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The History of Work-Disability in the UK, from the 1880s to the 1950s

by John Macnicol

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Introduction: the present debate

Since the early 1970s, there have been marked improvements in the aggregate health status of the UK population. Between 1970 and 2009, life expectancy at birth increased from 68.72 years to 77.11 years for men, and from 74.98 years to 81.35 years for women. Life expectancy at age 65 also increased between 1981 and 2009, though by much less than is often assumed - by 4.3 years for men and 3.5 years for women: its current rate of increase is only 2 per cent per annum. Between 1968 and 2008, age-standardised mortality rates for men and women declined by 51 per cent and 43 per cent, and are now at their lowest-ever recorded level. This success story needs to be tempered by two reservations: first, there are substantial social class differentials in mortality; and second, self-reported health appears to have worsened (in part, a result of rising expectations), health care utilisation rates have risen (again, a function of increasing supply of resources, improved diagnostic techniques and new technology) and disability-free life expectancy has become a smaller proportion of total life expectancy. There is also much debate about whether these health gains at older ages will continue in the future.¹ Nevertheless, we can conclude with reasonable confidence that, since the early 1970s, the health of the UK population has improved markedly.

¹ For an example of the 'pessimistic' viewpoint, see S. Jay Olshansky et al, 'A Potential Decline in Life Expectancy in the United State in the 21st Century', *New England Journal of Medicine*, 325, 11, 17 March 2005, pp. 1138-45.

Yet concurrent with these improvements there has occurred a remarkable counter-trend: the number of people claiming disability-related benefits of all kinds has almost tripled since the 1970s, reaching a high-point of 2,740,000 in May 2005, and then slightly declining to 2,640,000 now. This level of claims was unaffected by the employment growth of 1992-2008, which caused other claimant groups (notably, lone parents and older people) to return to work in increasing numbers. On the face of it, there has been a threefold increase in the number of people considering themselves too sick to work. How is this paradox to be explained?

The first factor to consider is the overall socio-economic context. Since the early 1970s (the OPEC-led oil price shock of 1973 being the catalyst), western economies have experienced profound economic changes, amounting to no less than a second industrial revolution. There has been a massive 'redistribution of work' - from older men to women of all ages, from heavy industry to service jobs, from full-time jobs to part-time, from old industrial regions to new centres of economic growth, and so on. This is graphically illustrated if we look at the changing occupational structure between 1981 and 2006. The proportion of all jobs in manufacturing declined from 31 per cent to 17 per cent (men) and 18 per cent to 6 per cent (women); and those in banking and finance rose from 11 per cent to 21 per cent (men) and from 12 per cent to 19 per cent (women). Virtually all net job growth in the UK economy has been via part-time jobs, which have increased tenfold since 1951 (from 831,000 jobs to nearly 8,000,000). There has also been a polarisation between 'work-rich' households (where at least two adults have jobs) and 'work-poor' households (where nobody has a job). All of these changes have impacted devastatingly on older men in the UK's traditional industrial heartlands, and at the same time the new service-based jobs (often part-time, feminised, low paid and insecure) have presented social and psychological challenges. In essence, there are two distinct problems in modern labour markets: deindustrialisation and worklessness,

which has left whole communities with little recourse to waged employment; and the growth of new jobs which, being low-paid and insecure, are inadequate to support a family and symbolise the slow shift from the 'male breadwinner model' to the 'adult breadwinner model'.²

