Happy, Healthy and Here: a Foucauldian Analysis of the Regulation of Employee Health

Russell James Jackson

A thesis submitted in partial fulfilment of the requirements of Sheffield Hallam University for the degree of Doctor of Philosophy

September 2003

Happy, Healthy and Here: a Foucauldian Analysis of the Regulation of Employee Health

Russell James Jackson

Submitted for the degree of Doctor of Philosophy at Sheffield Hallam University

Abstract

Academics have recently brought a Foucauldian analysis to bear on the field of employee health, but there is an absence of empirical research grounded in employee accounts. In this thesis, qualitative research methods and forms of Discourse Analysis are utilised from within a predominantly Foucauldian perspective, in order to explore the relations between the perceived shift toward an underlying neoliberalist political rationality and emerging forms of regulation. Neoliberalism is concerned to reform the conduct of individuals and institutions to make them more competitive and productive.

Research proceeds through analysis of a key cultural technology, the 'Revitalising Health and Safety Strategy Statement', and two case studies, Consignia and a small web-design company, The Byte. Consignia adopts a disciplinary regulatory approach to employee health, The Byte, a decentred (non)regulatory approach.

The state, through the Revitalising Health and Safety Strategy Statement, makes a subject position available for employees characterised by motivation, responsibility and productivity, that is 'happy, healthy and here'. An appeal is made to freedom: companies, groups and individuals are positioned as autonomous and responsible agents. Active participation in health and safety establishes local sites of self government that can be indirectly managed by the technologies of numericisation and performance.

The concept of responsibility is used strategically as a powerful persuasive trope, designed to change - or maintain - certain behaviours. At both Consignia and The Byte employees continue to subjectively experience health problems that they understand to be caused by work. Under contemporary problematisations they are positioned as (ir)responsible for failing to take adequate measures to protect themselves. The employee, caught within competing problematisations, can struggle to achieve an 'authentic' self. Responsibility for employee health has been successfully implanted into companies and employees through modification of localised discursive conditions. Regulation becomes understood as *the production of (de)responsibilisation.*

Acknowledgements

Three people in particular have been inspirational and invaluable in the production of this thesis. Chas Critcher and Kathy Doherty have patiently and deftly played numerous roles for me, providing much needed intellectual nourishment and, more often than any of us envisaged, first rate emotional support. Ronnie Moore has also been extremely helpful, particularly in the early stages of the thesis. Thanks.

Thanks are extended to all those in the Department of Communication Studies at Sheffield Hallam University, who manage to remain committed and cheerful in uncertain times. Special thanks to two postgraduate colleagues, Michael Bailey and Elly Tams, whose friendship and shared postgraduate experiences have been a comfort. Thanks to Sheffield Hallam University more generally for providing luxurious facilities and fine administrative and technical support.

It's been a pleasure to attend a variety of seminars and conferences and to gain valuable responses to three paper presentations at Portsmouth Business School, the Centre for Regional, Economic and Social Research at Sheffield Hallam University and the MedSoc 2002 conference. In particular I'd like to thank David Goss, Sue Yeandle and especially the organisers of the BSA Medical Sociology group's annual conference. Fascinating and inspiring presentations, discussions and drinking styles.

Many thanks also to all those 'participants' in the thesis. From the Royal Mail the postal workers, the Occupational Health Advisor, the Fitness Suite Manager, the Customer Processes Manager and the Chief Medical Advisor. From 'The Byte', thanks to the directors, the Office Manager and the employees. I thank all of the interviewees for their candour. Their openness and willingness to engage is a credit both to the individuals and the companies.

From further afield I thank Joan Eakin and Ellen MacEachen from the Department of Public Health Sciences at the University of Toronto. I look forward to continuing our discussions on neoliberalism, work, health and the ideas of a certain Mr. Foucault.

Thanks to the ESRC for providing funding.

Finally, thanks to friends and family, especially my wonderful parents. I'm a *very* lucky fella.

CONTENTS

PART ONE - THE REGULATION OF EMPLOYEE HEALTH

1.1 *Introduction*

This thesis attempts to identify some of the ways in which employee health is 'problematised' within emerging forms of government, in order to demonstrate how particular problematisations give rise to particular forms of regulatory activity. Government is here understood in its broadest sense, as:

> any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agents, employing a variety of techniques and forms of knowledge, that seeks to shape conduct, by working through desires, aspirations, interests and beliefs for definite but shifting ends (Dean, 1999:209).

The analysis is undertaken within the context of a perceived shift away from a welfarist society, toward a society influenced more by an underlying political rationality of neoliberalism.

When something is problematised, this does not involve merely manifesting a social phenomenon and suggesting it is problematic. Rather, *conditions* are developed in which possible solutions are formulated. The elements of the phenomenon that the different solutions attempt to respond to, themselves become defined in this process (Foucault, 1994a:119). In other words, social 'problems' are constructed in such a way that it is only possible to respond with certain solutions, and in proposing these solutions, the 'problem' itself is transformed. This thesis demonstrates that 'employee health' is problematised in ways that activate particular regulatory responses at particular sites. The thesis empirically examines these regulatory responses to certain problematisations of employee health, and traces some of the consequences for employees, companies, and the state. At a more theoretical level, the utility of a Foucauldian framework in undertaking empirical investigations is explored.

It should be made clear from the outset that this thesis is not directly concerned with employee health *per se* - it does not, for example, represent an attempt to evaluate the effectiveness of workplace health strategies and interventions, nor

assess the health 'status' of employees. It is, as the title suggests, a Foucauldian analysis of the regulation of employee health.

The thesis comprises two parts. The first part sets parameters upon the object of investigation, develops a theoretical framework, reviews the relevant literature, articulates research themes and questions, and outlines the methods to be used in the generation and analysis of the empirical data. The second part introduces and analyses the empirical data, and draws conclusions from the evidence presented.

This chapter begins with a discussion of contemporary understandings of the relations between work and health. It then introduces neoliberalism, and outlines some of the broad historical shifts and discourses which have shaped the ways in which work and health are conceptualised. It finishes with a discussion of the relations between neoliberalism and employee health.

The relationship between health and work

Work, understood in a broad sense as a form of human activity in which labour is exchanged for money, can be seen to be both good *and* bad for employees. Positively, there is financial recompense, employees may gain a sense of worth and learn the life-skills of self-discipline and self-control. A sense of job-satisfaction may be derived, and social opportunities may arise. Negatively, some work may be experienced as frustrating and unrewarding. Racist, sexist and ageist attitudes and workplace bullying may be encountered. Some jobs are intrinsically dangerous and there are many occupational hazards and diseases from which employees may suffer. Over the last two decades awareness of 'new diseases' such as RSI and stress, has increased. Employees may experience a sense of job insecurity or of being trapped in a dead-end job. There are numerous factors which contribute to an employee's subjective experience of work, but the important point is that work - however it is conceptualised - contributes in significant ways, both positively and negatively, to people's sense of health and well-being.

Of course, there is disagreement about exactly what 'health' is, and differing opinions about what, if anything, should be done about it. These disagreements are manifested in everyday disputes and interventions. Some of the wider issues around health, including an exploration of some of its historical antecedents, will be discussed later in this chapter. Understanding health in the context of work introduces the extra dimension of productivity. What is the relationship between health and productivity? To what extent does health compromise or complement productivity? The term 'healthy' is applied as a prefix to other terms like society and nation, and increasingly to company and organisation. Are there links between a healthy society, a healthy company, and a happy, healthy, productive employee? Proponents of Occupational Health, Health and Safety, and Workplace Health Promotion are sure that there are.

Approaching health at work

Until very recently, in the UK, two broad ways of regulating employee health - distinct yet overlapping - can be identified. *Occupational Health* deals primarily with diseases and illnesses that are presently understood to be caused by work activities. *Health and Safety* is arguably more concerned with reducing accidents and identifying hazards encountered in the work environment. In the last decade of the twentieth century, *Workplace Health Promotion* initiatives have been introduced at many workplaces. Generally, mainstream occupational health and safety activities are concerned with prevention and protection activities. These activities are subsumed within workplace health promotion and the additional dimension of 'promotion', that is seeking to boost health in a positive manner, is added. Although still not widely practised in workplaces, Health Promotion in general has, unlike Occupational Health and Health and Safety, received a great deal of critical sociological attention (Goss, 1997; Bunton, Nettleton and Burrows, 1995; Nettleton and Burrows, 1997), some of which will be introduced within the key literature review, undertaken in Chapter Three.

Employee health and well-being has become a central theme in mainstream media and practitioner oriented magazines and journals, with an explosion of academic research across a variety of disciplines (Danna and Griffin, 1999).

National and local newspaper articles now regularly address employee health issues. Recent examples include: *Forget your company car, try a six pack - Firms are learning to keep their staff healthy - and hard-working* (*Observer*, January 2003); *Advantages of a healthy workforce - A healthy workforce means a healthy company* (*Sheffield Telegraph*, August 2001); and *Together we can work it out - Joined a gym for new year? Your boss may also be keen that you get in shape - how companies have recognised the benefits of healthy employees* (*Guardian*, January 2000). Everyone seems to agree that the individual's experience at work (physical, emotional, psychological and social) impacts upon their health. Employees spend about one third of their waking hours at work (Danna and Griffin, 1999:358) and it is now widely accepted that work and personal lives are interrelated domains which can have reciprocal effects. Stress from work is understood to combine with stress from everyday life. There is a common belief that stress can result in ill health. Occupational health professionals and employee representatives articulate an increasingly sophisticated understanding of the determinants of poor health at work, which they suggest comprise factors such as job design, rewards, levels of control over one's work, social support networks, bullying, sexual and racial harassment and the relations between managers and workers, as well as the more traditional health and safety concerns such as correct lifting and handling, protective clothing etc. The true breadth of the consequences of the impact of work upon health, not to mention the costs to workers, organisations and society, are only now becoming apparent (Danna and Griffin, 1999).

Productive employees

However, perhaps the main impetus for this renewed interest in employee health and well-being stems from concerns about the perceived relation between health and productivity. It is widely claimed that employee health and well-being impacts directly upon productivity, for example in sickness/absence costs and in the inability of employees to cope with increasing demands, such as longer hours and more intensive working practices.

This renewed interest in employee health is of direct concern to this thesis. Although workplace health strategies and interventions may be couched in

terms of protecting the health of the employee, improving employee relations, or as the employer offering something positive to the employee (for example access to leisure facilities such as on-site gymnasiums), from a different perspective such strategies and interventions can be seen as being motivated primarily by a concern with increased productivity and competitiveness. The promotion of health may be seen by some employers as being a cost effective means for the regulation of sickness absence, and as a way of increasing an employee's ability to cope with the pressures of working life. There are competing explanations offered for the determinants of health, for becoming involved in the health of employees, and consequently there are different ways of approaching employee health in different workplaces. An employer's willingness - or not - to become involved in the regulation, and in some cases promotion, of employees' health is manifested in workplace health strategies and practices. These competing claims and motivations will be explored in detail within the empirical chapters.

Healthy workplaces

One manifestation of a government endorsed employee health strategy, which recognises the influence of environmental factors upon health, is the 'settings' approach, based on a belief that settings themselves (for example workplaces, schools, cities and communities) influence health. Within this framework, increases in work(place) intensity are associated with increases in stress and symptoms of ill health. One response to this has been to provide health facilities within workplaces. Throughout the 1990s increasing numbers of employers provided health and fitness facilities for employees in their work environment, thereby reducing the distance between, or 'de-differentiating' (Lash, 1990), leisure and work. This perceived erosion of the boundaries between work and non-work, or public and private, is of concern to this thesis.

This shift toward providing health facilities within workplaces is reminiscent of the 'Rational Recreation' movement of paternalistic, modernising industrialists in the nineteenth century (Bailey, 1978), which included UK companies such as Rowntrees and Cadbury. From the Rational Recreation movement onwards, some employers have intervened directly in the *lifestyle* of their employees by

providing facilities for physical recreation. The motivations and justifications given by employers for involvement in the lifestyle of employees, as well as employee responses to such involvements, are also of concern to this thesis. What is not in doubt is that the workplace has again come to be seen as a legitimate territory for considering interventions into health.

This resurgence of interest in settings as a site for health interventions can be traced to the North American and in particular Canadian approaches to health. Several influential reports impacted upon the trajectory of thinking about the relationship between health and work in the UK, the *Lalonde Report* in 1974, the *Epp Report* in 1986, the *Ottawa Charter* in 1987 and, most recently, the *Jakarta Convention* in 1998. The *Epp Report* (Health Canada, 1986) was influential in its consideration of the relation between the environment and health, and helped develop and establish the modern settings approach. Settings were central to the *Ottawa Charter*, which aimed to promote health 'where people learn, work, play and love' (WHO, 1987, p. ii). McGillivray states that the:

> Ottawa Charter also stimulated ideological debate around the acceptable balance between personal responsibility for health and the role of supportive environments in determining health inequalities (Mcgillivray, 1999:60).

This tension between personal responsibility for health and the role of supportive environments is also a central concern of this thesis. Exploration of the ways in which this tension is managed, both by the state and within particular organisations, and the subjectively experienced responses to its management by individual employees, will be one of the guiding themes of the empirical chapters.

Pressure on welfare state finances, and the perceived shift toward a more neoliberalist state, has also driven UK Governments to look at the potential opportunities within the workplace for alleviating the burden of welfare. This has been recognised in recent UK Government policy documents, including *The Health of the Nation* (Department of Health, 1992) and *Towards a Healthier Scotland - A White Paper on Health* (Scottish Office, 1999). Donzelot has claimed that one of the legacies of Thatcherism, and at the heart of neoliberal

governance, is the transformation of the social contract between the state, its citizens, and its organisations (Donzelot, 1991). There have been fundamental changes in what Conrad and Walsh describe as 'the corporate jurisdiction over employee health and behaviour' (Conrad and Walsh, 1992:89). McGillivray suggests that by this Conrad and Walsh mean that organisations are being re-imagined as socially responsible for citizens' health and fitness, and are expected to shoulder more responsibility for their employees (McGillivray, 1999). Donzelot (1991) suggests that the role played by organisations begins to extend beyond organisational change to impact on social policy:

> ... the new health policies convert the social audit of enterprises into instruments for socially mobilising individuals towards savings in cost of health care and collaborate in their pursuit ...(of) the transferring of responsibility to the individual (Donzelot, 1991:279).

Donzelot, Conrad and Walsh and McGillivray all point toward the idea that there has been a dispersal of state responsibility for health, in part to organisations, and through them, in some instances, toward individual employees. This claim that there has been a dispersal of responsibility for health is a central concern of this thesis, and therefore data which supports or refutes the claim will be foregrounded within the empirical chapters.

Following on from 'body-optimisation' (Taylorism), the 'optimisation of working environments' (Human Relations Movement) and 'lowering the risks' in most workplaces of accidents and body failure (Health and Safety), modern work organisations seem to have rediscovered the body as a 'terrain in which further adaptations' designed to improve productivity and cut costs can be made (Haunschild, 2001). Emerging initiatives include: medical screenings; fitness programmes; stress management; dietary advice; and lifestyle counselling. Health management is geared around ensuring employees do not get ill through work but Haunschild claims it can tend toward addressing the consequences of longer hours, more intense working practices, increased job insecurity etc. By persuading and then helping employees to become healthier, and therefore better able to cope, the subjective, local, organisational, national and global factors influencing working conditions may be overlooked. Any data suggestive

of employer strategies aimed at increasing an employee's ability to cope with the pressure of work will be emphasised within the empirical chapters.

Making the business case

It is widely argued that the future success of organisations is dependent upon having well qualified, highly motivated, and healthy employees. Since the War, traditional Occupational Health and Health and Safety practices have significantly improved health in the workplace by reducing accidents and preventing occupational diseases. However, these approaches are seen by many employers as inadequate to address the issues of continued absence through sickness costs, and the inability of some employees to cope with changing work practices and demands. It is suggested by proponents of workplace health initiatives that organisations which are serious about promoting employee health - as opposed to implementing the minimum legal requirements - experience major increases in production and significant reductions in absence due to sickness, thus increasing the chances of economic success. The Government's 1999 *Healthy Workplace Initiative* is a prime example of this thinking.

Of course there are many difficulties associated with developing interventions to combat work-related ill health. Take for example the problem of workplace stress: many meanings are attributed to it, making it difficult to discern exactly what it is that is being addressed; there are difficulties with interpreting the sometimes conflicting research findings; the extent to which non-work stress is carried into the workplace is difficult to ascertain; and the outcomes of complex organisational changes which may give rise to stress are very difficult to trace. All of these factors and more may influence what is done about the problem of workplace stress. There is no doubt that stress acts as a catalyst for much contemporary thinking about employee health, therefore attention will be paid to it within the empirical chapters.

Daykin (1998) makes explicit the problem of the boundaries between the more traditional approaches of Health and Safety and Occupational Health, and the

new, more lifestyle based interventions undertaken predominantly - though not exclusively - by Health Promotion specialists. According to Daykin, the different models of employee health held by these distinct arenas effectively form a continuum in which particular employee health problems and needs, at particular workplaces, may be conceptualised in radically different ways. The underlying theoretical models and concepts (knowledges) which inform the development of workplace health strategies is of concern to this thesis because, as Daykin points out, different ways of conceptualising people, causes, and health itself, give rise to different approaches to employee health (Daykin, 1998).

Employee health - why now?

Smallman (2001) states that evidence suggests the long-term twentieth century trend toward safer workplaces has slowed and may have reached a plateau. A number of specific recent developments suggest a new impetus around the issue of workplace health. First, figures from the Health and Safety Executive suggest that, excluding accidents, the cost of work-related ill health to society has risen to approximately twelve billion pounds per year (HSE 1999), thus giving a primary motivation for employers to claim a 'legitimate' reason for becoming more involved in the health of their employees. Second, in March 1999 the Government launched the Department of Health's *Healthy Workplace Initiative* as part of the wider *Our Healthier Nation Strategy*. It suggests 'good health is good business' and advocates addressing health issues through:

> the culture of an organisation, which ensures that it actively promotes a healthy workforce and recognises the benefits of better health for worker productivity, and for the business prospects of the organisation (Department of Health, 1999).

This strategy document, identified in the early stages of research, explicitly connects employee health with productivity, and is suggestive of a link between an underlying neoliberalist rationality and Government thinking about employee health[1]. Third, a new long-term occupational health strategy entitled *Securing Health Together* was launched in 2000. Fourth, in 2001 the Health Education

[1] An attempt to analyse this document was undertaken in the early phase of the research. It appears as appendix A.

Authority became the Health Development Agency, and it now has a high profile Workplace Health team. Fifth, the above factors are complemented by recent European wide workplace health legislative activity, and initiatives instigated by the EU Commission, the World Health Organisation and a number of Work Research Centres.

Finally, and most significantly, in 2000 the *Revitalising Health and Safety Strategy Statement* was launched by New Labour. This Strategy Statement is the fullest and clearest statement of Government intent available concerning the regulation of employee health. It is the most significant Government attempt to shape approaches to employee health and safety since the Health and Safety at Work Act of 1974. Issued jointly by the Department of Environment, Transport and Regions and the Health and Safety Commission, it sets out Government thinking on employee health and safety. As the most significant contemporary documentary data available concerning the regulation of employee health, it is subject to analysis in the empirical second part of the thesis.

These developments represent a renewal and shift in Government thinking about employee health which may be symptomatic of wider changes in the way society is governed, and which may impact upon individual employee's subjective understandings and experiences of the relations between work and health.

Accompanying these developments has been an explosion of interest in the emergent modern diseases related to new working conditions, such as RSI and stress, which are gradually being brought to the attention of critical social theorists. Turner, for example, one of the first to write about a number of modern diseases such as RSI, ME, anorexia nervosa and Munchausen's syndrome, states that such illnesses are often difficult to diagnose and difficult to treat. There is also a certain amount of professional and political controversy around them, which sometimes questions whether or not these conditions exist. Turner's work highlights the *constructed* nature of illness and disease and draws attention to the underlying knowledges which inform the development of particular classifications. The idea that such diseases are of a constructed

nature will inform subsequent analyses. Particular attention will be given to accounts of stress and the strategies developed to deal with it, as this represents an emerging and contested form of ill health often thought to be work-related.

Turner goes on to articulate what he perceives to be a central paradox facing modern Western democracies: while trying to provide for equality of opportunity it has become extremely difficult to provide for equality of outcome in health terms without a serious invasion of personal liberties (Turner, 1995:216). The greater the demand for personal equality, the greater the requirement for surveillance and regulation of society. The so-called medicalization of society involves detailed bureaucratic regulation of bodies in order to formulate a meaningful abstract conception of health. In turn this leads to greater regulation, along with the increased potential for interventions into behaviours which may be deemed harmful to health. Those bodies not deemed healthful may find that they are targeted for health improving interventions. A host of different interest groups thus converge and claim legitimate expertise on the site of the employee's body. These include managers, economists, psychologists, sociologists, politicians, and a range of health professionals, as well as employees and their representatives, all of whom make competing claims as to the origins, causes and consequences of - as well as solutions to - a vast range of factors perceived to contribute to the health and well-being of employees. The influence of professionals and experts, and the use of surveillance and regulation techniques, are of concern to this thesis.

With the dismantling of the welfare state, organisations are seen to be increasingly central in the distribution of resources. The definitions of good or bad employees are malleable, and may vary from sector to sector, between and within organisations. Organisations may increasingly define the normative standards against which individuals are subjected/measured. In the case of sickness, for example, 'normalising discourses' become significant. Rather than having a mean/average acceptable number of days that can be taken as sick leave, organisations may try to bring the average down. Instead of normalising *sickness*, it is *lack of* sickness which becomes the aim. It is increasingly recognised that a good employee is, in part, someone who rarely goes off sick,

so part of the thesis is aimed at unearthing the extent to which employees and employers feel it should be their responsibility to ensure employees stay as healthy as possible, in order to minimise time off through sickness.

The introduction has thus far introduced a number of elements within the 'employee health problematic'. It has been established that governmental, organisational, academic and lay interest in employee health is strong. There exists a variety of motivations and knowledges which inform its regulation, and a variety of styles of regulation are available for adoption. For some, there is a direct link between health and productivity. For others, the status and constructed nature of new diseases such as stress is important. There is also a wider concern over the dismantling of the welfare state, and its potential replacement by a neoliberal one. It is to neoliberalism that the thesis now turns.

1.2 *Neoliberalism*

Fairclough claims that neoliberalism, understood as a 'restructured global form of capitalism', is on the ascendancy, representing nothing less than a 'new order' (Fairclough, 2000:147). The political, social, and economic context for a whole range of policies, practices and behaviours, it is claimed, is undergoing a profound transformation. Many leading thinkers within the social sciences (for example Barry, Osbourne and Rose, 1996; Bauman, 2001a, 2001b; Beck, 1992; Fairclough, 2000; Giddens, 1998; Hall and Jaques, 1983, 1989; Lupton, 1999; Peterson and Lupton, 1996; and Rose, 1989, 1999a, 1999b) also discern this recent and fundamental shift in contemporary Western society, away from a welfarist society, based on collective responsibility, toward a more neoliberal society, based on individual responsibility. Rose states the position well:

> .....political reason from all quarters no longer phrases itself in the language of obligation, duty and social citizenship. It now justifies itself by arguing over the political forms that are adequate to the existence of persons as essentially, naturally, creatures striving to actualise themselves in their everyday, secular lives. Within such rationalities, it appears that individuals can best fulfil their political obligations in relation to the wealth, health and happiness of the nation not when they are bound into relations of dependency and obligation, but when they seek to *fulfil themselves* as free individuals. Individuals are now to be

> linked into a society through acts of socially sanctioned consumption and responsible choice... (Rose, 1999a:166 original emphasis).

Individuals, it is claimed, are increasingly encouraged, directed and expected to become less dependent and more self-responsible, in order to secure the nation's - and their personal - wealth, health and happiness. If this is accurate, then there should be evidence of this shift, especially within those areas most directly concerned with wealth, health and happiness. In this thesis, evidence for this shift is to be sought within the field of employee health. But what is neoliberalism? What are its key characteristics?

