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How International Organisations Compete: Occupational Safety and Health at the ILO, a Diplomacy of Expertise

From the appearance of the forensic concept of «occupational disease» at the end of the 19th century to current European regulations, the crucial advances in occupational health have been fought out at the transnational level. This article analyses the role of international bodies in this process.¹ In general terms, we detail the manner, extent and limitations of their influence, their use of expertise and their interaction with voluntary associations representing «civil society». More specifically, we examine the dialectic of cooperation and competition that affects international bodies and how variations in the strength of these two forces feed back into their internal structures.

Consequently, we combine the history of transnational social and health policy with institutional history, while attempting to avoid the pitfalls of the latter. Too often institutions are examined «statically», independently of any overall view of the issues involved. Too often analysis remains within the walls of an organisation and fails to place its importance in context. We would rather examine international bodies «in action» as they fight silicosis and pneumoconiosis, which were the most formidable occupational diseases of the twentieth century. We begin for reasons of seniority and size with the industrial hygiene section and later service (IHS) of the International Labour Organisation (ILO), which we use as a filter. Our intent is to describe the broad, changing pattern of the institutions that have sometimes cooperated and sometimes competed with the IHS, whether global, such as the League of Nations (LoN) and the World Health Organisation (WHO), or regional, such as the European Coal and Steel Community (ECSC). At that scale, it is possible to understand the changes within the IHS, both organisational (merger with the ILO’s industrial safety service in 1953) and operational (gradual shift from a medical approach to one based on safety engineering). Most of all, we study to what extent the emergence of major socio-medical models («Occupational medicine», «Health at work», «Industrial safety») has been the outcome of those transnational dynamics.

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1. The ILO’s Industrial Hygiene Service between the World Wars

Luigi Carozzi, a reforming physician at the ILO

Although silicosis is disappearing from the collective memory in many countries, it was the most lethal occupational disease of the twentieth century. Even now, it is rapidly advancing in industrialising countries, justifying a joint ILO/WHO elimination programme. This incurable deterioration of the lung by exposure to silica dust (SiO$_2$) affects virtually all industrial sectors and consequently a wide variety of countries. The cost of silicosis, with its massive effect on major labour-intensive industries beginning with mining, and the complexity of its nosology and aetiology, have made it a hard cause for the labour movement and medical officers of health. The «solution» has consequently been systematically sought in transnational exchanges. The IHS of the ILO was in the forefront.

Like most of the ILO’s other services, it was created following action from the late nineteenth century onwards by international associations pressing for extended workers’ rights. Significantly, at the Berne conference in 1906, an international convention was drawn up to prohibit white phosphorus in the manufacture of matches. The idea was established that occupational diseases, as a forensic category, were to be discussed at the international level. A pathology contracted in the workplace only becomes an «occupational disease» in the official sense if employers, unions and the legislator have previously agreed to define it as one.

A permanent international commission, currently the International Commission on Occupational Health (ICOH), works in this area. It was created on 13 June 1906 following the first International Congress on Work-related Illnesses held in Milan at the same time as the Universal Exposition, renamed the International Permanent Commission on Occupational Medicine (CIPMT) in 1931, and was inspired by the community of reforming physicians in Italy. Working both nationally and internationally, its

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2 For contemporary examples of the variety of sectors and countries, see http://www.who.int/mediacentre/factsheets/fs238/en/index.html.

3 Onset may be delayed for tens of years if exposure is not intensive. During this latency phase, clinical detection of the disease is extremely difficult. Radiology, a more effective instrument, was only slowly adopted, mainly during the second third of the 20th century: even then, the identification of a silicosis-affected lung assumes an international medical consensus that, as we shall see, raises difficulties. The diversity of business sectors involved increases the problems in identifying the disease. Even within a given sector, exposure varies from one workplace to another according to the silica content, size and diameter of the dust particles, mixture with other types of dust, humidity, temperature and ventilation. The intensity of dust inhalation and consequent exposure to risk also depend on working patterns: intensity of effort, continuous or intermittent exposure, and frequency of work shifts, not to mention prevention techniques such as ventilation or humidification. Identifying the causes and symptoms of silicosis is further complicated by its frequent association with other lung diseases, especially tuberculosis.

4 It was then called the International Permanent Commission on Occupational Diseases. See F. Carnevale et al., «Concerning the First International Congress on Work-related Illnesses, Milan 9–14 June 1906: Success, News, Reports, Motions», Medicina del Lavoro 97 (2006) 2, 100–113. On the general development of these international networks and congresses, see M. Herren-Oesch, Hintertüren zur Macht: Internationalismus und modernisierungsorientierte Außenpolitik in Belgien, der Schweiz und den USA, 1865–1914 (Munich, 2000).
leader Luigi Devoto (1864–1936) obtained in 1910 the establishment of a Clinica del Lavoro in Milan that soon became an international focus for occupational health. He employed one of his protégés, Luigi Carozzi (1875–1963), to carry out surveys of working conditions in partnership with trades unions and voluntary associations.

Like Devoto and many social reformers of the time, Carozzi acted simultaneously at municipal, national and transnational levels. In 1910, he was elected to the Milan city council, which had continually supported initiatives for occupational health. Four years later, he left the Clinica del Lavoro to head the medical work inspectorate of the Ministry of Agriculture, Industry and Trade. But Carozzi was also, from the outset in 1906, the long-serving secretary-general of the three-yearly international congresses held by the CIPMT. He only stood down after the 1954 Naples congress, and in 1957 became the association’s «permanent honorary president».

As a result of his international experience, Carozzi joined the ILO in 1921 and headed the IHS (created in September 1920) until the start of the Second World War. This career move was not unusual: most of the senior officers in the ILO combined administrative or academic expertise with a long-standing commitment to the international reform movement, whether at the national level, like Albert Thomas himself, or the municipal level, like Imre Ferenczi and Louis Varlez. Carozzi, however, was to find himself in particular position within the ILO, a fact that partly explains why he became the silicosis man.

In the 1920s, there was no medical consensus on the very existence of the disease. Medical observations of dust diseases in mines and elsewhere had frequently been made since Antiquity without leading to any incremental scientific progress. There were a host of theories and names. Those that came closest to modern ideas increased in number in the nineteenth century but were not easily adopted. In 1871, the Milan physician Achille Visconti coined the word «silicosis», but it took decades until some of his colleagues acknowledged the hypothesis of lung damage from silica dust. The new word, rather than meeting with approval, competed with more specific terms (such as anthracosis, coal dust disease) or more general ones (pneumoconiosis, dust disease). Its acceptance was also hampered by an application of Ramazzini’s interpre-


6 The information in the last two paragraphs is taken from the commission’s website (http://www. icohweb.org/), with historical analysis by S. lavi coli, V. Guastella and D. Fano.

tation, which had fragmented the perception of the disease since the 18th century (distinguishing, for example, between «miners’ asthma», «glassblowers’ consumption» and «slate-workers’ schistosis»). Not least, it came up against an explanation that reduced silicosis to a complication of tuberculosis, which was put forward by the employers’ medical experts in order to avoid being obliged to compensate workers for an occupational disease.