The story of work disability since the 1970s is in many ways a metaphor for these changes. It also symbolises other broad themes. One is the whole question of how far economically inactive citizens should be forced to take any job, at any wage. Since the recession and stagflation of the 1970s and early 1980s, successive UK governments have adopted a neoclassical economic strategy of expanding labour supply in order to achieve steady, non-inflationary economic growth by exerting downward pressure on wages. This strategy is also a response to the reality that all net employment growth in the UK economy in recent decades has been via part-time jobs. Under New Labour (1997-2010), this was articulated in the language of 'rights and responsibilities', with an increasingly hostile condemnation of 'welfare dependency'. Intriguingly, New Labour deployed the emancipatory, post-civil rights 'social' model of disability to justify the labour market activation of disabled people, and a tightening-up of benefit conditionality: pushing more disabled people into jobs was presented as 'empowerment'.³ Another theme is that in western societies in the second half of the twentieth century there was a growing propensity to define minor conditions as disabling - often termed 'the medicalisation of everyday life' or the 'cultural inflation' of sickness. However now the opposite is taking place, and disability is being defined down. It is important to bear in mind that concepts such as 'retirement', 'unemployment' or 'disability' are essentially constructs of twentieth century welfare states, and now, as welfare states are

² For an interesting account, see David M. Smith, *On the Margins of Inclusion. Changing Labour Markets and Social Exclusion in London* (2005).

³ For example, Department for Work and Pensions, *A New Deal for Welfare: Empowering People to Work*, Cm. 6730. 2006, p. 15.

being cut back, these concepts are being eroded.⁴ Welfare discourses are moving 'back to the future'.

Welfare benefit caseloads in modern industrial societies are complex, reflecting the fact that postindustrial labour markets are highly variegated, with cross-cutting divisions of gender, age, region, skill, sector and so on. Before the current recession pushed unemployment up to c.2,500,000, joblessness in the UK was the product of supply-demand mismatches between these many headings. All activation programmes thus face the problem that they have to be precisely tailor-made to fit the individual circumstances of each client, which will in turn present a unique combination of factors.⁵ Generalisations are therefore hazardous, but broadly speaking we can divide the population on all incapacity benefits into two categories: first, deindustrialised older men, concentrated in those regions which led the industrial revolution; and second, a diverse and growing group suffering mental and behavioural disorders - more feminised, and located in areas where aggregate economic growth is reasonably sustained. Members of the first group are suffering because of a lack of jobs, and their predicament has been well researched in the pioneering work of Christina Beatty and Steve Fothergill. Their age-profile is older (some 850,000 of claimants to incapacity benefits are aged 55+) and therefore they might reasonably be expected to have moved into retirement or death in ten years' time. (New Labour's 2006 target of getting 1,000,000 of them off benefit by 2016 was in many ways a rationalisation of the inevitable.) With this group, the problem is one of programme duration and lack of outflows from benefit: hence the dramatic, if misleading, soundbite that, after being on incapacity benefits for two years, a person is 'more likely to die or retire than get a job'. The second group are suffering because

⁴ John Macnicol, 'Anti-ageism and the Neoliberalisation of Old Age', *Paper to the ISA World Congress of Sociology*, Gothenburg, Sweden, July 2010.

⁵ Hartley Dean, 'Reconceptualising Welfare-to-work for People with Multiple Problems and Needs', *Journal of Social Policy*, 32, 3, 2003, pp. 441-59.

of the nature of the new jobs and because an increasingly competitive labour market has created more social casualties. Interestingly, in its last years of office the New Labour government, anxious not to emphasise labour market demand as a causal factor, focused more on the latter group: the new trend in claimants, it argued, was 'away from the stereotype of middle-aged men in the industrial heartlands and towards a new generation with manageable mental health or musculo-skeletal conditions'.⁶

Claims to disability benefits have risen in many advanced industrial societies, the actual rate of rise depending upon factors such as eligibility criteria, replacement rates, cultural attitudes regarding disability, the age-profile of the caseload, programme duration, and so on.⁷ In the UK eligibility criteria were not significantly relaxed in the 1990s, though there had been in the 1980s a deliberate government policy of pushing some of the long-term unemployed onto Invalidity Benefit (as it was then called), in order to massage the official unemployment figures.

