



The managementization of everyday life – Work place health promotion and the management of self-managing employees

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abstract

Critical management studies (CMS) has shown how developments in contemporary work organizations tend towards an increasing 'managementization' of employees' social identities and lived organizational experience. Such findings indicate that organizations create a need for other 'external' sources of authority which may legitimately influence spheres of life beyond work. Yet, little attention has been paid to this issue. This paper seeks to compensate for this gap by shedding some light on how the managementization of employees' identities and lives is linked to expertise and practices dedicated to the improvement of employees' health and wellbeing. Based on a case study of the occupational health service industry, the paper shows how health expertise and its therapeutic techniques have become ideological and practical forces that augment the processes of managementization that CMS has studied. To the extent that the managementization of life, that CMS has studied, pushes or motivates individuals to adopt an investment orientation to life in general, the paper points towards how health expertise grounds this orientation in scientific discourse and paves the way for a strident moralism where a life in the pursuit of health and professional success comes to distinguish good and promising individuals from those who lack moral character and talent.

Introduction

A main argument of the burgeoning critical management tradition (CMS) has been that developments in contemporary work organizations tend towards increasing the 'managementization' of employees' lives. Allegedly, 'flexible', 'entrepreneurial', 'mission driven', 'value and team based', etc., organizations no longer seek to control the concrete tasks and behaviors of employees. Instead, it is employees' social identities and lived organizational experiences that are to be aligned with overarching organizational interests (e.g. Alvesson and Willmott, 2002; Casey, 1999).

CMS' argument points towards the idea that classic distinctions between the professional self and the private self, between professional life and private life, are becoming increasingly blurred (Cremin, 2003; Fleming and Spicer, 2004; Kunda, 1992). Furthermore, it points towards how managerial authority, in its urge to increase its sway and scope, progresses beyond its traditional and legitimate field of jurisdiction (Costea et al., 2007). Given that management hereby opens a need of other, external

sources authority, it is somewhat surprising that the majority of CMS studies have maintained a focus on strict management techniques and on activities that take place within work organizations. Relatively little attention has been paid to how discourses, activities and actors external to the structured domain of work organizations function so as to extend management as an ideological and practical force. This paper seeks to compensate for this gap by shedding some light on how the managementization of individuals' identities and lives links to discourses, practices, and expertise dedicated to the improvement of employees health and wellbeing. Based on a case study of the Swedish sector for occupational health services, the paper shows how health expertise and its associated therapeutic techniques have become ideological and practical forces that augment the processes of managementization that CMS has studied. Hence, the paper focuses on the 'managerialism' of health and medicine, i.e. the ways in which health expertise and practices can be understood as forms of management. To the extent that the managementization of life, that CMS has studied, pushes or motivates individuals to adopt an investment orientation to life in general, this paper points towards how health expertise and practices ground this orientation in scientific discourse and paves the way for a strident moralism where a life in the pursuit of health, wellbeing and professional success, comes to distinguish good and promising individuals from those who lack moral character and talent.

The paper contains three parts. First, it accounts for CMS' argument about managementization. Thereafter it presents empirical findings from a study of the occupational health service sector in Sweden; followed by a conclusion.

Managementization

CMS has combined various schools of Marxism, post-structuralism, and feminist theory to provide an approach to analyzing management that interrogates its philosophical assumptions and the imperatives and techniques associated with its practice (Fournier & Grey, 2000). This has given rise to a rich, and by now numerous, series of studies that raises questions about the scope and objectives of organizational power relations. Two arguments appear to have been particularly salient. On the one hand, CMS has pointed towards how the scope of organizational power relations has been extended and intensified in contemporary work organizations (e.g. Deetz, 1992; Fleming & Spicer, 2004). Management is suggested by CMS to have become less a matter of regulating and constraining individuals' free and spontaneous choices, than of working through these free and spontaneous choices (Maravelias, 2003). Via sophisticated recruitment procedures (e.g. Bergström & Knights, 2006), mentoring (e.g. Covaleski et al., 1998) and other HRM techniques that accumulate knowledge about employees and use it to coach and guide employees towards higher achievements (e.g. Barratt, 2003; Maravelias, 2009), organizational power relations are alleged to seep into individuals' very identities, thus making them up as 'corporate clones' (Covaleski et al, 1998: 294), i.e. distinct self-managing entities that nevertheless map the goals of the organization. On the other hand, CMS has argued that these, more encompassing forms of management, implies a moral discrimination, or differently put, an idealization of a particular type of subjectivity, namely that of the 'entrepreneur' (e.g. Cornelius et al., 2008; DuGay, 2008; McCabe, 2008). Allegedly, the 'good' employee is no longer the

obedient and predictable ‘organization man’ that Whyte (1956) once presented as the product of 20th century corporate fordism, but an ‘active’ and ‘motivated’ entrepreneur that is both willing and able to reconfigure him or herself to whatever criteria underlies the tasks and social settings at hand.