**Silicosis as a «strategic» cause for the ILO**

It is fascinating to observe the extent to which doctors’ positions in this debate were determined nationally by the nature of social insurance in each country, its benefits, funding, relative importance compared with private insurance, and the numbers of workers exposed to the risk. And yet it was the task of harmonising these positions in a transnational recognition of silicosis that became the prime mission Carozzi assigned the IHS. Two structural changes were about to make silicosis – at least for a generation – the «king of occupational diseases»: growing mechanisation of mining, greatly increasing the volume of dust inhaled, and the development of social or private insurance schemes.

Silicosis offered the ILO a relatively «protected» sector in which it could assert its monopoly over directly work-related causes. This did not often happen, even medically, since the Office was continually exposed to interference from the League of Nations’ health section. Formally, the LoN body’s director, Ludwik Rajchman (1881–1965), respected the ILO’s prerogatives by avoiding questions that specifically related to work. But in practice, it was easy for him to argue that a country that disregarded the ILO’s social conventions threatened the health not only of workers but also of their families, and consequently the population at large: these health risks justified a joint LoN/ILO commission, whose operating costs were always harder for the ILO to pay.

Behind this continual fight that the ILO, with its circumscribed prerogatives and reduced resources, fought mainly on the defensive, there was an unspoken struggle over the two ways of organising social and health action. The LoN’s model was rather local, voluntary and charitable, as opposed to the social insurance model that was national, tripartite and contributory, and which the ILO’s bylaws required it to advance. This vast organisational conflict, in which the LoN and ILO were the transnational representatives, was further complicated by the machinations of such players as private

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doctors who also organised themselves transnationally between the world wars, and adopted a basically hostile attitude toward social insurance.

Against this background, silicosis was a relatively sure and promising cause. In contrast with Adrien Tixier’s social insurance section, fully exposed to encroachments by the LoN, the IHS now had a non-infectious disease transmitted by contact with a substance rather than with people. There was therefore less of a risk that the LoN health section would take it over as a «general» public health cause, on condition, naturally, that it could be proved to be a specific disease that could only be contracted at work. In this case, Carozzi’s undeniable medical convictions matched his section’s interests: silicosis had to be recognised as an occupational disease to guarantee a wider field of action for the ILO since it was, after all, the most serious occupational disease in terms of both morbidity and mortality.

The cause that Carozzi had chosen also made sense internally. His section was in virtual competition with the industrial safety section set up one year later. A merger of the two had been considered and then dismissed because the Office was afraid that this would inevitably lead to the supremacy of the «engineering» approach. The scientific complexity of silicosis provided arguments for Carozzi to legitimize the priority of a medical approach: while not overlooking questions of safety engineering (prevention) and social insurance (compensation), the first task was to detail the disease’s pathogenesis and effects. In practice, study was extended to other disciplines, such as chemistry, physics, biology and engineering in the 1930s as medical consensus advanced – this extension was one point on the agenda of the 1938 Geneva conference on silicosis.

The legal aspect provided more reasons for this medical priority. In order to guarantee the credibility of ILO conventions, it was important that medical experts throughout the world agree to validate their scientific foundations in case of legal proceedings.\footnote{Cf. Carozzi’s letter of 12 March 1937 to Verne A. Zimmer of the Division of Labor Standards of the US Department of Labor, A_BIT, HY 1000/34/2.} Avoiding risky causes was part of the ILO’s \textit{habitus}.\footnote{See P. Weindling, «Social Medicine at the League of Nations Health Organisation and the International Labour Office Compared», \textit{International Health Organisations and Movements} 1918–1939, (Cambridge, 1995), 134–153.} But this was complicated in medical matters for which the Office had few resources. Apart from a few modest subsidies to academics in the 1930s, the IHS could not afford to directly commission research and had to use recognised evidences. Because the ILO did not think the case was sufficiently well supported or circulated in the medical community, it refused, despite the appeals of the international union movement, to put silicosis on the list of occupational diseases recognised by the 1925 international convention. In subsequent years, the ILO’s role was to advance the transnational debate by using its strengths: support from workers’ movements and from employers in those countries that had already recognised the disease, and the development of a medical, especially radiological, corpus of evidence for the existence of the disease.
Like other ILO sections, Carozzi’s IHS used its comparative advantage of possessing centralised documentary evidence from all over the world, provided by the Office’s exceptional network of correspondents. In the case of silicosis, this took the form of the impressive bibliographies the IHS supplied on request to government departments, voluntary associations and experts, and articles in the ILO’s *Encyclopædia of Occupational Health and Safety*, first published in 1930. Beyond pneumoconiosis, this tome was central to IHS strategy and its success in the interwar years. ILO action included the establishment of a network of experts sympathetic to the silicosis «cause». The Office searched for them around the world and tested their medical convictions if necessary by field missions.\(^\text{13}\) gave them international legitimacy and used their skills by appointing them to specialist committees. It is no accident that a substantial proportion of the archives of Carozzi’s section (and the ILO’s) is made up of appointment files: it was by creating commissions of experts appointed by nationality, skill and scientific positions that the Office formed a global medical forum on silicosis and handled its own internal balance of power.\(^\text{14}\)

This was a diplomacy of expertise – a diplomacy in a real sense – since Member-States sometimes refused or imposed, against the Office’s will, the appointment of one of their experts. It was a diplomacy, too, in that it had to take account of a balance of power that was both economic and scientific, and to respect the major industrial countries, but also keep them at a distance if their medical positions were too hostile to the advance of the cause. France, Belgium and the Netherlands paid the price of denying the existence of the disease throughout the 1930s by being kept out of major discussion forums and having to hold, as it were, counter-congresses in 1936 and 1937.

**Johannesburg (1930), the ILO’s first conference held outside Europe**

This artful balancing act reached its peak at the 1930 Johannesburg conference, called at the initiative of the Transvaal Chamber of Mines. This activism reflected the medical, radiological and legal advances achieved by South Africa in silicosis control and the specific approach for transnational reform.\(^\text{15}\) Rather than working against the market principle, this approach used it to extend social laws: the only way to guarantee competitive equality for employers in those countries that best protected their workers was to impose the same level of protection to those in other countries. This principle was applied literally for silicosis: it was partly in order to impose the recognition of the

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\(^{13}\) As was done in 1932 in Germany, a key country by its economic importance and because its medical community was one of the most divided on this issue.

