Healthy Discipline? Health Promotion At Work

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Abstract

This article addresses the rise of workplace health promotion and its significance for employment relations. It suggests that such initiatives, when linked to more general management techniques, have a 'double edged' nature. On the one hand, they provide the prospect of real health benefits and an improved quality of life. On the other hand, they operate as forms of control supporting the extraction of higher levels of performance and commitment from employees. Sometimes the 'management' of health warrants employer intrusion into non-work activities and discrimination against employees who are unable, or unwilling, to conform to the prescribed standards of 'positive health'. Most debate has concerned the former dimension, but in this article attention focusses on the 'disciplinary' potential of health-at-work and its role as a technology of power.

Introduction

Promoting the health of employees is currently rising on the managerial agenda of many organizations. According to Cooper (1994, p.4) there is an 'explosion' of health promotion or 'wellness' programmes in US and UK industry, covering activities such as fitness and exercise, smoking cessation, stress management, dietary advice and 'healthy lifestyle' counselling. In 1996, for instance, the UK Fitness Industry Association ran a national 'Fit for Business' campaign that promoted the provision of exercise facilities and trial corporate membership of health clubs (Baker, 1996). One exponent of the 'healthy organization' captures the spirit of this movement thus:

We need to manage the health of our employees as carefully as we manage our organization and the most effective way of improving the well-being of our staff is through the implementation of a planned programme of health initiatives. (Williams, 1994, p.7)

However, psychological rather than sociological perspectives dominate much discussion of workplace health promotion. Frequently uncritical and managerialist in tone, they view health promotion as an organizational policy that simultaneously improves employees’ quality of life and organizational performance (Cooper and Williams, 1994; Newell, 1995). For example:

If people can be educated to change their [health related] behaviour and attitudes so that they are more resilient to all types of pressure, this should benefit both the individual, who will experience improved mental and physical health, and the organization, which will benefit from a less stressed, and by implication more productive, workforce. (Newell, 1995, p.69)

The present article suggests that while we should not deny the benefits of workplace health promotion, neither should we obscure its operation as an adjunct of managerial control. We expose the latter dimension through a reading of organizational health promotion policies emphasizing their potential to regulate the behaviour of employees. In this way we understand the embrace of workplace health promotion not as a secular benefit provided by 'good' employers (Newell, 1995 op cit.) but as an integral part of emerging forms of labour management, accompanied by its own contradictions and ethical dilemmas. The evidence for this argument is drawn from a variety of sources including organizational policy guidance. The intention is to highlight emerging themes and provide some tentative but theoretically informed comment on possible implications for organization members.
Health at work

The concern with health at work is not new and, in the UK, can be traced back to the efforts of 'philanthropic' employers to provide for both the moral and physical well-being of their employees. As the nineteenth century progressed, this holistic stance was largely supplanted by the emergence of legal regulation, incorporated into various factory safety laws informed by scientific notions of public health (the so-called Sanitary Science; Armstrong, 1993). This concerned the 'interface between body and external geographical space' (pg.401), in particular the exchange of substances between the two (eg., bodily excretions into the environment, and 'foul air' into the body) and informed developments in workplace health and safety by emphasising control of the interchange between dangerous material in the workplace and the workforce. This has evolved into detailed laws covering a wide range of contaminants, informed and enforced experts (eg., in the UK the Health and Safety Executive). Both employers and employees are subject to this authority and dependent on its good services to safeguard important aspects of their health.

The view of health as an issue governed by medical and scientific rather than managerial authority is also reflected in established approaches to sickness (as opposed to environmental hazards). Here employee health occupies a well defined temporal and social space within the organization: it is of concern at the stage of recruitment, epitomised in the pre-employment medical or the GP's health statement and, subsequently, activated as and when illness strikes. In the latter event, there is generally an institutionalised form of Parsons' (1951) 'sick role': a set of procedures to which employees are obliged to conform if their illness is to be officially recognised. In Europe, at least, the space occupied by the sick role has traditionally resided outside the work organization with a state-provided health service. Once employees have adopted the appropriate sick role, they can be transferred to the medical authorities, the organization taking no further part in the proceedings, effectively suspending interest in the employee until the medical authorities indicate that resumption of work is possible. These two spaces, therefore, (ie., the organizational and the sick) are clearly segregated, neither engaging the other except at the boundaries.