The term ‘managementization’ is meant to capture both these arguments: it refers to how management has overflowed its traditional organizational habitat so that it is now the life of employees that are to be (self) managed for the sake of upholding social, active and flexible selves striving for professional success. More specifically, managementization is meant to capture the three interrelated dimensions implied by these arguments: an extension of management as an ideological and practical force into the ‘free’ spheres of individuals’ lives; a transformation of management into self-management; and an idealization of a particular type of self-managing individual, namely the individual that acts as an entrepreneur of him or herself.

Conceived in this way, managementization implies that attempts to manage individuals who expect and are expected to self-manage their work and life will inescapably be sensitive, in part contradictory, and possibly illegitimate. Who is entitled to interfere with how individuals manage their lives? To what extent and how can such interference be aligned with the notion that individuals freely manage themselves? Hence, managementization points towards the relevance of studying the possibilities of subtle and legitimate forms of managing self-managing individuals. More concretely it points towards the relevance of studying those parts of individuals’ lives, which traditionally have been considered to fall outside the confines of work, as objects of management. Of particular interest, then, would be studies which consider individuals’ lifestyles, family life, and social life as managerial sites and objects which are at times aligned with, and at times kept separate from, work. Furthermore, it points towards the relevance of studying sources of authority and expertise which traditionally have been considered as non-managerial. Discourses on health and wellbeing, various forms of health expertise and their associated therapeutic techniques, lifestyle discourse and lifestyle coaches, etc., appear here as examples of forms and domains of authority whose managerial functions and effects have been given relatively little scholarly attention.

A few exceptions are worth mentioning. One is Garsten and Grey’s (1997) study of the function and effects of contemporary ‘How To’ management texts. Garsten and Grey argue that such texts represent a form of secularized Protestant ethic. Within contemporary ‘post-bureaucratic’ organizations they are alleged to provide a form of individualistic self-help that encourages an aesthetic reflexivity among employees; i.e. they make the self a site for purposeful impression management, underpinned by the maxim that ‘we are not what we are, but what we appear to be to others’ (Garsten & Grey, 1997: 219). Garsten and Grey’s study is interesting in that it indicates how the involvement of the whole authentic self may be just a play act that individuals’ learn via the ‘how to’ discourse (cf. Kunda, 1992; Fleming and Spicer, 2004). Furthermore, it is interesting as it acknowledges how sources of expertise, which are formally unrelated to organizational hierarchies, nevertheless have considerable effects on individuals’ management of their selves at work. Yet, their study still maintains a focus on the management of the professional self within work organizations.

Pedersen's (2008) work on occupational stress and coping is interesting in this regard; it explicitly focuses on how individuals manage the boundary between the authentic self and the professional self, and between private life and professional life. More specifically, Pedersen points out how contemporary post-bureaucratic organizations subordinate individuals to two partly contradictory imperatives: 'commit yourself' and 'deal with it'. Whereas the first imperative implies that individuals are expected to involve and instrumentalize their whole authentic selves in work, the second imperative implies that individuals are also expected to be able to cope with the negative stress reactions that may follow from such a complete involvement by setting limits to it. Differently put involve your whole self, subordinate your life to principles of work and management, but make sure to know when and how you should set limits to that ambition! Yet, Pedersen's work does not present empirical findings and it says little about the interference of different forms of authority (such as therapists, stress coaches, etc.) that may 'help' individuals to manage these contradictory imperatives.

Finally, Hancock and Tyler's (2004) study of the 'lifestyle discourse' is interesting in this particular regard. Via an analysis of lifestyle magazines, Hancock and Tyler show how the lifestyle discourse has become a point of authority which 'teaches' individuals, at once, to energize their professional selves by developing active and rich lifestyles, and to balance professional and private concerns by setting limits between these two spheres of life. In line with Pedersen's (2008) argument, Hancock and Tyler (2004) show how the lifestyle discourse paradoxically advises individuals to protect their private spheres from the intrusion of the professional sphere by subordinating it to instrumental values and principles of management. That is, they show how the lifestyle discourse has become impregnated with managerial imperatives, encouraging and coaching individuals to adopt a managerial mindset and an 'investment orientation to life' in general.

Hancock and Tyler's (2004) study can be criticized for overstating the power of popular lifestyle discourses to influence individuals' lives. Even so, it is an interesting example of what I have referred to as 'the managementization of life', where, in this case the lifestyle discourse comes forth as an authoritative resource for individuals who attempt to instrumentalize their selves for the sake of more happiness and professional success. Hereby it points towards the significance of studying discourses, activities and actors external to the structured domain of work organizations as forms of management. That is what is attempted below. More specifically, via a study of the occupational health service sector in Sweden, I seek to show how transformations in the discourse and practices around the healthy individual imply an idealization of a type individual subjectivity which displays several affinities with the notion of the self-managing, social, active and above all entrepreneurial individual, as it appears and is idealized in contemporary managerial discourse. Furthermore, I seek to show how occupational health services and expertise can be considered as forms of management that take the lifestyles and selves of individuals as their objects of control and manipulation.