Ericson (2000) claims neoliberalism can be viewed as a model for governance 'beyond the state', comprising five basic assumptions. First, the state is given a minimal role. People are assumed to be rational, informed and active agents able to use self-restraint, who enjoy a willingness to share and have the capacity for self-governance. Civil society, understood as the set of institutions, organisations and behaviours situated between the state, the business world, and the family, including voluntary and non-profit organisations, philanthropic institutions and social and political movements, it is thought, can be a self-generating basis of social solidarity. Second, the market is absolutely central. Economic growth is supposed to provide security and prosperity through diverse groups and individuals participating in the free market, which operates at a global level. There is an attempt to re-define the social sphere as a form of economic domain. Third, risk plays an important conceptual role both in the management of diverse hazards (individual, local and global) and in the encouragement of certain forms of risk-taking behaviour, especially in the economic sphere, for example in the encouragement of greater creative and entrepreneurial risk-taking. Because of the rate of change in the modern world, people must become 'educated, knowledgeable, reflexive risk takers', flexible enough to cope with transitions throughout their lives. Fourth, individual responsibility is emphasised and expected. Each person becomes their own 'political economy', making informed consumer choices, not only about goods and services, but also personal security markets and, significantly for this thesis, labour and health. Finally, within a framework of 'responsible risk taking' there is the tendency to perceive differences and inequalities that arise more as matters of personal choice rather than of being influenced by external, more

structural factors beyond the control of the individual (Ericson, Barry and Doyle, 2000:532-533).

Concerning employee health, the assumptions of neoliberalism which initially give rise to concern are the focus on risk and individual responsibility. Beck (1992) suggests that to live in a 'risk society' is to be uncertain about the future. New risks are identified and defined and people are encouraged to seek solutions. The distribution and construction of risks may have profound implications for the way in which employee health risks are understood and acted upon. The turn toward individual responsibility may lead to the view that there should be less protection and assistance for those who suffer ill health as a consequence of 'choosing' an 'unhealthy lifestyle', or of failing to adequately protect themselves from work-related health risks, rather than placing the onus on employers to provide safe and healthy environments. Under neoliberalism, if one ends up unhealthy, it may be understood as being caused by poorly considered risk decisions. Risk and responsibility are to be core concerns within this thesis.

But how did this perceived 'transformation' in the way society is governed come about? And what are some of the wider implications of this transition for the areas of work and health?

From liberalism to neoliberalism

Liberalism, emerging in Europe in the sixteenth century, has never been static and has undergone various significant transformations. Early liberals assumed the market to be 'natural and free'. However, as Gordon (1991) suggests, extensive legal interventions provided the 'correct' conditions for it to operate as a sphere in which conduct was perceived as 'enterprise' (Gordon, 1991:41-42). While the objects of government remained broadly similar, liberalism recognised that both society and the economy could be governed more actively. In response to some of the costs and failures of nineteenth century liberalism, there arose a perceived need to 'socialize society and economy'. New 'technologies' were developed, including social insurance, which attempted to promote the social responsibility of the individual, organisations and institutions,

and the government, through the mutuality of social risk. By linking the 'free individuals' and 'economies of liberalism' together to reduce risk and ensure prosperity - by spreading the costs of individual failings across and throughout society - the door to a society based on welfarism had been opened. However, neoliberalism emerged in response to the perceived deficiencies of liberal government.

Lemke (2001) provides insight into the mechanisms of neoliberalism. Emanating from the U.S. Chicago School, neoliberalism opposes state interventionism and, in the name of economic liberty, is broadly critical of bureaucratic apparatuses and perceived threats to individual rights. A key element of the Chicago School's approach was the expansion of the economic form to apply to the social sphere. Economic 'analytical schemata' and criteria for economic decision making are transposed onto spheres which are not exclusively economic: there is an attempt to re-define the social sphere as a form of economic domain. The model of 'rational economic action' serves as a principle for justifying and limiting government action and there is an attempt to universalise competition and invent market oriented systems of action for institutions, groups and individuals (Lemke, 2001:197). Thus, scant resources are allocated for competing goals.

Neoliberalism also attempts to discern the reasoning which persuades individuals to allocate energy and resources into one thing rather than another. Human action is thought of as being governed by 'economic rationality': the economic comes to include all forms of human action and behaviour, including consideration of one's health status. Thinking in this way allows for the critical evaluation of governmental practices by market concepts: practices and interventions can be assessed to see if they are 'good value'. The use of economic concepts extends to neoliberal thinking about work and labour with its theory of 'human capital'. For a wage labourer, their wage is not simply the price for selling their labour power, it is instead income from a special form of capital. It is a special form of capital because the ability, skill and knowledge cannot be separated from the person who possesses them. This human capital comprises both the physical/genetic predisposition *and* the entirety of skills resulting from 'investments' such as nutrition, education and training, but also love, affection

etc. Wage labourers are no longer conceived as employees dependent upon an employer but as 'autonomous entrepreneurs' with full responsibility for their own investment decisions, endeavouring to produce surplus value: they are constructed within neoliberalism as 'entrepreneurs of themselves' (Lemke, 2001:197).

Having introduced the defining features of neoliberalism and discussed some of the implications for an analysis of the regulation of employee health, the chapter now turns to some of the more general shifts and changes within the spheres of work and health.

Neoliberalism and work

Over the last thirty years there have been a number of significant changes in employment practices and patterns, some of which have implications for the way employee health is problematised. These include: increasing participation in the labour force by women; the ageing of the workforce; labour market deregulation (which may extend to the deregulation of workplace health measures); the rise of structural and intermittent unemployment; the effects of globalisation, including the ability of large companies to go to where the more affordable labour is situated (which may give rise to increases in feelings of insecurity); increased employment in the service sector; and changes in the organisation of working life (perceived by many to result in an 'intensification' of work processes and practices, often including the extension of the hours worked and an emphasis upon flexible working) . These changes have led to increases in short term contracts and part time working, and an increase in the number of career changes people are anticipated to make during their working life. Accompanying these changes, and to some extent stimulated by them, has been increased global competition, innovations in the technologies used in the workplace, changes in management practices, and new contractual relationships between employers and employees, combined with diminishing union membership. Finally, corporate trends toward 'downsizing' and 'outsourcing', often to enable niche marketing, have led to increased job insecurity and work activity in the small to medium enterprise (SME) sector. These trends carry the potential to radically alter not only the ways in which

work itself is defined and structured, but also the nature and definitions of occupational health risks (Wynne, 1999:7-10). As it is not possible to discuss all of these changes here, a few will be chosen which reflect some of the basic tenets of neoliberalism, namely, trends toward 'flexibilisation' and the shift toward increased individual 'responsibilisation'.

Strategies of flexibilisation

Rose (1999a) claims that the 'labour contract' and 'wages' were, since the beginning of the twentieth century, the main ways in which the work of the individual was linked to the productive 'apparatus'. Although by no means universal, lifelong full time employment was the ideal. Rose suggests that this ideal, with its way of dividing employment and unemployment and of providing full time work with a full time wage, is currently 'under question' (Rose, 1999a:156). Throughout Europe there are decreasing numbers of people in full time work, and decreasing numbers in long-term jobs. Increasingly, people are in part time, casualised, and short-term employment. The point Rose makes is that the economic insecurity, now so widespread, is significant because it 'is now given a positive value in economic strategies'. As an explicit political strategy of economic government it is called 'flexibilisation' (Rose, 1999a:156-7). This profound change in employment and economic practice is contested at both the macro and micro levels. At the macro level, previously considered rigidities in the labour market are being challenged; at the micro level, there are numerous struggles over what is acceptable or appropriate in terms of increasing the flexibility of relations between the individual and the workplace. Rose suggests that the economic, the social and the subjective are linked within the nexus of the workplace, the wage and the labour relation. The labour of individuals is linked to broader economic flows. Until recently the conduct of the labourer was 'regularised' through a highly formalised and consistent work regime, and access to social benefits was provided as a '*quid pro quo*' for employment. In short, work regularised, individualised and disciplined the labourer (Rose, 1999a:157). Throughout the industrial revolution, strategies were adopted which produced a series of norms. Regulations evolved concerning hours to be worked and a whole range of other working conditions, including the minimum requirements for a duty of care for the health and safety

of workers. The 'optimisation' of both the economic and the social was undertaken predominantly through the regulation of labour (Rose, 1999a:157). Now, however, Rose claims that through flexible work practices and strategies, possibilities for 'new configurations' arise. At one pole lies an opportunity for the integration of life and work, often referred to now as the home/work balance. At the other - for Rose more significant - pole, we find that work is increasingly dominated by insecurity. Evaluations, appraisals, productivity measures etc., mean continued employment must be constantly earned by each individual, continually under threat from down-sizing, outsourcing and so forth. As Rose claims, 'perpetual insecurity becomes the normal form of labour' (Rose, 1999a:158): at one and the same time there is a perceived increase in flexible working patterns, *and* increases in job insecurity. As the new century gets under way, Rose suggests that a period characterised by life-long social labour acting as the primary mechanism for integrating individuals and families, and the promise of lifelong social support for those outside the labour market, is at an end.

The principal motivation and justification offered for flexibilisation is ultimately increased company and individual productivity and competitiveness. Flexibilisation is a recurrent theme within New Labour's *UK Employment Action Plan for 2000*. This central strategy aims to secure flexible workers, able to continually adjust their 'choices' about the work they are required to do and the skills necessary to realise employment: 'the promotion of enterprise, innovation and productivity is a central objective for both the UK Government and the devolved administrators' (*New Labour, UK Employment Action Plan for 2000*:5). The *Action Plan* also states that 'existing and new employment regulations should be rigorously tested to ensure that burdens on business are minimised'. This is a clear indication of an attempt to move toward a more deregulated work sphere: the corollary of flexibilisation is deregulation.

Around the above developments, questions of choice, agency and power arise. For example, the question of flexibility for whom and at what cost? can be lost in the positive rhetoric of flexibilisation. There are also questions around the blurring of the boundary between home and work, the private and the public. While some people appear to be freer to balance their work and home lives,

increasing employer and consumer demands mean some employees may have to work long or inconvenient, unsociable hours. There will be a focus upon flexibilisation within the empirical data.

Strategies of responsibilisation

The practice of encouraging employees to join insurance schemes provided by trade associations or friendly societies in order to secure themselves against misfortunes which may affect them, their families and dependants in the future, became increasingly widespread throughout the nineteenth century. At the beginning of the twentieth century, these were turned into national schemes of compulsory social insurance. The individual worker became part of a collectivity where individual risks were pooled across a lifetime. After nearly a century of compulsory social insurance, Rose suggests there is now an important strategic shift in the politics of security: 'social insurance is no longer seen as a socialising and responsibilising principle of solidarity' (Rose, 1999a:159). It is now perceived not to provide adequate security and to be a drain on individual incomes and national finances. Because it is claimed there is little motivation to minimise or take responsibility for the (economic, health etc.) risks one faces, it is seen by the proponents of neoliberalism to stifle responsibility, inhibit risk-taking and produce the dependency culture. Social insurance, and the welfare state more generally, are widely perceived to be aggravating the division between the included and excluded. Increasingly, those who are able to provide for their own security - against illness, poor pensions, accidents etc. - do so through private health insurance, pensions etc. Those who will not or cannot are increasingly likely to experience inadequate or inferior responses.

Each of us is now encouraged to invest in private insurance schemes in order to master our fate and optimise our existence. Fears and anxieties about the future are exacerbated and exploited. As well as there being a market driven 'industry of risk', there is also a 'politics of risk' at work (Rose,1999a:159-160). Politicians and various media exhort us to be responsible for securing our own fate by managing risks effectively, for example by encouraging us to take more responsibility for minimising crime ('Crime: together we can crack it' campaign) (BBC, 2002) or to take more responsibility for our health (manifested in

numerous Government funded healthy eating, smoking cessation and sensible drinking campaigns).

In terms of how this wider societal shift relates to employee health, Oechsler suggests that decentralisation and flexibilisation will increase the responsibility individual employees have for their particular element of the overall business process. Not only will employees be regarded as business process owners, but they will be increasingly expected to manage their own health in order to satisfy the continually greater production needs of their employers. As globalisation continues, increased competition is inevitable which may lead to more competitive attitudes in the workplace. Oechsler suggests internal market mechanisms, based on individualised productivity targets and measures, may gradually take over from more established forms of employee appraisal, further adding to the employees' experience of work intensification and job insecurity, thus increasing the potential for negative health consequences (Oechsler, 2000).

In the forward to the *UK Employment Action Plan For 2000* Gordon Brown and David Blunkett assert that:

> Modern Technologies and new ways of working mean a changing labour market, *in which the right skills and the ability to adapt to rapid economic change are of paramount importance.....too many people don't yet posses the skills employers are looking for in this new age of work, and risk exclusion from the economic growth that should benefit us all...* (New Labour, 2000:4, my emphasis).

New Labour's emphasis is clear: individual employees must gain the 'ability to adapt' to rapid economic changes or 'risk exclusion' from the labour market.

Overall, neoliberalism has the aim of minimal social security, combined with maximum individual independence and autonomy. The implication for employees is clear: the state no longer wishes to take responsibility for their future and it is therefore up to employees to become more responsible for taking measures to protect themselves from misfortune. Those failing to do so have no-one to blame but themselves. It is speculated here that, under a neoliberal political rationality, the state's unwillingness to take responsibility for

its citizens extends to employee health needs, and thus companies and individual employees may be increasingly expected to take responsibility for employee health. But, if companies and employees *are* to become more responsible for employee health, to what does the term *health* relate? Are there particular understandings of employee health which have been shaped by historical contingencies?

1.3 *Health*

Historical components of health

To analyse contemporary policies and practices aimed at securing and improving employee health, it is necessary to not only examine contemporary manifestations of these attempts within particular policies and within particular workplaces but also to situate them in an historical context. This next, albeit selective, historical section both foregrounds some of the continuities in thinking about employee health and exposes some of the ruptures and shifts that have occurred in its conceptualisation. The aim is to identify several key competing 'discourses' around health which have left some presence, which are not necessarily realised chronologically yet inform the development of strategies aimed at the regulation of employee health. One discourse which has profoundly shaped contemporary understandings of health is that of *public* health.

Public health

The nineteenth century public health movement in the UK was led principally by Edwin Chadwick and was characterised by interventions directed toward the 'environmental infrastructures' which affected individual health (Midha, 1997:26). Often interpreted as a philanthropic gesture of the Victorian elite, the underlying motivation can be seen as economic. In the new era of industrialisation and colonisation, at a time of great administrative and statistical innovation, there emerged the fear that ill health and premature death led to decreases in worker productivity and reduced profits (Lupton, 1995). Rapid industrialisation aggravated existing problems and the city became a site for

environmental action, focusing especially on the problems of dirt, sewage disposal, poor water supplies, overcrowding and dangerous housing (Lupton, 1995).

In 1842 Chadwick published *The Report on the Sanitary Condition of the Labouring Population of Great Britain*, which made explicit the demonstrable link between the social conditions of an area and the health of the local population (Midha, 1997:32). It suggested very clearly that environmental and engineering solutions would be preferable to existing medical solutions in making a positive impact upon health. In short, structural factors began to be recognised as more important than individual factors. Public health, as opposed to individual sickness, was a newly emergent concept based broadly on the premise that society, as an organic whole, could become sick in its entirety. The significant difference from prior formulations of sickness was that the public's health was not solely at risk from physiological disease but also from behaviours defined as socially problematic. Thus, in addition to environmental changes, particular behaviours began to be targeted as a consequence of a generalised health discourse.

This view of socially problematic behaviours is in part premised upon the idea that society as a whole has a purpose to which its members must be fitted. Moreover, part of being a *useful* member of society increasingly meant being a *healthy* member, so that the individual became an economic asset rather than a wasted resource. Partly through the public health movement, the health and welfare of the population was gradually transformed from being predominantly a matter of individual morality, into a broader, generalised appreciation of the economic value of human resources. 'Healthy' was beginning to signify 'normal', and 'unhealthy', 'abnormal'. The emerging population health knowledge began to be utilised in the development of 'useful', that is, 'productive' bodies.

The *Public Health Act* of 1848 established a general Board of Health and enabled local authorities to establish local boards to be responsible for environmental health provision and regulation. This marked for the first time that the government was to claim responsibility for safeguarding the health of the population (Lewis, 1980). However, the influence and power of the public health

movement and the medical establishment more generally brought wider changes in the power structures of wider.

Medicalisation and individualisation

The nineteenth century also ushered in a formalisation and consolidation of the medical establishment. A wide ranging history of its evolution is beyond the scope of this thesis but a few key points which are salient to the thesis will be emphasised.

Hospitals, asylums, detoxification centres, chemists, druggists, and doctors surgeries - all places where individuals were examined - became sites for the production of a new form of knowledge. The knowledge produced by medical examinations of patients enabled for the first time the routine documentation of individuals. The constitution of a comparative system made possible the measurement of overall phenomena, the description of groups of patients, the characterisation of collective facts and the gaps between individuals and their distribution in a given population. This led not only to the formation of *generalised* conceptions of health and the relations between health and work, but also to the constitution of the individual as a describable, 'analysable object' (Foucault,1977:184-191).This had implications for the development of occupational health: a new field of knowledge was emerging from widespread techniques and practices. This early form of monitoring and surveillance enabled the beginnings of occupational health through the establishment of records detailing correlations between particular occupations and particular forms of health complaint. However, with the development of vaccination and immunisation programmes at the beginning of the twentieth century, the environmental and structural factors influencing health once again began to be downplayed. In response to this, the emerging public health model sought to include and embrace education and personal hygiene. The success of Victorian reformers such as Chadwick appears to have been cited by successive governments to suggest there was a *diminished* need to further focus upon those more structural and environmental factors which contribute to ill health. This facilitated, at the beginning of the twentieth century, a shift toward more educative, individual-oriented strategies for securing the population's health.

This constant oscillation, disputation and struggle over the determinants of health demonstrates the potency of health as a 'site' for registering wider societal conflicts and changes.

Health education

There is a suggestion by some commentators that, as well as being motivated by philanthropic and economic concerns, the public health reforms also represented a moral crusade (Lupton, 1995). Epidemics were viewed also as evidence of 'individual neglect' (Midha, 1997:34). Lupton suggests that 'cleanliness was indeed next to Godliness for the Victorians, and rhetoric around the need to defeat dirt and disease verged on the zealous'. Middle class Victorian Britain emphasised links between cleanliness and the 'purity of one's moral standing' (Lupton, 1995:34 - 35). In the context of a moral crusade against the build up of rubbish and other unhygienic practices, the moralistic overtones had an ideological function; namely to represent the working classes as a problem for public health reformers. A need was identified to 'civilise and improve' the moral as well as material circumstances of the poor and the working classes. Physical exercise and diet were increasingly seen as key determinants of good health. According to Midha, the rationale behind this shift was that, since by the early twentieth century disease and illness had become largely preventable, people should therefore be encouraged to adopt a healthy lifestyle (Midha, 1997:41). This represents a key shift toward the introduction of notions of personal responsibility for health which was to become a key component of neoliberal discourse much later.

Beveridge's 1942 report on *Social Insurance and Allied Services* envisaged that a sense of personal responsibility *and* mutual obligation would permeate society. Influenced by Beveridge's ideas about society, the *National Health Service Act* of 1946 inaugurated in 1948 the National Health Service. The welfare state had become the defining model for governing society. Combined with a move toward full employment, the new Health Service was designed to secure improvement in the physical and mental health of the people. Public Health continued to be increasingly concerned with questions of individual behaviour and lifestyle and the promotion of the public's health continued to be

dominated by a health education model, which gave little regard to the socio-cultural and economic constraints which prevented many from taking up the advice offered.

The idea of the welfare state which predominated through the post-war political landscape was based on the idea that the gradual betterment of the conditions of *all* the 'forces and blocs' within society (for example professional/manual, employed/unemployed, old/young etc.) could be achieved. Political strategies were devised which maintained the principle of productive labour while 'cushioning its harshness in the workplace' and decreasing the fear of unemployment, at the same time ameliorating the hardship of the worst off in society (Rose, 1999a:135). Instead of unfettered competition or social revolution, society had a form of government that allowed for the perception of 'social progress' for all classes. It is only now, with the advance of neoliberalism, that old ways of relating to state and self are once again mutating (Rose, 1999a).

Neoliberalism and health

Whereas liberalism was more inclined to secure people's health in an indirect manner, by ensuring good housing conditions, drainage systems, access to clean water etc., combined with delegating responsibility to the medical establishment for caring for individual patients, the neoliberal model proposes that 'technologies of health' should be as direct as possible (Osbourne: 1997:185). Neoliberal government proposes numerous targets and measures which operationalise otherwise abstract ideas about health. For example financial targets, waiting lists and operations undertaken, all exhibit the generalised strategy of quantification. Instead of aiming for the 'absolute' goal of health, it opts for realisable targets and goals. Osbourne suggests this leads to two key phenomena central to neoliberal governance. First, the language of the 'strict specification of de-limited and targeted domains for intervention', and second, the imposition of a principle intended to 'animate and regulate' the overall strategy and particular targets: in short, the principle of 'responsibilisation' (Osbourne, 1997:185). Government policy and health promotion rhetoric stresses the *shared* responsibility for health and fitness *and*

the citizens' obligations for their own body maintenance: what it is to be a 'good citizen' increasingly involves health considerations.

It is now possible to hypothesise that governmental policy on health is increasingly diffused into organisations, and through them, to individuals. The aim may be to encourage self-responsibility and, ultimately, self-governance. In the context of employee health, neoliberalism relies upon particular understandings of health and illness developed within the disciplines of medicine, science, biology, and psychology, in order to make particular conditions calculable, but only to the extent that the employee is still ultimately conceived as a rational economic individual who 'invests' in their health and well-being, and who expects a certain 'profit' and 'risks' making a 'loss'. The profit is here conceived as improved health and well-being and the consequent improved potential for sustainable economic income generation; the loss is conceived as the allocation of resources such as time, energy, money and self-discipline, along with the possible concomitant reduction of activities deemed unhealthy. It becomes the task of the various apparatuses and technologies associated with employee health to respond to a 'demand' for potential health improvements and harm minimisation, as long as the 'costs of supply' are not too high.

Neoliberal employee health theory

We are now in a position to hypothesise that neoliberal employee health theory concerns itself with ensuring that the costs of intervention should never exceed the costs of ill health. In this approach, good employee health policy should not aspire to eliminate ill health completely. Rather, it should try to strike a temporary and forever fragile balance between maintaining acceptable health levels which allow the employee to be productive, and ensuring the costs of interventions do not impact negatively on profitability. The ideal scenario for neoliberalism would be to completely eliminate the costs of intervention, while ensuring the continued good health of individual employees (and thus continued increases in productivity and competitiveness, through employee resilience and reduction in absence costs). The extent to which this objective is articulated,

worked toward or realised, will be a guiding principle within the subsequent empirical analyses.

1.4 *Aims of thesis*

So far the thesis has identified the re-emergence of a concern with the regulation of employee health. It has hypothesised that this may be informed by a neoliberalist political rationality, which has implications for the ways in which institutions and companies approach the problem of employee health. By investigating contemporary understandings of, and approaches to, employee health, it is envisaged that emerging forms of regulation will be illuminated. We are now in a position to outline the main aims of the thesis, namely:

To explore the relations between the perceived shift toward an underlying neoliberalist political rationality and emerging forms of regulation, through an investigation into the different ways in which the regulation of employee health is problematised at various sites.

The emerging themes identified in Chapter One were:
A perceived renewal of interest in the regulation of employee health.
A perceived generalised dispersal of state responsibility for health.
A perceived tension between personal responsibility for health, and the role of the supportive environment.
The significance of the motivations offered by employers for becoming involved - or not - in their employees' health.
The significance of the influence of health professionals, experts and related knowledges, in developing and implementing strategies concerned with the regulation of employee health.
The implications of a renewed interest in the regulation of employee health for the boundaries between work/non-work.
The perceived existence of emerging strategies aimed at increasing an employee's ability to cope with the intensification and flexibilisation of work.
The significance of the perceived influence of employee health monitoring and surveillance techniques.

The constructed nature and role of key terms, for example 'risk' and 'stress', encountered in the regulation of employee health.
The perceived influence of an underlying neoliberalist political rationality on the regulation of employee health.

If, as Peterson (1996:48-49) claims, 'neoliberalism calls upon the individual to enter into the process of their own self-governance through processes of endless self-examination, self-care and self-improvement', then from within a sociological perspective a search for empirical evidence which refutes or asserts this contention should be undertaken. It *appears* to be the case that shifts in the underlying governmental rationalities that help to strategically regulate the behaviours of individuals and populations, *may* have profound consequences, both for the ways in which strategies which target employee health are developed and implemented, and for the individual employee's subjective understandings and experiences of the relations between work and health. If we *are* living under a new neoliberal order, then what are the implications for the ways in which employee health is regulated? How are we to discern the perceived influence of neoliberalism upon the regulation of employee health? How are we to conceptualise regulatory processes? In short, what theoretical framework may add to our understanding of the regulation of employee health?