Until recently there has been relatively little interest in a complementary organizational 'health/wellness' role through which the significance of an employee's positive health is defined as contributing to organizational performance. But it is to the construction of such a role that policies of health promotion now contribute in increasing numbers of organizations (Townley, 1994, pp.126-7; Sigman, 1992; IDS, 1991):

Wellness is the concept of developing a healthy lifestyle through proactive, preventative programmes that can influence risk. It is based on the belief that individuals should take responsibility for their own health and that employers have a role in helping them to do this.(Wellness Forum, undated)

This is achieved by seeking the active involvement of the individual employees in a health 'project', rather than casting them as the passive recipients of 'preventive' measures designed to regulate those external factors that cause illness. Health promotion claims that the incidence of illness is diminished by persuading individuals to 'exercise control over their bodily deportment' (Lupton, 1994, p.31). Compared to the workplace regimes of secular health, that of health promotion moves beyond discrete social and temporal spaces such that a clearly defined sick role, while not disappearing, is complemented by an institutionalised 'health/wellness' role permeating both work and non-work activity (Townley, 1994, p.127; Garrahan & Stewart, 1992). It is to the contradictions embedded within this approach that the next section is devoted.
The Healthy Workplace

The reasons for the providing health promotion often appear contradictory. There is a clear implication that it saves the organization money (exactly how and how much is the subject of debate, e.g., Santora, 1992; National Health Service Management Executive (NHSME), 1994). There are equally strong assertions that such programmes are less about yielding a direct quantitative return on investment than providing an employee benefit (in fact, a general social good), any return from which is an indirect bonus (Sigman, 1992; Newell, op cit.).

The down playing of direct gains to the providing organization gives the benefits of workplace health promotion the appearance of a 'gift' to the employee; in a study of UK companies, a major reason for introducing health promotion was claimed to be 'a felt need to improve employee relations by displaying a sense of caring concern' (cited in Sigman, op cit., p.25). The requirement of reciprocity implicit in this social exchange does not seem to demand any sacrifice on the part of the recipient (since the giver's benefit arises vicariously from the employee's self-interested behaviour change); in short, it appears as a non-zero-sum game. As a recent account of an 'exemplary' UK hospital scheme puts it:

Emphasis on 'fast-tracking' [giving employees preferential access to medical advice and services] for staff treatment is generating quicker access to medical treatment and reducing sick leave and long-term absence. On-site dentistry will also reduce the amount of time off for staff and ultimately benefit the Trust. So there will be fitter and better people on site. (Health at Work in the National Health Service [HAWNHS], 1994, section 5)

This appearance of mutuality, however, obscures a subtler balance of reciprocity which hinges on a nebulous but nonetheless potent expectation of commitment, a commitment that is exacted, at least in part, through the disciplines of the 'healthy workplace'.

Elements of the 'double-edged' nature of managed health promotion can be seen in the corporate provision of facilities such as gymnasias or games areas (Sigman, 1992; Baker, 1996). Apart from the manifest benefits of (potentially) better health for those involved, the provision of such facilities in-house has the effect of reorganizing available social space so that greater amounts of employees' leisure time are spent at work, breaking down the rigidities of own-time/company-time. For example, a mid-afternoon 'fitness break' allows productive working into the evening, or ensures that 'rest time' is spent in ways which retain awareness of organizational membership (and responsibility) rather than ones providing competing commitments (Reichers, 1985)(1). Baker (1996, p.13) provides the following illustration (without any sense of irony):

An improvement in staff health and morale benefits both employer and employee. 'I've got two children, I get up at 4.30am and I couldn't cope without this gym', says Karen, 34, a secretary at a leading firm of London solicitors. 'I come here every day and it relieves a lot of stress. My colleagues really notice the difference when I get back to my desk.' Karen works out next to Simon, 26, a corporate manager who works up to 80 hours a week. 'Regular work-outs give me more energy and better health,' he says.