\(^{14}\) Silicosis was the only disease to which the IHS devoted a specific structure, with the creation of a specialist sub-committee in 1936.

disease in the French and Belgian coalfields that the Chamber was ready to co-fund the 1930 ILO conference.

The conference was exceptional in many ways. It was the first ILO conference held outside Europe, and its agenda actually included the objective of defining silicosis. For two weeks, the international experts considered to be most qualified in the matter were brought together and asked to reach an agreement on the nosology, aetiology and prevention of the disease on the basis of a detailed questionnaire prepared by the ILO. While not, as we have seen, excluding questions of prevention and compensation, the conference approved a corpus of medical evidence established by experts from various countries, who had been approached and questioned on a proactive transnational basis, in interaction with industrial questions. Its consequences were decisive: perhaps even more than the C42 international convention on silicosis finally adopted in 1934, Johannesburg initiated the process of recognition of the disease by ILO Member-States.

In addition to the choice of international experts and countries represented, another reason for the conference’s success was the meticulous preparation of the agenda and the questionnaire by a pair of men who personified the principle which was described above – of joint national and transnational action. As was the case during the period leading up to the recognition of silicosis, Carozzi worked in close collaboration with Alexander Jeremiah Orenstein (1879–1972), head of the medical service of the Witwatersrand gold mines and father of South African occupational medicine. The alliance was a revealing one. After examining the similarities between Carozzi’s IHS and the ILO’s other sections, it is important to stress its specific medical underpinning. In most areas, the ILO’s director, Albert Thomas, was able to follow closely the daily action of his senior officials. In contrast, Carozzi, in a certain tension with his superiors, enjoyed some autonomy in a field that was undoubtedly of interest to Thomas, but naturally less easily comprehensible in terms of its evidence and networks. Exceptionally, Carozzi had gained the upper hand in the appointment of members of the Correspondence Committee. On the other hand, his section was

16 In mid–1929, Carozzi, Orenstein and the British ILO deputy-director discussed the extension of the Johannesburg conference to not strictly medical considerations. See A_BIT, SI 22/1/1, in particular the letter of 24 May 1929, in which Butler suggests that Orenstein reserve the matter for the Empire Mining Congress to be held earlier in 1930, and Carozzi’s letter to Butler of 10 August 1929.

17 Including the exclusion of a country like France, hostile to recognising silicosis, which had been the only country to object to the principle of the conference on a financial pretext (see J.-C. Devinck and P.-A. Rosental, «Une maladie sociale avec des aspects médicaux: La difficile reconnaissance de la silicose comme maladie professionnelle dans la France du premier XXe siècle», Revue d’histoire moderne et contemporaine (2009) 1, 99–125).


19 After the war, David Vaage, the new head of the ILO’s industrial safety section, reported in a memorandum with great surprise on this practice (16 May 1946, A_BIT, HY 1003): «Whereas for the Correspondence Committee on accident prevention we have always consulted the governments and asked them to propose candidates for membership on the Committee, I understand..."
to some extent restricted to «technical» issues, as compared with the social insurance section which, as we have seen, was in political competition with the LoN’s health section. By its extent and specific nature, silicosis was a fruitful cause for the ILO as an organisation and for Carozzi personally.

This collaboration with Orenstein illustrates another recurring feature of the ILO’s action, namely its symbiosis with international associations of social reformers. In the way Carozzi developed his networks in the global world of occupational medical officers, we may see once more the crucial role of the CIPMT, which contributed to construct this transnational forum of strategic importance for the ILO. The twofold national/international aspect was key here, since the Clinica del Lavoro, the nerve centre of the association, spread its influence far beyond Italy to the emergent world of occupational medicine. The CIPMT’s members also contributed to the ILO’s network of informants we have already mentioned. In more operational terms, the association supported the ILO’s pressure to sign international conventions and transpose them into national law.

Its three-yearly congresses were often linked with ILO action. In 1929, the CIPMT met in Lyon for a specific congress with the deliberate purpose of bringing pressure to bear on France to catch up in the control of occupational diseases in general and silicosis in particular. This initiative, which turned out to be of strategic importance for France, came this time from the duo of Albert Thomas and Étienne Martin: the latter, professor of forensic pathology at Lyon, had, in the First World War, been medical inspector in the arms factories for which the former was responsible as a minister of armament. The conference failed to require employers to take account of silicosis, which in turn had an impact on the organisation of the Johannesburg conference and its concentration on medical aspects. But it did have a delayed effect in France on the process of recognition of the disease by prompting radiological research in this area.

CIPMT members also worked as activists and trailblazers by reporting back to their own countries on the state of transnational debate and by pushing for the recognition of silicosis. Via these members the ILO set up a sort of circulatory system whereby medical information flowed into the centre to be summarised and directed out to the national and local limbs. This to-and-fro that produced first the medical definition of silicosis and then its gradual recognition by Member-States apparently also occurred in other ILO sections. Its particular prominence in the control of occupational diseases stemmed from the fact that in this forensic field, it was important to act both on legislation and the state of scientific knowledge. Luigi Carozzi’s section succeeded in making this mechanism work between the world wars. Now we shall see how the obstacles in its path – competition from other international bodies and attractiveness of industrial safety – loomed larger after the Second World War.

that Dr Carozzi’s practice was (for the Correspondence Committee on Industrial Hygiene) to propose and select candidates himself.»

2. A Detrimental Decline

The organisation of the ILO’s sections after the Second World War was marked by the 1941 move to Montreal and whether or not it was possible to ensure continuity of action following the Director-General John Winant’s decision in May 1940 to break with international organisations’ tradition of neutrality.\(^\text{21}\) The ILO, which enjoyed benevolent support from the British and American governments and its contacts in the American Federation of Labor and the UK Trades Union Congress, sought to distinguish itself from the moribund secretariat of the League of Nations. It tried to gather together the skills of the LoN’s functional organisations, in particular its Economic and Financial Section, which had found refuge at Princeton.\(^\text{22}\)

Against this background, the industrial hygiene work was suspended. Carozzi, a well-known anti-Fascist stayed in Geneva where, after resigning from the ILO on 30 June 1940, he was appointed professor at the medical school.\(^\text{23}\) The Office had no officials in Montreal with the medical knowledge to even update the documentation in this field. The Safety Section, however, continued some of its work, establishing in particular model regulations for factories together with American and British associations. The Accident Prevention Correspondence Committee met regularly to devise what would become an organisation reference for factories.\(^\text{24}\)