Under New Labour, welfare reform was pursued with renewed vigour after 2006, and attention was paid to the stubborn problem of long-term disability. The new 'Pathways to Work' scheme was gradually introduced, until it became mandatory for all new claimants, Incapacity Benefit is gradually being replaced by the Employment and Support Allowance and a stricter work capability assessment has been introduced. All of this has occurred against a background of growing public and press criticism of work-disabled people, with claims that a majority of them are capable of work.⁸ Conditionality has intensified under the

⁶ Department for Work and Pensions, *Reducing Dependency, Increasing Opportunity: Options for the Future of Welfare to Work* by David Freud (2007), p. 28.

⁷ Leo J. M. Aarts, Richard V. Burkhauser and Philip R. de Jong, *Curing the Dutch Disease. An International Perspective on Disability Policy Reform* (1996)

⁸ Christopher Hope, 'Three in Four Sickness Benefit Applicants "Fit to Work" or Stop Claiming Due to Medicals', *Daily Telegraph*, 28 July 2010.

new Conservative-Liberal Democrat government, which aims to push as many of the long-term disabled as possible onto Jobseeker's Allowance (where they will be pressurised much more to accept any job or lose their right to benefit).

How should work-disability be defined? It is a truism that all disability is an interaction between person and environment. Work-disability therefore involves a complex interplay between an individual's self-defined state of health and their working environment. It can be viewed as having several component parts on each side of the equation, and the interaction between these component parts is complex:

Individual

Prevailing health expectations

Doctors' definitional thresholds

Self-referral thresholds

Medical technology

Diagnostic techniques & timing

Functional ability

Workplace

New technology

Stress of work

Demand for product

Local economy

Globalisation

Workforce downsizing

& existence of a job

With this in mind, we need to look backwards at how this problem was discussed in the past.

From the late nineteenth century to the First World War

The 1880s marked a turning-point in the economic and social development of the UK. It is outside the scope of this paper to consider all the component changes, which interacted in a highly complex way. For our purposes we need only note that the 1880s witnessed the

amalgamation of firms into larger units of production, increasing international economic competition, a growing emphasis on individual workplace productivity, an intensification of work for all urban workers and, as a consequence, an increasing displacement of older male workers from the workforce. It is from the 1880s that modern 'jobless' retirement commences: whereas in 1881 73.6 per cent of UK males aged 65+ had been recorded by the census as 'gainfully occupied', by 1931 this had fallen to 47.9 per cent, by 1971 it was 23.5 per cent and now it is just under 11 per cent. Before the 1880s, retirement had been intimately associated with disability, as the Poor Law category 'aged and infirm' demonstrated. Most workers moved to progressively lighter tasks as they aged and became less physically capable, their diminishing incomes often supplemented by Poor Law outdoor relief. Retirement in its modern sense had little meaning: it tended to be confined to a wealthy elite.

By the 1890s, these displaced older workers were attracting much attention. The social literature of the time is littered with concerns that older workers were not sharing in the general improvement in living standards and real wages: economic progress appeared to be passing them by. As one commentator (a prominent friendly society member) argued in 1896, it was now 'recognised by all students of industry' that

improved methods of production, the introduction of machinery, the competitive stress involved in the fight for the world's markets, have placed old age, inconvenienced already by its natural disadvantages, at an ever-increasing discount.⁹

Modern urban industry appeared to 'age' workers more rapidly than did traditional rural society. Charles Booth's extensive researches discovered that urban workers appeared to 'break down' earlier than did agricultural workers. As he graphically put it,

⁹ George Turner, 'State Pensions in Old Age', *Oddfellows' Magazine*, XXVII, 261, Sept. 1896, p. 271.

In one way or another effective working life is ten years longer in the country than in the town, or, speaking generally, is as seventy to sixty.¹⁰

The most interesting source of contemporary evidence is to be found in the oral sessions held in front of the 1893-5 Royal Commission on the Aged Deserving Poor (the Aberdare Commission). Witness after witness testified to the fact that older male workers appeared to be getting 'worn out' at progressively earlier ages compared with the rural economy.