Methodology

The basic interest in the study of the occupational health service (OHS) sector in Sweden was to understand better how its services relate to human resource management (HRM) programs and activities within its client companies. More specifically, to the extent that contemporary HRM practices increasingly seek to make use of ‘the whole’ individual, attempting to foster particular subjectivities that freely subordinate to corporate values (Barrat, 2003; Covaleski et al., 1998), the aim was to study what role occupational health services and health experts play in this pursuit. The material presented below is part of a study of the Swedish sector for occupational health services that was conducted in two stages, first between 2004 and 2006, and second between 2007 and 2009. In the overall study, 43 in-depth interviews were carried out; yet for spatial reasons only about 20 of these interviewees are reported in the material presented below. Five separate groups of interviewees were involved in the study: the first group consisted of health professionals from seven different organisations within the occupational health service sector. This group could be further broken down into the interviewees’ specific professions as physicians, physic-therapists, psychologists, health coaches, ergonomists, and so on. For the sake of the readability of the text, however, I have referred to all of them as ‘health professionals’ in the account below. The second group consisted of executive staff from the seven OHS companies. The third group consisted of human resource managers working for four different firms that are customers to the occupational health service companies. The fourth group consisted of line-managers in the customer firms. Finally, the fifth group consisted of employees who had taken part in some kind of health promotion program or service. Human resource managers, line managers, as well as employees who had taken part in some health promotion program were contacted in client companies to the selected OHS companies. The selection of companies in the OHS sector as well as client companies was based mainly on access. Interviews were semi-structured; participants were asked to describe their role, how they found this role to have changed, which main problems and issues they dealt with and which concrete methods they used.

Worksite health promotion in the Swedish sector for occupational health services

During the last decade, the Swedish OHS sector has undergone a significant transformation relating to its system of finance and regulation. Traditionally it was regulated by cooperative agreements between unions and employer organisations and 50% of the costs were subsidized by the Swedish state. In the mid 1990s state funding was terminated and the OHS sector became market financed. This had a number of significant ‘contractual implications’ (Donzelot, 1991), i.e. effects on organizational, individual and professional identities, and on professional relations: in particular, the new contract mechanisms resulted in that the cooperative agreements were replaced by supplier-customer relations. That is, OHS companies were driven to establish relations with and win the loyalty of employer representatives – who now became their customers. In that process both the type of clients/customers and the type of health services offered shifted. Previously, OHS had primarily been directed towards the quantitatively largest groups of employees in the working population and the services

mainly concerned prevention and rehabilitation of work related injuries or illnesses. Now, an executive of an OHS company explained:

The leading OHS companies seek to get away from working with prevention of illness and injuries. I mean, heavy labour intense industries, where a significant part of the preventive health measures used to be directed, have either been thoroughly automated or have moved to low-wage countries. And there is no money in working with the lower end of the service sector. It is among the high-end companies that the profitable customers are to be found. Normally such companies do not have problems with directly work-related ill-health; they have problems with stress and other socio-psychological issues, which concern their employees' private lives as much as their working life.

Hence, being successful in the profitable segment of the market is no longer about preventing ill-health; it is about providing services that help employees stay healthy and fit for work. High-end companies are explained to have employees that have to deal with a high tempo, high but imprecise expectations, an abundance of choices and opportunities, and potentially conflicting interests especially relating to the private and professional life balance. A health professional explained:

Such employees confront health risks that concern the difficulties of managing all parts of their lives; at times they suffer from stress, they are depressed because they do not spend enough time with their kids, sometimes they do not sleep well, and so on. But that is not the whole story, they are also part of a culture where the norm is that you should constantly try to improve, become healthier, etc.

The OHS companies have responded to the needs of these customers by providing services that concern both dimensions touched upon in the last quote: helping employees steer free from health risks and helping them improve their health and well-being. The general term for such services is Work Site Health promotion (WHP). A health professional defined WHP in the following way:

If our objective is to prevent ill-health, we search for concrete health hazards in employees' immediate work-environment and give directives as to how these can be handled. When, however, our objective is to promote employees' health and wellbeing our perspective is much broader and we do not give directives, but try to help or coach employees to freely choose a healthier way of working and living. Hence, rather than saying that an employee should work and live in this or that particular way, we map the employee's work routines and lifestyle, trying to distinguish what is already good from what is not so good, and then we try to promote the former by providing the necessarily skills.

This view corresponds with that reported in other studies, where WHP is distinguished from traditional medical treatments by its ambition of being patient-centred in its approach and holistic in its mode of analysis (e.g. Mead and Bower, 2000). In the OHS sector this has implied that the focus of the OHS companies has shifted away from the work-environment towards the private sphere of their clients' lives. A health professional explained that this change of focus...

...is somewhat problematic because the very definition of OHS is to deal with work-related health issues. I am not saying that our services do not concern work-related health issues. But mostly the distinction between work-related health and non-work-related health is very difficult to make. If, for example, one of my clients is stressed out and depressed, is this because he has a hectic job with a lot of responsibility, or is it because he has three children and his wife wants a divorce? In such a situation I obviously cannot leave the family situation a side, but neither can I truthfully say

that the roots of the problem are work-related. But mostly this does not matter, because if the employee is important to his employer, the employer wants him back regardless if his basic problems are private or professional.