From 1944 onwards, the head of the Industrial Safety Section, David Vaage, at the request of the Governing Body, took the first steps to reassemble the Industrial Hygiene Correspondence Committee. He represented the ILO at a number of occupational health congresses, while recognising that he was not qualified in that field. Attempts to recruit doctors were unavailing since the BIT could not afford to attract top American specialists. In February 1946, Vaage reported back pessimistically to Edward Phelan\(^\text{25}\) and asked to be relieved of the task. The ILO, he wrote, was not living up to its reputation of excellence acquired before the war, although the Declaration of Philadelphia, adopted by the International Labour Conference in May 1944, officially recognised the solemn obligation of the ILO to further programmes that would achieve «adequate protection for the life and health of workers in all occupations». The Office was not matching its resources to this mission, in a field that it claimed fell fully within its competence.\(^\text{26}\)

In 1945, the United Nations were already working on the creation of a World Health Organisation, whose charter was adopted in July 1946. The allocation and coordination of its competencies with those of other international institutions were entrusted...
to the Technical Preparatory Committee that was recently formed for that purpose by the UN Economic and Social Council (ECOSOC). Now required to specify its prerogatives, the ILO reconstructed its industrial hygiene activities on the basis of its experience with silicosis control, culminating in a major conference on pneumoconiosis planned for Sydney in 1950.

Called upon for his expertise, Luigi Carozzi criticised the loss of knowledge due to the war years, compared with the previous twenty. Returning to the case where he had left it, he identified, as he had often done as director, the most competent experts, and he detailed the various national positions. In May 1946, the silicosis expert sub-committee was reassembled. Carozzi persuaded the Office to reappoint eminent people whose competence was crucial, such as Alexander J. Orenstein and the British doctor John Middleton. He then argued for the inclusion of representatives from Belgium and Scandinavia. When the question of appointing Professor Jules Leclercq was raised, he recalled France’s long opposition to recognising silicosis as an occupational disease. In all, the reestablishment within ILO of competence in industrial hygiene was based, as before, on forming a network of experts, along with some newcomers.

In March 1948, Edward Phelan presented the programme of the Sydney Conference to the Governing Body. One preliminary report recalled the IHS’s pioneering role in pneumoconiosis control and the importance of the Johannesburg conference and suggested returning to a general programme close to that decided in 1929: this was approved. The participants of the Sydney Conference were to produce a situation report on the knowledge of the various types of pneumoconiosis and preventive measure to be envisaged, whether social and medical or physical and technical. It would also examine the definition of minimum compensation standards for disabilities caused by dust disease.


28 See A_BIT, HY 1004. A similar conference had been planned at the 1938 ILO silicosis meeting but was prevented by the war. The idea was repeated by the Australian minister for health and social services, J. M. Fraser, at the International Labour Conference in Paris in October 1945. It was supported by two of the ILO’s industrial committees, Coal Mines and Iron and Steel: these tripartite committees, set up by the ILO in the late 1930s with membership decided by the Governing Body, had the precise prerogative of convening specialist conferences. One had addressed the safety of underground work in coal mines. Annexe VI, Industrial Committees, Document A, Résolutions adoptées par la Commission de l’Industrie Charbonnière, London, December 1945, Minutes of the 98th session of the ILO Governing Body, Montreal, Mai 1946, 109–110.

29 Letter from Carozzi to Vaage, 6 March 1946, A_BIT, HY 1004. Since the Belgian labour minister Troclet responded to the announcement for the preparation of the conference, the ILO decided to appoint to the sub-committee Dr André Uytdenhoef, senior medical officer at the ministry of labour.

30 Correspondence between Raoul Lafrance and Luigi Carozzi, A_BIT, SH 1001. At that time Carozzi had a special relationship with ILO leaders. In 1945, Edward Phelan gave him the difficult mission of going to Rome to re-establish contact between the ILO and Italy.

31 A_BIT, HY 1005, Constitution of the sub-committee on silicosis.
3. From Industrial Hygiene to Health and Safety: 
Analysis of a Strategic Repositioning

Health and Politics: Issues at the Sydney Conference (1950)

The new director, David A. Morse, continuing his predecessor’s line, considered that the time was ripe to formally re-establish the IHS. The Office engaged a Danish doctor, Aage Grut, who had been a senior medical inspector of factories and a senior executive in the social insurance system in his country. Although he was not well-known for his knowledge of pneumoconiosis, he fully understood the main issue the forthcoming conference would address: the reconstituted IHS needed to take its place in the new international system being set up.

In late 1947, the ILO had signed a general cooperation agreement with the WHO as part of the United Nations system. This document, copied from the agreement with the FAO, detailed the legal aspects of coordinating the activities of specialist institutions under ECOSOC. The ILO and WHO agreed on the need to pool their knowledge in the fields of social security, help for medical services and industrial hygiene. The demarcation of competence and procedures of cooperation were left to be defined by joint WHO/IHS committees: Aage Grut hoped that the Sydney Conference would assert the ILO’s «medical competence», with support from Luigi Carozzi, who remained influential. The Italian doctor was one of the first experts appointed by the ILO to the joint Industrial Hygiene Committee in June 1949, along with a number of the specialists he had proposed, such as Merewether and Greenberg.

The main themes of the conference were inspired by the last pre-war conference on silicosis in 1938, and also by the colloquium held in Lyon on 3–4 October 1949 for mine doctors and pneumoconiosis experts. At their urgent request – expressed in particular by Albert Policard – one task was to lay down standard international diagnostic criteria that was «easy to use and adaptable by all» to determine workers’ entitlement to compensation. Aage Grut asked Dr Pierre Cazamian, chief medical officer of the Cévennes mines, to establish a draft radiological classification as a basis for discussion. Grut circulated this in December 1949 for evaluation by the experts expected in Sydney, particularly Professor Charles Gernez-Rieu, director of the Pasteur Institute, and Dr Charles Fletcher of the Pneumoconiosis Research Unit in Cardiff.