In principle health promotion aims these facilities not just at the 'sport oriented' but at all those who need them, being designed to 'appeal to staff irrespective of age, gender or level of fitness' (Sigman, 1992, p.26). In a number of instances, promotion of a healthy lifestyle is sustained by a connection with other aspects of human resource strategy such that 'good health' is contingent upon other facets of employment discipline. In the case of Sony Corporation of America (Santora, 1992), for instance, an employee's take-up of health screening programmes is rewarded with extra 'flex dollars' (that can be spent as part of the corporation's flexible benefit package). Similarly, Sigman (1992) provides the
following account in which the elision of health promotion and the management of human resources is readily apparent:

Health promotion is beginning to overlap with the management development and training schemes offered by personnel departments. The personnel division of North Wiltshire District Council, for example, has a wide and varied training programme, 'Training - for your development', and subscribes to the motto 'To manage is to care'. In addition to stress management courses, the council has recently offered health related courses such as 'pre-menstrual syndrome and work', and 'Lifestyle factors and health'. Companies appear to be focusing upon improving the quality of staff, as opposed to recruiting new employees. Health promotion has an obvious role to play in this. (Sigman, 1992, p.26; emphasis added)

In this way health promotion takes on a 'mindful' form, addressing the employee through education, from conventional instruction to the more intimate guidance offered by counselling, the mainstay of most 'employee assistance programmes' (see Cunningham, 1994; Pickard, 1993) and a core component in much stress management. This technique, in its intimate, individualised and private form, allows employees to address issues concerning their 'whole life', not just the working component. Townley, for instance, suggests that this parallels the confessional, and the 'training' effects which Foucault ascribes to it:

Part of the value of the confession is that it produces information that becomes part of the individual's self-understanding. It is also important to notice that these practices shade into other practices based not merely on accessing individuals, but allowing or training individuals to assess themselves. Training enables individuals to identify what is happening within themselves in order to become more effective. (Townley 1993, p.536)

As one manual of workplace counselling suggests, 'a company's most precious resources really are its people and, if so, they need to help to maintain peak performance. . . Counselling is one way in which the psychological maintenance of people can be achieved (Pickard, 1993, p.20). Similarly, 'When it comes to counselling, the important thing is that you feel you have some responsibility for the well-being and healthy productiveness of those around you' (Redman, 1995, p.13).

These examples point to a 'spread' of health rhetoric into other human resource policies, opening the way for the workplace as a whole to be regarded as a site where 'healthy' activity is legitimate, desirable and, increasingly expected (see Newell, 1995; Cooper & Williams, 1994). Under these conditions, the surface equality characterising the gift-like nature of health promotion is increasingly underpinned by a possessive component (Fox, 1993, pp.93ff) that makes growing demands on the employee. In particular, the addition of health to the managerial agenda calls into question the basic premise that health promotion is based on voluntary commitment. This does not mean that health promoting behaviour becomes a compulsory duty imposed on employees--although this may be the case in extreme instances--but rather develops a normative power which creates an informal pressure to conform. This will be especially acute where senior managers are actively driving a health initiative and/or this is coupled with job insecurity such that non-participation is equated with a lack of job commitment. Thus, from being an optional benefit, regimes of health promotion are easily transformed into another standard of managerial judgement.

One instance of the attempt to redefine this generalised expectation is the development of measurable classifications that facilitate extensive monitoring of individual and collective health practices. This is demonstrated in the following extract from a hospital manual designed to implement aspects of the UK government-sponsored programme 'Health at Work in the National Health Service':

All NHS [National Health Service] environments in which treatment and advice are given are "healthy", thus reflecting that the best care and advice are given by those whose own health needs are being met . . . For [health promotion in the form of the Health at Work
policy] to be effectively implemented in the NHS, it has to be part of the performance culture... When the information [from the health indicators and outcome measures] is fed back... it can be put onto a central database. This information can also be aggregated together to examine the total picture of Health at Work in the NHS within the region—or within specific areas.