This thesis aims to explore the extent to which neoliberalism influences the ways in which strategies concerning the regulation of employee health are formulated, operationalised and understood at the national, organisational, and employee levels and to trace the consequences of particular problematisations. In order to undertake this investigation from a sociological perspective, a suitable theoretical framework, from within which data can be gathered and interpreted, must be developed. The next chapter refines and develops this framework.

Chapter Two - Theoretical Framework

2.1 *Introduction*

This chapter serves a double function: it continues to combine a review of the relevant literature with the development of a general theoretical framework to be used for the generation and interpretation of empirical data. The literature deemed most relevant to the concerns of this thesis appears in the next chapter, and is used to help develop research themes and questions which will guide analysis in the empirical second part of the thesis.

In the previous chapter it was suggested that an emergent form of neoliberal political rationality has implications for the ways in which society is regulated. How a society understands and thinks about the relations between work and health shapes the development and implementation of strategies aimed at the regulation of employee health. As 'regulation' is absolutely central, it will be discussed in detail. This discussion is used to develop an appropriate theoretical, and eventually methodological, framework for studying the 'regulation of employee health'.

2.2 *Regulation*

Marxist approaches to regulation

Questions around the regulation of society are at the heart of critical sociology. Throughout the sixties and seventies, Marxist analysis, with its emphasis upon the political and the economic, tended to dominate critical sociological studies. 'State activities' were thought to be the key site for regulating society. The 'mode of production' produces both historically different social relations between the different classes, and different social institutions. In *The German Ideology*, Marx and Engels claimed that the class which controls the means of economic production also controls the means of intellectual production. However, the 'ideas of the ruling class' are not simply imposed upon subordinate classes, but instead represent their interests as the common interests of all members of society. This is achieved through 'ideology'. The ideology which leads the

working classes into a 'false state of consciousness', stands in opposition to 'the Truth' of a situation, which can be discerned through careful (Marxist) analysis.

Marxist approaches to understanding, explaining and attempting to change society were radically challenged following the events of May 68. Due in part to the 'failure' of May 68 and a rising current of thought termed 'structuralism', Marxism faced three main criticisms: firstly, with a more sophisticated approach to language, Marxism's concept of ideology appeared crude; second, Marxism was criticised for its overemphasis upon the state as the 'seat and source' of 'power' and its insistence upon 'economic determinism in the last instance'; finally, there was the problematic area of a suitable theory of the subject. These broad criticisms reflected the beginning of 'the linguistic turn', the most basic argument of which being that we can only 'know' 'reality' (and ourselves and others) *through* language. Therefore, a thorough understanding of the role of language, and its relationship with consciousness and reality, becomes an essential component of any critical thinking.

Louis Althusser had been working on the problem of the subject and developing a materialist understanding of language from within a Marxist framework throughout the 60s, his main concern being to give Marxism the status of 'science' (science, for Althusser, stands in opposition to ideology). Ideology is reconceived as a 'material practice' reproduced in and through the practices and productions of the Ideological State Apparatus. The function of ideology was seen by Althusser (1977) to be that of 'constructing concrete individuals as subjects'. Specific ideological discourses 'hail' or 'interpellate' people: people become subjects through this process, and are simultaneously subjected *to* something. Any text which speaks directly to a person - any text in which the person recognises (an aspect of) themselves - 'interpellates' them. For Althusser this 'recognition' is actually an act of ideological 'misrecognition' - the 'you' created by the text masks a subject's 'real' interests. Althusser's work has implications for a material conception of language: if language has a materiality, and the truth of a text is bound up with ideology, how is a 'True', non-ideological text to emerge? These explicitly Althusserian themes profoundly shaped the trajectory of critical thought, and helped clear the way for the development of

post-modern and post-structural theories and concepts (Sarup, 1993:77). They also indirectly influence our understanding of the concept of regulation.

Initially it can be said that a Marxist analysis, even one informed by Althusserian and Gramscian developments, would take as its starting place the centrality of state power, and would frame the study within primarily politico-economic terms. It would attempt to assess the major economic and political benefits to the state of regulative action. Marxism constructs the state as a macro-structure of power which functions to support industrial capitalism, displayed through major public institutions such as the police, law and the church. Marxism specifies the *why* of regulation, but remains dependent upon the concept of ideology (and/or hegemony), situated within a state-centric understanding of power, to explain the *how* of regulation. With the perceived shift away from a centralised welfarist state, toward a 'decentred' neoliberalist one, we may therefore ask if there are not other perspectives which may be better able to inform us about not only the operating of a more decentred form of power, but also about the *how* of emerging forms of regulation.

A decentred approach to regulation

In a useful critical reflection on the notion of regulation, Black (2002) suggests that increasingly regulation is seen as decentred from the state (Black, 2002:1). By this she means that regulation is no longer centred on the state but has been diffused throughout society. She suggests that regulation is still misunderstood as a form of 'command and control', comprising the use of legal rules supported by various sanctions. The state is seen as the sole guiding force behind regulation. This model, Black suggests, is based on 'simple cause-effect' relations, envisaging a linear progression from policy formation to implementation. That regulation clearly fails in so many areas of social phenomena is not in question. From the command and control perspective only the reasons for failure are discussed, including: the instruments used are inappropriate and unsophisticated; government has insufficient knowledge to identify causes and solutions to problems; implementation of regulation is inadequate; those subject to regulation are insufficiently inclined to comply; and regulators are insufficiently motivated. For Black this view of regulation lacks

theoretical rigour, and fails to recognise a fundamental shift in the way regulation is practised in contemporary society. She suggests there are alternative, more productive ways of thinking about regulation which 'enable us to recognise better how certain forms of power and control are exercised throughout society' (Black, 2002:2-3). Black's proposals for a more sophisticated and theoretically rigorous understanding of regulation may be useful in developing a framework in which to undertake an analysis of the regulation of employee health, and thus illuminate the larger concerns of this thesis pertaining to the relations between neoliberalism and emerging forms of regulation.

For Black, a decentred understanding of regulation has five central notions: 'complexity', 'fragmentation', 'ungovernability', 'interdependencies', and the 'rejection of a clear distinction between public and private'. Each of these notions will be taken in turn, before summarising the implications for the development of the theoretical framework to be used in this thesis.

First, complexity recognises both causal complexity and the difficulties of fully comprehending the interaction between actors and society/structure: social problems are seen as the result of a variety of interacting factors, which cannot be fully understood and which are subject to change. The dynamic nature of relations is emphasised with actors recognised as diverse in their 'goals, intentions, purposes, norms and powers'.

Second, there is fragmentation of 'knowledge, power and control'. No single actor has all the knowledge required to solve a particular problem, or to make regulation fully effective. This point is sometimes more radically framed as *all* information being 'socially constructed' - the view that there are no 'objective social truths'. The example Black gives to demonstrate this point is of subsystems such as politics, administration and law constructing their images of other subsystems only through the 'distorting lens of their own percetual apparatus'. In addition to knowledge, 'power and control' are fragmented, and are dispersed between actors, and between social actors and the state, the state being seen as just one - albeit significant - 'regulatory system'.

The third aspect of the decentring analysis concerns the 'autonomy and ungovernability of actors'. Autonomy here means not 'freedom from interference by government', but action continuing in the absence of intervention. In the absence of regulation, actors or systems are self-regulating, and regulation cannot take their behaviour as constant. This has several implications for regulation: first, regulation may produce unintended changes in behaviour and outcomes; second, the form of regulation may have to vary depending upon the attitude of the regulated to compliance; third, the autonomy of others and limitations in knowledge mean there can never be a single actor which can dominate the regulatory process; fourth, an autonomous actor may be 'insusceptible' to external regulation; finally, a recognition that actors or systems may have the capacity for self-regulation means that that capacity must be harnessed for government at a distance to be effective.

The fourth aspect concerns 'interactions and interdependencies' between social actors, and between social actors and government in the process of regulation. Rather than society having needs/problems and government having solutions/capacities, each is seen as having both needs and solutions, 'mutually dependent' on each other for their resolution and use. This leads to the fifth and final element of a decentred formulation of regulation which is the collapse of the public/private distinction and a rethinking of the role of formal authority in governance and regulation. In decentred analyses, regulation is what happens in the absence of formal legal sanction - it is the product of interactions rather than the formal, 'constitutionally recognised' authority of government. However, the concept of authority still has a role to play, as other organisations increasingly share in the state's authority to 'make and enforce binding decisions'. Additionally, 'networks', comprising many actors, are incorporated into the regulatory process. In the absence of formal governmental or legal sanction, these 'webs of influence' also produce regulative outcomes: regulation becomes 'not so much an activity as a product of activity' (Black, 2002:2-6).

There appears to be little agreement on the function of regulation. For many, the goal is the project of 'welfare economics': the correction of market failure. However, regulation is increasingly conceptualised in terms of the 'management

of risks'. Black's foregrounding of risk as central to regulatory activity has implications for the study of the regulation of employee health.

Implications of a decentred approach to regulation

Black claims that a decentred view of regulation may reveal it in previously unsuspected places. But once regulation loses its analytical link with the state she asks, 'what does it become?' In order for any study of regulation to have a degree of analytic purchase, it must have some boundaries, or *any* 'influencing factor' may become pertinent. How regulation is conceptualised depends to some extent, therefore, upon the object of study. The way a problem is thought about - in our case the relations between work and health - has implications for the 'what' and 'how' of regulation: implications for the proposed *solutions*. Black suggests utilising the concept of 'technology', defined as 'the understanding of and ability to employ, manipulate, or alter the physical or human environment and the products of that understanding'. Any ability to control or influence is hampered or facilitated by some kind of technology. It remains unclear whether these technologies constitute regulation or whether they are just its instruments. It is more important to ask '*what it is*' that is being regulated, and '*how*', through which technologies, regulation is achieved. If it is 'the health of the employee' that is targeted for regulation, we should explore the technologies involved. Black suggests analysts should focus on 'not what we call the activity or phenomena that is the subject matter of enquiry or analysis, but *what it is'* (Black, 2002:16). This thesis will nevertheless argue that what we call a phenomenon may have profound consequences for understanding and action.

Black concludes by suggesting that developing a 'decentred conceptualisation of regulation' may help increase our understanding of 'contemporary socio-political relations', and 'unsettle our understandings of where the forces of legitimacy, authority and power are located in society' (Black, 2002:27).

Black suggests that a theoretical framework robust enough to explore the difficult area of regulation in contemporary society must meet specific requirements: it must be able to recognise and take account of the diversity of multiple and interacting factors which influence any regulative situation,

especially those beyond the state; it should identify various technologies; it should recognise the concept of risk as central to regulation; and it must be able to offer a theory of the subject which recognises both structural influences and autonomous capacities. Ultimately, the framework should be able to reveal regulation in previously unsuspected places. These requirements for a theoretically sophisticated and robust analysis of regulation then, contain three broad theoretical 'sites': 'power and technologies'; 'risk'; and 'the subject'. Each of these will be discussed in turn.

2.3 *Power and technologies*

The theoretical framework for this thesis must have a conceptualisation of 'power' capable of appreciating the complexity of causal relations and which can identify influence at multiple sites in multiple forms. In the context of regulation, with its aim of *producing* particular pre-defined 'outcomes', one conceptualisation seems ideally placed: the Foucauldian understanding of power.

Perhaps Foucault's single most significant contribution to critical thought was in his reconceptualisation of power. He perceived power to have been oversimplified by both the Left and the Right. Whereas the Right saw Soviet socialist power as totalitarian, power in Western capitalism was denounced by Marxists as state-led class domination: both, Foucault argued, neglected the actual 'mechanics of power'. Developed as a means of complementing the perceived deficiencies in existing practical and theoretical understandings of power, this aspect of Foucault's work represents a rethinking of 'power-relations'.

Power/knowledge

For Foucault, power 'works' through attempting to construct and maintain forms of 'subjectivity', appropriate to the prevailing socio-economic and political 'norms' of the day. Knowledge - embodied in 'discourses' and their related practices, as well as the institutions and organisations in which they reside - is the medium through which power acts upon the subject. Particular knowledges

shape particular subjectivities but not in uniform ways. For example, over the years workers have been conceptualised, shaped, and regulated in numerous different ways, becoming 'objects of knowledge' to be acted upon in various ways by a variety of 'experts'. The subjectivities of workers and managers have been 'constituted' in different discourses at different times. One task of this thesis is to explore the contemporary impact of 'workplace health discourses' upon the constitution of work-based subjectivities. In order to appreciate the implications of this reconceptualisation of power for our understanding of the regulation of employee health it is necessary to briefly look at some of Foucault's relevant works and ideas.

Disciplinary and bio power

One form of power greatly concerning Foucault and subsequent social theorists is 'disciplinary power'. In 'Discipline and Punish' Foucault emphasises how during the 17th and 18th centuries there was a 'technological take-off in the productivity of power' (Foucault, 1994c:120). Power, he claims, was reconceptualised as a 'productive network' which ran through the whole social body. Administrative and disciplinary procedures were formed, more efficient and less costly economically than previous techniques, for example in the organising of social facilities such as hospitals and prisons. Foucault does not want to say that the state isn't important, rather, relations of power necessarily extend beyond the limits of the state. The state cannot occupy the whole field of 'actual power relations' and it can only operate on the basis of other existing power relations (Foucault, 1994c:123).

If we look at Foucault's reconceptualisation of power relations in the context of health it can be seen that the sickness of the individual became linked with the 'mismanagement' of the social order during the demographic upswing in Western Europe at the end of the 18th century. The urban concentration of populations and the increasing danger of epidemics fostered the need for increased knowledge about populations in the form of statistics about all manner of human behaviour. These statistics were used to develop 'instruments of government' designed to manage populations as political and economic

problems. Knowledge and power thus combine to produce new ways of acting upon social phenomena.

What struck Foucault about this new form of 'productive power', and what most users of Foucault's ideas utilise in the areas of work, health, and organisations, is the way that it began to exercise itself through 'social production and social service'. The new power was aimed at 'obtaining productive service from individuals in their concrete lives' (Foucault, 1994c:125). This power needed to gain access to the bodies, acts, attitudes, and modes of everyday behaviour of individuals - which is why administrative and disciplinary methods of assessing, measuring, and gathering information about individuals are so important in the Foucauldian view. Simultaneously, these 'individualising' tendencies of the new techniques of power were accompanied by the need to grapple with the 'phenomenon of population': a need arose to 'undertake the administration, control and direction of the accumulation of men', thus establishing the problems of demography, public health, hygiene, housing conditions, longevity and fertility. The emergence of population as a distinct area of knowledge promoted modern 'arts of government', the purpose of which was to ensure the

> welfare of the population, the improvement of its conditions, the increase of its wealth, longevity, health, and so on; and the means the government uses to attain these ends are themselves all, in some sense, immanent in the population: it is the population itself on which government will act (Foucault, 1994c:217).

For Foucault, the 'power techniques' which enable both disciplined individuals and the government of populations are '*productive*': they are aimed at producing healthy, self-controlled individuals inhabiting docile and useful bodies (Foucault, 1977a:136-8).

'Power mechanisms and relations' Foucault subsumes under 'disciplines' (Foucault, 1977a, 1980, 1981). Disciplines increase control over humans and help produce their subjectivity. From this perspective, workplace health techniques and strategies designed to regulate the health of the employee become disciplinary 'micro-practices'. Systematic conceptions of employee health issues form a coalition of different professions such as doctors, health promoters, occupational health specialists, health and safety officers, as well as

psychologists, medical insurers and trade union representatives. They all develop instruments and methods - 'technologies' - of gathering information about individual employees, their bodies and capacities, as well as about worker populations, thus creating 'power/knowledge complexes'.

Employee health strategies contribute to administering, cultivating, and controlling the workforce as a population of the organisation (see also Deetz 1992; Townley 1993, 1994; Mckinlay and Taylor, 1998). Individual employees are treated as objects of 'surveillance and control'. Those developing such strategies become positioned as experts in employee health. The 'knowledge' gleaned from the 'objects', for Foucault, demonstrates that 'like surveillance.. .....normalization becomes one of the great instruments of power' (Foucault, 1977a:184). Within the disciplinary context, deviations from established 'norms' help constitute individual subjects. Thus, disciplinary power (which tends toward individualisation) is very much linked to 'bio-power' (which targets populations). The important point to note here is that power is always already 'dependent' on both forms of knowledge and the *possibility* of 'resistance', which is why Foucault always writes and talks about power *relations*.

Power in organisations

Foucault, particularly in *Discipline and Punish*, stressed the important role of organisations in the development of modern disciplinary power, which many organisation theorists have reiterated (Knights and Willmott 1989; Knights and Morgan 1991; Townley 1993, 1994; Hopper and Macintosh, 1998; Clegg 1998). Health management contributes to the nexus of power/knowledge that constitutes us as 'self-examining' and 'self-regulating' subjects. The body of knowledge around health, well-being, and fitness, and the institutions connected with this knowledge, provide influential normative and normalising standards dividing the sick from the healthy (see also Foucault 1983a:208). This power is not primarily repressive: besides control and subjugation it is highly 'productive', especially of 'self-regulating' subjects. At the level of population - here the company's workforce - health management exemplifies what Foucault (1983a:213-215) calls 'pastoral power': a technique of power that, by looking

after the whole community (workforce) and each individual (employee), aims to assure 'salvation' (health, well-being etc.) for each and all.

Applications of his ideas about power by organisational theorists often perpetuate a misreading of Foucault, that, as power is everywhere, then it must have determining properties which primarily *limit and restrict* a subject's actions, indeed, that subjects are stripped of their agency. However, Foucault asserts that the exercise of power:

> operates on the field of possibilities in which the behaviour of active subjects is able to inscribe itself. It is a set of actions on possible actions; it incites, it induces, it seduces, it makes easier or more difficult; it releases or contrives, makes more probable or less; in the extreme, it constrains or forbids absolutely, but it is always a way of acting upon one or more acting subjects by virtue of their acting or being capable of action (Foucault, 1994c:341).

Thus, far from being stripped of agency, subjects *always* have options. Foucault suggests 'government' - when it started to take its modern form of the state in the 16th century was originally designated as 'the way in which the conduct of individuals or groups might be *directed*'. To govern in this sense was 'to structure the possible field of action of others'. Defined this way, the exercise of power *always* includes the element of 'freedom': power is only exercised over 'free subjects'. Relations of power leave open possibilities of response.

Having discussed Foucault's conception of power relations, and some of the consequences of his formulation for thinking about the health of individuals, populations and organisations, there remains the problem of how best to think about the role of the state. Even from within a decentred understanding of regulation there has to be a way of conceptualising how localised attempts to regulate certain features of society interact with and are influenced by the wider concerns of the state. This chapter now turns to a still developing notion, again instigated by Foucault, until recently largely ignored by critical thinkers, but which may afford a richer understanding of contemporary processes of regulation, namely, 'governmentality'.

2.4 *Governmentality*

'Government' in Foucault's use of the term is not equivalent to the Government or state, but it is linked to the political culture of the time. It is (yet) another form of power, but this time relating to the 'conduct of conduct', and is described as the 'contact point between technologies of domination of others and those of the self' (Foucault, 1988:19). It is activity aimed at guiding, shaping or in some way influencing the behaviour of others, which utilises 'technologies'. It can encompass relations between individuals, between groups or institutions, and between 'self and self'. This definition provides a conceptual linkage of the governmental, organisational, and subjective levels involved in the regulation of employee health.

Government from this perspective doesn't characterise the subjects of government as passive but rather positions them as active agents whose behaviour and conduct can be shaped and directed. The concern is primarily with 'practices' rather than institutions. Practices are not simply 'applications' of policy but are conceptualised as interventions within a particular sphere, in our case that of employee health. So rather than focus upon the unintended consequences - though these are important - the main object of analysis from a governmentality perspective becomes the 'intended consequences' (Osbourne, 1997:176).

For Dean - one of the main developers of the governmentality perspective - government entails a rational and calculated attempt to direct human conduct, conceived as 'something which can be regulated, controlled, shaped and turned to specific ends' (Dean, 1999:11). The 'conduct of conduct' includes, but is not limited to, actions taken by the state. As well as the actions of state and non state institutions and organisations, and even individuals in specific roles and contexts, there is also 'self-government' - the action of self on self. For Dean, then, as for other governmentality theorists, the central task is to discern the 'how' of government: how we are governed and how we govern ourselves within different regimes, and the conditions under which such regimes emerge, operate and are transformed (Dean, 1999:23). This thesis is concerned very much with the 'how' of regulation in the context of a shifting governmental

rationality, and it seems therefore that the governmentality perspective may be useful in the subsequent empirical analyses.

Self government implies autonomous, 'self-actualizing' subjects utilising 'technologies of self' - processes through which individuals shape their own conduct, as opposed to a regulation of conduct dependent upon the state. Thus, Rose speculates that neoliberal rule depends upon

> techniques of government that create a distance between the decisions of formal political institutions and other social actors, conceive of these actors in new ways as subjects of responsibility, autonomy, and choice, and seek to act upon them through shaping and utilising their freedom (Rose, 1996:53-4).

The governmentality perspective potentially meets Black's requirement for a decentred understanding of regulation. This perspective entails a rejection of the Marxist ideology thesis which views humans' sense of freedom and autonomy as a 'sham', as existing in a state of 'false consciousness' and as a disguise behind which looms state domination. From a governmentality perspective, freedom/autonomy *itself* becomes the basis for neoliberal rule. Where Marxism insisted on the basic binary opposites between freedom and domination, the governmentality perspective enables a view in which it can be seen that freedom can itself be implicated in the micro-processes of control, as a key element in forms of subjectification.

Thus, the key theoretical breakthrough claimed by governmentalists is an exploration of the ways in which individuals and human collectivities are governed, and humans 'subjectivated'. For Foucault, 'political theory' - liberal or Marxist - still visualised and theorised political power and rule in contemporary society 'through the prism of sovereignty, law and coercion' (Milchman and Rosenburg, 2001:134). Governmentality theorists try to grasp the structures of contemporary power and rule, claiming that conventional ways of analysing politics tend to 'imagine a centralised body, a collective actor with a monopoly of the legitimate use of force in a demarcated territory', which was 'presumed to underpin the unique capacity of the state to make general and binding laws and rules across its territory' (Rose, 1999a:1). Governmentality is obtained not by a totalising deterministic or oppressive form of power, but by bio-power directed at

whole populations and simultaneously at individuals, so that they are both individualised and normalised. The concept of bio-power operates in a double sense, as a power over life, focused on the disciplining of the individual, in the form of an 'anatomo-politics of the human body', and as the regulatory control of the population, in the form of a 'bio-politics of the population' (Foucault, 1981:139).

Foucault's understanding of power relations, from within a governmentality perspective, is here adopted as part of the explanatory theoretical framework accounting for changes in the regulation of employee health. Regulation of the population can be analysed in tandem with the ways in which individuals regulate themselves, and can also usefully be deployed in analysis of the 'mediating' role of organisations. Since most governmentality studies lack empirical data, there is a case to be made for more evidence driven, empirically based studies.

The next point for discussion is Black's assertion that the concept of 'risk' is increasingly central to regulation. This section commences with a general discussion of risk before introducing some instances in which risk has previously been 'articulated' with Foucauldian, and particularly governmentality perspectives.

2.5 *Risk*

The sociology of risk

The concept of risk was discussed widely throughout the nineties (see for example Beck, 1992; Douglas, 1992; and Lupton, 1999). Much of this discussion concerned the potential implications stemming from a perceived 'new climate of risk', especially in relation to 'identity formation' and 'personal security'. Douglas was among the first to contribute to social theories of risk. Through her predominantly anthropological studies in the seventies, she became aware of how 'modern' societies seemed to react to fears over pollution in a similar way to the 'tribes' she had studied in her book *Purity and Danger.* Modern populations seemed to largely ignore some risks, for example flooding

and road crossing. She suggested that the risks people tend to focus on are less to do with a person's psychology and more to do with the way individuals construct their understanding of the world and their place in it. Cultures vary in their degree of stratification or solidarity (Douglas, 1992). For Douglas, what becomes considered a risk, its causes and its magnitude, depends upon membership of, and identification with, their culture.

In reviewing neoliberalism in Chapter One, the context of risk emerged as strategic in both in the management of diverse hazards (individual, local and global) and in the encouragement of certain forms of 'risk-taking' behaviour, especially in the economic sphere, for example in the encouragement of greater creative and entrepreneurial risk-taking. Beck (1992) suggests that to live in a 'risk society' is to be aware of the possibilities and uncertainties of any course of action, the individual being confronted with a complex diversity of alternatives, especially in relation to 'lifestyle'. The 'self-reflexive subject' constituted in response to this new 'climate of risk' is seen to actively engage with their own biography. In a risk society technological innovations bring new risks, but 'modernist instrumental rationality' suggests that every problem has a technological solution. Of course, some people are more affected by the distribution of risks than others, so what becomes *defined* as a risk influences who is perceived to be most 'at risk' and where resources to minimise risks should be channelled. The 'reflexivity' which Beck foregrounds stems from the perceived need for access to knowledge about the different risks which face us, which are neither consistent nor equally distributed throughout society.