The Sydney Conference thus occupied a space between medical concerns and a new political context, defined by internal changes at the ILO, the arrival of new members and the creation of the WHO. Most of the representatives at Sydney came from

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32 See Aage Grut’s personal file, A_BIT, P 4180.
33 On these initial reactions to competition from the WHO, see A_BIT, WHO 3 and WHO 3–1.
34 Albert Policard was a professor at the Lyon medical school and an ILO expert. On his part in France’s refusal to recognise silicosis in the 1930s, see Devink/Rosental, ‘Une maladie sociale…».
35 Cazamian proposed a classification into two major groups, A and B, each divided into 7 subgroups. Group A concerned radiographs with discrete opacities and Group B, more controversially, radiographs with diffuse opacities.
the United States and the Commonwealth, together with northern Europe, Switzerland and France, and the ILO’s experts. At what was still a colonial period, few emerging countries were represented, and there were no German or Italian expert present.\textsuperscript{36}

The ILO’s Member-States were undergoing many changes with the creation of health insurance and occupational medicine systems in the industrialised countries, and with mechanisation in many sectors of the industrial production. As a result, the aim in Sydney was both to review national legislation and to harmonise diagnostic techniques. The shift from a clearly identified disease, silicosis, to a family of diseases, the pneumoconioses, represented a new conception of the problem, one that was no longer thought of in terms of poisoning, which had historically underlain the definition of occupational disease.\textsuperscript{37} This implied reasoning in terms of the respiratory mechanisms produced by inhaling dust in various occupational circumstances.\textsuperscript{38}

But this semantic shift from silicosis to pneumoconiosis\textsuperscript{39} aroused controversy among the conference attendees, and Luigi Carozzi expressed this in a written report prior to the conference. At the Johannesburg conference, the medical experts had avoided any debate on pneumoconiosis, which was too varied and poorly understood at that time. To put together affections as differentiated as asbestosis (caused by asbestos dust), siderosis (iron dust), byssinosis (cotton dust) and others, said Carozzi, was likely both to impede the harmonisation and effectiveness of legislation that often differed from one pneumoconiosis to another and to extend to less serious respiratory diseases that should not necessarily give rise to financial compensation.\textsuperscript{40}

In practice, the Sydney Conference marked not so much a final shift to pneumoconiosis, but rather a tension (which still exists) between two approaches to dust-induced occupational diseases. First, in medical terms, while the conference enabled the ILO to reassert its predominance for the most serious family of occupational diseases, it failed to establish uniform diagnostic criteria that could be used to calculate disability rates for the victims of dust diseases.\textsuperscript{41} Including silicosis in the general...
category of pneumoconiosis added further complication to an issue that, as we have seen, was already fragmented by such considerations as the nature of the inhaled particles, the various stages of lung disease, and possible superinfections (e.g. tuberculosis, bronchiolitis). Second, in political terms, this «globalisation» of the disease raised the profile of the non-extractive industries (i.e. steel-making, civil engineering, etc.), although many were already concerned by silica dust.

Third, the guidelines the conference produced ultimately downplayed the role of doctors, although they were still dominant in Sydney. Extension to all types of dust increased the importance of prevention because the establishment of exposure thresholds deemed to be tolerable gave priority to the measurement and reduction of suspended dust rates, or even at this early date the hope of removing dust altogether. It also meant promoting rehabilitation policies, with a definition of functional standards to formally define the borderline between staying at work and disability. The conference ended by calling for a meeting on pneumoconiosis «from the point of view of engineers, physicists and chemists».

The question of early diagnosis also raised issues that, albeit partly therapeutic, concerned the «optimisation» of labour management, from hiring policy to job reallocation for pneumoconiosis victims. Setting international standards, even at a low level, became more of a priority than before, seeking a correlation, difficult to find as we have seen, between physiological diagnosis (breathing tests, detection of dyspnoea) and radiological diagnosis.

A weakening of the medical position and redeployment in the 1950s

In the years following the conference, a major issue was lung radioscopy. Even though the lack of correlation between radiological and physiological diagnoses was repeatedly pointed out at the conference, only radiology could be used to form the basis of a medical consensus on pneumoconiosis and to determine their severity, on the condition that the radiographs were interpreted and used in the same manner. To that end, a new international classification for radiographs was proposed in an appendix to the proceedings of the Sydney Conference. It introduced a large number of fine distinctions in defining the stages of the disease, attempted to connect the shape of the lesions observed with the type of dust inhaled and the complications (tuberculosis), and proposed an initial interpretation of opacities and tree-in-bud patterns. But unanimity was not achieved.

Aage Grut now made harmonising radiological standards a key aim in his activity, despite his failure to set up a radiology sub-committee and raise the necessary standards to determine disability due to pneumoconiosis.

So much so that Orenstein, in a letter dated 4 June 1950, even asked Grut to see that engineers were included in the discussions by contacting the Sheffield Council of Underground Machinery Manufacturers (A_BIT, SH 24–3–1–1).

Third international conference, Conclusion n° 30, 158.

Ibid., vol. 2, 353.
financial resources to hire a researcher to liaise on this point between the various laboratories.\textsuperscript{45} Existing classifications were often more local than national (depending on research centres or the actual use of radiologists on the ground).\textsuperscript{46} Grut encouraged two laboratories, one in Britain and one in France, to establish an initial «entente radiologique».\textsuperscript{47} the Pneumoconiosis Research Unit in Cardiff, headed by Charles Fletcher and largely financed by the Medical Research Council,\textsuperscript{48} and the Nord-Pas-de-Calais coalmines’ medical research centre in Douai, headed by Dr Balguaries, in liaison with Drs Aupetit, Declerq, Nadiras and Jean-Jacques Jarry, the chief medical officer of the Charbonnages de France. The results of this joint work were presented in the summer of 1951 at a meeting of Benelux mine doctors.\textsuperscript{49} But despite Grut and Fletcher’s hopes, the ILO did not help with the circulation of the so-called Cardiff-Douai standards and left this to the initiative of the doctors who had devised them.\textsuperscript{50}

Evidence of the rise of industrial safety concerns was the criticism in the late 1940s of Grut’s «too medical» approach by members of the ILO Governing Body and other staff within the ILO. The fight for «the prevention and suppression of dust in mining, tunnelling and quarrying»\textsuperscript{51} was now on the agenda, with three international meetings from 1952 to 1962, leading to recommendations for legislation, enforcement and research. The ILO, which received first annual and then five-yearly reports in a standard format from the various labour ministries, redeployed its action against pneumoconiosis toward prevention, regulation and rehabilitation, including questions of radiological diagnosis, without interfering with the medical definitions.\textsuperscript{52} Grut was more in favour of studying the physiological aspects of dust inhalation and the effects of prevention on workers’ health, and saw his position decline as the influence of engineers grew at the expense of doctors.\textsuperscript{53}

\textsuperscript{45} In a letter to Jens on 24 July 1950, Grut estimated the cost at $11 000 (A_BIT, SH 24–3–1–1).

\textsuperscript{46} The Canadians, for example, under Riddell, adapted the South Africans’ eight-stage classification, while the Japanese, under Yamamoto, used three. In all, when Marcel Robert took over the case in 1953, he listed 17 proposals for radiological standards, some of which had appeared after Sydney. See also in this issue Mackowa and Rosental’s article on silicosis in Czechoslovakia.