Although this evidence was anecdotal and impressionistic, it did come from those with direct experience of the late-Victorian labour market. For example, a wire-worker from Finsbury, London, testified that, in his own trade, new technology (in the form of tools) had increased the pace of work compared to his father's day; another witness, a carpenter from Birmingham, claimed that in large towns a man of only 55

is looked upon upon as almost played out, and the competition of younger men is so great that he has very little chance if he gets out of employment at that period of life of ever getting on again at his own trade.¹¹

The main sources for systematic evidence on the sickness experience of workers in the nineteenth century are the records of the friendly societies. These mutual self-help bodies drew their membership predominantly from the skilled, male working class, and their membership was growing in the late nineteenth century, reaching 4,200,000 members in registered societies in 1898, with perhaps another 4,000,000 in unregistered ones. The two big federal organisations, the Manchester Unity of Oddfellows and the Ancient Order of Foresters, consisted of many branches spread all over the UK. Coverage for old age per se

¹⁰ Charles Booth, *The Aged Poor in England and Wales* (1894), p. 321.

¹¹ *Royal Commission on the Aged Poor*, 1895, C-7684-II, vol. III, *Minutes of Evidence*, pp. 742, 880

(via superannuation schemes) was uncommon and confined to only a few trade unions, but the societies paid benefits to those of their members unable to work through sickness or infirmity. Strictly speaking, conditions such as 'natural decay' were not supposed to be categorised as 'sickness' and thus justify benefit claims, but by the end of the nineteenth century sickness benefit was increasingly becoming a surrogate old age pension for older members. Sickness benefit claims rose at all ages, but particularly for older members, who also experienced a higher duration of claims ('protracted sickness').

Friendly society finances were closely monitored and regulated by the state: their financial soundness was in the hands of their consultant actuaries, who were not loath to dispense rigorous advice. However, various factors inclined the societies towards an increasingly elastic definition of sickness in the last decades of the nineteenth century. Modern scholars have discussed these possible factors, such as age compositional changes in membership, more liberal attitudes towards what constituted sickness, different administrative practices, or the fact that the societies' driving-down of doctors' fees (in the interests of cost-cutting) resulted in more perfunctory medical assessments.¹² One factor - stressed elsewhere by this author¹³ - is that, since the friendly society definition of sickness was 'inability to work' or 'incapacity from labour', the societies, faced with growing job insecurity experienced by their members, became more generous in their interpretation of sickness.

There were several reasons for this. First, the fraternal ethos of the societies, plus the fact that their internal workings were closely monitored by their members, especially in the

¹² James C. Riley, *Sick, Not Dead. The Health of British Workingmen During the Mortality Decline* (1997), p. 75. For a good general discussion, see Martin Gorsky, Aravinda Guntupalli, Bernard Harris and Andrew Hinde, 'Ageing, Sickness and Health in England and Wales During the Mortality Transition', *Paper to the Annual Meeting of the Social Science History Association*, 25 October 2008.

¹³ John Macnicol, *The Politics of Retirement in Britain, 1878-1948* (1998), ch. 5.

smaller branches, disinclined them to be anything less than generous with their older members who had long records of contributions. The adverse effects of labour market changes at a local level would be well known to society members. Again, competition for new members meant that the societies had to appear to be generous in dispensing benefits: it would look bad if older society members had to have recourse to the Poor Law. Providing sickness was certified by a society doctor, and confirmed by the observations of fellow members, payment of benefits was a contractual right. Doctors would have had intimate knowledge of local labour markets and would be sympathetic towards those long-serving older society members whose sickness masked de facto unemployment. As one well-informed observer put it,

When the period of loss of wages arising from the disability of old age and worn-out working powers arrives, the society's doctor in many cases feels compelled to stretch a point and, rules notwithstanding, to judge cases brought to his notice by the heart rather than the head, lest the old folk become altogether destitute and fall on the poor-rate.¹⁴

As is well known, the friendly societies faced something of a financial crisis at the end of the nineteenth century owing to this rise in protracted sickness. Bentley Gilbert's famous verdict that the unfolding of the epidemiological transition was bankrupting the societies, compounded by their tendency to use outmoded life tables,¹⁵ has been substantially moderated by subsequent historians: the 'crisis' was manageable, and was dealt with by a number of means, notable raising weekly subscriptions. A steady influx of new members kept contribution income buoyant. Nevertheless, the rise in protracted sickness aroused

¹⁴ J. Frome Wilkinson, 'Friendly Society Finance', *Economic Journal*, II, 8, Dec. 1892, pp. 725-6.