As the quotes above more or less explicitly state, the turn towards WHP implies a fundamental change of the OHS sector. Whereas OHS was defined by its concern with health issues that were work related in that the causes of ill-health or some health risk were to be found at work, OHS now increasingly concern health issues, which affect or may affect employees' work performance, but where the causes of potential or actual ill-health are to be found in the private sphere or in the integration of the private and professional spheres of employees' lives. Hence, with the turn towards WHP the main task of the health professionals in the OHS sector is to help companies make sure that their employees' whole life-situation is such that they are likely to remain not only healthy in a restricted bio-medical sense but also in the sense of being able and efficient at work.

The fact that the OHS sector has begun examining their clients using a much wider lens is also reflected in how the very notion of health was understood. A health professional said:

To us, health is no longer merely a question of whether or not our clients are defined as such in medical tests, it also relates to clients' lifestyles; if they are motivated, active, self-conscious and able to take care of their health.

Hence, health is increasingly seen to signify certain behavioural and personal characteristics. The active and motivated employee that seeks to improve in all areas in life, and that maintains a vigilant attitude towards his or her health and wellbeing, is typically seen as healthy, whereas the employee that lacks drive, that is negative, and seems unwilling or unable to care for his or her health, is typically seen as representing a risk group of 'the potentially ill'. A health professional pointed out that this new, more encompassing notion of health is directly related to a new culture and management philosophy in their customers' organizations:

I think the new type of health services that we provide relates to how health has become an integrated part of most of our customers' culture and philosophy. It is often assumed nowadays that a healthy company is an efficient company. Healthy individuals are seen to be more change prone, self-going, and so on; so nowadays all companies want to take the 'health-turn'.

Hence, the turn towards WHP conveys a partly new notion of health that implies a particular life as active, motivated and self-aware. Furthermore, this new, more encompassing notion of health is not merely seen as a value in its own right, it is also seen as a vital resource that makes employees more productive, flexible, and generally more appropriate for the type of work and careers that contemporary working life can offer.

Worksite health promotions – two examples

The OHS companies offer a range of services that may generally be given the label WHP – stress programs, work-family life programs, body mass index (BMI) programs, and so on. To illustrate the more concrete meaning and effects of such programs I will

account for two examples below. One is a so-called *lifestyle, health and career coaching* program that many OHS companies offer. Mostly employees attend this type of program as a form of benefit, a sign that one is considered valuable by one's employer. An HR manager explained that:

These programs are not for all employees. They are intended for those employees that are in the middle of their careers, that want to perform better at work, that want to be more challenged, more enthusiastic about work, and so on, but that find it difficult to combine those ambitions with the rest of their lives where they might have a family, a house with a garden and all of those things.

Typically a lifestyle and career-coaching program involves a series of three to five steps. A health professional explained:

The first step is to help the employee describe for him or herself how he or she lives on a day to day basis; what kind of work he or she is doing; whether or not he or she is happy with life in general; whether or not he or she is satisfied with his or her work and career; whether or not he or she is able to uphold a sound balance between work, family and private life, and so on.

By asking and answering these questions, the employee is meant to become aware of his or her life and career, and can begin to think about whether or not he or she is on the right track. The second step is to establish a comprehensive 'self-analysis'. Here the employee is asked first to describe his or her personal characteristics, then to describe what he or she believes that other people would say are his or her main personal characteristics, and finally to point out which of these characteristics are his or her strong qualities and which that are his or her weak qualities. Based on the two first steps, the employee is then, as a third step, given the task of working out his or her visions and goals, on the one hand concerning his or her work, and on the other hand concerning the rest of his or her life. Once these steps are completed the health professional helps the employee work out a concrete plan of how the career and life goals can be achieved. But this was not something that the health professional did for his or her client:

My role is that of a coach. I ask the questions and thereby direct the employees' attention in some directions instead of others. But it is the individual that comes up with the answers. It is so much more powerful to hear yourself say what you feel about yourself, your job, etc., than to hear it from someone else.

In these mapping, analysing, and goal setting activities, work and private life are treated as two separate spheres that should be managed using the same basic principles. A health professional said:

While it is important to keep these spheres apart, it is also important to see how they interrelate. You cannot excel in your career if you do not consider how it affects your private life and vice versa. So in both spheres strategic problems need to be pin pointed and related to one another and goals have to be set which consider how the other sphere is affected.

A concrete example of such activities was given by one health professional who had recently coached a promising, up and coming manager in his mid 30th. The manager had begun showing signs of stress, which, amongst other things, surfaced in the form of a sleeping disorder and in irritated and aggressive behaviour that significantly affected the working climate among his subordinates. The health professional explained:

In this case I helped him see how his professional life and his private life were two equally important domains; because, until then everything had been about work. At first he did not admit that, but when we mapped out his daily routines, his interests, what he thought about, dreamt about, etc. it became obvious that most of his days and nights were occupied by work.