Fox claims that Beck's 'realist analysis' does not really address the impact of culture upon the construction of risk *as a concept* - the focus upon reflexivity remains 'at the level of the organisation, not upon the sense making activities of subjects' (Fox, 1999:201). Developing and critiquing both Douglas and Beck, Fox suggests his own 'typography of risk' through a discussion of sociological 'models' of the 'risk/hazard opposition' (Fox, 1999:198-219). This typography may be useful in clarifying the position to be taken on risk in this thesis.

The first position, termed 'realist or materialist', suggests that the underlying ontology of a hazard is real and material: a risk (the likelihood of a negative occurrence) maps onto the hazard (the circumstances which lead to the occurrence). This position is usually adopted in the practices of 'risk management and assessment'. Thus, in much regulation, strategies are devised to minimise the likelihood that the hazard will manifest itself in a negative outcome. There may be instituted a general policy, specific preventative measures or educational programmes. Fox suggests that this position is not inherently political and could be used by any of the different interests which may engage discursively with the identified hazard. This approach enables a formal 'process of scientific analysis of risks', although (significantly for this thesis), problems remain over how a consensus is reached over what constitutes a risk and, once identified, who should be responsible for taking measures to avoid it. These difficulties, Fox claims, soon lead to moral ambiguities.

The second position outlined by Fox is what he terms 'culturalist or constructionist'. Here, risks are opposed to 'hazards'. Hazards are seen as natural and neutral, whereas risks become the value laden judgements of those concerned about the hazard: what is considered risky is constructed by concerned parties. The hazards remain resolutely 'real'. This leads to the analysis of 'risk perception' and includes studies relating to health and illness (Gabe, 1995; Bunton et al 1995). The two main themes emerging from this form of analysis concern the 'moral dimension of risk' and the kinds of knowledge which inform 'perceptions of risk', as it is suggested that 'powerful social forces shape the way in which information is perceived and acted upon' (Grinyer, 1995:49). Experts in 'risk assessment' may be unaware of the complexities of certain risks which may, in the context of working practices for example, be best understood by the persons who are most familiar with them. The 'cuturalist/constructionist' position emphasises the 'moral character of the risky individual' (Fox, 1999:208). In the context of workplace health and safety, employees have a responsibility to work safely, if they do not, then they may be considered culpable, leading to 'victim blaming'. Further, 'risk reduction' - especially in the workplace - always involves a cost, and judgements must be

made over the balance between profitability and safety. Different perspectives lead to different understandings of what constitutes an 'acceptable risk'. The solution offered is a more sophisticated analysis, which understands both the 'scientific' and 'real world' understandings of risk, and how they impinge on the daily lives of those affected.

The final position outlined by Fox he terms 'postmodern'. Utilising some of Foucault's ideas, it argues that hazards themselves are social fabrications, the 'reifications of moral judgements about the 'riskiness' of choices made by human beings' (Fox,1999:209). Things considered hazardous only become so in particular situations. He cites the example of a discarded hypodermic syringes in a hospital. The 'inert' object becomes transformed into a risk through the discourse of 'risk assessment'. As Foucault has remarked, *everything* is *potentially* dangerous. Thus the selection of some objects, procedures or human behaviours as hazardous must depend on some *prior* judgement. Risk assessment always utilises prior knowledge about what is deemed serious or trivial, probable or unlikely. These judgements sometimes arise from 'scientific sources', sometimes from 'common sense'. The judgements themselves will always be evaluative: the claimed objectivity of risk assessment thus becomes illusory. Different groups with different interests disagree about what constitutes an acceptable risk because their *discourses and conditions are contingent*. Fox claims it is not simply 'outlooks on risks' that are dependent on the social milieu, but hazards themselves: both risks and hazards are 'cultural products'. Further, if hazards themselves are constructed from contingent and partial descriptions of the world, then the attribution of riskiness is

> grounded not in objective estimation, but entirely upon what Foucault calls power/knowledge; the 'knowledgeability' which both discursively constructs objects and confirms the authority of the person claiming the knowledge (Fox, 1999:210).

Risk assessment, from this position, constructs not only the risks and hazards, but also establishes the subjectivity of those it addresses as individuals or populations 'at risk'. It follows that the subjectivity constructed for employees within the regulation of their health is one that suggests they are perpetually 'at risk' - from both hazards and themselves.

This raises the possibility that, just as risks and hazards are socially constructed in discourses, so is 'health' itself. The subjectivity constructed in risk assessment and other attempts to regulate the health of the employee, such as health and safety discourse, is a 'risky' and sometimes 'culpable' self. *All* definitions of health have a political element in that they try to persuade us to adopt a particular perspective on the person deemed healthy or ill. Many health professionals suggest it is possible to control and if necessary change health-related phenomenon. Attempts are made to *persuade* subjects deemed 'unhealthy' to alter their behaviours, even though it may well impinge negatively on other aspects of their identity, on other experiences which may contribute - socially, politically, economically or emotionally - positively to their well-being and sense of identity.

Marxist, Weberian and Foucauldian traditions have all tended to emphasise the constraints on human action and agency. While postmodern writings continue to discuss the possibility of 'refusing' and 'resisting' the 'totalising effects' of various discourses, Fox suggests the notion of 'choice' has been marginalised. There is a common understanding that, if one is made ill or unhealthy from work, then this is deemed immoral or unfair, as health is claimed as a basic human right. However, if 'work', 'health' and 'risk' are *all* to some extent social constructions, this means that approaches to the regulation of their interrelations will always to some extent depend on a series of 'subjectively made' 'choices' about appropriate courses of action: individual subjects will every day make choices - conscious or not - about the extent to which they compromise their health in a work setting. Because these conceptions are always already contingent, dependent upon a complex nexus of localised conditions, the 'subjectivities which are created around risk, health and work are relative, and grounded in discursive fabrications of what is to be positively or negatively valued' (Fox, 1999:216).

Fox argues that in the work/health nexus, risk can be seen as 'the active process of choosing as life unfolds'. One implication is that it is not adequate to point out which phenomena are *really* hazardous or to assume that, by making claims concerning what causes the 'real' harm, we are necessarily acting in the best interests of those we may be trying to assist. For Fox, risks may, in some

circumstances, 'be an opportunity to become other' (Fox, 1999:217). Careful analysis of the empirical evidence may reveal the extent to which Fox's propositions may extend our understanding of the concept of regulation.

Governmentality and risk

Castel, writing from within a Foucauldian governmentality perspective, also explicitly links risk to the concept of health. However, he emphasises the power experts have to define and regulate subjects. He focuses upon emergent 'preventative strategies' - strategies which are evident within some attempts to regulate employee health. Castel suggests that, by focusing not on individuals but on 'factors of risk', experts have created far more targets for preventative intervention. Such strategies may represent new management techniques specific to neoliberal societies. This is important for the discussion of regulation as it suggests that risk *itself* may be conceptualised as a '*technology* of regulation'.

Peterson (1996), building on the work of Castel (1991), suggests neoliberalism requires individuals to regulate their own health through self-examination, self-care and self-improvement, in order to limit demands for health care. Thus a possible outcome of attempts to regulate employee health through the 'management (technology) of risk' may be to enable a shift away from the state, as protectors of individual health, toward an emphasis on the individual's responsibility to protect themselves from risk. Individuals may become expected to adopt healthy lifestyles and avoid risks. Those positioned as ignoring health risks may be perceived as 'choosing' to expose themselves to the dangers of illness, disability and disease, which may remove them from a useful role in society and incur costs on the public purse (Castel, 1991:281-298). Castel, Fox (1999), Lupton (1999) and Peterson (1996) all emphasise the way risk is associated with the concept of 'choice'.

In this section, various understandings of the term risk have been discussed and some of the implications for the regulation of employee health - and for regulation more generally - have been outlined. Scholars integrating an understanding of risk into a Foucauldian perspective have also been reviewed.

However, there remains a difficulty with these accounts. While they focus on the potential consequences of society's interest in risk, especially in relation to choice, they do not theorise the kind of 'subject' presupposed by risk discourse, beyond being positioned as rational self-reflexive, self-regulating agents of choice. Thus, the next section turns to the problematic area of 'subjectivity', and specifically addresses the adequacy of a Foucauldian theory of the subject.

2.6 *The subject*

The problem of choice

> Sickness was experienced as a misfortune and, as you know, misfortune engenders compassion. Confronted by the new medicine and by our medical predispositions, we have a responsibility to see that these possibilities are or are not realized as a function of our choice of life. If we are responsible, disease no longer becomes an object of compassion; on the contrary, it is one of accusation (Ewald, 1999:89).

Ewald (1999), Fox, (1999) Giddens (1998), Beck (1992) and Bauman (1996) all emphasise the role of choice in relation to risk. Bauman suggests that 'it is the individual responsibility for choice that is equally distributed, not the individually owned means to act on that responsibility' (Bauman, 1996:88 quoted in Scambler and Higgs, 1998). Gidden's work on 'structuration' claims that the key process motivating and reflecting agency is choice, hence the need to identify 'restraints on choice'. These constraints come in three kinds: material, those derived from sanctions, and structural. However, when a human being acts, it may *always* be regarded as the implementation of a choice *or* as the effect of a cause or causes. The notion of 'reflexivity' favoured by Beck and Giddens constructs the self as the 'author of choices': subjects are seen to inevitably want certain things that are locally available or prescribed. The heart of the 'structure/agency' debate is often couched in these terms. However, in either case - as agency chosen or caused - the '*conditions and circumstances* of what is done' will always be relevant to understanding what occurs (my emphasis, Loyal and Barnes, 2000:519). A Foucauldian analysis interprets a subject's motivations through an understanding of the relevant *conditions*. Thus the pre-eminence of both the cause and effect *and* choice models of agency are

challenged. This is of significance for this thesis, as actions can always be considered both 'chosen ir/responsible action' or 'caused'. For example, if a worker is given a great deal of autonomy in a workplace and they occasionally undertake work activities which may have negative consequences for their health, then it is through careful exploration of the multiple factors - *the conditions* - which influenced the behaviour, that a rational explanation can be proposed. The term 'conditions', as well as relating to structural, discursive and organisational factors, can include embodiment, subjective beliefs and perceptions. Behaviour can always be seen to be both caused *and* chosen. By gathering empirical 'evidence', the *conditions* themselves which impact on the causes/choices can be explored and illuminated. With this assertion in mind, the chapter turns to a discussion of the 'subject' encountered in Foucauldian theory.

Foucault's subject

In addressing the concerns of this thesis, an attempt is made to locate the political effects of specific forms of regulation upon the subject. For Foucault, a central focus of his historical approach to human behaviour - genealogy - was the human body. The 'body' is conceptualised as an initially 'undifferentiated site' which is invested, governed and transformed by specific *power relations*. According to Foucault, the 'human sciences' provide the knowledge of groups and individuals which renders the body amenable to inscription. Foucault's wider project was to understand the ways in which something called 'the subject' is formed, reformed, dispersed *and regulated* over the planes of a 'discursive reality' (Williams, 2001:175-6, my emphasis). Foucault analysed how the body of the subject became a site for the inscription of knowledge. Theories of state power, he argued, failed to account for the multiplicity of ways in which the subject's subjugation is achieved. Any individual subject's actual position is always already a strategic relation: mobile, fluid, and continuous. *Relations of power* invest institutions and individuals with possibilities for action: a field of possible actions is thus delimited.

According to Foucault, the body can be reconstructed, reformed and constituted by different modes of discipline. The 'panoptican', for example, is a 'micro-physics of power' which is able to explore, break down and re-arrange the body

- it aims to match its potential as an effective disciplinary schema with the minimum requirement of supervision. This form of disciplinary power individualises, classifies, and manipulates the body according to certain precepts of knowledge. Crucially, this form of power develops in the subject skills and strengths where weaknesses and instability once lay. The subject (following the law of economic utility) must be a cost-effective unit.

> He who is subjected to a field of visibility and who knows it, assumes a responsibility for the constraints of power: he makes them play spontaneously upon himself (sic) (Foucault, 1977:202).

Althusser's[2] struggle with how the materiality of ideology links to the constitution of the subject is resolved by Foucault as 'the processes of subjection'. Williams succinctly outlines Foucault's position on the relation between the powerful forces which 'subject' us and the subjected individual:

> if the site of production of subjectivity is a moving substrate of force relations then it is crucial to recognise that the subject is not the passive recipient of power but a source of volatility, an unfinished project of social being whom power can seek to master but never contain (Williams, 2001:182-3).

Foucault was critical of psychoanalysis and deconstruction because they pursue a form of linguistic analysis to the detriment of a wider consideration of the discursive and non-discursive conditions and practices. Williams claims the production of the subject may best be understood as

> a vacillating moment - a push and pull - a dynamic constitution of the subject where the body is viewed as the physical-material site of ideas about the subject and knowledge (Williams, 2001:186).

This 'vacillation' is, as was alluded to earlier, neither naïve voluntarism nor dogmatic determinism. How we can ever hope to explore the 'truth' of the subject remains problematic.

The question of truth is central for Foucault: it is not independent of its effect nor prior to its relations, rather, it is always bound up with a discursive formation,

---

[2] Foucault studied under Althusser at the École Normale Supérieure, Paris, and at the University of Clermont-Ferrand between 1960 and 1968.

with *relations of power/knowledge*. For this thesis, there is no priority given to truth, nor is priority given to the subject. The relations between the subject and truth, and between agency and discourse, are relations and effects that are immanent to each other. They will inevitably alter, relocate and reconstitute themselves in an endless sequence. This rejection of cause is implicit in Foucault's ontology of the subject. The construction of the subject can only be understood within the wider mesh of power/knowledge relations - relations which ceaselessly modify and reform it, producing new modes of subjectivity. The subject becomes an open territory and a site of multiple possibilities. The subject is always an unfinished project of subjectivation: subjected by external and internal forces. People's capacity for action, then, takes place at the 'interface between, on the one hand, people's sensibilities, their moral choices, their relations to themselves and, on the other, the institutions that surround them' (Foucault, 1994c:367).

The subject and truth

> The essential political problem for the intellectual is not to criticize the ideological contents supposedly linked to science or to ensure that his own scientific practice is accompanied by a correct ideology, but that of ascertaining the possibility of constituting a new politics of truth. The problem is not changing people's consciousness - or what's in their heads - but the political, economic, institutional regime of the production of truth (Foucault, 1994c:133).

In *Madness and Civilisation* Foucault demonstrates that psychiatry has claimed truth as a weapon against power, as the opposite of power - that is the more truth the less power. However, he conceived truth as the *accomplice* of power - the more truth the more power. His suggestion that if every time an absolute truth is claimed, this claim has certain 'effects of power', then the task of the critical sociologist becomes complicated and delicate. He resists the proposition that the opposite of a notion of a 'negative power' that 'masks and conceals' truth is a discourse that 'unmasks and reveals' truth (Wandel, 2001:375). Countering homogenising and normalising 'truth claims' with new truth claims is not an option. These claims and counter claims reflect (and contribute) to the salient *conditions* themselves. It therefore becomes a matter of exploring the

pertinent conditions and 'allowing' those affected to make up their own minds about appropriate courses of action.

Asked if the subject is 'a substance' Foucault replies that it is not, that it is 'a form, and this form is not always identical to itself' (Foucault, 1994a:290). We have multiple types of relationship to our self in different contexts, in different relations with others. As his interests shifted, he suggested that the subject 'constitutes itself in an active fashion through practices of the self', although those practices available to us are 'nevertheless not something invented by the individual himself (sic)', rather, they are 'models that he finds in his culture and are proposed, suggested, imposed upon him by his culture, his society, and his social group' (sic) (Foucault, 1994a:291). He reiterated that it is not power *per se* that informs the constitution of individuals but *power relations*, and that as these exist 'in every social field, this is because there is freedom everywhere' (Foucault, 1994a:292). Quizzed about truth, Foucault finds it significant that questions of truth have become more fundamental, more important to us than, say, questions around self-care. The question of truth is fundamental to a Foucauldian epistemology, as

> it is within the obligation to truth that it is possible to move about in one way or another, sometimes against effects of domination which may be linked to structures of truth or institutions entrusted with truth (Foucault, 1994a:295).

> It seems to me that we must distinguish between power relations understood as strategic games between liberties - in which we try to control the conduct of others, who in turn try to avoid allowing their conduct to be controlled or try to control the conduct of others - and the states of domination that people ordinarily call 'power'. And between the two, between games of power and states of domination, you have technologies of government - understood, of course, in a very broad sense that includes not only the way institutions are governed but also the way one governs one's wife and children. The analysis of these techniques is necessary because it is very often through such techniques that states of domination are established and maintained (sic) (Foucault, 1994a:299).

'Strategic games between liberties' may play a central role in the regulation of employee health, for example in formulating what is considered to be 'legitimate' sickness, in assessing what constitutes a 'work-related health risk', and in more

general understandings of how working practices influence employee health and well-being.

Foucault's shifting conception of the subject posits a human bound up in dynamic and complex relations of power, knowledge and truth. However, toward the end of his life, Foucault seemed to express some regret at possibly overemphasising the determining effects of the 'conditions' of existence, at the expense of thinking more about the ways in which it may be possible to 'self-fashion':

> Perhaps I've insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of self (Foucault, 1988a:19).

Technologies of the self

Much critical work in the areas of work, organisations, management practices and health which utilise a Foucauldian perspective, concentrate on Foucault's 'middle period' - the period associated with the disciplinary society typified by panopticism, (self) surveillance, the directing of conduct and other techniques and practices of control. However, his 'later' works - specifically *Volumes Two and Three of the History of Sexuality* and a few interviews - have only recently been applied to work and health. Even rarer is the incorporation of some of his later notions concerning 'self-fashioning' and 'self-discipline' with empirical sociology.

The historical difference between the Christian 'know thyself' and the Greco-Roman notion 'take care of yourself' reflected Foucault's conviction that there is no one core identity which a search for knowledge can reveal. However, individual agency and the possibility of positive self-transformation can be identified. 'Technologies of self' afford individuals the opportunity to create new modes of being, with the potential to be different from the 'ways of being' imposed upon subjects by the power/knowledge net formed within disciplinary regimes.

Though still very much concerned with 'games of truth', his interest shifted toward those 'games' construed as 'practices of self-formation of the subject', rather than as 'coercive practices' (Foucault in Bernauer and Rasmussen, 1987:2). By exploring the ways in which individuals thought about themselves, their relations with others and especially how one could be free of the tyranny of desires and passions which may impact negatively on us, Foucault suggested that, by considering our own pleasures and desires, we may be able - in a contemporary context - to fashion new ways of being which may involve a minimum of domination of others. The last two Volumes of the History of Sexuality indicate a break with his previous conceptions of 'subjectivization' and point to the potentially liberating outcomes of works undertaken on the self, through care of the self.

It is not a primary concern of this thesis to attempt to evaluate the ethical merits or benefits of particular health practices to particular employees - that is more directly a concern for employers, health practitioners, and employees themselves. This thesis is a critical analysis of the relations between the perceived shift toward a neoliberal regime, and emerging forms of regulation, in the field of employee health. However, in utilising a Foucauldian perspective, it is important to evaluate the framework. The shift away from emphasising the technologies of domination and power, toward a focus on agency as the exercise of work on the self, sits uncomfortably with his earlier work, which leaves little room for individual agency beyond compliance or resistance to disciplinary power/knowledge relations. Ransom best addresses this problem when he says:

> The problem with the functioning of disciplinary power is that individuals are subjected to forms of power that are extremely difficult to identify and almost impossible to resist. What Foucault sees as valuable about Technologies of Self is the possibility that an individual might be produced who is more aware of the possible effects of disciplinary procedures and so stands in a better position to resist them (Ransom, 1997:139).

Recent research into intensity at work (Deetz, 1998; Docherty, Forslin, and Shani, 2002; Starkey and Hatchuel, 2002) utilises Foucault's ideas about 'technologies of the self'. Starkey and Hatchuel (2002), for example, suggest

that autonomy without self-management and lacking in self-care can increase 'stress' and forms of 'self domination'. This leads to questioning how best to get around both 'alienating discipline' or 'destructive autonomy' (Starkey and Hatcheul, 2002:651). Those deeply committed to their work may sacrifice other parts of their lives. 'Autonomy', in this context, appears 'not as a universal value' but as a form of 'work rationalization', the effects of which become dependent upon 'existing practices of self government' (Starkey and Hatcheul, 2002:652). The term autonomy, like control, has no universal meaning or value outside of their relations with existing (self and organisational) practices, which may complement or refute the 'positive effects' of each. The extent to which these different 'states' are valued by particular employees and the consequences of those evaluations is a matter for empirical analysis.

This section has introduced Foucault's shifting theory of the subject and latterly introduced his ideas around 'technologies of the self'. Toward the end of his life, issues of 'freedom' became central. Within a discussion of regulation in which power, knowledge, expertise, forms of control and the like are centred, it is important not to lose sight of concepts such as freedom. Even though it may be a 'socially constructed term' with 'implications for understanding and acting', it has very strong and positive connotations, implying some kind of ethical consideration. Therefore the issue of freedom warrants careful analysis within the empirical chapters.

So far this chapter has responded to Black's call for a decentred approach to the study of regulation by drawing on Foucault. His emphasis upon power as dispersed, productive and mutually dependent upon knowledge for its effects, appears to provide us with a suitably decentred account of power. The concept of governmentality appears to provide a framework in which regulation can be specified in relation to individual and localised instances, *and* more organisational and state influenced ones, utilising a vocabulary of technologies. The works of Fox and Castel demonstrated how Foucault's work furthers our understanding of risk - a key concept which is central to neoliberalism and, Black suggests, to contemporary forms of regulation. In the last section the problem of the subject within Foucauldian thought was introduced. But how do these distinct yet related concepts 'articulate'? Through what 'medium' are they

'conjoined?' How is the 'constructed nature' of so many key terms to be theorised? If the second part of the thesis is to be spent analysing 'empirical evidence', what form should that evidence take? And, at the 'risk' of asking something antithetical to the spirit of Foucauldian analyses, what 'unites' all these distinct factors? The answer, in short, takes us back to the Marxist problem of developing a suitable 'theory of language', and to the Foucauldian notion of 'discourse'.

2.7 *Discourse*

The production of meaning and the construction of what counts as truth are central concerns in any theory of 'discourse'. In the context of regulation conflicts arise over what is claimed to be true: there are questions around who has the power to proclaim the truth, who is authorised to speak the truth, and thus of the relations between 'power, knowledge and truth'. It is important therefore to examine the conditions under which truth comes to be established or contested. As we have seen from the previous discussions, language is only one, albeit important, element of the ways in which a subject's relationship to itself and others is shaped. Within this thesis what is important is not so much 'what' or even 'how' language means, but *what it does* - what it enables subjects to imagine and to do with themselves and others.

Initially we can say that particular discourses emerge at particular cultural, temporal and spatial (for example, national, institutional and organisational) moments, gaining widespread acceptance because, in part, they are more or less congruent with the prevailing order within which they are produced, maintained, and reproduced. Discourses, especially those concerned with human behaviour and activity, are always historically and culturally contingent, relatively open to interpretation, and subject to change. And, of course, they are always associated with a multitude of 'interests'. However, somewhat ironically, the meaning of 'discourse' is itself contested. The position adopted here follows Hook's (2001) interpretation of Foucault's understanding of discourse.

Foucault considered how knowledge is 'produced', inducing 'power' through what he calls 'discursive practices' in society. Discursive practices are described as 'a body of anonymous, historical rules, always determined in the time and space' that have defined a given period. For Foucault there is no knowledge without a particular discursive practice (Foucault,1970).

Discursive practices are constituted by the actions of the members of a particular field of human activity (often professionals, associated with the practice in question), their interactions with each other, and the texts, communications and artefacts they produce from within that practice. Discursive practices are the material manifestation of particular underlying knowledge-based discourses. There persists much confusion about the boundary between the 'discursive' and the 'non-discursive'. Initially it should be recognised that there is no 'prediscursive providence', since we come to know meanings and distinguish truth claims precisely on the basis of discourse. However, *everything* is not subsumed into discourse, albeit that knowledge of the world, estimations of truth, and our capacity to speak and write are all governed by discursive formations. The 'extra-discursive' is best thought of as the 'material level of discursive practices'. A difficulty with the Foucauldian epistemology is to separate the material from the textual, to grant each an integrity separate from the other. Hook stresses the 'physicality of the effects of discourse and the materiality of its practices': underestimating neither the 'material effects of the discursive nor the discursive effects of the material' (Hook, 2001:536-7). The *conditions* thought to be of empirical significance include textual and non-textual factors. For example, texts outlining a practice are considered in tandem with the practice *itself*. Of the material effects of discourse, 'truth-effects' are deemed of great significance.