¹⁵ Bentley B. Gilbert, *The Evolution of National Insurance in Great Britain* (1966)

much comment at the time and it is well worth considering because in many ways it was a rehearsal for the debate one hundred years later.

The apparent rise in sickness was, of course, counter-intuitive, in that it had occurred alongside great improvements in real wages and the built environment, reductions in mortality, and so on. In short, it seemed puzzling to many contemporaries that one section of society should be falling behind the overall rise in material prosperity. The rise in long-term sickness was also occurring among the labour aristocracy - exactly those men most deeply imbued with Smilesean virtues, and the least likely to be workshy malingerers.

The most systematic and important contemporary investigation was by Alfred Watson, consultant actuary to the Manchester Unity of Oddfellows. It showed that sickness benefit claims had risen at all ages in the Manchester Unity between 1846-8 and 1893-7, but the highest rate of increase had occurred among those members aged 65+. Thus the 'weeks of sickness' experienced by those aged 65+ had risen from 1.8 per cent of the total weeks of sickness to 31.6 per cent over that period. The most striking feature was the increase in protracted sickness (that is, more than two years' duration) and permanent sickness.¹⁶ Watson's classic study was methodologically imperfect and has been criticised by modern historians, but his evidence regarding protracted sickness stands largely unchallenged.

From this brief exploration we can see that the late nineteenth century debate on work-disability was extraordinarily similar to that of today - for example, the suspicion that both friendly society members and their doctors had inflated their definitions of what constituted work-disabling sickness. What was less frequently mentioned - except by a few

¹⁶ Alfred W. Watson, *An Account of an Investigation of the Sickness and Mortality Experience of the I.O.O.F. Manchester Unity During the Five Years 1893-1897* (1903)

contemporaries¹⁷ - was the fact that both increasing job insecurity and the disappearance of jobs was the major driver behind the rise in long-term sickness claims by older friendly society members.

An interesting and very prescient commentary on this phenomenon was provided by the economic historian T S Ashton in 1916, based on his study of the sickness records of Amalgamated Society of Engineers members before and during the First World War. It might be intuitively assumed, suggested Ashton, that 'when earnings are high, and employment good, the numbers on sick benefit would grow, because men would be able to afford an illness'. Conversely, in times of economic depression recorded sickness rates would fall: workers would try to remain in work, for fear of losing their jobs to others. In fact the reverse was true, and Ashton's research showed that there was a correlation between unemployment among engineers and sickness benefit claims by them.¹⁸

From the First World War to the 1950s

Between 1912 and the launching of the National Health Service in mid-1948, the principal source of health care for the majority of the population in the UK was National Health Insurance (NHI).¹⁹ Originally introduced as something of a partial measure - in Lloyd

¹⁷ For example, Turner, 'State Pensions', p. 271.

¹⁸ T. S. Ashton, 'The Relationship Between Unemployment and Sickness', *Economic Journal*, XXVI, Sept.1916, pp. 396-400.

¹⁹ Information for this section is principally taken from: Bentley B. Gilbert, *British Social Policy, 1914-39* (1970); Noelle Whiteside, 'Private Agencies for Public Purposes: Some New Perspectives on Policy Making in Health Insurance Between the Wars', *Journal of Social Policy*, 12, 2, 1983, pp. 165-94; Noel Whiteside, 'Unemployment and Health: An Historical Perspective', *Journal of Social Policy*, 17, 2, 1988, pp. 177-94; Noel Whiteside, 'Counting the Cost: Sickness and Disability among Working People in an Era of Industrial Recession, 1920-39', *Economic History Review*, 40, 2, May 1987, pp. 228-46; *Social*