\textsuperscript{47} A_BIT, SH 24–3–1–1, 30 June 1951.

\textsuperscript{48} The progressive Cardiff doctors preferred job reallocation and prevention by innovative use of radiology. See A. McIvor and R. Johnston, Miners’ Lung. A History of Dust Disease in British Coal Mining (Ashgate, 2007), in particular, 96 – 98.

\textsuperscript{49} A. Cochrane, I. Davies and C.M. Fletcher, «Entente Radiologique. A Step Towards International Agreement on the Classification of Radiographs in Pneumoconiosis», British Journal of Industrial Medicine 8 (1951) 4, 244 – 255.

\textsuperscript{50} At various international meetings, such as the Paris conference on pneumoconiosis (September 1952) and the Copenhagen international radiology conference (July 1952). See A_BIT, SH 24–3–1–1, letter from Fletcher to Grut, 14 January 1953. Fletcher also spoke at the Saranac Symposia, held by an American laboratory that had been archiving radiographs since the 1930s (see Markowitz and Rosner, Deadly Dust, 187).


\textsuperscript{52} Ibid., 385.

\textsuperscript{53} Grut-Fletcher correspondence, 16 and 30 June 1951, A_BIT, SH 24–3–1–1.
The new head of the Industrial Safety Section, Marcel Robert, successfully argued for bringing the two sections closer together, as requested by the most active industrial committees (Coal, Iron and Steel); he was supported by the employers’ and workers’ representatives of the Governing Body when the Sydney Conference Report was presented in June 1950. The Governing Body called for another meeting, this time including technical experts on pneumoconiosis prevention. It also decided that an expert committee would be formed to redefine the ILO’s health and safety programme so as to improve cooperation between engineers and doctors.

In its session on 6–10 March 1951, the Governing Body stipulated that «health and safety at work are indivisible, and should be treated as two aspects of the same problem». At the end of 1951, the ILO Director-General began to set up a single Safety and Health section, using this as the basis to adjust the membership of the correspondence committee.

Aage Grut attempted unsuccessfully to oppose this trend, citing Carozzi’s work and the conflicts he had had with his superiors during the entire interwar period: if expertise was to be credible, it needed to enjoy relative autonomy within the ILO structure. The dispute led to Grut’s resignation in 1952. David A. Morse asked for it on the grounds of insufficient administrative capacities, but it was in fact due to his dogmatic and tactless assertion of his independence, which had brought Grut into direct confrontation with Deputy Director-General Jef Rens. Marcel Robert became head of the new section formed by the merger in January 1953. It had nine members, three assistants and a number of secretaries, but the Office agreed that there was a need to recruit doctors. Meanwhile, the two Correspondence Committees, Occupational Health and Accident Prevention, were merged from 1954 onwards.

4. Complementary Rivals: ILO and ECSC

This strategic change of direction by the ILO can only be understood against the new constellation of international bodies that was threatening its monopoly in social insurance matters. Although the Office kept its prerogatives over the organisation of social insurance departments after 1945, at the June 1950 International Labour Conference, a coalition of government and employer representatives challenged its competence in defining minimal standards of social insurance: they argued the need for a specifically «medical» international opinion, which could only come from the WHO.

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54 The term used in the 1949 staff list.
58 He did not renew some contracts and produced new post descriptions for their replacements (A_BIT, SH 1000–1 112).
59 See Morse’s explanatory letters to Grut, A_BIT, Z 8–1–21.
60 A_BIT, Z 8–4–9.
61 See Morse’s memoranda and Robert and Grut’s internal comments, A_BIT, Z 8–4–9.
was a great contrast from the interwar period, when the exclusivity in social insurance was the Office’s best line of defence against the claims of the LoN. The joint committee on social security norms and standards, which the ILO and WHO set up in the late 1940s, was only in appearance a continuation of the earlier joint LoN/ILO committee: the Office was now in a much weaker position and was forced to cooperate and even encourage the WHO’s formation of a committee of experts in social security.\textsuperscript{62}

A form of role sharing did, however, quickly emerge. The ILO used its extensive institutional and regulatory knowledge of social insurance to address the «medical» side of social security standards. It stressed the voluntary and temporary nature of its cooperation with the WHO by clearly refusing to make it institutional. The relationship between the two consequently became complicated, to say the least, especially when the WHO created a highly active «social and occupational health» section in 1950. The ILO, threatened with the loss of this field of action,\textsuperscript{63} attempted to redefine its specific nature. These tensions, which would last a good ten years, were perceptible at the session of the ILO’s Occupational Health and Safety Correspondence Committee held in Geneva at the end of 1954. The WHO representative A. L. Bravo (Chile) explicitly intended to add «workers’ health» to public health questions. He asked that it should be the topic of a joint WHO/ILO committee, drawing a strong reaction from his audience.\textsuperscript{64}

The 1953 merger was only an imperfect response to the gradual erosion of the ILO’s leadership in the face of the WHO’s comprehensive environmental approach: at the end of the 1950s, the section recognised these difficulties.\textsuperscript{65} The WHO understood that for the early industrialised countries, the ILO was effective and better informed in occupational medicine. But the WHO claimed leadership for developing countries, where the size of the rural sector and embryonic social protection raised, in its view, a general epidemiological problem.\textsuperscript{66} And even on its home continent, the ILO had to face another emerging organisation: the European Coal and Steel Community (ECSC), founded on 8 April 1951.\textsuperscript{67}

\textsuperscript{62} The memoranda exchanged between the head of the ILO’s Social Security Section, R. Stack (UK), and his Chief Actuarial Adviser, A. Zelenka (Czechoslovakia), and those sent to the assistant director C. J. Jenks, clearly show that this cooperation was mere window-dressing forced on the ILO in order to have WHO support in its dealings with doctors’ unions (A_BIT, WHO 3–3).

\textsuperscript{63} Ibid., in particular Stack’s letter of 27 May 1955 to Luis Alvarado.

\textsuperscript{64} A_BIT, SH 1000–3–1–401 A, 41, 11th and 12th sessions, 6–7 December 1954. The ILO experts, including doctors Barthe, Bezemer and Didonna, for their part stressed the specific nature of occupational diseases, involving technical, economic and social factors in which the ILO had recognised expertise.

\textsuperscript{65} Occupational Health in the World, June 1961, A_BIT, Z 8–1–140. This internal report by Murray for David A. Morse and probably R. W. Cox was circulated for opinions to Rens (who annotated it), Yalden-Thomson and Robert, confirming that the section’s status was of concern at the highest level.