Hook argues that 'conditions of truth', the criteria under which something is to be considered true, are precisely contingent on current forms of discourse. A Foucauldian conception of discourse suggests a scepticism toward conventional understandings of truth. Truth is thought of as a 'carefully delineated set of conditions of possibility under which statements come to be

meaningful and true' (Hook, 2001:525). From this perspective, attaining truth is not the goal of analysing discourse. Certain discourses operate as truthful and this demonstrates the 'bases of power' which underpin, motivate, and benefit from the 'truth claims' of the discourse in question. Attention is paid to the underlying forms of knowledge in which truth claims are rooted. Hook suggests tracing these forms of knowledge to their 'material conditions of possibility': to the 'multiple institutional supports and social structures and practices' which underlie 'the production of truth' (Hook, 2001:527). Discourse should be understood primarily in relation to its 'power effects', which include the (de)legitimising of institutions, organisations, groups and individuals.

Discourse in general refers to an interrelated system of statements which 'cohere around common meanings and values ... (that) are a product of social factors, of powers and practices, rather than an individual's set of ideas' (Hollway, 1983:231). Within any discourse 'subject positions' are available to the individual, but these are not 'coterminous' with the individual (Henriques, Hollway, Urwin, Venn and Walkerdine, 1984). Subject positions, not unrelated to Althusser's process of interpellation, are articulated within discourses and offer us particular ways of being and behaving, and particular understandings of ourselves and events in the world. It is therefore important to critically explore how particular subject positions are constructed in discourse, in order to investigate the underlying reasons why certain positions are preferred. It is also important to emphasise that which cannot be said within a particular discourse.

'Texts' play a role in generating, enabling and limiting empowered/ disempowered subject positions but the analysis of discourse is not just simply 'reading textuality'. Foucault stresses relations of power rather than relations of meaning. Power is never a function of the text *alone*, so undue power should not be attributed to the internal properties or structures of language: power in language links to and stems from 'external, tactical and material forms of power' (Hook, 2001:530). Power must be grasped and traced through the analysis of tactical and material relations of force. It is imperative not to prioritise the textual over the material: discourse must not be reduced to narrative (Hook, 2001:526). This point is stressed here in order to highlight that this thesis, while concerned with the 'production of meaning', constructions of truth, the provision of subject

positions within texts etc. also recognises the fundamental influence of *material* elements such as people, organisations and practices, upon understanding and behaviour. Within this thesis there is a need to include analyses of the 'extra-discursive/extra-textual' practised forms of power.

From this perspective then, discourses are considered forms of practice. The context and other salient 'conditions' are emphasised, as well as the text. It is essential to 'concretely tie discourse to the physical and material arrangements of force' (Hook, 2001:531). Foucault uses the term 'eventualization' to signify that discourse can fruitfully be thought of as an 'event', as something which is 'done' to something else. This conceptualisation rediscovers connections, encounters, supports, blockages, plays of forces, strategies etc. that appear to be self evident, universal, and necessary. By recognising the numerous causes of a particular discourse, the object of analysis (as event) can be analysed according to the multiple processes that constitute it. Analysis proceeds by 'progressive and necessarily incomplete saturation - a polymorphism of data sets' (Hook, 2001:531). Thinking of 'discourse as event' enables analysis to isolate often very different and multiple forms of origin, and may reveal 'functions of exclusion', for example the ways in which certain ways of understanding are excluded from particular texts. This method of analysis should also help reveal the material components acting upon and within discourse. The more heterogeneous the analysis, the more discourse can be tied to the motives and operations of power interests. This form of analysis of discourse aims to demonstrate how enmeshed power is within discourse. Considered as an event, or an 'active occurring', discourse can be conceptualised as something that '*implements* power and action *and* something that *is* power and action' (Hook, 2001:532, my emphasis). Hook thus makes the distinction between discourse 'as effect' and 'as instrument' of power. The empirical data to be subject to analysis in this thesis should ideally comprise multiple data sets.

From this perspective, where everything has multiple and contingent 'origins', simplistic cause and effect models of explanation are problematised. The requirement is to search for 'similar functions across a variety of different forms' including language, practices, material reality, institutions, and subjectivity: it is

stressed that textuality is only one 'realisation-point' of discourse. The key functions to be searched for in the empirical data are those related to processes of (de)regulation. The analysis of textual data should be substantiated by reference to another epistemological order outside of textuality. Textual findings are corroborated by 'extra-textual dimensions' (including material forms of practice and subjective understandings), which Hook calls a 'double epistemology' (Hook, 2001:539).

Discourse is understood as both the *effect* of power and as an *instrument* of power: it is always already both the instrument *and* the result of power. Discourse facilitates and endorses the emergence of relations of material power. Remaining solely within the text - as so many Discourse Analysts do - makes it difficult to engage effectively with discourse as an instrument of power. Breadth rather than depth becomes important. Hook suggests there is a need to 'map' discourse, to trace its outline and its relation of forces across a variety of discursive forms and objects. This is why this thesis has so far looked at some of the salient historical and wider political developments (Chapter One), and, in the context of the regulation of employee health, should also explore a range of relevant texts, practices, technologies, organisational settings and subjective understandings. The thesis will attempt to follow Hook's prescriptions and drive the analysis through to the extra-discursive.

2.8 *Summary*

This chapter commenced with a rejection of a Marxist approach to the analysis of the regulation of employee health on the grounds that, despite various revisions, it remains overly state-centric, relying upon a monolithic conceptualisation of power. Black's critical reflection upon a decentred understanding of regulation led to the introduction of Foucault's re-conceptualisation of power relations as productive and decentred. The central concept of risk was then discussed and recent 'articulations' of Foucauldian concepts to risk were introduced. It was claimed that the governmentality perspective, seen to conjoin state, organisational and subjective concerns, and able to conceptualise certain practices and processes as technologies, may provide some analytic purchase for contemporary understandings of risk and

regulation. The problem of the subject was then turned to, Foucault's shifting conception of it mirroring the classic sociological dilemma of the extent to which humans are determined by the societal structure or are seen as free agents of choice. Finally, Hook's interpretation of Foucault's concept of discourse was outlined. This offers the prospect of a unified analytic approach to the various theoretical difficulties encountered in trying to understand the processes and practices of regulation in contemporary society. The particular understanding of discourse to be adopted in the thesis emphasises extra-textual as well as textual factors. Taken together, this theoretical frame should illuminate the relation between the perceived underlying neoliberal rationality and emerging forms of regulation.

The next chapter examines in some detail the emerging Foucauldian perspective on workplace health. The three authors associated with this perspective explicitly utilise a *primarily* Foucauldian framework to explore the *specific* issue of employee health. The review of their work helps to further develop the research themes and questions to be used in guiding the empirical analyses.

3.1 *Introduction*

There exists a wealth of Foucauldian inspired literature in subject areas salient to this thesis, for example: neoliberalism (Barry, Osbourne and Rose, 1996), risk (Lupton, 1999; Peterson, 1996), management and organisations (McKinlay and Starkey, 1998), and health and medicine (Jones and Porter, 1994; and Peterson and Bunton, 1997). Much of it has been used to guide the development of the general framework of this thesis. A number of authors also *refer* to Foucault in order to explore the relations between health and work (for example, Daykin, 1999; Fox, 1999; Pinder and Wilton in the collection edited by Daykin and Doyal, 1999; Townley, 1994; Deetz, 1998; and Rose, 1999a). However, there are only three authors who explicitly utilise a *primarily* Foucauldian framework to explore the *specific* issue of workplace health (Goss, 1997; MacEachen, 2000; and Haunschild, 2001). As these are the key texts within this emerging field, and are the ones most closely related to this thesis, this chapter will examine each of them in turn in some detail. The critical discussion then broadens to encompass the introductory and theoretical chapters, in order to formulate the general research themes and questions which will help to guide the subsequent empirical analyses.

Goss

Goss (1997) was the first to focus exclusively upon workplace health from within an explicitly Foucauldian frame. His article, entitled *Healthy Discipline? Health Promotion at Work*, has as its focus the rise of workplace health promotion and its significance for employee relations. He 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' but on the other, they operate as 'forms of control' supporting the 'extraction of higher levels of performance and commitment from employees'. The article's attention is focussed upon the 'disciplinary' potential of health at work, and its role as a 'technology of power'.

Goss's strategy initially is to identify textual examples of support for the benefits of organisational health promotion policies and then to emphasise their potential to regulate the behaviour of employees. Attention is directed to the claims made by Williams (an exponent of the healthy organisation), Newell (author of *The Healthy Organisation*) and The Wellness Forum (individuals from leading organisations in the UK committed to promoting wellness in the workplace). Their key claim is that improvements in the well-being of employees also result in benefits for the organisation, their general argument being that the promotion (and improvement) of employees' health should therefore become a management concern. While involvement in health promoting practices is kept optional for most employees, Goss questions whether their presence constitutes a 'normative' power which creates informal pressure to conform.

Goss then examines a number of extracts from the Government sponsored programme *Health at Work in the National Health Service*. This programme encourages the development of 'measurable classifications' that facilitate the extensive monitoring of individual and collective health practices. The emphasis in the document is upon promoting 'healthy behaviours' for employees, such as smoking cessation, healthy eating, regular exercise etc. Goss suggests that health promotion provides organisations with an 'expert discourse on health' which endorses ethically suspect managerial actions, for example employer intrusion into the private lives of employees and the possibility that criteria of 'positive health' will be used as a basis for 'discrimination and/or exclusion from the workplace'. Three more short extracts are taken from the *Health at Work in the National Health Service* document, the outline of the *Great Weight Loss Campaign*, a question and answer section on alcohol consumption and a brief reference to an NHS manager's recommendation that compliance with health schemes be written into employee's job descriptions.

Goss suggests that the identified texts are evidence to support the view that health promotion can operate as a 'technology of power' by imposing discipline onto individual bodies. A further issue for Goss is the extent to which this discipline is shaped by the context of its application, since within the workplace the context is not simply one of health, but also of the organised interests of capital and labour. The disciplinary processes present in health promotion for

Goss operate through 'panopticism' (which renders employee actions visible, thus enhancing their 'calculability' and potentially exposing them to 'performance appraisal'), and through 'regimes of governmentality' (which deploy knowledge and discourse to create 'internally regulated forms of subjectivity', for example 'self-conscious self-discipline').

Goss concludes by suggesting that there is consensus surrounding the benefits of health promotion and therefore 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.

MacEachen

MacEachen's (2000) article, entitled *The mundane administration of worker bodies: from welfarism to neoliberalism*, is the most empirical of the three papers. It is concerned with the administration of the Canadian workers' compensation scheme. The theoretical frame, like that of Goss, takes Foucault's concepts from his 'middle period', emphasising notions of discipline and surveillance, the micro-physics of power, and governmentality. It is a qualitative case study, comprising interviews with thirty-five managers and health and safety representatives at four newspaper workplaces in Canada. The focus of the interviews was on how the managers understand and respond to workers complaining of Repetitive Strain Injury (RSI). MacEachen frames her discussion in terms of a contemporary 'disjuncture' between welfarist rationalities, which assume collective insurance techniques such as workers' compensation, and neoliberal rationalities, which she suggests assume a greater emphasis on individual responsibility to avoid risk.

The article begins with a discussion of the key differences between welfarist and neoliberal rationalities, in the context of workers' compensation schemes. The reader's attention is directed to the shifting balance between citizens' rights and state responsibilities, highlighting the potential for more neoliberalist informed approaches to employee health to encourage increased 'self (employee) responsibility' (for health). In order to explore this tension, she asks:

'when does a worker suffer from a legitimate work-related injury and when is a worker guilty of failing to take individual responsibility for occupational risk?' (MacEachen, 2000:315). The response to this, she claims, is profoundly influenced by the competing rationalities of welfarism and neoliberalism. The compensation scheme itself is seen as an embodiment of a key regulatory system, in which the shift from welfarist to neoliberal rationality may be seen to have consequences for individual employees.

MacEachen's analysis of the accounts offered by managers focussed on three main areas: understandings of and attitudes to workers complaining of RSI; the ways in which worker's bodies are disciplined/regulated, including methods of training and surveillance; and, finally, a discussion of the theoretical and moral implications of the corporate disciplinary gaze.

The key finding from the first area, concerning the managers' attitudes to workers with RSI, was that managers perceived RSI to be particularly prevalent among those workers 'who lack (self)discipline'. The key findings from the second area, concerning the techniques of training and surveillance, were: firstly, that in the view of the managers, the education and information given to employees concerning bodily techniques (designed to minimise RSI) meant that employees who developed RSI could be held personally responsible for 'composing their body in an ungovernable manner'; and secondly, echoing one of Goss's primary concerns, there was an extension of surveillance and monitoring techniques into the employee's private, home life, comprising an expansion of the corporate jurisdiction of workers' bodies. The theoretical and moral implications of her analysis suggest the worker body can be viewed as a 'bio-political site' in which health becomes a prime arena for contesting rights and responsibilities within the shifting rationalities. The extent to which occupational injury is seen as 'inherent risk of occupational process', or seen as 'subject to blame and individual responsibility', is assessed in the context of the shifting rationalities.

It is clear from MacEachen's study that the preferred employee is one who takes upon themselves the responsibility for avoiding occupational risks. The move away from emphasising a 'healthy' work *environment*, and toward

producing a 'disciplined and responsible worker *body*', shifts questions about responsibility for 'workplace conditions' from workplace managers and owners to employees themselves, raising the question 'whose body is it?' As the disciplined worker is expected to maintain optimal fitness in readiness for work, the boundaries between work and leisure, and public and private, are blurred.

Haunschild

Haunschild's (2001) article, *Humanization Through Discipline? Foucault and the Goodness of Employee Health Programmes*, is the most recent. It refers extensively to the work of Goss and is the most theoretical and the least empirical of the three.

The article, like Goss's, is framed by suggesting that there is no doubt that health management can improve employee well-being and can have positive outcomes for the organisation but nevertheless 'the *mere* goodness of such programmes has to be questioned'. The first section of the paper shows how health management activities fit with 'processes of discipline' in our society, while the second section discusses some of the possible 'normative implications' of such a Foucauldian analysis.

He begins by asserting that there are issues around employee health which deserve scrutiny, not least 'the very taken-for-grantedness of the assumption of what is good'. He asserts that health management activities are an instance of 'power mechanisms' supported by a coalition of different professions which contribute to the formation of power/knowledge complexes. The micro-powers of particular localised health strategies, aimed at individual employees, are complemented by strategies of 'bio-power', aimed at populations - in this case the population of workers - who are administered, cultivated and controlled in order to produce docile and useful bodies. This perspective alone, Haunschild asserts, is enough to highlight the potential dangers characterising health promotion at work. But merely accepting Foucault's accounts, he suggests, leaves open questions around 'Foucault, ethics' and 'normative consequences'. A key question for Haunschild is whether a Foucauldian analysis can give us

concrete help in talking about the 'good and bad' of company health programmes.

After an outline of Foucault's 'middle-period' (with the notable exception of the notion of governmentality), Haunschild turns his attention to the various attempts made to emphasise and encourage self-regulation and self-control in health-related behaviour, which imply the active involvement and participation of employees. The broadening definition of health, which increasingly incorporates physical, mental and social elements, widens the scope of such programmes in the direction of the employee's entire 'lifestyle'. He suggests that 'organisations today seem to have re-discovered the whole body as a matter of surveillance and control'. Promoters of employee health programmes usually stress the (negative) economic consequences of illness *and* the necessity for employees to cope with the growing demands and pressures resulting from the 'changing nature of work in the New Economy'.

Haunschild goes on to suggest that 'in these times of job tasks and job loads becoming more intense and stress-inducing', the demand for employees to control their health grows. He asks 'who in business can dare to admit to be not healthy (or even not fit) and who can, as a result, admit a lack of will-power to take care of one's own health?' (Haunschild, 2001:7). Once this will-power is there, it covers company as well as leisure time and space. He suggests that via the concept of wellness, the company extends its regulation of the body of the employee into all areas of that individual's life. The body of knowledge around health, well-being and fitness, and the institutions connected with this knowledge, provide influential normative and normalising standards dividing the sick from the healthy.

Goss, he suggests, highlights the 'productive' side of disciplinary power for criticising health promotion, whereas for Haunschild, Foucault stresses that there is no escape from power: that we can just change from one system of power to another, a space beyond power, is an illusion. Foucualt's reluctance to compare 'before and after with respect to goodness and badness', Haunschild argues, is a direct consequence of Foucault's reference to Nietzsche's notion of 'truth', understood as being nothing of importance outside a system of power.

This suggests a 'normative neutrality'. While Foucault has been widely criticised for his (non)normative stance, Haunschild claims that he tries to show that the concept of 'freedom' *itself* is a modern way of thinking about human agency, and that as truth is a product of power/knowledge, Foucault resists the temptation to make explicit his normative assertions. However, Haunschild claims that Foucault's work *can* be useful for investigations on what is meant when we say 'good' or 'bad'. Haunschild suggests that what we can learn from Foucault is that well-being in organisations presupposes a certain subject. By analysing the production of certain kinds of subject, we are able to discern the operation of power.

As even fundamental concepts like 'illness, disease and health' are the product of discourse (which Haunschild sees as being synonymous with 'culture'), health promotion is neither generally good nor bad. Because, with regard to health, the positive side of power is so obvious at first glance (taking care of one's health makes lives longer, leads to less epidemics, better fitness etc.), the issue appears to be why such a 'good' thing should be subjected to scrutiny and criticism. But rather than saying things are 'good' or 'bad', Foucault suggested that everything has the potential to be '*dangerous*', so Haunschild reframes his question as 'what is dangerous about taking care of employee health in organisations?' In order to answer this question, he lists four key areas for further consideration. Firstly, 'common beliefs' about 'the goodness of health' should be investigated, along with the extent to which proponents of employee health programmes claim to be 'politically neutral'. Second, the 'organisational influence' on people's opportunities to take care of their bodies in the way they like should be explored. Third, the 'possibilities for change' in respect to the above should be explored. Fourth, as discourse restricts both who can speak and what can be said, the extent to which employee health discourse excludes the persons affected should be investigated.

Haunschild concludes by bringing the reader's attention back to the fact that employee health promotion is strongly evidenced in modern capitalist organisations and reiterates that this represents an example of the disciplinary power that co-evolved with capitalism. Since health management is connected with 'organisational selection procedures, production processes, resource

allocation and the distribution of outcomes and risks of capitalism' (Haunschild, 2001:12), any normative or ethical analysis of good or bad health management would do well to consider the specifics of organisations and, hence, the characteristics of employment relationships. Finally, he suggests that analysis is required as to what extent Foucault's later work on the self's relation to the self might weaken the critique that Foucault lacks theoretical concepts to say something about the practice of social actors and the experience of their self in relation to discursive practices. As Foucault does not promise alternatives or solutions, Haunschild concludes by suggesting future analyses might follow Alvesson and Deetz's (1996) diagnosis that what is lacking 'is serious efforts to ground ideas of local resistance in specific empirical contexts'. We are now in a position to list each of the author's key questions and claims.

Summary of questions and claims

The key question posed by Goss is:
What is the price paid by some employees resulting from the increase in workplace health initiatives?

The key claims made by Goss are:
That workplace health strategies, particularly workplace health promotion:
1. *May operate as forms of control supporting the extraction of higher levels of performance and commitment from employees.*
2. *May constitute a normative power which creates informal pressure to conform.*
3. *May facilitate employer intrusion into the private lives of employees .*
4. *May result in positive health being used as a basis for discrimination and/or exclusion from the workplace.*
5. *May be shaped by the context of its application.*

The key question posed by MacEachen is:
When does a worker suffer from a legitimate work-related injury and when is a worker guilty of failing to take individual responsibility for occupational risk?

The key claims made by MacEachen are:

1. *More neoliberalist informed approaches to employee health encourage increased self (employee) responsibility (for health).*
2. *Employees who develop RSI are likely to be held personally responsible .*
3. *Workplace health initiatives may facilitate employer intrusion into the private lives of employees.*
4. *Workplace health becomes a prime arena for contesting rights and responsibilities.*

The key questions posed by Haunschild are:

1. *What is dangerous about taking care of employee health in organisations?*
2. *Can a Foucauldian analysis give us concrete help in talking about the good and bad of company health programmes?*

The key claims made by Haunschild are:

1. *Health management activities are supported by a coalition of different professions.*
2. *The scope of company health programmes is widened in the direction of the employee's entire lifestyle.*
3. *Self-regulation and self-control concerning health-related behaviour are encouraged.*
4. *Demand for employees to control their health is growing.*
5. *Knowledge around health and the institutions connected with this knowledge provide influential normative and normalising standards.*
6. *Well-being in organisations presupposes a certain kind of subject.*

Haunschild is the only author to explicitly identify areas for further research. The areas to be investigated are:

1. *Common beliefs about the goodness of health.*
2. *The extent to which proponents of employee health programmes claim to be politically neutral.*
3. *Organisational influence on people's opportunities to take care of their bodies in the way they like.*
4. *Possibilities for change should be explored.*

5. *The extent to which workplace health discourse excludes the persons affected (from engaging with such discourse).*
6. *The extent to which the specifics of organisations, including the characteristics of employment relations, influences health management.*

Each of the three authors discussed here emphasise different elements of the 'problematisation' of employee health. Many of the issues raised in the preceding chapters are touched upon, foregrounded or developed. *Taking the whole of the thesis thus far*, it is possible to discern five key areas of concern which warrant careful attention throughout the remainder of this thesis: institutional/organisational context; panoptic tendencies - monitoring and surveillance; subjective understandings and experiences; self-responsibility; and neoliberalism. Each of these research themes will be discussed in turn, leading to the formulation of research questions designed to guide both the methodological choices and the subsequent analyses.

3.2 *Research themes and questions*

Institutional/organisational context

A recurring theme throughout the thesis, foregrounded by all three authors in the key literature review, is the perception of a generalised shift in the approach taken by organisations to the regulation of employee health. There is a perceived move away from the more traditional concerns of health and safety and occupational health - such as accident prevention and the provision of healthy working environments - toward a more focussed concern with the health and well-being of individual employees. The suggestion is that organisations are increasingly aware of the link between improved employee health and well-being and increased productivity - both 'negatively' (through reduced absence costs), and 'positively' (in terms of increasing an employee's ability to cope with more intensive work processes and practices through improved resistance to the harmful effects of work). The Foucauldian view emphasises *localised* relations of power. Goss, Haunschild and MacEachen emphasise the importance of the organisational context in the playing out of shifting employee health concerns. Haunschild explicitly suggests that any analysis of health

management would 'do well to consider the specifics of *organisations* and, hence, the characteristics of employment relationships' (Haunschild, 2001:12). The identification of this alleged broad shift within organisations is of central concern to this thesis, as is the influence of localised conditions upon problematisations of employee health. Initially then, research questions designed to explore this claim are: *What form do institutional/organisational employee health strategies take? What are the key motivations and justifications offered, by whom, for becoming involved, or not, in the health and well-being of employees? What role do health professionals/experts play in shaping employee health strategies and in directing the health-related behaviours of employees? What kind of subject is presupposed by workplace health strategies?*

Panoptic tendencies: monitoring and surveillance

Monitoring and surveillance practices are at the heart of Foucauldian visions of modern disciplinary power relations. In thinking about and investigating the perceived generalised shift in the ways in which employee health is thought about and acted upon, 'panoptic tendencies', the roles of monitoring, administration and surveillance, are centred. There is the potential for an organisation's concern with the health and well-being of its employees to act as a catalyst for not only developing new strategies to deal with employee health issues, but also for extending the corporate 'disciplinary gaze' into areas of employee's lives previously considered to be part of the 'non-work/private' domain, thus bringing into view a terrain previously considered to be outside the legitimate concern of the work organisation. The implication is that there is an extension of disciplinary power which has the potential to make inroads into every aspect of an employee's life in order to secure, as MacEachen puts it, the demand for employees to 'keep their bodies in a state of constant readiness for work' (MacEachen, 2000:325). The boundaries between work and non-work, public and private, it is claimed, are eroded.