The 'solution' that the health professional worked out with this client was to treat his work and his family life as two separate enterprises. The health professional went on:

By treating his family as an enterprise of equal importance as the professional enterprise he was managing, he began to find it easier to balance work and private life. His wife, who is a housewife, was titled president of the family enterprise while he was president of the professional enterprise. So, now there were two managers and two enterprises.

In general the lifestyle, health and career program can be seen as expressions of how OHS companies seek to exploit a growing concern among HR managers, that employees who may have the proper formal competencies lack the necessary and required social and lifestyle skills (e.g. the capacity to flexibly adjust to changes in the work situation, to cope with stressful situations, staying fit and healthy, etc.). As expressed by an HR manager:

Companies have always searched for excellence when they hire and promote people. But today, the meaning of the word 'excellence' has much wider connotations. It is no longer just a statement about the particular set of occupational skills that a person may hold. Now, excellence is also used to characterize a person who leads a particular type of life; who is physically active, who eats proper food, who avoids unnecessary risks, who is moderate on drugs and alcohol, etc.'

In this context, the *lifestyle, health and career program* is supposed at once to help companies monitor the potential of their human resources and to help employees help themselves become healthier, happier and, in that process, better able to match the expectations of their employers.

Another type of WHP program that many OHS companies offer is the *stress program*. In terms of the issues this program seeks to cover, its focus is narrower than the *lifestyle, health and career program*. Furthermore, in contrast to the former program, it is intended for employees that have shown early signs of ill-health caused by stress. Yet, the programs are still basically similar in that they do not primarily analyse and correct the organization of work, but the lifestyle and the self of the individual. In the case of the stress program, the objective is to teach individuals how to handle stress, or perhaps rather, early signs of stress, by giving them better 'self-knowledge' and abilities to maintain 'a dialogue with themselves'. Yet, a health professional explained, 'it all has to start with the clients accepting that they are responsible for their lives; that they are not victims and that they always have a choice.' The health professional explains:

Many clients initially place their stress-problems outside themselves. It is their job that is too demanding, or their boss that expects too much or is unable to set realistic and clear goals and performance standards. We try to turn that around. We want them to see that the problem and the solution lie within themselves.

Hence, the idea of individual responsibility is emphasized by the stress program. A health professional explained that the focus on individual responsibility does not imply that the OHS companies would consider the employees' work conditions as unproblematic with regards to stress:

On the contrary, but the possibilities of changing work conditions are generally very limited. We can help by temporarily limiting the responsibilities and the performance criteria of those employees that come to us with stress problems. Yet, in the long run the employees either learn to cope with their work or try to find other less demanding work.

In this respect, the professional environment of the clients is basically treated as given, i.e. as something that profoundly affects the clients' health and wellbeing, but that the clients cannot do much about, other than learning to cope with it. A health professional explained:

Ultimately we do try to teach them how to cope with their work and life, we teach them to listen to themselves, to choose, and to accept the fact that in the final instance it is they themselves that are responsible for their health and wellbeing. If the result of the stress program is that a client decides to leave their work for some other career, so be it.

Hence, in the stress program the focus of the therapeutic sessions is the individual and the aim is to teach the individual to adapt to work rather than the other way round. Differently put, the problem, or at least the part of the problem, that the health professional seeks to do something about, is found on the individual level, not on the organizational level; it is the individuals' lack of abilities to cope with stress and to set limits and prioritize that is at the centre of the health professionals' attention. In this pursuit, the first step in the therapy is to establish a trustful climate that helps the employee to accept and commit to 'the fact' that he or she has a problem with stress. A health professional said:

Daring to be open and honest about the fact that you do have a problem is very important; because stress has a lot to do with an experience of not being able to meet expectations. Declaring openly that you have a problem relieves you of some of that burden, at least momentarily, and gives you the opportunity to be honest towards yourself and to accept that you have a problem.

A second step in the therapy revolves around mapping out the daily routines of the employee. These mapping procedures did concern how the employee not only handled his or her work but also the rest of the employees' daily routines. A health professional said:

Many companies talk about 'the 24 hour employee' these days. It means that they take an interest in and care for their employees both at work and in their lives outside work. This is not merely a question of being nice and caring. Managers know that the ways in which employees live outside work significantly affect their abilities and their efficiency at work.

Clients are taught to deal with stress not only by being more aware and reflective about their own behaviour and attitudes but also by starting to think in strategic terms about all areas of their lives. More specifically, clients are taught to make distinctions between work, private life and self, and to set goals in all three areas. A health professional explained:

it is a mindset that we want our clients to adopt. They should be aware of what they are doing and they should think in terms of how the different areas of life, work, private life and self, relate to another.