George's famous phrase, no more than an 'ambulance wagon' - NHI appeared more radical than it actually was because of the controversies that attended its passage through Parliament in 1911. Two years after its inception (in late 1914), NHI covered 13,689,000 manual workers and other employees earning less than £160 per annum (the income tax limit). This number had risen to 19,706,000 by late 1938 (with overall population growth, and a raising of the eligibility income limit to £250 per annum). Sickness benefit of 10s0d (50p) per week was paid to men and 7s6d (37p) per week to women for six months, followed by disablement benefit of 5s0d (25p) per week for an indefinite duration. These benefit rates were raised in 1920 to 15s0d (75p), 12s0d (60p) and 7s6d (37p) respectively, and then reduced slightly (in the case of married women) as an economy measure from January 1933. The scheme was funded by state-supervised contributory insurance (since the scheme covered those below the income tax limit) and administered through the 'approved societies'. Notoriously, NHI had several glaring faults: the dependants of a wage-earner were not covered (which meant that the majority of working class women and children had no guaranteed right to health care until 1948), self-employed working people were also not covered, there was no routine access to specialist treatment in a hospital and additional benefits (mainly ophthalmic and dental) were patchily provided (depending on the solvency of the individual approved society). These deficiencies and the administrative complexities of the scheme exacerbated all the usual problems of measuring the 'true' level of morbidity. NHI sickness records were therefore a less-than-perfect reflection of the health of the nation. (For example, claim levels by region were not routinely published.) Nevertheless, something interesting can be learned from the course of NHI sickness claims in the inter-war years. For the purposes of this paper, the focus will be on the way that unemployment and increased job insecurity pushed up sickness benefit claims, against a background of falling mortality and

Insurance and Allied Services, Cmd. 6404, 1942 (the Beveridge Report); and my own previous researches into the inter-war years.

improving health. Then, as now, it was a paradox to many contemporaries, especially those in the health-related professions who prided themselves on the improvements in public health that had taken place since the late nineteenth century.²⁰

The inter-war depression engendered an enormously wide-ranging debate on the effect of unemployment and low incomes on physical and mental health. After a brief postwar economic boom, unemployment started to rise in 1921, reaching 1,751,000 in June 1926, and falling slightly to 1,059,000 in May 1927; it then rose again, reaching just under 3,000,000 in January 1933. There then occurred a slow fall and stabilisation for the rest of the 1930s; but even on the outbreak of the Second World War unemployment totalled 1,232,000. Rarely in the inter-war years did unemployment fall below 10 per cent of the insured population, and at its highest it reached 23 per cent. As is well known, inter-war mass unemployment was a product of a worldwide recession bringing about a slump in demand for the products of the old 'staple' industries, exacerbated by changes in world markets induced by the First World War.

The human impact of unemployment was, of course, greatly exacerbated by its regional concentration in those 'depressed areas' that were centres of the recession-hit heavy industries (most notably, coal mining, shipbuilding, iron and steel production and heavy manufacturing) located in South Wales, the North West and North East of England and central Scotland - precisely those regions that have high levels of claims to long-term sickness and disability benefits today. In the 1930s, these depressed areas became the focus of numerous investigations into the effect of unemployment on child nutrition, maternal and infant mortality, life expectancy, psychological well-being, and so on. Indeed, at least one medical researcher argues that the 1930s recession has had a cumulative, inter-generational

²⁰ See, for example, Sir George Newman, *The Building of a Nation's Health* (1939).

impact on health status in those areas today.²¹ The controversy over health status in the 1930s was a bitter and protracted one, not least because it was a cardinal principle of the National Government's neoclassical, deflationary economic strategy to keep wage and benefit levels low in order to cut production costs and render British-made goods more competitive on world markets. There were frequent accusations that this strategy was condemning the unemployed and their families to extreme poverty and even malnutrition.