A further concern resulting from increased health monitoring and surveillance, highlighted by Goss and MacEachen, is that the consequences of the increased knowledge of employees may include health based discrimination and possible

exclusion. Clearly this thesis will have to pay careful attention to any health monitoring and surveillance technologies. Research questions designed to guide analysis of this theme are therefore: *What evidence is there to suggest the existence of health-related monitoring and surveillance? What evidence is there to suggest that monitoring and surveillance technologies play a role in extending the organisational gaze into non-work domains? What evidence is there to suggest an erosion of the boundaries between work and non-work, public and private?*

Subjective understandings and experiences

Foucauldian studies emphasise localised conditions. The potential significance of organisational and managerial influences upon employee health processes and practices has been highlighted. However, the key absence from all Foucauldian studies into workplace health is any attempt to investigate, and therefore assess, how health at work is subjectively experienced and understood *by the employees themselves*. The main expressed concern for the authors in the key literature review is to highlight the potential for shifts in the regulation of employee health to have negative consequences *explicitly for employees*, yet none of them explore the subjectively experienced responses of employees to these perceived changes. The ways in which employees' health-related behaviour is constructed and acted upon, and their subjective understandings of the relations between health and work, are of paramount importance within this thesis. Despite the theoretical sophistication of previous accounts, the extent to which they shed light on these factors is limited by the omission of the employees' perspective, although Haunschild suggests it would be useful to explore the extent to which Foucault's writings on 'technologies of the self' may be usefully deployed to 'say something about the practice of social actors and the experience of their self in relation to discursive practices' (Haunschild, 2001:12).

Research questions designed to explore subjective accounts concerned with employee responses to - and understandings of - workplace health strategies are: *What subjective employee responses are evoked by the employer's approach to workplace health? What are the motivations and justifications*

articulated by employees for complying or resisting workplace health strategies? In what ways do subjective accounts illuminate the relations between work and health-related behaviours?

Self-responsibility

The possible transfer of responsibility for health, away from the state and toward individuals (Donzelot 1991; Rose, 1999a; Peterson, 1996) has been a recurring theme throughout the thesis. The key change identified by the authors in the literature review, within the generalised shift of focus in the regulation of employee health, is upon encouraging employees to become more 'self-conscious' (Goss), more 'self-disciplined' (Goss and MacEachen) and more 'self-regulating and self-controlling' (Haunschild) concerning their health-related behaviours. This emphasis upon self-directing behaviour can be subsumed, as MacEachen does, into a generalised strategy of encouraging employees to become more 'self-responsible' for their health and well-being. If there is indeed a tendency for employees to become more 'self-responsible' for their health, another key research question is therefore: *What evidence is there to support the view that employees are self-responsible for their health?*

Neoliberalism

This thesis is fundamentally concerned with identifying and critically evaluating the perceived influence of an underlying neoliberal rationality and its relation to the regulation of employee health. Attention has been paid throughout the thesis to neoliberalism, its characteristics, techniques and goals. From the key literature review, only MacEachen explicitly emphasises the influence of the underlying rationality of neoliberalism, Haunschild only referring fleetingly to the conditions of 'modern capitalism'. A broad research question then, is: *What evidence is there to support the view that an underlying neoliberal rationality informs the regulation of employee health?*

The research themes and questions developed above are designed to help address the substantive concerns of the thesis. However, in addition to these, the research also has conceptual and metatheoretical concerns which stem

from utilising a Foucauldian framework to explore the relations between the perceived shift toward an underlying neoliberalist political rationality and emerging forms of regulation, through an investigation into the different ways in which the regulation of employee health is problematised at various sites. The key literature review has brought into focus two central conceptual and theoretical concerns.

3.3 *Theoretical and conceptual concerns*

Firstly, the authors in the key literature review fail to foreground the constructed nature of key terms and concepts used in workplace health discourse. From the broadly social constructionist perspective developed in this thesis, it is hypothesised that key terms and concepts shape both the strategic development and implementation of particular employee health strategies, and they also shape individual employee's subjective experiences of health at work. Rose (1999a) has asserted that key terms and concepts are more important for 'what they do' rather than 'what they mean'. The *lack* of intrinsic or fixed meaning in terms and concepts allows them to be *mobilised* in ways designed to achieve something. From the epistemological position adopted in this thesis, both the *construction and mobilisation* of key terms are centred within the empirical analyses.

Second, there is the problematic use of the term 'power'. The three authors in the key literature review draw attention to the centrality of the *productive* nature of power: for Goss health-at-work operates as a 'technology of power'; for MacEachen the 'micro-physics' of power are emphasised; and for Haunschild health management activities are an instance of 'power mechanisms'. What all three fail to make explicit is that, as discussed in detail in the previous chapter, Foucault avoids a particular conception of power *per se* and instead prefers to speak about 'power relations', or 'power/knowledge'. The articles demonstrate a sophisticated appreciation of Foucault's understandings of power, and an appreciation of its positive, productive capacities as well as its negative, repressive ones. However, while it is sometimes useful to talk about power as an abstract concept, within the concrete analysis the important point is to recognise its dependent nature: there can only ever be *relations* of power from

within a Foucauldian framework. Within this thesis, the development and implementation of particular employee health policies, processes and practices, as well as individual employee's subjective experiences of work/health, can only be understood within the wider mesh of power/knowledge relations - relations which ceaselessly modify and reform both employee health practices/processes *and* the employees' subjective understandings and experiences of them.

The salient literature has now been reviewed and research themes and questions designed to guide the empirical analysis in subsequent chapters have been developed. The next chapter introduces the methodological dilemmas and difficulties which accompany the generation of empirical data from within a predominantly Foucauldian theoretical framework, and proposes adoption of specific qualitative and discursive research methods in order to identify, gather and analyse salient empirical data.

4.1 *Introduction*

This chapter is an account of the research process. It explains and justifies which data were taken to be most relevant to the research questions, where and how they were collected and recorded and the analytic procedures used in their analysis. The main sections discuss the sites of the research, including the use of two case studies; the collection of interview and documentary material; and the analysis of textual and interview data, utilising forms of discourse analysis. Initially it is necessary to discuss a problem for the project. The normal expectation is that there is a symbiotic relationship between the theoretical orientation of a research project and its methodological procedures. A rich theoretical framework has been developed using Foucault's ideas, but his methodological prescriptions are decidedly vague.

> We cannot just apply a ready-made Foucauldian methodology, rather we must actively and creatively use his work and ideas (Lloyd and Thacker, 1997:2).

> If we conceive of Foucault as providing us with tools rather than with truth or with political solutions, then we recognise that what Foucault is good for will be in part a matter of what we use him for (Shumway, 1989:159).

A problem researchers encounter when utilising a predominantly Foucauldian theoretical framework is that Foucault himself was reluctant to codify any particular methodological approach. Foucault tells us *what* to look for, but in terms of methodological detail, not specifically *how*.

> ....it is a matter not of examining 'power' with regard to its origin, its principles, or its legitimate limits, *but of studying the methods and techniques used in different institutional contexts to act upon the behaviour of individuals taken separately or in a group, so as to shape, direct, or modify their way of conducting themselves, to impose ends upon their inaction or fit it into overall strategies, these being multiple consequently, in their form and their place of exercise; diverse, too, in the procedures and techniques they bring into play.* These power relations characterise the manner in which men (sic) are 'governed' by one another (my emphasis) (Foucault, 1994b:463).

Foucault alerts us to the view that power is exercised over subjects in different institutional contexts, through different 'methods and practices'. Attempts are made to direct conduct not just from one sovereign site, but from many different sites. The role of analysis is to identify and examine those different sites and techniques through which attempts are made to shape conduct, in order to identify the operation of power. The governmentality perspective alerts us to the importance of certain 'technologies' (cultural, panoptic and disciplinary), 'techniques' (counting, calculation, 'numericisation') and 'rationalities' (political ideas such as neoliberalism) in the shaping of conduct. Governmentality also makes explicit the connections between the macro (state/national), meso (institutional/organisational) and micro (subjective/self) levels. When combined with Foucault's understanding of discourse, which emphasises not only texts but also professions, practices, and spaces, that is discourse as material *conditions*, a picture emerges of where we should look to discern those processes which contribute to the shaping of conduct.

At the macro level, relevant cultural technologies - that is state sanctioned policies/initiatives - aimed at the regulation of employee health should be identified. At the meso level, organisational approaches to the regulation of employee health are relevant, and at the micro level, the way individual employee conduct is shaped must be examined. While these levels may be theoretically discrete, analysis should reveal the extent to which existing and emerging forms of regulation are shaped by neoliberalism, and how they are taken up, reflected, contested, ignored or in some other way influence those organisational and individual practices and processes concerned with employee health. Two social science research strategies developed within qualitative sociology are flexible enough to fulfil these requirements and to absorb the theoretical framework: at the macro level, 'policy studies'; and at the meso and micro levels, the 'case study' approach.

4.2 *Sites for data collection*

Much of this research is concerned with sense-making. Explicitly, it foregrounds how risks to health are understood, framed and implicated in behaviours, both

by individuals who are subject to regulative health processes and practices *and* by those who inform, develop and implement employee health regulations.

Policy

Though neoliberalism and decentred approaches to regulation downplay the role and influence of the state, it still has an important role to play in attempts made to regulate the health of employees. Therefore, as suggested in Chapter One, it becomes necessary to identify and analyse *the* key employee health related 'cultural technology' at the macro level, which explicitly attempts to cultivate particular attributes and forms of conduct, and which assembles particular techniques to achieve these ends.

Selection

The *Revitalising Health and Safety Strategy Statement* is the most significant development in the field of employee health since the creation of the 1974 *Health and Safety at Work Act*. Announced in March 1999 by the Deputy Prime Minister, the initiative attempts to make employee health concerns central to Government policy. Published by the Health and Safety Commission and the Department for Environment, Transport and Regions in June 2000, it is the Government's most comprehensive and widely circulated statement of intent regarding the relations between work and health[3].

Case studies

The case study is less a research method than a strategy for deploying research methods. The aim is to understand a case - or cases - in depth, in its natural setting, appreciating its complexity and context. The main goal of a case study approach is not to measure the distribution of characteristics across a population, but rather to aid understanding of processes and connections (Yin, 1994). A 'case' can be seen as a 'phenomena occurring within a bounded context' (Punch, 1998:152). Yin suggests case studies are empirical enquiries which investigate contemporary phenomena in their 'real-life' context, when the

[3] The document is available at appendix C.

boundaries between phenomena and context are not easily discerned and in which multiple sources of evidence are used (Yin, 1994:23). Case studies contribute to knowledge in four key ways: first, there is the intrinsic value to be derived from furthering our knowledge of a particular case; second, it may provide a fuller understanding of the important aspects of a new or problematic research area; third, it can be used in conjunction with other research approaches (Punch, 1998:156); and fourth, it is seen as especially useful in terms of the generation of generalisable theoretical propositions (Yin 1994). An 'instrumental' case (Stake, 1995) aims to provide greater understanding of an issue, theory, or both. In a 'collective' - that is multiple - case study, the comparison and contrasting of different cases may shed light on the processes, practices and different understandings of phenomena. The rationale for multiple case studies is further reinforced by the possibility of theoretical replication, whereby cases are selected to be different in ways that are thought to be theoretically important. If similar processes can be identified at two contrasting cases, this can strengthen the claims made about the particular phenomena.

A significant problem for the case study 'method' is that of identifying the 'unit of analysis' - its boundaries need to be clearly identified if there is to be methodological rigour. Ideally, theory complemented by broad research questions should guide the design and analysis of the case study, and the results of the study should develop the theory. Another important point in undertaking 'comparative' case study research is to be able to consider the conditions which may produce different sorts of outcome. Taken together, and complemented by the policy as cultural technology approach, these factors suggest a useful strategy to adopt in the empirical part of the thesis would be a carefully chosen comparative case study. Not only could the extent of the perceived links to the underlying neoliberal rationality be established, but the concrete conditions, practices and processes involved in - and subjective understandings and experiences of - the regulation of employee health in two contrasting settings could be explored.

The above requirements point toward the selection of cases which offer access to a range of practices, technologies and processes aimed at the regulation of employee health, along with access to the subjective understandings and experiences of those implementing, and subject to, said regulatory activities at the organisational, (health) professional and employee levels. *Workplaces*, as bounded units of analysis, satisfy all of these criteria. As in depth studies are required, and in view of the practical limitations of time, a decision was made to undertake studies at two workplaces.

One aspect of the regulation of employee health identified in the initial stages of the research process which seemed potentially highly relevant to the concerns of the thesis was 'health screening'. As a practice with implications both for shedding light on the mechanisms involved in regulating the health-related behaviour of employees and for having the potential to inculcate the 'taking of responsibility' for one's health, health screening constitutes a potentially significant 'technology' involving monitoring and surveillance. It embodies the theoretical concerns of risk, governmentality and power relations, both organisationally and subjectively. Familiarisation with workplace health literature throughout the first year of study revealed an employee 'screening project' which received a great deal of favourable and positive publicity, particularly within the Occupational Health literature: the 'Q-Health' project. This remains the largest employee screening project undertaken in the UK and was undertaken by the Post Office (soon to become Consignia) in conjunction with BUPA between 1995 and 1998. The Q-Health project acted as the catalyst for choosing Consignia as the first case study.

Consignia is a unionised, long established, public sector company with a predominantly blue collar and sizeable workforce, spread over disparate geographical locations and with a variety of work roles and an hierarchical management structure. Consignia has its own in house Employee Health Services Department which is responsible for providing information and advice to all Consignia managers and employees. Consignia can be seen to signify one pole of the working continuum which represents a mode and style of

working which, while not unaffected by the underlying neoliberal rationality, certainly predates it.

The second case study was selected to provide a direct contrast to Consignia: a non-unionised, new, private sector company with a small and predominantly professional workforce, based at a fixed location with little variation in work roles and without a centralised employee health department. The other case study was chosen to fulfil these criteria, and can be seen to represent a recognisably neoliberal workplace, with flatter management structures, flexible working practices and an emphasis upon 'knowledge workers' employed within the 'new economy' (Deetz, 1995). The second 'case' became a small web-design company: The Byte.

The contrasting work organisations afforded the opportunity for exploration into how the regulation of employee health is approached, constructed, realised and understood in widely differing situations. Because the theoretical framework conceptualises the different elements of the working environment and working processes and practices as part of the discursive conditions, and therefore 'data', full details of both companies appear in the case study chapters.

Getting in - access issues

According to Van Maanen and Kolb, the practical difficulties of gaining access to 'closed settings' in case study research involves a combination of 'strategic planning, hard work and dumb luck' (quoted in Bryman, 2001:292). Bryman suggests measures which proved useful in securing access to the two cases: use friends and contacts; gain the support of someone within the organisation; identify and secure access from 'gatekeepers'; provide a clear explanation of the research; be prepared to negotiate; and be honest about the amount of people's time you want to take up (Bryman, 2001:295).

Having established that Consignia would be a potentially useful first case study, knowing how best to approach such a large organisation proved challenging. The key initial dilemma was whether or not to go through a potentially lengthy, formal process of writing and risking rejection, as well as potentially allowing

Consignia to guide my interactions and activities, or whether to attempt a more informal, localised approach which would potentially give me greater flexibility, and which might contribute to eliciting potentially more open and less guarded responses from employees whose suspicions may otherwise be aroused by the introduction of a researcher by more senior staff. For interviews with 'frontline' staff, the latter approach was adopted, and following Bryman's advice about using friends and contacts, several weeks were spent encouraging a friend who is a postal worker to informally introduce me to a local low level manager who was in a position to secure access to 'frontline' (shop floor, administrative and delivery) employees. This proved to be a successful strategy. Following an informal meeting with the manager, access was approved. Because Consignia has a centralised Employee Health Services Department, it was thought important to interview some of the key personnel from within it. This called for a more formal strategy of writing and phoning in order to arrange interviews sanctioned by senior staff. This approach was also successful.

The opportunity to undertake the second case study at a small web-design company also arose through an informal contact, a 'friend of a friend'. Upon hearing about the research in an informal setting, one of the directors at a newly formed UK web-design company indicated that they would be amenable to allowing me to spend time in their office, and to interviewing any personnel about anything, as long as individual and company confidentiality and anonymity were assured. The assurances were given and an informal research contract was established.

4.3 *Data*

Interviews

The *main* source of data within the case studies was generated through semi-structured interviews. Interviewing is a method of data collection central to many qualitative sociological research projects. The extent to which interviews should be 'structured' is a central concern. Generally, the research questions and the stage the research is at should act as indicators of the extent to which interviews are structured. Initial interviews tend to be more 'open', with more

structured interviews occurring later in the research when a more precise focus has emerged.

Because the time I could spend at each location was limited, and as the theoretical concerns and broad research questions had already been formulated, semi-structured interviews were undertaken at both sites. The interviewee's viewpoint or perspective is more likely to be expressed more freely in a relatively 'open' designed interview situation, than in a fully structured interview, and the opportunity for interviewees to introduce topics is enhanced. 'Situational competence', that is interactional management skills, on behalf of the interviewer is deemed essential for a 'successful' interview, combined with a rudimentary understanding of, or familiarity with, the field and related issues (Flick, 1998). In order to achieve situational competence, pilot interviews were undertaken. During the main pilot interview of a Health Promotion expert, attention was focused on developing the ability to make decisions during the course of the interview, for example knowing when to elicit more detail by use of silence in some instances and 'tag' questions in others, or when to sensitively 'close off' unproductive responses by the interviewee. This form of interviewing is especially useful for exploring a specific phenomenon, allowing for access to the subjective viewpoints of those involved in the process, practice or behaviour under investigation. The technical difficulties that may be encountered in a recorded interview situation (one pilot interview went unrecorded and another was subject to interruptions) were also confronted.

In the semi-structured interview more or less open questions (that is 'how', 'what' and 'why' questions) are refined from a longer list of specific questions and organised in an interview guide. These open questions are then supplemented by and integrated into an 'annotated research instrument' (see appendix B for all interview schedules), designed to help the interviewer steer the interaction toward those areas deemed more salient to illuminating the general research questions.

The questions used in the interviews were designed to gain maximum coverage of health issues, without reflecting too fastidiously the (still emerging) concerns of the thesis, and were tailored to the different 'levels' of interviewees. For

example, the questions for all 'frontline' interviewees covered five basic areas, yet allowed for some flexibility if the responses seemed to be relevant and productive. These areas were: the general health of the employee; their experience of the employment conditions; their understanding of the general approach to health at their workplace; their understandings of any salient workplace hazards; and their opinion on the role of the state in health-related issues. These clusters of questions were also used for the interviews with the directors at The Byte. The questions for the health professionals at Consignia were more tailored, with the interviewees understandings of the role of the Employee Health Services, the Q-Health project, stress and wider developments both in occupational health and at Consignia, all thought to be of concern to the thesis.

A high degree of sensitivity to the interviewee and their responses is needed throughout the course of the interview, combined with the usual good listening and observing skills, and in particular a constant awareness of what has already been said. If the guide is applied too fastidiously, it might restrict the benefits that flow from openness and more contextually oriented information. A further balance is needed in terms of the time available for the interview (Flick, 1998:92-95). If the guide is used consistently, not only is the possibility of increasing the comparability of the data in the future improved but the chance of having to undertake a further interview with the same interviewee is dramatically reduced.

Permission to record all the interviews was secured from the interviewees themselves at both the web-design company and Consignia. The only other recorded interview was with the Chief Medical Advisor and Director of the Employee Health Services, who kindly consented to a telephone interview. All interviews lasted between 45 minutes and 2 hours and were transcribed verbatim for the content only. The final interview dataset for Consignia comprised nearly fifty thousand words, that from the web-design company, over twenty thousand.

All research outcomes involving interactions are the product of particular social encounters. Interviews are never simply opportunities for vocalising beliefs,

understandings or experiences in a straightforward way. To some extent they can be thought of as 'performances' in which interviewees 'assume identities and manage impressions'. Attention must be paid to 'the conditions of production of a text, to the reception and interpretation of it by the researcher' (Melucci, 1992:387).

Sampling

The research themes, general research questions and the theoretical frame required that ideally data should be generated from interactions with a range of employees and employers, from directors to those with a responsibility for formulating and introducing regulatory health strategies, practices and processes, through those with a responsibility for dealing with day to day employee health issues, to employees who were the targets of regulatory health measures. At Consignia two workplace locations were chosen, the first influenced by the way access to Consignia was secured. This was a large sorting office comprising mainly 'shop floor' employees, drivers and some administrative staff, where the initial contact was made. The second location was a smaller delivery office within which numerous examples of the archetypal figure of Consignia - the 'Postman' - could be found. Access to this location was again secured informally through a contact of the sympathetic manager. These locations have been kept confidential in order to maintain the promised anonymity of the employees.

The rationale for choosing the interviewees at The Byte was based upon the desire to interview two of the 'partners/employers/founders/directors' - of which there are four - and three of the employees - of which there are seven. The two most senior partners/Directors were interviewed. Two of the employees were selected 'randomly', that is, they were the ones that happened to be free at the time the recorder was brought in. The final interviewee was the Office and Finance Manager, who had financial, personnel, administrative and, significantly, health responsibilities.

Recruitment

Having met unofficially with the Consignia manager and convinced him through careful explanation of the purposes of the research that it was not a threat to himself nor his employees, the openness and willingness of Consignia staff to help with the research was very welcome. It was assumed that at Consignia a guarantee of anonymity would help to secure more candid responses to sometimes personal questions, and would decrease the potential for anxiety should the interviewees wish to articulate critical remarks about Consignia practices or personnel. The only exceptions to the anonymity were the Customer Processes Manager and the Chief Medical Advisor/Director of the Employee Health Services, who were happy to be seen to be representing Consignia.

Once accepted as a 'legitimate' researcher who was not working on behalf of Consignia, it became possible to recruit interviewees through a snowballing method. Only the practical limitations on time and the amount of data that could be subject to analysis limited the data collection. While negotiating access to the Employee Health Services Headquarters the Chief Medical Advisor to Consignia requested that any publications resulting from the research be sent to him, to which I agreed.

From the sorting office one Occupational Health Advisor, a Fitness Suite Manager and four 'shop floor' employees acted as informants. From the delivery office, three Postmen acted as informants. All the interviews took place between October 2000 and November 2001. One visit to the Employee Health Services Headquarters was made in October 2000, and only the Customer Processes Manager, and, later, the Chief Medical Advisor/Director of the Employee Health Services were agreeable to acting as informants. Further details of the interviewees are given in the case study chapters.

At the web-design company two directors, the Office Manager (with responsibility for employee health concerns) and three employees agreed to act as informants during two visits in July and August 2001. At The Byte anonymity was a condition of the research.

Practices and conditions

While the emphasis of the case study analysis is upon the accounts of the interviewees, it should be borne in mind that a range of other factors contribute to the overall analysis. The theoretical framework means that, in addition to subjective accounts, a range of other factors act as 'data'. For example, monitoring and surveillance technologies, working conditions and the physical environment may all contribute to furthering our understanding of the localised discursive nexus in which the regulation of employee health occurs. For this reason, efforts were made to examine practices as much as accounts of them. For example, the Q-Health project undertaken at Consignia is analysed as a significant data source.

Documentary data

Especially at Consignia, formal documents were identified and analysed which included Consignia's Annual Report 2001/2, the Employee Health Services 'guide for managers' and other advice leaflets produced by the Employee Health Services.

Ethical concerns

It is up to individual researchers to ensure that responsibility is taken for accepting, interpreting and applying ethical principles, including respect for autonomy, beneficence, non-maleficence and justice. Informed consent is central. Ethical principles lead to dilemmas in practice. The position taken on ethical dilemmas influences one's research conduct in the field, at the writing up stage and beyond. For many, as a result of taking a position on an ethical dilemma, the use of 'covert' techniques is unacceptable. This is the case in this study and therefore the research was discussed with interviewees beforehand, in order to try and ensure that the relationship was as free as possible from any coercion or undue influence. While a few participants were familiar with the techniques and methods of social science research, others were not, and may have been sceptical about its potential benefits. It was therefore important to attempt to explain the research in a language and manner meaningful and

appropriate to the participants. The study was framed as being an investigation into the relationship between work and health. Consent was negotiated at every stage and the interviewee's autonomy was respected: that is, I made a conscious decision to try and remain uncritical of the understandings and beliefs expressed by the interviewees, even if I did not agree with them.