The measures proposed in this manual form a part of the contract negotiation process between purchasers and providers within the health service and relate to overall characteristics of an organization's workforce, providing indicators for reducing the number of smokers, reducing obesity, reducing alcohol consumption, increasing participation in physical activity, reducing stress, increasing awareness of HIV/AIDS and promoting safer sex (Health Education Authority [HEA], 1992). To this end managers are, inter alia, encouraged to 'introduce physical activity programmes and enable staff to be more active during leisure time, to provide and promote healthy choices of food, and to promote sensible drinking' (HEA, 1992, p.4; emphasis added).

While in theory these outcome measures are impersonal and at the aggregate level, the intention is to encourage managements to cascade down health promotion targets to individual staff and, in turn, to monitor their performance against these. Commitment to the regime of health promotion becomes de facto incorporated into the behaviour expected of individual employees. Not only are managers subject to these processes themselves but their performance is likely to be assessed in terms of their ability to 'persuade' subordinates to become healthier, thereby meeting performance targets.

These issues are not simply about improving health in a neutral or self-evident sense; they create the expectation that individuals should take responsibility for their own health as part of the duties of a 'good' organization member. As the following extract from the 'question and answer' section of the 'Health at Work in the National Health Service' brochure (HEA, 1992) illustrates, such an expectation, when part of a formal policy, is to be 'taken seriously':

Q. What right have you got to stop me going to the pub and drinking in my own time?
A. None, but, in order to reduce accidents and inefficiency, it is emerging practice that people do not drink during working hours. The Health at Work initiative will build on existing work undertaken by your workplace to promote good health. This may include advice on promoting drinking habits to ensure a safe and healthy work environment...

Q. If I refuse to help with the initiative, what will happen to me?
A. ... Senior managers will be committed to these developments. If you have any concerns about the initiative, you should discuss them with your line manager. The initiative must involve staff, rather than be imposed upon them. (HEA, 1992, p.6; emphasis added)

This emphasis is further reinforced when, against several of the indicators, health care staff are exhorted to behave in an 'exemplary' manner regarding their own health, setting a standard 'visible to all'. This is most strongly stated in the cases of smoking and obesity where the indicator is 'about the exemplary and educational role for health professionals when in contact with the general public'. In these areas, achieving positive health is both a professional and a personal project, the practice of which teaches moral lessons that have a particular resonance for members of a putative 'performance culture'. As Lupton suggests in her assessment of Crawford's (1984) study of lay conceptions of health:

[This] elicited responses about concepts of health that revolved around the notion of health as self-control, encompassing concepts of self-discipline, self-denial and will-power. Health thus became a goal to be achieved by intentional actions, involving restraint, perseverance and the commitment of time and energy... reflecting a general moralization of health achievement similar to that of the work ethic. Body weight in particular symbolized self-restraint, with a thin body a testament to control and an...
overweight body signifying the lack of will-power and self-indulgence. (Lupton, 1994, p.43; emphasis added)

Health promotion is clearly compatible with other management techniques which define and identify the qualities required of employees working in flatter, more quality-driven organizations, providing a training in self-discipline coupled to a standard of performance assessment. On this basis the conventional psychologistic stance on health promotion at work is distinctly one-sided when it is presented as an unambiguous benefit, capable of marking out 'good' and 'bad' employers:

'Good' employers in the 1990s recognize that work has a significant impact on employees which can be positive or negative. They attempt, through their human resource management policies, to maximise the positive and minimize the negative impacts . . . organizations can become more 'healthy', with the consequent benefits to employees, the community and the organization. (Newell, 1995, p.9)

The other side of the coin is that the adoption of health promotion as part of the labour management process also has the potential to mark out 'good' and 'bad' employees according to the normative standards of managerial interests (Legge, 1996). Such a practice is described by Fox (1993) with reference to hospital staff and patients. This, he suggests, should be read as concerned with the exercise of power, and the ways in which, in turning the patients' symptoms into signs (of disease, malingering, time-wasting or non-medical problems) staff read off messages inscribed on the bodies which could only be read with expertise, rewrote these patients as legitimate cases or rubbish, and constituted them into subjectivities (as deserving or undeserving) . . . While the good patient is a docile body, inscribed in the gaze of the doctor, made a subject through the doctor's power and knowledge, the creation of the bad patient as subject of power is problematic as a consequence of his/her resistance to discourses (on what a good patient or good citizen should be like). (Fox, 1993, pp.32-3)