With regards to the WHP programs accounted for above, as well as to others offered, it is generally underlined that participation is voluntary and that active and motivated

participation is required for any of the WHP programs to have any positive and lasting effect. An HR manager explained that ‘whereas the employees have a direct right to demand that their employers see to it that the work environment is safe, the employers cannot command their employees to eat properly, to exercise, and so on’. In that connection, a health professional said that ‘we can provide our clients with the necessary knowledge and skills and inform them about the responsibility they have to keep themselves in shape, but we cannot obviously demand that they actually do what we advise them and want them to do’. Yet, some of the health professionals underlined that there are delicate issues implied here: ‘Even though it may not be spelled out, nowadays companies tend to employ people, not only because they have certain formal competencies, but also because they are fit, healthy, and perhaps even because they look good’. In that connection, some health professionals underlined that ‘if you never read anything, just sit around watching TV, eating fast-food and never exercise, you might end up as a very unattractive employee’. These quotes indicate that although the employers have no right to command employees to live in such a way that they remain not only healthy but also attractive and capable employees, this was still expected, especially from employees with career ambitions. An HR manager meant that this is furthermore underlined by the fact that ‘many companies have begun to focus on health issues in recruitment processes and in the yearly development talk that all employees have with their superiors’.

In addition to this normative pressure there is also a potential coercive pressure on employees to take part in and to follow the WHP programs provided by the OHS companies. This is when an employee is unable to cope with work because of his or her health status. As said by a health professional: ‘if someone cannot cope for instance with stress and is relieved from work because of illness, this person is obliged to follow the therapeutic procedures and the directives outlined by the responsible medical professional’. In general, this relates to what Parsons (1951) referred to as ‘the sick role’, namely, that a person who is diagnosed as sick or injured has a right to care and is relieved of his or her ordinary responsibilities – e.g. concerning work – provided that the person subordinates to the authority of medical expertise. What this means is that when an employee has been diagnosed as ill because of his or her incapability to work, the health professionals have considerable power to influence all spheres and parts of the employee’s life. Furthermore, the employee has considerable incentive to follow the directives of the health professionals since limited health improvements, or limited motivation and activity in trying to become better, can be taken as a sign that the employee is inappropriate for his or her job and should seek other assignments. A former client of WHP services (a key account manager in a bank) said that:

When I began working here I was very ambitious and my bosses gave me loads of work. I never said no, and I could not, really, because I mean, you are not supposed to say no; it is sort of expected that new employees who are relatively fresh from the university should be prepared to work hard and long hours. Yet, after two years or so I started getting stress problems – at times I could not sleep and I got emotionally unstable. I did receive help from a therapist, but I still remained unable to put in those long and demanding hours. My therapist eventually advised me to seek another job because of health reasons, and I did. But I think it is sick that I should be considered ill because I cannot cope with a job where it is expected that you work enthusiastically up to 12 hours a day.

Discussion

This paper attempts to contribute to the discourse on self-management and the management of self-management by studying how measures and expertise, which are geared towards furthering the health and wellbeing of employees, take part in a managementization of particular lifestyles and selves. Generally, the case study concerning the OHS sector has pointed towards the affinities between the discourse on health and that of enterprising employees. Almost as a repetition of the person idealized in the discourse on enterprising employees, we saw how contemporary WHP programs picture the healthy individual as one that leads an active life, is motivated and, above all, self-managing. The current affinity between these two discourses is, however, somewhat paradoxical from an historical point of view. For whereas the former is intimately related to the neo-liberal political doctrine that was forcefully implemented in Europe and the US in 1980s via Thatcher's and Reagan's right wing administrations (e.g. Rose, 1993; Du Gay & Salaman, 1992), the latter derive from the 1960s' and 1970s' protest movements located at the very far left of the political spectrum (e.g. Crawford, 1980; Korp, 2007). More specifically, it was in the late 1960s, when a series of research reports by public authorities on health risks related to smoking, chemicals, occupational hazards, etc, was acknowledged by anti-authoritarian and anti-corporate groups within the burgeoning environmental movement, that the roots of contemporary discourses and practices of health were established in the form of the 'healthism movement' (Crawford, 1980; Zola, 1972). Healthism emerged as a critique of medical expertise' and practice' specific etiology; i.e. the ways in which medical expertise and practice isolate the individual from the social context in which ill-health is acquired. Hereby medical practices were criticized for seeing and treating merely the symptoms of ill-health while missing out on the more fundamental causes of ill-health which, according to healthism, were to be found in the social and material context surrounding the individual. Yet, even though healthism hereby opened the possibility for multiple causes of ill-health, its anti-authoritarian inclination drove it to situate the problem and the solution of ill-health at the level of the individual (Crawford, 1980; Lupton, 1997). More specifically, healthism turned the attention towards the macro-constraints of to health and well-being, but emphasized that we should not, and need not, subordinate passively to authoritarian medical professionals. On the contrary, our health was seen to be directly related to the extent to which we took control over our own lives. In this respect, healthism emphasized that we do have a choice and a responsibility to cultivate a lifestyle and a self that lead us to greater health and well-being.