The guaranteed anonymity at the outset of the research is not without implications. Problematically, the 'frontline' interviewees, safeguarded by the guarantee of anonymity, may have taken the opportunity to be highly critical of individuals and practices that they perceived as being unfair or unjust. It may have been perceived as an 'opportunity to sound off', although the data suggests that they were both critical and complimentary about different aspects of employment conditions. Conversely, they may have remained suspicious of my motives, and may have doubted my ability to ensure their anonymity. Beneficially, many interviewees welcomed the opportunity to speak to someone about their working conditions, health concerns, and indeed, in some cases, quite personally about their private lives. Generally, it was probably a welcome change from their routine, and some explicitly wished me luck with my research.

4.4 *Data analysis*

The methods of analysis to be utilised depend both upon the forms of data gathered and the theoretical perspective adopted. Because the study uses insights gleaned both from discourse and governmentality theory, as well as risk and regulation theory, it is clear that while much of the data gathered would be of a textual/discursive nature, attention was still to be focussed upon 'material practices'. For example the Q-Health screening project could be viewed as either a 'discursive practice' (from a strictly Foucauldian perspective) or as a 'risk technology' (from a governmentality perspective). Practices inevitably have a textual/discursive dimension, yet as discussed in the theory chapter, analysis must not remain solely within the textual domain. However, for the purposes of analysis it is clear that the data derived both from the 'cultural technology' (the Health and Safety Commission's *Revitalising Health and Safety Strategy Statement*) and the transcribed interviews are *in practical terms* of a primarily textual/discursive nature. It is clear therefore that appropriate, established

methods of text/discourse analysis will be drawn upon to guide analysis of this data.

The approach taken to the data utilises existing discourse analytic techniques. The analytic method adopted in the case studies explicitly takes elements from both discursive psychology and critical discourse analysis - both of which utilise insights from Foucault's work - and complements them with insights gleaned from governmentality studies, risk theory and decentred regulation theory. The analysis of the *Revitalising Health and Safety Strategy Statement* also utilises elements from these approaches and theoretical perspectives but complements them with insights from the 'discourse as policy' and policy as cultural technology approaches. The next section highlights the key features of the discourse analytic approaches that were appropriated and utilised in the analysis of the data.

Policy as discourse and cultural technology

The emergent 'cultural-policy studies paradigm' is practised predominantly in Australia, the chief protagonist being Tony Bennett. He has argued (Bennett, 1992) that greater thought and attention needs to be paid to the variable and multiple forms of power which characterise particular 'cultural technologies'. He suggests that the 'institutional conditions' which give rise to policy are of fundamental significance. Culture, according to Bennett, is best thought of as 'a historically specific set of institutionally embedded relations of government in which the forms of thought and conduct of extended populations are targeted for transformation' (Bennett, 1992:309). Its emergence is conceptualised as part of the 'process of increasing governmentalization of social life', the ultimate objective of which is 'the permanently increasing production of something new, which is supposed to foster the citizen's life and the state's strength' (Bennett, 1992).

Bennett's views, based on his reading of Foucault, resonate with Donzelot's 1977 conception of the social as a 'particular surface of social management'. In reading culture as a 'historically produced surface of social regulation', we are able to frame an analysis of the neoliberalist mobilisation of the concept of

health within the workplace, broadly within Bennett's terms. Bennett alerts us to: (1) the specific types of attributes and forms of conduct that are established as targets (2) the techniques that are proposed for the maintenance or transformation of such attributes or forms of conduct (3) the assembly of such techniques into particular programmes of government, and (4) the inscription of such programmes into the operative procedures of specific 'cultural technologies'. From this perspective, such factors should be identifiable within the *Revitalising Health and Safety Strategy Statement*.

Watson (2000) suggests an approach to policy informed by Foucault which interrogates (policy) discourses to see what assumptions are embedded within them. The assumption here is that seemingly benign policy documents may have complex and contradictory effects. She suggests they may create subject positions which may not have been those initially desired. She argues for an exploration into the role and interests of a variety of experts and others given legitimacy to construct both problems and preferred solutions. Watson's approach - although she does not make an explicit link - is itself clearly similar to the 'policy as discourse' approach. Goodwin (1996) claims that viewing policy as discourse 'frames policy not as a response to existing conditions and problems, but more as a discourse in which both problems and solutions are created' (Goodwin, 1996:67). Goodwin claims that in many policy studies, research policy is often viewed as 'what governments do'. The starting point for analysis is 'the problem' addressed by the policy, whereas policy analyses with a more discursive approach tend to view the 'problems' as being 'given shape' or even 'created' by the policy proposals themselves (Bacchi, 2000:48). Precisely 'how' this is achieved becomes the topic for analysis. From this perspective, policy production becomes a discursive activity.

Edelman was among the first to explicitly link Foucault's works with the analysis of policy, and produced a succinct definition of policy as 'a set of shifting, diverse, and contradictory responses to a set of political interests' (Edelman quoted in Bacchi:48). This definition locates Bennett's cultural technologies firmly upon political terrain. As Bacchi suggests, taking a constructionist line, it is important to be sensitive to the way 'problems' become framed, as this affects

how the problem is thought about, and how this in turn limits the possibilities for action.

The view that policy can be seen as 'discursive activity' alerts us to the ways in which what is written within a particular cultural technology/policy text limits both exactly *what it is* that is talked about, and, once the 'problem' is established, exactly *how* it is talked about. It both limits and defines particular phenomena in particular ways.

From within the policy as discourse approach the (often potentially negative) effects of the policy discourse upon those subjected to particular policies (who are considered to have less power at their disposal) are emphasised. Yet the subjective experiences of particular groups or individuals *subject to* the policies remain outside of the research. Thus, judgement about the extent to which cultural technologies/policy discourses 'actually' realise their stated intent, and the extent to which they either liberate or subjugate particular subjects, can only be explored through analysis of how elements of particular technologies/policies affect particular subjects in particular territories (times and places). Whether or not the subject positions constructed by the *Revitalising Health and Safety Strategy Statement* constitute an inflexible space for those they are addressed at, is discussed at length in the case study chapters.

Having outlined the general approach to be taken to the *Revitalising Health and Safety Strategy Statement*, this section on data analysis is broadened to look in more detail at the actual methods of analysis to be applied to the textual manifestations of the empirical data.

Critical Discourse Analysis

The phrase 'critical discourse analysis' is used somewhat confusingly to signify both a particular approach to the analysis of discourse developed by Fairclough, and a broader movement of which his approach is but one example (Philips and Jorgenson, 2002:60). Fairclough's theory of critical discourse analysis is close to the theoretical framework developed within this study in that areas of social existence, for example institutions and material practices, are seen to be in a

dialectical relation with discourse: discourse is both constitutive and constituted (Fairclough, 1992b:64), or to use Hook's phrase, both 'an instrument and effect of power' (Hook). In contrast to Foucault, Fairclough has spent considerable time developing methodological tools for empirical research.

Combining detailed linguistic analysis (for example functional grammar), Foucauldian informed macro-social analysis, and the interpretive tradition within sociology (for example ethnomethodology and conversation analysis), Fairclough explores the links between the textual and societal/cultural structures. At the most general level, language use is understood as social practice. Discourse can mean both general discourses such as political or scientific, and 'particular ways of speaking which give meaning to experiences from a particular perspective' (Philips and Jorgenson, 2002:67). Discourse helps to construct particular social identities, particular social relations and particular systems of knowledge and meaning. Text, understood as the material manifestation of discourse, is embedded in its context at these levels: the immediate situation involving participants in a particular setting, the wider institutional or organisational setting and the societal level.

These three levels correspond to the thematic interests of this research, and resonate with the governmentality perspective's concern to identify mechanisms of power at the macro, meso and micro levels. These levels correspond to the state influences upon approaches to the regulation of employee health, the organisational context in which regulation occurs, and the subjective understandings of particular employees, employers and health professionals within specific organisations.

A central concept to critical discourse analysis is that of interdiscursivity. This refers to the way different discourses can become articulated together in a communicative event (Philips and Jorgenson, 2002:73). Interdiscursivity is an example of intertextuality. All texts inevitably refer in some way to prior texts, or if we adopt Foucault's view of discourse as event, communicative events always draw on earlier events. These processes point toward on the one hand, a sign of potential societal change, especially when discourses/texts are mixed in unusual or complex ways, but on the other hand, when discourses/texts are

mixed in a conventional way, this can be an indication of the stability of a social order and therefore point toward the preferred order within the text. Fairclough recognises that change is created in part by drawing on existing discourses in new ways but that the possibilities for change are limited by existing power relations.

There are distinctive stages to the research process which are: choice of research problem with the objective of explanatory critique; the formulation of research questions; identification of data sources; transcription; analysis; and presentation of results. These stages are followed in this thesis. The analysis itself involves three broad areas at the level of discursive practices, texts and social practice. At the textual level, linguistic tools are available to analyse how versions of reality are constructed. At the broadest level of analysis, it is noted that particular strategies are adopted in order to 'frame' particular texts. The framing of a text offers a general perspective or a particular slant upon its content and is designed to offer the intended recipient a perspective from which it should be understood. Transitivity draws attention to the extent to which events and processes are connected with subjects and objects within the text: which agents are seen to be active or passive, which are affected or unaffected, who benefits or not from the constructions given within the text. All give clues about preferred positions and understandings, and thus about power relations. Register alerts the analyst to whose voice is being used within the text - 'I', 'you', and 'we' all signal issues of legitimation and categorisation. Conversely, nominalisation brings attention toward the removal of agency - there is an absence of participants, usually signalled by the use of passive verbs or the turning of verbs into nouns, thus actions become devoid of agents. This signifies an attempt to conceal or distance the agent(s) responsible for an action, and thus signals issues of de-responsibilisation. Presuppositions signal things/actions/ideas which are taken for granted, assumptions which are not explicitly stated and which should be challenged by the analyst in order to see if they hold 'true'.

Traditional psychology assumes that mental phenomena like cognitions and emotions have object status and exist 'inside' individual heads. The 'turn to the text' by critical psychologists explicitly rejects this 'inside-out' approach and reconceptualises mental categories and subjective experience as constituents of social processes (Burman and Parker, 1993; Gergen, 1985; Parker, 1997). Discursive psychological analyses are guided by a broad theoretical framework which rejects the cognitivism of traditional psychology. Attention is focussed on the constructive and functional dimensions of discourse (Potter and Wetherell, 1987; Edwards and Potter, 1992; Potter, Edwards and Wetherell, 1993) and a rich resource of discourse studies, which throw up features of discourse construction and interaction that may apply across different contexts (Potter and Wetherell, 1994).

Potter and Wetherell (1995) outline and discuss five key theoretical principles which together provide a framework for the analysis of discourse. Each of these is reviewed, then followed by a discussion of how each principle translates into recommendations for analytic practice when engaging with text.

First there is a focus on construction and description. As Discursive Psychology is grounded in social constructionist epistemology, a basic theoretical assumption is that 'reality' is to be constructed by participants in the course of social interaction: the world (matters of mind, identity and reality) cannot be neutrally represented in text. Social constructionism focuses our attention on an important characteristic of talk about the world - its '..could have been otherwise..' quality (Edwards, 1997:8). Thus, in practice, a discursive psychology discourse analysis treats any account as one possible *version* of reality. The focus is on the meanings that are given to the events, people, institutions and psychological phenomena (motivations, emotions, intentions, states of mind) at particular points in text.

Second, there is a focus on action. This principle reflects discursive psychology's theoretical grounding in ethnomethodology and its empirical discipline of conversation analysis. In discursive psychology, descriptions of the

world, self and others are understood as open-ended and flexible (see above), and this constructive work is linked to the accomplishment of social actions, that is, sense making practices are understood as *consequential*. In practice, analysis therefore involves interpretation of the pragmatic business and ideological and political work that may be accomplished through talk. Particularly relevant to this thesis is the focus in several discursive psychology studies (for example Edwards and Potter, 1992; Beattie and Doherty, 1995; Edwards, 1997; Doherty and Anderson, 1998) on the *interactional management* of identity (how people get categorized in talk) and the ways in which the particular constructions of identity offered are consequential - especially in terms of implications of fault, blame and responsibility for issues/events under discussion.

Third, speaker's accountability is examined. Discursive psychology draws attention to the way in which arguments and explanations are constructed so as to display lack of stake or interest in a position being developed (and thus avoid accusations of spite, harshness etc.). In versions which deal with accountability (for example where fault, blame or responsibility for states of affairs may be assigned to persons or groups), speakers are generally likely to be concerned with 'how they look'. In practice, this translates into an analytic concern with the rhetorical features of the discourse, such as the promotion of credentials as a 'qualified', 'neutral' or 'sympathetic' observer.

Fourth, there is a focus on rhetoric. This principle focuses our attention on the conflictual nature of social life, the way in which arguments or opinions are always expressed in a rhetorical context, that is, are designed to counter explicit or potential alternative arguments (Billig, 1987; Billig et al, 1988). Following this principle, a discourse analysis will aim to trace through the argumentative strands in the talk, to document which opinions are being put forward and how they are argued for or against. This also involves the identification of rhetorical procedures that make arguments appear credible or difficult to undermine (Potter, 1996).

Finally, throughout analysis there is a combined focus on discursive practices and resources: what people *do* with their talk, and the interpretative resources

that people draw on in the course of those practices. Wetherell (1998) particularly stresses this point in her characterization of discursive psychology as a 'hybrid' or 'synthetic' approach to Discourse Analysis. Discursive psychology weaves together a range of influences, particularly poststructuralist (highlighting the cultural and historical forms of argument and sense-making) and ethnomethodological (highlighting local conversational activity), with the aim of clarifying, interpreting and discussing the broader interpretative resources that members draw on in their everyday sense-making, and the social and political circumstances of discursive patterning.

A Hybrid approach to the analysis of discourse

All three approaches are potentially useful to this research: the links between localised textual instances with wider society are emphasised; they offer systematic frameworks for the analysis of texts; they make explicit attempts to integrate insights from Foucault. Both critical discourse analysis and discursive psychology claim that their frameworks are amenable to the analysis of both written and spoken texts, although discursive psychology makes a claim to be particularly appropriate to the analysis of talk in interaction. Critical discourse analysis draws attention to the production and reception of particular discourses, although 'very few critical discourse analysts' undertake analysis at the reception end of the process (Philips and Jorgenson, 2002:82). In practice most critical discourse analysts concern themselves with written texts. All of the analytic approaches bring attention to the notion of 'absences'. This alerts the analyst not only to consideration of how one way of putting things is preferred over another, usually equally rational explanation, but also to the way information which may be relevant is excluded from the text. Finally, the concept of 'subject positions', discussed in Chapter Two, is widely used in discourse analytic frameworks to address issues of identity and subjectivity, and is a central analytic construct within this thesis. When situated within the overall framework, a powerful analytic grid is formed with which to undertake analysis of the empirical data.

4.5 *Summary*

After a year spent immersed in the relevant academic literature on work, organisations, employee identity and health, talking to occupational health and health promotion specialists, attending relevant conferences and joining academic networks, as well as increasing my knowledge about Foucault, theories of risk and regulation, qualitative social science research methods and the different forms of discourse analysis, the need to adopt a multi-perspectival approach which utilised insights from different sociological traditions became clear. This chapter has justified the selection of a key policy document and made a case for the use and selection of two case studies. Issues around access, the use of interviews and selection of the sample of subjects have been discussed. The methods to be used in the analysis of documentary, interview and wider discursive features, have been developed.

It is asserted that empirical analysis of the regulation of employee health from within a social constructionist perspective will illuminate the perceived influence of neoliberalism and bring to light the various problematisations of employee health. With one eye on the adequacy of the preceding analytic framework, and guided by the identified general research themes and questions, it is to the empirical analysis that the study now turns.

PART TWO - EMPIRICAL ANALYSES

Chapter Five - Analysis of the *Revitalising Health and Safety Strategy Statement*

5.1 *Introduction*

The thesis has so far hypothesised that the underlying political rationality of neoliberalism attempts to mobilise a strategy of flexibilised, decentralised (de)regulation, which may result in processes of (de)responsibilisation, in order to achieve the state's objectives of increased productivity and competitiveness. In the field of employee health, it is hypothesised that (de)responsibilisation may be realised through the construction of employee health and safety as a particular kind of problem, requiring particular solutions, thus rendering employee health amenable to modification (employee health is problematised in a particular way). The modifications aimed for are thought to be conducive to aligning the interests of companies and employees with the interests of the state. Particular 'cultural technologies' are used to facilitate these processes. From this perspective, political rationalities become manifested in texts and practices.

The most significant contemporary cultural technology in the field of employee health was identified in Chapter One as the *Revitalising Health and Safety Strategy Statement*. It is the fullest and clearest statement of Government intent available concerning the regulation of employee health since the Health and Safety at Work Act of 1974. The *Revitalising Health and Safety Strategy Statement* identifies and frames work-related health hazards/risks as something in need of management. This chapter subjects the *Revitalising Health and Safety Strategy Statement* to analysis[4].

In line with the theoretical framework, the preferred method of analysis and the main concerns of the thesis, analysis will attempt to discern how the *Revitalising*

[4] The *Improving Health is Everybody's Business* statement of intent from the 'Healthy Workplace Initiative" was identified in the early stages of the research as a significant text. It was subject to analysis from an exclusively Foucauldian perspective, before the theoretical framework and methodology had been fully developed. The analysis appears in full at appendix A. The variation in the techniques of analysis shed light upon the particular cultural technologies/texts in question, and helps to illuminate more theoretical concerns around the appropriateness and explanatory adequacy of the different techniques of analysis.

Health and Safety Strategy Statement: frames and problematises employee health and safety; formulates and justifies particular 'solutions' to the 'problem'; constructs identities (for example the Government, the Health and Safety Commission, companies and employees) in particular ways, making particular subject positions available to them; and represents its preferred approach to the regulation of employee health and safety through the rhetorical organisation of the text.

The hybrid form of analysis, outlined in the last chapter, makes use of Foucauldian inspired cultural-policy studies. Goodwin suggests that viewing policy as discourse frames policy as a discourse 'in which both problems and solutions are created' (Goodwin, 1996). This approach is useful in exploring how attempts are made to shape and direct behaviours and understandings, at the macro level of the state. When aligned with analysis of the case study data, the significance of the state's construction of employee health for companies and employees should be more easily comprehended. The *Revitalising Health and Safety Strategy Statement* is understood as a key cultural technology, which has as its aim the conduct of conduct in the field of employee health.

The Revitalising Health and Safety Strategy Statement

The document itself (available in its original form at appendix C) has a red and black title on the green cover in which the letters 'vital' in 'revitalising', are italicised. This is accompanied by photographs representing various work environments/occupations (office, construction and health), thus signalling its wide ranging and inclusive nature. Each page has numerous health and safety signs on the background of the text. The *Revitalising Health and Safety Strategy Statement* has two forewords: one by the Deputy Prime Minister, John Prescott, and one by the Chair of the Health and Safety Commission, Bill Callaghan. The forewords are followed by a brief 'overview' which includes the aims of the RHSSS. In addition to the forewords and overview there are four main sections: 'Consultation'; 'Targets for Great Britain'; '10-point Strategy Statement' and; 'Action Plan'. As the *forewords*, *targets* and the *strategy statement* provide the framework from which the (often very general or technical) action points are derived, it is these sections that the analysis will

focus upon. The least relevant sections (overview, consultation, action plan, and 'annexes') have been excluded from analysis.

Aspects of the *Revitalising Health and Safety Strategy Statement* relating to the core concerns of the thesis, namely, neoliberalism, risk, regulation and the anticipated processes of responsibilisation, are foregrounded. This chapter proceeds by introducing and contextualising the *Revitalising Health and Safety Strategy Statement*. This is followed by a short section examining the significance of its use of targets, which further contextualises the subsequent detailed analysis of the forewords and the strategy statement.

Contextualising the Revitalising Health and Safety Strategy Statement

In March 1999 the Deputy Prime Minister announced a programme which, he believed, would bring about 'a real change in workplace culture' (*Revitalising Health and Safety Strategy Statement*:3). Their followed a consultation period in which over 7,000 copies of the main consultation document were circulated to a range of public and private sector workplaces, supplemented by 40,000 summary leaflets aimed at employers, workers and small and medium sized enterprises. The consultation document 'set out the economic business case for further action' in the field of workplace health and safety (*Revitalising Health and Safety Strategy Statement*:11). From the 1,478 responses key themes were identified and integrated into the final document. In June 2000 the Health and Safety Commission and the Department of Environment, Transport and the Regions jointly published the *Revitalising Health and Safety Strategy Statement* (RHSSS hereafter).

The RHSSS is the most explicit statement of the Government's and the Health and Safety Commission's/Executive's position concerning employee health and safety, and is designed to frame and drive all other thinking about employee health for the next twenty years.

The RHSSS represents a textual manifestation of the state's problematisation of employee health and affords the opportunity to analyse the extent to which this key cultural technology is informed by the political rationality of neoliberalism.

5.2 *Targets - a risky business*

One of the most significant techniques used increasingly by government and other institutions in an attempt to influence behaviour is the use of numbers. Both from a governmentality and the related cultural technology perspectives, their use is deemed to be of great significance. Within the RHSSS great play is made of the introduction, 'for the first time', of targets for health and safety (RHSSS:15). The claim is made that the targets are developed in order to 'drive forward this new strategy' (RHSSS:15). They are:

> - reduce the number of working days lost per 100,000 workers from work-related injury or ill health by 30% by 2010
> - reduce the incidence rate of fatal and major injury accidents by 10% by 2010
> - reduce the incidence rate of cases of work-related ill health by 20% by 2010
> - achieve half the improvement under each target by 2004 (RHSSS:16)

Work-related ill health is here made intelligible, calculable and practicable through numerical representation. In the detailed analysis which follows we will see how quantification is used in key parts of the text to justify and legitimate the development and introduction of the RHSSS.

Rose has claimed that numbers, realised in 'indicators', 'measures' and 'targets', have become 'crucial techniques for modern government' and are 'indispensable to the complex technologies through which government is exercised' (Rose, 1999a:198). Political judgements, which are often hidden behind the all pervasive use of numbers, have to be made about exactly *what* to measure, *how* to measure it and *how* to present and interpret the results: the judgements *themselves*, made at each stage of the process, become less visible through their subordination to numerical representation. This is reminiscent of the social constructionist perspective on risk which posits that risk reduction always involves a 'cost', and, in the context of workplace health and safety, judgements must therefore be made over the balance between profitability and safety. Different perspectives lead to different understandings of what constitutes an 'acceptable risk'. The messy business of judging, for example judging precisely what qualifies as work-related ill health, is excluded

from the text. This alerts us to a potential resistance on behalf of the Government and the Health and Safety Commission to take responsibility for making these difficult judgements.

Different workplaces have differing health priorities due largely to the nature of the work undertaken. The *extent* to which particular forms of ill health are understood to be related to work is contested (MacEachen, 2000). Attempts to delimit exactly what 'counts' as work-related ill health has profound consequences for a target based approach, and a target based approach has implications for what 'counts' as work-related ill health. The use of specific targets within the RHSSS may produce a renewal of disputation over the extent to which certain conditions are defined as being work-related. Stress, for example, may be subjectively perceived by employees to be solely work-related ill health, but employers and health professionals may construct it in different ways. Analysis of case study data may reveal the extent to which particular understandings of ill health are constructed as work-related, and reveal some of the judgements made as a consequence of these constructions. These constructions and judgements may be seen to have consequences for the process of responsibilisation.

The centralised accumulation of information relating to workplace ill health undertaken by the Government and the Health and Safety Commission, and its inscription in centralised numerical representations, brings new calculable spaces into existence. Foucault warns us that this may bring into being new conduits of power between those who wish to exercise power and those over whom they wish to exercise it. MacEachen demonstrates how changes in the worker's compensation scheme in Canada, resulting in part from numericised representations of incidence rates and financial costs, gave rise to disputes over the extent to which some recognised forms of ill health were constructed as work-related. Rose states that 'turning the objects of government into numericised inscriptions, then, enables a machinery of government to operate from centres that calculate', adding that 'figures and so forth all allow a centre to maintain its hold over the actions of those who are distant from it' (Rose,1999a:212). Rose makes it clear that there are implications for individuals in the adoption of this form of governing:

> ...we should not think of these practices that make individuals calculable purely as technologies of domination, for they can also be technologies of autonomization and responsibilization. Numbers, and the techniques of calculation in terms of numbers, have a role in subjectification - they turn the individual into a calculating self, endowed with a range of ways of thinking about, calculating about, predicting and judging their own activities and those of others (Rose, 1999a:214).

The activity of rendering the territory of work-related ill health into numerical form may have consequences for the way individual employees conduct themselves. For example, statistical information concerning the incidence of particular manifestations of work-related ill health influences which risks become constructed as salient in particular work practices or places. The mechanisms utilised in particular workplaces for addressing such risks inevitably involve processes of responsibilisation. Employee health screening programmes also depend upon calculable representations of health risks in order to motivate personal behaviour modification.