\textsuperscript{66} Bravo claimed that the WHO’s position was supported by India and Brazil (A_BIT, SH 1000–3–1–401 A). But this position did change: in the early 1970s, the ILO was asked to examine farm sector working conditions, beginning with the effects on farmers of chemical fertilisers.

\textsuperscript{67} See M.-Th. Bitsch, Histoire de la construction européenne de 1945 à nos jours (Brussels, 1996), 61–79, and, from a more theoretical point of view, E. B. Haas, Beyond the Nation-State: }
Article 55 of the Treaty of Paris required the ECSC to lay down what was to be the basis of a social Europe via a workers’ protection programme. Given the countries and sectors involved, the creation of this regional organisation was of particular concern to the ILO since it included regions of intermediate political status, such as the Saarland, and to some extent Germany and Italy with their major industrial basins. With the creation of an integrated, democratic Europe as part of a joint effort of reconstruction, the ILO hoped that this would facilitate the approval, ratification and application of international conventions.

The ECSC’s Labour Problems Division soon launched its own occupational health and safety programme to encourage and coordinate research. Silicosis was a prime concern and a partnership began, at first informally, with the ILO’s Safety and Health Section (SHS). In November 1953, Marcel Robert accompanied the representatives of the High Authority’s Labour Division, Glisendi and Humblet, as they contacted European laboratories to recruit experts for their medical research programme. In November 1954, it was proposed to create the Occupational Health and Medical Research Committee, chaired by Albert Policard, within the ECSC. In June 1955, its work with the ILO’s SHS was formalised in a regular exchange of documents and then, one year later, via observers at each other’s meetings. Whatever the ILO’s apprehensions over the emergence of this new player may have been, its inability to fund research opened the way for cooperation as hoped for by the Labour Division of the ECSC, particularly on radiological diagnosis and dust control.

The ECSC’s subsequent creation of commissions dedicated to «human factors», occupational medicine and rehabilitation, and the extensive movement of experts, only increased the overlap with the ILO, causing either convergence or friction. In addition to their different levels of intervention, the two bodies continued to differ in their forms of action, financial resources and the relative place accorded to employers’ functionalism and international organization.
interests. In some cases, the ECSC commissions took part in the ILO’s work on standardisation, and in others, allowed employers the chance to delay the process, as shown in the sensitive matter of radiological classification: within a few years, the ECSC’s attempts to make it one of its key research areas caused some tension with the IHS, the pre-eminence of which Marcel Robert was anxious to maintain. Whereas the ILO promoted the Cardiff-Douai standard in Western Europe, the ECSC supported the German Zorn-Worth classification. The antagonism came into the open when the ECSC research commission opened a European radio-histology research institute in Bochum in 1957. Not to be outdone, on 27 October 1958, the ILO held a conference in Geneva on radiological classification, followed by the circulation to 51 countries of 900 sets of 14 standard radiographs. Despite this initiative, the expert meetings of the ECSC’s «working group on radiological diagnosis» in Bochum and Luxembourg resisted this international classification. One of the senior officials, the German doctor Otto Zorn, criticised the ILO standards for addressing pneumoconiosis too broadly, and ignoring the specific nature of miners’ silicosis. In return, Dr Alberto Annoni, an ILO expert, accused the coalmines’ experts of always wanting to «differentiate themselves from other industries» and especially focus on «forensic concerns relating to forms of compensation».

Indeed, in addition to the subordinate position of the doctors in relation to the coalmines, the ECSC research committee tended to split between the German experts, who had not been at Sydney and were reluctant to accept the ILO’s international classification, and the French doctors behind the Cardiff-Douai entente.

The point at issue was indeed the ILO’s capacity to produce a standard recognised worldwide since the ECSC’s research committees enjoyed considerable financial and experimental resources and the ability to circulate their conclusions among European governments and industrial groups. But the work of adjusting radiographs, interpreting opacities and lesion effects varied considerably from one type of dust to another, and demonstrated the difficulty of coming to firm conclusions about the disease. Another point of issue was the methods and techniques of exposure (format, radiology or radiophotography). Meetings within the ECSC finally led to an initial

74 A_CECA, CEAB1–710 and CEAB11–712 140 (348), Observation sur la classification internationale, 1957. This highly technical discussion addressed radiograph interpretation.
77 Letter from Fletcher to Grut, 13 December 1950, A_BIT, SH 24–1–1–1.
78 In theory, the ECSC had the technical and political means to produce standards, but the High Authority was not very proactive in the field of social protection. Ernst Haas, for example, points out its failure in terms of social housing and the difficulty workers had in exerting effective pressure on the employers (The Uniting of Europe, ch. 12, «The High Authority: independent federal executive?», 451–485).
alignment on the broad position and returned the question to the ILO’s remit. At another meeting in Geneva in 1968 a classification was adopted and a framework was set in preparation for the Fourth International Conference on Pneumoconiosis to be held in Bucharest in 1971. For three years, a working group including ECSC experts worked to revise the classification and settled on a new set of standard radiographs, which the ILO distributed on request.\[^{79}\] The IHS still led the debate and the harmonisation and updating of international pneumoconiosis standards, and the radiological classification was revised for the last time in 1980. Although this classification was without prejudice to national legislation on disability or compensation criteria, it did achieve agreement on the interpretation of the various stages of the diseases’ development. However, this example demonstrates that in order to maintain its legitimacy and leading role on these matters, the ILO had both to work together or in cooperation with the other organisations and resist any competition that would be to its disadvantage and reduce its power of final decision.

The record is just as mixed with respect to the policy effects of the interaction between the two bodies. The ECSC contributed to strengthening the ILO’s competence over matters of occupational health in the industrialised countries in opposition to the WHO by taking it as its exclusive international reference source. But at the same time, the process of European integration ironically complicated the ILO’s work by imposing its own standards for social and health regulation: until then, the ILO had usually designed and applied its standards first within the countries of Western Europe.

