaching in occupational health at a select number of universities (Manchester, Glasgow and Durham universities were

allocated funds). The experiment did not have a knock-on effect. The message of those working in the universities remained in specialist publications. It is hardly surprising, therefore, that they were not taken notice of by a wider audience who might have been able to exert pressure on firms to adopt the researchers' findings. The promotion of occupational health by the Nuffield Foundation was hampered by a failure of the research to be widely disseminated, and by the *voluntary* adoption by firms of researchers' findings. The second scheme, was an attempt to provide an industrial health service for a group of small firms in the same locality. The experiments, most notably in Slough, were not widely adopted. In the post-war years industrial health never became a significant part of industrial relations management and so the likelihood of its adoption was minimal. So too, with the rôle of industrial health in medical education: it never became a significant part of medical education and the health care system continued in its predominantly curative rather than preventive role; industrial medicine competed for recognition along with all the other specialisms which had grown up during the twentieth century.

Despite pressure from the labour movement, occupational health remained a low priority for Governments, whether Conservative or Labour. Stonewalled by Governments, the TUC changed its tactics and from the 1960s focused on health and safety improvements at the level of the firm. A Government committee of inquiry into health and safety at work in the early 1970s proved to be a false dawn. When a genuine revival in interest in occupational health occurred, it came from local initiatives.

Projects in Sheffield, Camden, Bradford and now Liverpool are re-establishing the importance of good working conditions for urban public health. In 1979 a small-scale project began in two GP surgeries in Sheffield to try and discover whether primary health care could deal more effectively with work-related health problems. Patients were interviewed in GPs' waiting rooms about their work and their health. Patients were also seen outside the surgery to try and build up a picture of the relationship between work and (ill) health. The pilot project discovered that 44% of workers visiting their GP were suffering from work-related ill-health. Deafness and dermatitis were the most frequent conditions linked to people's work. Gradually the project extended its work to other surgeries in Sheffield. The findings of the researchers were fed back to patients and doctors alike, and in some cases this has led to

direct action. Camden and Bradford followed Sheffield's lead and a decade after the Sheffield project was launched, Liverpool began a similar one. Liverpool's traditional areas of employment (such as ship-repairing and unloading cargo) as well as the newer industries have all produced work-related illnesses.

The advantages of placing an occupational health scheme in urban health centres are numerous. Most (90%) firms have no occupational health scheme (only a rudimentary first aid one) and GP-based schemes can provide continuity when people change jobs, retire or are made redundant. Those workers (such as women and ethnic minorities) who are most typically marginalised in the labour force and have periods out of paid work have most to gain here, but because the onset of an industrial disease can occur years after the initial exposure, the urban health centre is important for all adults. The reduction or removal of some hazards should help to improve the urban public health environment in one of the UK's unhealthiest cities. Current primary health care projects are small-scale and tend to be run on a shoe-string, but their impact seems to be immediate and direct, in contrast with larger projects in the past which have failed to exert any influence. Interest in occupational health has revived in peace-time, but it relies on local initiatives not central government support.

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Reference

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