It is plausible to suggest that health promotion provides organizations with an expert discourse on health which allows a similar process of definition (eg., the health consciousness that defines the 'exemplary' health worker, against the 'bad' health worker who recalcitrantly retains unhealthy habits). From this perspective the conjunction of health promotion with wider human resource policies has the potential to generate outcomes of considerable ethical import. These may range from concerns over employer intrusion into the 'private lives' of employees, to the possibility that criteria of 'positive health' will be used as a basis for discrimination and/or exclusion from the workplace. The latter could identify the 'unfit', the 'physically unattractive' (for instance, those who are overweight, Laabs, 1995), sexual and racial minorities associated with 'unsafe sex' (for example, HIV-positive medical staff continue to provoke tabloid outcries, despite well-established data on negligible risks, see Goss & Adam-Smith, 1995), those who smoke, and those considered to drink 'abnormally'(2). In many of these areas the indicators of health carry (in practice if not in theory) strong gender and class dynamics (Cockburn, 1991). Obesity, for instance, is looked upon as more 'problematic' in women than men (Lupton, 1994; Bordo, 1990) as is alcohol consumption (Collinson & Collinson, 1994; Plant & Plant, 1992), smoking (Goddard, 1990) and sexual promiscuity (Patton, 1994). If positive health becomes an additional index of physical capital (Bourdieu, 1984) this raises questions of access to capital enhancing activity: women, who remain the bearers of the majority of domestic and childcare responsibilities (Cockburn, 1991; Collinson, et al, 1990), may find it significantly more difficult to find either time or energy to engage in such health promoting programmes with the result that their stocks of such capital are perceived by human resource/occupational health experts as diminished and their 'exemplary' status thus undermined. The ability to engage in health promotion activities that are closely linked to workplace culture can also serve as the basis for forms of exclusion and/or marginalisation that are most likely to affect groups already subject to social disadvantage (eg., the disabled; Oliver, 1990). Consider the following example of a campaign suggested for National Health Service staff.
Great Weight Loss Campaign

The aim of this project is to combat coronary heart disease, strokes by: enabling staff in NHS workplaces to lose excess weight in a supportive and competitive atmosphere by adopting a healthy diet and lifestyle. We intend: Each department will appoint a team leader per team of four people; each team must be identifiable by a different name, eg., Wonford Whales, Occupational Heavies, etc. Prizes to be awarded to teams that lose the most weight amidst much publicity, ie., 'Express' and 'Echo', 'Health for All', 'Expressions', local radio and regional newsletter.

Although the aim of reducing disease is laudable, there are issues concerning the way in which body weight is articulated, in particular, the implication that it is a matter of personal choice, that to be 'overweight' should be a source of shame (hence, the pejorative team names) and that to overcome this 'affliction' is a matter of pride, endorsed by the organization. Those who are unable or unwilling to support this view of the healthy body are, in Goffman's (1964) terms, at risk of being 'discredited' by the publicity of the competition itself and becoming permanently 'discreditable' if the drive to control body weight becomes an established principle of exemplary status. This type of pressure may lead to situations where employees are prepared to risk damaging their health by, for example, concealing illnesses or disabilities that they fear may serve as a basis for exclusion from work (as has been the case with many people infected with HIV, see Goss & Adam-Smith, 1995; 1996), or engaging in excessive/compulsive dieting or exercise in an attempt to conform to a perceived standard of acceptability. In addition, there are the stress and anxiety that may result from failing to meet this 'standard' (Giddens, 1991).

This is a potential for discrimination that is likely to be encouraged by the rhetoric used to persuade employers to adopt health promotion on grounds of economy (ie., having a healthy workforce can save/earn you money) which implies (even if it is not stated) that 'unhealthy' employees are a financial liability and should, therefore, be avoided or excluded if unamenable to, or incapable of achieving a healthy lifestyle. For example, in the USA Turner Broadcasting Systems Inc. has refused to hire smokers since 1986 and the City of North Miami requires job applicants to sign an affidavit that they have not used tobacco products for the previous year (Laabs, 1994). While there is little documented evidence of this having happened within the context of employment in Europe (that is to say, explicitly on the grounds of failure to promote one's own health as opposed to the consequences of being 'unhealthy' - although see note 1 below) there have been recent UK cases where doctors have refused to give lifesaving heart surgery to smokers unable to stop smoking, and dentists refusing to treat children who were considered to have too much sugar in their diet. Taking a step further, a report from a personnel manager cited in one of the 'Health at Work in the NHS' manuals advocates the following:

... staff are being actively encouraged to take exercise and cycle to work ... As the scheme develops it will be incorporated into job descriptions highlighting health issues in the workplace. (HAWNHS, 1994, section 5)

Conclusion

Even though it may be instigated for other reasons, health promotion can operate as a technology of power. By necessity it imposes a discipline upon the individual body; at issue is the extent to which this discipline is shaped by the context of its application. Within the workplace this context is not simply one of health, but also of the organized interests of capital and labour. The foregoing account can be read through the lens of that critical management theory which has drawn upon post structuralism to examine the role of management discourses in the exercise of power and control. Townley (1993), for instance, examines the management of human resources from a Foucauldian perspective which presents an alternative way of perceiving and ordering material. Rather than thinking in functional terms of recruitment, appraisal, remuneration, and so on, in this perspective an
emphasis is placed on how [human resource management] employs disciplinary practices to create knowledge and power. These practices fix individuals in conceptual and geographical space, and they order or articulate the labour process. (Townley, 1993, p.541)

This disciplinary process is often portrayed as operating in two (interdependent) modes, both of which apply to health promotion at work. The first, 'panopticism', understands individuals as subject to increasingly sophisticated forms of surveillance which render their most intimate actions and behaviours visible. For example, indicators and measures of health can become mechanisms for surveillance. These measures become especially powerful when coupled to electronic storage and retrieval devices such as personnel databases--‘electronic panopticons’ (Poster, 1990; Lyon, 1994)--that can be interrogated as part of performance appraisal. More generally, according to Townley (1993, p.529) the very process of classification and the consequent scaling of outcomes serves a disciplinary purpose, 'enhancing the “calculability” of individuals, as each classificatory or ranking system designates each individual to his or her own space, and in doing so makes it possible to establish his or her presence and absence'. The second process operates through regimes of 'governmentality' which deploy knowledge and discourse to create internally regulated forms of subjectivity, ie., self-conscious self-discipline (Foucault, 1979; Townley, 1994; Rose, 1989). This is addressed by Grey (1994, p.494) who points to the construction of career as a project of the self, such that the ‘regulation of behaviour through the discourse of career, has the effect of transforming those instances of disciplinary power that might normally be thought of as regulative . . . [they] become constructed as benevolent aids to career development’. The concept of career, however, is only one technology through which (self)disciplinary power will operate. Thus, as a 'lifestyle commitment' workplace health promotion too can be read as a project through which (and in addition to any health benefits) productive forms of subjectivity are created. As Lupton (1994) has commented:

health education is a form of pedagogy, which, like other forms, serves to legitimize ideologies and social practices by making statements about how individuals should conduct their bodies, including what type of food goes into bodies, the nature and frequency of physical activities engaged in by bodies, and the sexual expression of the body. Self-control and self-discipline over the body, both within and without the workplace, have become the new work ethic. (1994, p.31)

Because of the consensus surrounding the benefits of health promotion, the foregoing analysis may be perceived as unrealistically destructive. However, it is precisely because of the firmness of this consensus that a critical stance is necessary; the point is not to deny the positive contribution of health promotion at work but to show that these benefits (for some) come at a price, and that this is a subject for legitimate debate.
References


Wellness Forum, (undated), Keeping Business Healthy, London.


Notes
1. A recent BBC TV 'Money Programme' (16.2.97) illustrated the 'hot house' culture created within the US Head Office of the Nike Corporation where the provision of a whole range of 'lifestyle facilities', including gymnasia and sports activities, was intended to encourage employees to spend longer hours on the 'company campus' and discourage external distractions from the creative process.

2. A notable recent UK case involved a TV executive who lost an offered job after a company doctor 'labelled him a heavy drinker . . . after he admitted drinking a bottle of wine a day on a business trip'. The Observer, 12 November 1996, p.25.