The NHI scheme was tested to breaking point in the inter-war years. During the First World War, full employment increased NHI contribution income and decreased benefit claims, which boosted approved society funds. But claims began to rise as unemployment rose from 1921 onwards: by 1927, NHI claims had risen by 33 per cent for men, and 50 per cent for women.²² Expenditure on sickness benefit rose from £8,010,000 in 1914-5 to £13,153,000 in 1921-2 and £20,482,000 in 1926-7; it then stabilised at just under £19,000,000 per annum.²³ While a funding crisis never actually materialised, there was enough concern to cause some cuts and a tightening-up of administration in the early 1930s. NHI in the inter-war years was the subject of some controversy - admittedly, not as bitter as the controversies that bedevilled unemployment insurance - over subjects like the administrative efficiency of the approved societies, the financial surpluses they had built up by the end of the 1930s, the question of what to do with contributors who became unemployed and fell into arrears, the treatment of married women (basically, the question of whether maternity constituted 'sickness'), and so on. But for the purposes of this paper, only one of these will be considered - the effect of unemployment on self-defined health, and the related accusation that a significant number of NHI claimants were malingering. The term 'malingering' (originally

²¹ D. J. P. Barker, *Mothers, Babies and Health in Later Life* (1994)

²² Whiteside, 'Private Agencies', p. 175.

²³ *Social Insurance and Allied Services*, p. 214.

used by military doctors to denote the use of feigned sickness to evade combat duties)²⁴ began to be applied to this phenomenon.

The NHI scheme contained within itself some contradictory incentives. On the one hand, there is anecdotal evidence that some sickness benefit claimants with families pressurised health insurance GPs ('panel doctors') to certify them 'fit for work' because (after 1921) unemployment benefit carried dependants' allowances and was therefore higher in value for a family man. For example, in 1936 a man with a wife and three children would have been able to claim 35s0d (£1.75p) per week in unemployment benefit, but only 15s0d (75p) per week if on sickness benefit. (One of Beveridge's tasks in his 1942 Report was to remove this anomaly.) Unemployment benefit was on the margins of subsistence (as defined by the many inter-war poverty surveys), so sickness benefit was drastically below it: such a family would have required £2 per week to reach an agreed 1936 subsistence level - nearly three times the level of sickness benefit level and six times the level of long-term disablement benefit. The 50 per cent reduction as sickness benefit became disablement benefit after six months was designed to sift out all but the most genuine cases. In addition, after 1930 the government tried to tighten up the scheme by such measures as forcing approved societies to increase domestic surveillance by 'sick visitors', designed to test the authenticity of claims. On the face of it, therefore, the financial incentive was markedly *against* sickness benefit.

On the other hand, sickness benefit was generally easier to claim, and was subject to less conditionality than unemployment benefit (for example, the 'genuinely seeking work' test in the latter). Unlike unemployment benefit, it could be claimed during a trade dispute, and sickness benefit claims rose temporarily during the General Strike of May 1926 and the

²⁴ An interesting guide to doctors is Sir John Collie, *Malingering and Feigned Sickness* (1913).

subsequent miners' lock-out. Again, after January 1935, about 1,000,000 unemployed were transferred to the Unemployment Assistance Board and subject to the controversial household means test, which had been introduced in 1931; sickness benefit had no equivalent, being a contributory entitlement.²⁵

Intriguingly, in the inter-war years there were exactly the same allegations as there are today regarding the tendency of panel doctors who worked in the high-unemployment depressed areas to dispense sick notes too readily, out of misguided kindness. Such doctors would be aware of the devastation caused to local economies by the world recession, and would feel considerable sympathy for men thrown out of work as a result. Bentley Gilbert recounts a 1926 speech to the annual conference of panel doctors by Walter Kinnear, Controller of the Insurance Department of the Ministry of Health, expressing deep concerns about this and warning them not to turn the NHI system into a form of the dole.²⁶ Some argued at the time that the problem was a result of factors such as lax administration in certain approved societies, their reluctance to countenance any criticism of their workings, the tendency of would-be claimants to 'shop around' until they found a panel doctor willing to certify them as unfit to work, or panel doctors being too anxious to attract new patients (and the related capitation fee) by appearing to be generous with sick notes.