### 5. Conclusion

The story we have told illustrates not only the ILO’s relative weakness with respect to States, which is almost inherent in its status, but also even more the way it managed to adjust its action and role over time with respect to other international organisations. It is important in correcting the traditional gaps in institutional history: focusing on an organisation too often means reifying its importance and room for manoeuvre, and neglecting the wider picture of which it is only a part. This observation bias becomes more problematical as we come closer to the present time, since the process of the creation of international organisations (global or regional) has advanced considerably.\[^{80}\]


\[^{80}\] The list of institutions represented at the *ad hoc* meeting of the Occupational Safety and Health Committee in Geneva in May 1972 gives an idea of these changes: in addition to the WHO, there were the FAO, the International Atomic Energy Agency, the Commission of the European Coordinating Committee and the OECD.
role in producing global standards intended to apply to local situations was that it understood the increasing complexity of the panoply of international bodies, and worked to maintain its pivotal position in the collection and circulation of information, at the cost of greater formality in its procedures. That was why, in 1959, together with the International Social Security Association (ISSA) and financial support from the ECSC, it set up an International Occupational Safety and Health Information Centre (CIS)\textsuperscript{81} to focus on prevention,\textsuperscript{82} and renewed its ability to publish reference encyclopaedias on occupational health and safety on the model begun by Carozzi.\textsuperscript{83}

In addition to this vital area of documentation, the ILO’s major but controversial role in combating dust diseases, the most lethal of the 20th century, reveals its manner of action and its constraints. Its defensive position with respect to the League of Nations’ health section was repeated in more difficult conditions after 1945 with the creation of the WHO and also, ironically, the recognition of silicosis, for which the IHS had pressed so successfully. The ILO quickly lost its medical pre-eminence in this field: silicosis was now recognised and, except for the question of radiograph standards, the new priority was prevention, which belonged to safety engineering. The ILO then adopted the solution it had rejected between the world wars: merger of the two sections, occupational health and safety, in 1953. Although the WHO increased its «social» role on the prevention side, it now had strictly medical grounds for taking over the place that the LoN’s health section had not even hoped for. Even in Europe, the bastion of the ILO, the well-funded ECSC monopolised the financing and coordination of medical research, much of it backed by the coal and steel industries. The ILO was relegated to an almost more diplomatic and official role within a joint programme with the WHO for the elimination of silicosis, which is still going strong.

However, this relative withdrawal on the medical front is less a departure than a shift of emphasis. It has led to a cognitive reappraisal and the arrival of a new model. When it was founded, the ILO was the main guarantor of the forensic concept of «occupational disease» which, with some variants, had been internationally recognised by the end of the 19th century. The precision of this concept and its effectiveness in extending the field of social legislation were counterbalanced by its relatively circumscribed nature: fragmented between industrial sectors, it could, according to the balance of power in each country, obscure the social aspects of the organisation of work.\textsuperscript{84} The SHS, the result of the merger of the occupational safety and health sec-

\textsuperscript{81} A_BIT, CIS \(0\)–\(02\) and CIS \(0\)–\(03\). Robert became CIS director in 1962, enabling a doctor, Luigi Parmeggiani, from the \textit{Clinica del Lavoro} like Carozzi before him to take over at the IHS.

\textsuperscript{82} A_BIT, CIS \(0\) and SH \(1\)–\(1\)–\(10\), for the correspondence on this point between David Morse, Marcel Robert and Renato Morelli, the president of ISSA, in May and June 1958. The mission of the CIS is, \textit{inter alia}, to anticpate new risks such as «the speed of technological progress» and «the appearance of new substances with unknown effects».


\textsuperscript{84} F. Carnevale, «Il corpo al lavoro, il lavoro del corpo. Salute e lavoro nelle culture dei lavoratori e
tions, was forced to redeploy and even defend «the status of the worker in the workplace», leading the ILO to consider ergonomics and workplace hazards (e.g. noise, heat). To make sense of this, the section had to convert to a broader vision,\(^85\) contributing to the general movement from «occupational medicine» to «occupational health». There was still the ambiguity of being associated with a productivist misuse of labour, but this integrated vision of «occupational health» became clearer in the 1970s and was eventually promoted ten years later by the European Union. So the series of shifts caused by an increasing number of international organisations after 1945 laid the basis for the emergence of the model that at present shapes this field of endeavour.

The process has been largely a symbolic one since in many respects the European Union now occupies the relative position that the ILO had during the interwar period: as then, the EU uses the principles of the market and fair competition to justify raising occupational health standards in the countries seen as lagging. The impact of the emergence of the newly industrialising countries, however, does not merely challenge the national adoption of legislation mainly defined at European level. Before the Second World War, the ILO based its effectiveness on a set of relatively comparable industrialised countries:\(^86\) it promoted the ideas of social and legal protection for workers in the name of fair international economic competition, with a gradual levelling up of national social legislation. The enormous range of situations at the present time inverts this virtuous circle: by adopting equivalent constraints now, the new industrialised countries would lose their comparative advantage in wage costs. One may fear for the impact on occupational diseases, including those that seem from a European point of view to be the most «archaic».

Translated from French by Roger Depledge.
How International Organisations Compete: Occupational Safety and Health at the ILO, a Diplomacy of Expertise

During the twentieth century the domain of industrial medicine and industrial diseases has been a scene of crucial struggles at the transnational level. Based on the cases of silicosis and pneumoconioses the article examines the role of international institutions in this process (ILO, LoN, WHO, ECSC). As the relationships between Luigi Carozzi, Albert Thomas and Ludwik Rajchman show, their interactions mix cooperation and concurrence and consequently have an impact on the internal structure. Changes in the action models are the result and the taking into account of immission loads and a global work environment as well as the relations between industrial hygiene and industrial security, is partially to be considered as a result of this game in which diplomacy and expert knowledge, but also the pressure of employers, trade unions and erudite associations and societies come into operation. The concept of health at work leads us to consider the European Union as the inheritor of these dynamics which were conceived to articulate social protection and health protection with the free play of market forces.

Internationale Organisationen im Wettbewerb um Sicherheit und Gesundheit am Arbeitsplatz: Die ILO und die Diplomatie der Expertise


Comment les organismes internationaux rivalisent: Santé et sécurité au travail au BIT, une diplomatie de l’expertise

Les combats déterminants en matière de maladies professionnelles et de médecine du travail au XXe siècle se sont déroulés à l’échelle transnationale. À partir du cas de la silicose et des pneumoconiose, l’article analyse le rôle des organismes internationaux dans ce processus (BIT, SDN, OMS, CECA). À l’instar des relations
entre Luigi Carozzi, Albert Thomas et Ludwik Rajchman, leur interaction mêle la coopération et la concurrence et exerce des effets de retour sur les structures internes. Elle agit de plus sur les modèles d’action: la prise en compte des nuisances et de l’environnement de travail, les rapports entre hygiène industrielle et ingénierie-sécurité, sont pour partie le fruit de ce jeu où diplomatie et expertise interviennent, ainsi que la pression des employeurs, des syndicats et des associations et sociétés savantes. Par maints aspects, l’Union Européenne, avec la notion de santé au travail, est l’héritière de ces dynamiques conçues pour articuler protection sociale et sanitaire et libre jeu du marché.

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