Despite its anti-corporate – leftist – origin, it was this emphasis of individual agency and responsibility that opened up an interest for healthism both, among the professional middle-class and among private corporations (Korp, 2007). In the 1970s, after decades of steady growth, the stagnating economy in the US and Europe gave the professional middle-class reason to question its class position. In the continuous efforts to maintain class position – and to cope with the 'fear of falling' – that, since then, has been character trait of the professional middle class (Sennett, 1998; 2003), healthism appears to have been embraced as an element that can help it reassert its work ethic. The steady growth of the market for WHP programs since the 1980s (Zoller, 2003) is the clearest sign that private corporations also have welcomed healthism. Through WHP programs, private corporations have received more than instruments for the provision of healthy

work; they have received instruments for the institution of an ethic saying that individual employees should continuously seek to improve in all areas of life.

In the account above, we saw how WHP programs were embraced in both these regards. On the one hand, we saw how they made health, wellbeing, and prosperous careers derivatives of individuals' choices of lifestyles. Via the health professionals' advice and support, individuals were provided with knowledge to sleep better, to balance private and professional life better, to eat better, etc. Yet, more important than providing individuals with 'proper' knowledge was to make them accept that they were responsible for their health and to make sure that they had enough 'self-discipline', 'motivation', and 'self-control' to shoulder this responsibility. Hence, the WHP programs contributed to nurturing ascetic personal qualities and management oriented practices intended for all spheres of life.

On the other hand, we also saw that the WHP programs represented opportunities for those that had the required character traits to mark their distance and moral superiority over those that lacked them. This discriminatory tendency is in fact implied already by the name WHP, which indicates that the purpose of WHP programs is not to create self-discipline, motivation, self-control, etc., i.e. the moral faculties that are seen to underlie health; rather, it is to promote them and to guard against the threats that may result if individuals lose them. In this respect, the WHP programs are not conduits to better health, wellbeing and success which are available to everyone. On the contrary, for those that lack the moral faculties required for a healthy life and a prosperous career, they instead come forth as a form of tests revealing precisely these deficiencies.

To the extent that WHP programs thus operate as mechanisms that enable some employees to emerge as 'winners', worthy of praise for their self-managing capabilities and their moral qualities, can we then conclude that they also let other employees emerge as 'losers', worthy of nothing but blame for their lack of moral character? I am inclined to answer no, because as we saw in the account above, the tendency was not to allocate blame to those individuals that failed to mobilize the positive and disciplined spirit required to meet standards of health; the tendency was rather to define them as ill or potentially ill. Even though WHP emerged from the healthism movement with its holistic focus and empowering therapies that developed as an outright critique and attack on traditional medical practices, it appears at this point to enable a profound 'medicalization' of those that fail to live in accordance with the healthy lifestyles they seek to promote (cf. Korp, 2007). By 'medicalization' I then mean processes whereby more and more of everyday life comes under medical dominion, influence and supervision (Zola, 1972). In the account for the OHS sector, there appeared to be two main reasons for the medicalization of employees and their lifestyles. One relates to how the very basic principle of WHP programs, i.e. to further health by making individuals aware of the criteria of healthy lives, also makes individuals aware that they are inescapably surrounded by health risks. Somewhat paradoxically, WHP hereby contributes to making all people potentially ill (Lupton, 1997). The other relates to 'the economy of medicalization', i.e. to what the parties involved gain and lose by being diagnosed as ill or disabled. Generally, medicalization leads the diagnosed individual into 'the sick role' (Parsons, 1951), which, essentially, implies that the individual is relieved from his or her responsibility for the condition he or she is in, provided that the

individual subordinates to the prescriptive rules of medical authorities (Hallerstedt, 2006; Parsons, 1951). Once diagnosed as ill, employees that are unable to cope with their work because they are overweight, drink too much alcohol, are stressed out, etc., can no longer be blamed for their carelessness, but can instead demand both, to be relieved from work and to receive medical care. Employers, on their part, can get rid of unproductive employees without being drawn into 'a blame game'. Furthermore, via medical authorities, they receive legitimate powers to demand that employees actually change their behaviors (e.g. eat better and less, exercise more, and so on) in accordance with the prescriptions of medical authorities.

Generally, the account indicates that these medicalization tendencies pave the way for two, in part new, forms and functions of professional medicine. On the one hand, a form of medicine that does not provide care for the sick but anticipatory care for the healthy (Skrabanek, 1994). Examples from the account above are the so called 'health screenings' that most OHS companies offer their clients. Such anticipatory medical services are not the same as traditional preventive medical services, which typically concern merely vaccination against specific diseases and the reduction of the spread of infection (Skrabanek, 1994). Instead of such attempts to control identifiable agents of disease, anticipatory medical services combine the risk calculating methods typically used by insurance companies with medical expertise to provide clients with probabilistic speculations about health risks and expert advice as to how clients may avoid or post-pone these risks. As we saw in the account above, it was via an alliance between such anticipatory medical services and WHP programs that a modified version of the classical Parsonian sick role was established (Parsons, 1951), a 'potentially sick role', i.e. a role that tells us that we must never forget that we are always potentially ill, and that makes us aware that we have a responsibility of making sensible use of the opportunities (e.g. WHP programs) we are given for the sake of managing our lifestyles for continued health, wellbeing, and professional success.