However, the whole question of incentives internal to the benefit system must be placed in the much bigger context of the economic depression. As today, lack of labour market demand encouraged the more infirm to self-classify themselves as too sick to work, rather than as unemployed (and fit enough to take any suitable job offered). Only a small part of the increase in recorded sickness can be attributed to improved medical diagnostic techniques.

²⁵ Whiteside, 'Unemployment and Health', pp. 187-8.

²⁶ Gilbert, *British Social Policy*, pp. 289-90.

Those who would be first displaced from the labour market by economic recession would be those with the most health-impaired lives. Once unemployed, with little prospect of regaining work, they would perceive their symptoms as work-disabling. It is clear, therefore, that sickness was being used to mask de facto unemployment. As in every recession, the line between 'sickness' and 'unemployment' became blurred - especially in the case of mental disorders, which in 1934-5 amounted to over one-third of 'chronic' disability cases (off work for one year or more).²⁷ Interestingly, in the 1920s, short-term claims to sickness benefit predominated; but in the 1930s these claims stabilised, and it was the long-term claims to disablement benefit that continued to rise²⁸ - exactly what one would expect to find in a prolonged recession. As Noel Whiteside observes,

When unemployment rose in the 1930s, numbers of 'impaired lives', with no hope of finding work, settled into semi-retirement on disability benefits and public assistance.²⁹

Even Bentley Gilbert, whose somewhat stern account is entitled 'unemployment and malingering', acknowledges that

the line between sickness and well-being for a man suffering economic deprivation was likely to be unclear even to the individual.³⁰

In other words, in a recession both employers and employees become more stringent in their assessment of what constitutes 'employability'.

²⁷ Whiteside, 'Unemployment and Health', p. 188.

²⁸ Whiteside, 'Counting the Cost', pp. 233-5.

²⁹ *Ibid.*, pp. 240-1.

³⁰ Gilbert, *British Social Policy*, p. 285. Gilbert (p. 292) states that 'most society records seemed to show that scarcely one-third of the contributors claiming sickness benefit were in fact ill'.

In the late 1930s, as today, there was a growing concern in governmental circles that long-term unemployment had eroded the will to work in the depressed areas. The problem was of course resolved, in somewhat spectacular fashion, by the Second World War.

Unemployment fell significantly from mid-1940, with the enormous economic stimulus created by a war economy (assisted by military call-up removing from the civilian labour market many men and women of prime working age). During the War, many groups who had previously been marginal to the labour force (including those judged to be 'unemployable') found jobs in a very tight labour market. The problem of work-disability disappeared. In the full-employment 1950s, sickness benefit claim levels remained constant, at just under 1,000,000 claims per annum. From the 1970s, however, things began to change once again.

Conclusion

From this necessarily-brief and tentative exploration, we can see that the past hundred and fifty years have witnessed three occasions during which, for the population sub-groups affected, trends in mortality and morbidity have followed divergent paths and levels of work-disability have risen. In each, there has been a vibrant debate over the many factors that might cause levels of recorded sickness to rise - a loosening of eligibility conditions for sickness benefits, the alleged monetary attractiveness of those benefits (compared with the alternatives), over-sympathetic assessments by doctors, lax administration, compositional changes in the population affected, a rise in malingering and fraudulent claims, the infectious spread of a 'welfare dependency' mentality, an increase in mental and behavioural disorders, and so on. Yet there has also been a realisation that sickness is a continuum which is subject to many contextual influences, and that the most powerful of these is labour

market restructuring, causing jobs to disappear and/or producing lower-quality replacement jobs. The crisis in the first period was ameliorated by the introduction of old age pensions and a growing acceptance of the inevitability of retirement. The crisis in the second period was abruptly resolved by the Second World War and the subsequent twenty-five year postwar boom in manufacturing. It remains to be seen whether supply-side policies will be able to resolve this latest crisis.