On the other hand, the medicalization tendencies appear to open for an authoritarian medicine, which takes care of the increasing number of individuals who are diagnosed as ill, disabled or as suffering from one of a multitude of new psycho-social 'disorders' that have emerged during the past two decades. The common denominator of these new diagnoses is precisely that they originate in some deviance from norms of healthy and functional lifestyles. Examples abound: compulsive gambling, substance abuse, eating disorders, stress disorders, sexual addiction, learning disabilities, procrastination disorders, etc. The labeling of groups of individuals as sick or disabled because they have failed to manage themselves in accordance with norms and ideals of health, wellbeing, employability, etc. is a way of leading them into the classical Parsonian 'sick role' where they are relieved from their moral responsibility, and thus from their failure, provided that they subordinate to the authority of medical expertise and to public authorities that make administrative decisions based on medical diagnoses.

Hence, whereas anticipatory medicine joins hands with WHP to distribute opportunities and freedom to shoulder the responsibility for one's health and career, authoritarian medicine distributes labels of ill-health and the freedom from responsibility for one's health and career that comes with subordination to medical and public authority. In

either case, it makes the individuals' selves and lifestyles objects of managerial interventions.

Conclusions

Issues of health in working life used to be seen as closely related to the classical liberal notion of 'the social' (cf. Dean, 2007). 'The social' emerged in the 19th century as a concept encompassing a critique of the ills and risks related to the functioning of the industrial capitalist economy. It gave rise to a social way of governing (which reached its apogee in the European welfare state projects of the mid 20th century) that combined collective responsibility and individual compensation in areas of health, unemployment, education, and so on. Dean (2007) argues that the current neo-liberal regime implies the gradual dismantling of 'the social', and the social way of governing, in favor of a new system that emphasizes individual responsibility and choice among resources and expertise in the areas of health, education, employment, etc., which are no longer made available by the state, but by the market. With regards to this issue, Cornelius et al. (2008) recently asked whether health professionals are becoming means that no longer primarily help individuals by protecting them from the ills of the economy, but that instead help the economy by maintaining a population of 'economically feasible' individuals, or by turning 'economically burdensome' individuals into 'economically feasible' individuals. Differently put, are health professionals becoming resources that no longer protect the social against the ills of the economy, but that instead protect the economy from the ills of the social?

By and large, the study of the OHS industry accounted for in this paper outlines some of the consequences of the dismantling of the social described by Dean (2007). As such it also generates a partly affirmative answer to the question raised by Cornelius et al. (2008). More specifically, the OHS industry and the WHP programs it offers employees in its customer companies, emerge as parts of a neo-liberal way of governing society that views the social, and the systems of collectivized responsibility for the potential ills and risks of the economy that it implies, as risks themselves to the performance of the economy (Dean, 2007). Collectivized responsibility via a welfare state is typically seen to lead to a reduction of individuals' freedom of choice, to an unfortunate shrinking of the market economy, and to a lethargic, irresponsible population (Cornelius et al., 2008). Here the provision of WHP programs by market financed OHS companies comes forth as a dismantling of the social through an individualization of health risks. Differently put, it comes forth as a new form of 'prudentialism' (Rose, 1993) where the main focus is no longer the employer's collective responsibility for the safety of the working environment, but the employer's distribution of opportunities to employees who are meant to use them, to take an individual responsibility for leading a life that makes them not only healthy but also up to the challenges of work.

The study of the OHS industry has shown how the possibilities of such a shift in responsibilities are closely related to a partly new way of understanding health. More specifically, the study has shown how health has come to imply not merely that an individual passes a clinical test but also that the individual leads an active, flexible and above all self-managed style of life. The study has furthermore shown how it is in

relation to such an understanding of health that health professionals stand out as potential authorities in the management of self-managing and enterprising individuals. As noted in the introduction to this paper, the management of self-managing, healthy and enterprising individuals is at odds with all forms of direct authoritative interventions; just as entrepreneurship cannot be called forth via orders or demands, so also healthy lives cannot be maintained via authoritarian medical instructions. The management of self-managed, healthy and enterprising lives must instead be based on the provision of proper knowledge and therapy, or coaching, to help individuals freely adopt the active and motivated attitude required to shoulder their accepted responsibilities. It is this role that WHP programs, and the health professionals providing them, have the potential of playing; they contribute to making up individuals that manage themselves for greater health, wellbeing, and professional success. Here, however, it is important to point out that the paper has also shown how the affinities between health and a self-managed and entrepreneurial lifestyle tend towards transforming those groups of individuals that lack 'motivation' and 'initiative', that remain 'dependent', 'collective', and 'self-sacrificing', i.e. those individuals that fail to display or learn the character traits and lifestyles of the idealized enterprising individuals, from a status as unsuccessful and unemployable, to a status as ill, potentially ill or deviant. Hence, health professionals and their associated therapies do not merely come forth as significant points of authority in the management of self-managed individual lives and careers, they also come forth as authorities that manage the population by singling out the 'economically feasible' from the 'economically burdensome'.

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