The emphasis upon targets in the RHSSS functions to draw attention away from processes of responsibilisation, and the messy business of having to make situated decisions about employee health issues. The localised complexity involved in making judgements about which behaviours or activities are to be understood as health risks, and judgements about who should be responsible for their identification and resolution, is downplayed by the introduction of national targets. The targets in the RHSSS help to construct work-related ill health as problematic and in need of intervention. However, the responsibility for deciding what qualifies as work-related ill health, what should be done about it, and whose responsibility it is to do something about it, are obscured by the focus on targets. The implications of the localised risk based regulation of workplace health related behaviours for employers, health specialists and employees, will a subject of analysis in the case study chapters. Data from the contrasting case studies should reveal both the extent to which techniques of numericisation play a part in the regulation of health, and the extent to which a risk based approach to employee health influences concrete instances of responsibilisation. Having suggested that a target based approach to employee health and safety may have wide-ranging and significant implications, the

analysis now turns to the two forewords which act to identify and frame the 'problem' of employee health and safety.

5.3 *Forewords - a problem with causes needs a solution*

Prescott's foreword - the cost of death

> *Revitalising Health and Safety* is about injecting new impetus to better health and safety in all workplaces.
>
> The Health and Safety at Work Act 1974 was a landmark in making Britain's workplaces safer. For the first time all employers were required to keep their workplaces healthy and safe. The Act provides a strong framework for good, effective regulation and has transformed Britain's workplaces. We can see the results - the number of deaths at work today is a quarter of the 1971 level.
>
> But 25 years on, it is time to give a new impetus to health and safety at work. Too many deaths still occur at work. Each death or serious injury in the workplace is a tragedy; a tragedy that causes devastation for workers, their families and loved ones; a tragedy which, perhaps, could have been avoided in the first place.
>
> Society as a whole pays when things go wrong. We estimate that the total cost to society of health and safety failures could be as high as £18 billion every year. We can and should do something about this.
>
> That's why, last year, I announced our *Revitalising Health and Safety* Initiative, a strategic appraisal of our health and safety framework, building on the hard work of the last quarter of a century and setting the agenda for the first 25 years of the new Millennium. Our aim is to reduce the impact of health and safety failures by 30% over 10 years.
>
> Transport safety is not covered in this statement. Nor does it seek to anticipate in any way the outcome of Lord Cullen's public inquiry into the tragic rail accident at Ladbroke Grove junction.
>
> *Revitalising Health and Safety* reflects the changing world of work and the need for our regulatory system to match it. It also acknowledges that certain areas of work, such as construction, still have a high accident rate and that we must work hard to combat this.
>
> The work of the Health and Safety Commission and Executive will be vital in making *Revitalising Health and Safety* a success. Preventing accidents and ill health, rather than dealing with the consequences, must be their priority.
>
> *Revitalising Health and Safety* foreshadows tougher sentences for health and safety offences, and also an examination of new, innovative penalties.

> We want this initiative to succeed. That's why I'm committing the Government to show clear leadership as an employer, procurer and policy maker. I hope this will inspire others right across our diverse economy to commit to new action and share in the benefits of good health and safety management.
>
> I believe that the *Revitalising Health and Safety* initiative will bring about a real change in workplace culture - a change that will blaze a trail for effective partnership between employers and workers in all aspects of working life.
>
> John Prescott

John Prescott is the Deputy Prime Minister for New Labour and one of the main connotations he holds for the British public is that of (tough) 'working class' cabinet member. As such, it may have been decided that his 'worker' credentials may be better appreciated by the majority of employers and employees than, say, those of Tony Blair or Gordon Brown.

Prescott's foreword establishes the need for the introduction of a new strategy aimed at work-related health and safety. It therefore represents a key site in which to express the formulation of the 'problem': the text contains particular constructions of the nature of the problem, offers explanations for why the problem exists, and makes the case for the imperative to change. The foreword begins to reveal how areas of activity and responsibility are to be thought about within the RHSSS. It attempts to establish 'source credibility' through a rhetorical strategy which involves constructing agents within the text in particular ways. The foreword exists to justify the proposition of the need for change, and attempts to communicate this to a wide range of audiences. Analysis proceeds by exploring how these factors are achieved within the foreword.

The problem is initially constructed as being concerned with outmoded regulation, thereby establishing a need for change without having to go into detail about the nature of the changes required. This is difficult as there is a desire to suggest that the Health and Safety at Work Act of 1974 was a 'landmark'. It is established as effective and able to deliver calculable results - for example the 75% reduction in deaths at work since 1971. However, in order to introduce this new initiative, the Health and Safety at Work Act has to be

undermined in some way, without alienating those in the audience who may not want to perceive any weakening of its authority. This is achieved by introducing two narratives: the imperative for excellence and the changing world of work. The narrative of the changing world of work is not expanded upon in Prescott's foreword, but it is picked up elsewhere in the RHSSS, and will therefore be returned to later in the analysis.

Prescott asserts that all workplace deaths are tragedies which have consequences. The consequences are framed as 'costs': the *human* cost of the devastation caused to worker's families and loved ones; and *financial* costs, constituting part of the annual £18 billion. This is the first major indication of the influence of neoliberalism, which tends to treat all social phenomena as reducible to calculable costs and benefits, the aim being to make social phenomena more amenable to control and manipulation. Highlighting the costs to families has implications for how the identity of the state is constructed. New Labour is constructed as a 'caring' state, one that cares about families and is aware of the factors which impact negatively upon their lives. The text thus frames New Labour as being concerned with certain kinds of problems. However, the foreword also constructs New Labour as knowledgeable, capable and dynamic 'experts': they are qualified and prepared to take measures to relieve this suffering. Because they recognise the financial costs to society as well as the human ones, they are constructed as also being good financial managers, as prudent and trustworthy. But how is the *cause* of these costs established within the text? The costs are blamed on 'health and safety failures'.

The foreword initially foregrounds the number of *deaths* arising from health and safety failures, before broadening this to include serious injuries. By the end of the foreword it is *all* work-related accidents and ill health which are constructed as problematic. Seen in the context of arguing that the1974 legislation is outmoded, the deaths, ill health and serious injuries are re-imagined as calculable and amenable to target setting. References to deaths and accidents also serve the function of strengthening the case for action. But to what does the phrase 'health and safety failures' point? The text is here systematically vague: it is difficult to define a 'health failure', or to say what counts as one. It is difficult to say under what conditions something may be legitimately considered

a health and safety 'failure'. It is speculated here that the causes of work-related ill health, and thus what is to be considered work-related ill health, is a highly contested area. The phrase remains undefined and agentless within the foreword. It is further speculated that it is here *functional* to be vague: through a strategy of deliberate vagueness, the state avoids responsibility for having to define or decide what constitutes health and safety failure and consequently what is to qualify as work-related ill health.

However, the state is keen to be seen as active, and it attempts to foster this position by demonstrating its commitment to showing leadership: the state is happy to identify the problem, define it as a largely economic problem, and formulate a broad strategy with specific targets. What it is not happy to do is to take responsibility for the detail, which includes taking measures to implement the strategy. Having constructed the problem in a particular way, a solution is then proposed. This comprises the view that the problem should be prevented. In attempting to prevent the health and safety failures, a need is identified for a pro-active and effective State which is willing, if necessary, to introduce appropriate legislation in order to address this predominantly economic problem. The turning of this initially human cost into a financial problem is a hallmark of neoliberalism. The dominance of the neoliberal approach to social issues is here demonstrated by the way that it now appears normal - sensible even - to 'cost death' in this way, as if the death of a worker equates to a calculable amount of money.

Having decided that the state will be part of the solution, the solution is developed and delivered in an entrepreneurial manner: innovation is emphasised, and it is hoped the strategy will 'blaze a trail' of 'initiative' taking. The status of the strategy itself is constructed as a catalyst for change, and not just any change, but 'real' change.

The physical and material relations of force the text is tied to comprise *threats* of 'tougher sentences' and examination *of* 'new, innovative penalties' for health and safety offences. There is an attempt to balance these negative relations of force with the incentive to 'share in the benefits', although exactly what these benefits are, and exactly who is to share in them, is not made explicit.

Callaghan's foreword - we all pay

Foreword by the Chair of the Health and Safety Commission

The importance of good health and safety is evident to anyone who has seen the consequences of health and safety failure. Those who suffer most are the injured, the ill and the bereaved. But all of us lose from poor health and safety: employers and employees, consumers, and the providers of public services. Society and the nation at large cannot escape the £18 billion bill every year.

The Health and Safety Commission warmly welcomed the initiative taken by the Deputy Prime Minister last year when he launched the consultative document *Revitalising Health and Safety*. This exercise has helped raise the profile of health and safety. Action and achievement are now the watchwords. We need nothing less than a step change improvement in health and safety over the next decade.

So the challenging targets to reduce health and safety failures that we publish here must engage all the stakeholders in the health and safety system: employers, workers, Government, local authorities, employers' associations and trade unions, professional bodies and safety charities, and many others.

In the coming year I shall be asking all our stakeholders to draw up their own action plans in order to meet these targets. I particularly welcome the Government's commitment to show clear leadership as an employer, as a major purchaser of goods and services, as an investor and as policy maker.

The partnership approach of the Health and Safety Commission has achieved much over the last 25 years. But a new world of work poses new challenges and we must never be complacent.

We shall rise to these challenges and meet the targets set out here if we all continue to work in partnership.

Bill Callaghan

Callaghan's foreword is written in the same style as Prescott's and is strikingly similar. Throughout, the tone is 'managerial' and the language and mantra of New Labour are revealed in the emphasis upon partnership, change, targets and stakeholders. There is a restatement of Prescott's imperative for change, as 'we all lose' from our inability to escape the £18 billion 'bill'. This represents a careful balancing act which enables the issue to be addressed as an economic issue without the state or the Health and Safety Commission being accused of not caring. The theme of the changing world of work is reprised, and the way

change is emphasised serves as a justification for a new context, which requires new action.

The third paragraph becomes more explicit than Prescott's foreword in beginning to suggest the proposed division of labour needed to tackle the 'problem'. Prescott is constructed as agentic in launching the initiative and in identifying the need for change through instigating a process of consultation. Stakeholders are explicitly positioned as responsible for drawing up action plans in order to achieve the targets. The stakeholders are constructed as having equal responsibility for delivery of the targets. Stakeholder is here an ambiguous term, as every employer and employee could be considered a stakeholder in health and safety concerns. It is difficult to envisage how they *all* will be involved in drawing up 'their own action plans'. Clearly some stakeholders are more significant than others. The questions around responsibility for the drawing up and 'ownership' of the action plans are left hanging. Midway through his foreword he does list the supposed stakeholders, and 'workers' are included, the implication being that they are in some way responsible for ensuring that the proposed targets for reductions in the rates of work-related ill health and injury are met. The targets themselves are constructed as a pro-active element within the process of 'engaging the stakeholders'. The use of 'we' in his foreword is interesting and problematic: at one point it is the Government and the Health and Safety Commission to which he refers - 'the targets.....*we* publish here' - whereas his closing sentence is '*we* shall rise to these challenges and meet the targets set out here if *we all* continue to work in partnership'. The sliding meaning of 'we' further reiterates the confusion over ownership and implementation of the strategy. The view is forwarded that 'partnership' has been practised successfully in the past, and is the key to future success.

The narrative of the 'new world of work' posing 'new challenges', suggests many are employed in qualitatively different work environments, undertaking different work practices, than in the past. What this means in practice is unstated, but the advice he offers to deal with this is that 'we must never be complacent'. Complacency is mobilised as a commonplace argument: it is something universally recognised as intrinsically negative, and helps to construct the

Government and the Health and Safety Commission as *not* complacent. This connotes further their position as one of enterprise, as agentic innovators, thus invoking the spirit of 'doing' at the heart of entrepreneurial discourse.

Taken together the forewords construct the 'problem' of employee health, its causes and the need for a particular solution, in a very particular way. The 1974 Act is constructed as successful, but not successful *enough* for trail-blazing Great Britain. Health and Safety failure has been identified as the culprit, without suggesting what it is. The responsibility of the Government is constructed as providing targets and showing leadership. The state and the Health and Safety Commission are constructed as caring and economically prudent, innovative and dynamic. They construct themselves as *responsible*, while simultaneously encouraging others to *take responsibility* for implementing the targets. The next part of the document to be subject to analysis is section three, the '10 point strategy statement', which lies at the heart of the RHSSS.

5.4 *The Strategy Statement*

Preamble - fair, decent and safe?

> The 25 years since the Health and Safety at Work Act 1974 have seen steady but, in the recent past, slowing reduction in levels of health and safety failures. This has been a tribute to the strengths of the 1974 Act and the analysis that underpinned it. The rate of fatal injury to workers in Great Britain is less than half that in Germany.
>
> In striving to achieve maximum preventative effect, the Health and Safety Executive and local authorities have sought to balance their duties to give advice, inspect, undertake enforcement action and investigate complaints and accidents. There is no need to change this basic approach, but there is a pressing need for constant vigilance and further action to raise standards.
>
> That is why the Government has significantly increased the resources available to health and safety - additional resources of some £63 million were made available to the Health and Safety Commission and Executive in the three year Comprehensive Spending Review in 1998. As a result, the annual number of regulatory contacts the Health and Safety Executive has with employers and duty holders (including inspections) is estimated to have risen to 188,000 in 1999/00. The number of prosecutions for health and safety crimes has been rising each year and is estimated to have reached 1900 in 1999/00.

> A fair, decent and safe society depends on good regulation where alternative approaches, such as guidance, cannot secure the same outcome. Good regulation is about decent standards and protection for everyone, not bureaucracy and red tape. The Health and Safety Commission and Executive are committed to helping business – small firms in particular – by simplifying and clarifying health and safety law and guidance; improving the enforcement regime by ensuring it is consistent, proportionate, transparent and targeted; and cutting red tape by removing unnecessary forms and paperwork requirements.
>
> The 1980s and 1990s have been characterised by significant legislative activity, much of which has been driven by the European Union. It is now recognised by many, including our European partners, that the legislative framework is broadly complete. The challenge is to convert legal standards into real changes in culture and behaviour in the workplace, since only this can deliver continuous improvements in standards. We must also be alert to new areas of risk and the forces behind them, and be ready to develop strategies to tackle them. People management issues, such as stress, change and violence, continue to pose a threat to the effectiveness of the modern workplace.
>
> Many of the findings of Lord Robens' committee, which paved the way for the 1974 Act, remain valid today. Partnership between Government, employers, employees and unions remains crucial, as does self regulation based on goal setting law. But there is a need for new energy and a new strategic direction. This 10-point Strategy Statement sets the framework for further action over the early part of the 21st century.

The targets are 'underpinned by the 10-point strategy statement' which 'sets the direction for the health and safety system over the next ten years'. The text above is the preamble to the ten points, and it further reveals the Government's construction of the preferred approach to the 'problem' of employee health.

Once again the need for the new strategy is established, although this time, even though the 1974 Act has been demonstrably effective, it is the health and safety failure *rate* which is constructed as unsatisfactory. The 'slowing reduction in levels of health and safety failures' is here constructed as the problem to be addressed: the 1974 Act is good, but not good enough. The preamble begins to suggest which agents are expected to undertake the work needed to implement the new strategy. A need is identified for 'constant vigilance', which reprises the theme of the danger of complacency identified earlier. The Health and Safety Commission are constructed as 'striving', and thus *their* effort is not the issue here. The solution is not for them to work harder or change their basic scope of

activity - the 'basic approach' does not need changing. This absolves the Health and Safety Commission of responsibility for achieving maximum prevention of health and safety failures. The Health and Safety Commission is positioned as needing to maintain the high standards that they have already set for themselves, although unspecified 'further action' is required 'to raise standards'. This formulation is interesting because the exact nature and agents of this further action are ambiguous at this point in the text - it *could* be the Health and Safety Commission, but their contribution is here constructed as basically unproblematic. The only other agents of change referred to previously in the text are the list of stakeholders. The Government's role is here positioned as *enabling*: they are catalysts for change, able to identify the nature of the problem, set targets and ensure the broad economic conditions are in place for the strategy to be realised. They also enable *others* to address health and safety issues by making sound budgeting decisions, which allows them to direct funds toward tackling what they have identified as 'the pressing problems', and toward the right agencies charged with tackling those problems. There is the suggestion that the work rate of the Health and Safety Commission, measured in terms of the number of regulatory contacts, has demonstrably increased following the Government's decision to increase available resources. The relation between financial resources and regulatory contacts is implied in the text, although the purpose of these contacts remains implicit rather than explicit.

The text sets up an opposition between *regulation*, constructed as some kind of threat, and *guidance*, constructed as voluntary compliance. 'Good regulation' is reconstructed as primarily concerned with standards, and is offered as a mechanism to achieve a fair, decent and safe society. From a neoliberal perspective regulation is considered negatively, as something which is restraining and prohibitive, involving 'red-tape'. It is associated with the nanny state, or an overly bureaucratic approach to government. From a liberal perspective regulation is considered favourably as implying action and fairness, as enabling. There is a tension in the text over these perspectives which may reflect the inherent tensions in 'the third way'. It argues that 'good regulation' will deliver the improvements in health and safety standards understood to be imperative, but mobilises neoliberal counter arguments *against* regulation. Regulation is reconstructed and positively evaluated explicitly against these

possible counter arguments: good regulation contributes to a fair, decent and safe society. This tension occurs in the context of needing to address the diverse expectations and concerns of the different audiences. Everyone can agree that 'decent standards and protection' are good in the abstract. We can also all agree to ensuring fairness in enforcement of the law. The text stresses the new strategy is 'not about bureaucracy and red tape', and a commitment is made by the Health and Safety Commission to simplify the law, especially for small businesses. Labour was traditionally seen as the party of centralised regulation, inimical to the interests of small business. Clearly utilising elements of the neoliberal rationality, within the RHSSS they are now trying to position themselves as the party which is *against* red tape and *for* small business, *despite* the emphasis upon targets, tougher sentencing and the examination of innovative penalties for non-compliance.

The 1980s and 1990s are said in the preamble to be 'characterised by significant legislative activity, much of which has been driven by the European Union'. It is implied here that the EU is associated with bureaucracy and the introduction of more red-tape. Although subsequently referred to as 'our European partners', the way the term European Union is used suggests an uneasy partnership. The 'broadly complete' 'legislative framework' will have involved the UK Government, but it is stressed that this regulative activity was *driven* by our European partners. By downplaying the role of regulation, the strategy is able to focus upon the challenge to convert standards into 'real changes in culture and behaviour in the workplace', as '*only this*' is constructed as capable of delivering continuous improvements in standards. The *responsibility* for ensuring 'real changes' and 'continuous improvements' is here transferred *away* from the Government, the Health and Safety Commission and the EU, and *toward* the workplace. This sentence is highly significant in that it constructs the *best* way of realising 'good regulation' as enabling regulations (in this case aimed at the prevention of work-related accidents and ill health) to become absorbed into the culture and behaviour in the workplace, that is, the culture and behaviour of the work*force*. The term 'culture' is needed in addition to behaviour, as behaviour is concerned only with what people *do*, whereas 'culture', in this context, extends to include *every* aspect of working life, including how people think. If the prevention of work-related ill health is

absorbed into the culture, the need for regulation (and the associated costs) diminishes. From the cultural technology perspective, the RHSSS begins to represent an explicit attempt to regulate behaviour - or conduct conduct - *through* culture.

The preamble then turns to the need to be 'alert to new areas of risk and the forces behind them'. Trying to understand these forces is a laudable suggestion, but as Fox suggests, the selection of certain procedures or human behaviours as 'hazardous' always depends on some *prior* judgement. Risk assessment always utilises prior knowledge about what is deemed serious or trivial, probable or unlikely. Different groups with different interests disagree about what constitutes an 'acceptable risk' because their *discourses and conditions are contingent*. It is therefore likely that certain understandings of the 'causes of health and safety failures' will be contested and constructed differently within and across different workplaces. There is an implied relation between these new areas of risk and the context of the changing world of work. This is followed by a careful construction where 'stress' and other 'people management issues' are not constructed as *work-related health* risks, but rather as emerging risks *to the effectiveness of the modern workplace*. These emerging risks can be seen to be either health risks *or* risks to the effectiveness of workplaces. Deciding what kind of risks they are is not something the Government wishes to be responsible for. The view that these emerging risks may in some way be related to the emerging neoliberal principles and practices of flexibilisation and deregulation remains absent from the text. That 'stress', for example, in the context of a strategy about employee health, is constructed more as a risk to the effectiveness of modern workplaces, rather than to the health of employee, signals that what counts as 'work-related ill health' is a significant topic of analysis. How stress is thought about at different workplaces by different employers, employees and health professionals is in this context highly significant. Thus stress will be topicalised within the case studies.

Having analysed the preamble to the 10-point strategy, the analysis now turns to the ten points. Again, inevitably some points (i, ii, iv, v and vi) are more closely related to the concerns of the thesis than others. The least relevant points (numbers iii, vii, viii, ix and x) have been excluded from the analysis.

> i) The health and safety system needs to do more than just prevent work-related harm. It must promote better working environments characterised by motivated workers and competent managers. This will require a shift in focus from minimum standards to best practice. In so doing, we will make an active contribution to the wider Government agendas of competitiveness, sustainability, public health and social inclusion.

The first strategy 'point' concerns the inadequacies of the present system and signals a shift toward emphasising the promotion of better working conditions. This represents a move on from the prevention of health and safety failures, which was emphasised in earlier parts of the text as one of the main reasons *for* a new initiative. The view is developed that that there is a need to do *more* than 'prevent work-related harm', although this phrase would seem to encapsulate the primary reason for the Health and Safety Commission's existence, and the *raison d'etre* for a health and safety system.

A need is identified to 'promote better working environments characterised by motivated workers and competent managers'. Exactly how this is to be achieved remains largely excluded from the RHSSS. The concept of motivation is interesting here. To be motivated can be considered as a general state, in which people are thought of as 'self-motivated', implying an internal psychological characteristic. However, motivated can also imply a context specific understanding, for example, to be motivated by some external factor, such as being motivated to work by working conditions. This has implications for how the text is to be read. It could be understood that motivation is a product of the working environment, in which case such factors as working practices and conditions are emphasised. In this interpretation the responsibility for motivating employees would be largely with the employer. However, understanding motivation to be an 'internal state of individuals' emphasise such factors as, for example, wanting to come to work, or of valuing work as morally good for you. In this understanding the responsibility to be motivated would be understood as lying largely with employees. In both cases the responsibility of the state for ensuring motivated workers is removed. The variety in definition and cause works functionally within the text to afford both evasiveness and accusation

concerning whose responsibility it is to ensure motivated workers. By implication, de-motivated workers become associated with ill health, absenteeism and a lack of vigilance on safety issues. The notion of interdiscursivity is helpful here in that it enables us to recognise that concepts such as motivation, originating in the discipline of psychology, and recurring within enterprise and managerial discourses, begin to connect health to forms of behaviour which may have little or nothing to do with health *per se*.

An added benefit to this broadening of the health and safety system is to ensure that a contribution is made to the 'wider Government agendas of competitiveness, sustainability, public health and social inclusion': all of which signify particular 'takes' on disparate social phenomena, with the connections between each simultaneously complex and tenuous. Reasons are not given as to why 'sustainability', and sustainable development, for example, should be included in the RHSSS (se also RHSSS:15). As an example of interdiscursivity, the RHSSS seems to be attempting to capitalise on the high cultural and political value of the phrase, and the flexibility of its meaning, through extending what was originally a predominantly ecological/environmental discourse to encompass wider areas of social existence, including health related behaviours. There is no reason given either for the linking of 'public health' with motivated workers, other than to suggest they are in some unspecified way co-dependent. Linking health explicitly to motivated workers presupposes a link between poor health and unmotivated employees: the alignment of motivation with health signals the introduction of the preferred subject position made available for employees within the text, namely, *happy and healthy*. The next strategy point makes this subject position explicit.

> ii) The changing world of work means we must adjust our approach to health and safety regulation. The health and safety system must complement the Government's vision for a competitive, knowledge driven economy. We must recognise and promote the contribution of a workforce that is 'happy, healthy and here' to productivity and competitiveness. This is a workforce that understands its own responsibilities and benefits from a strong health and safety culture.

The second point is one of the most significant in terms of responsibilisation and moralisation. It is asserted that the 'health and safety system *must* complement

the Government's vision for a competitive, knowledge driven economy'. The changing world of work signalled earlier as an important context for modifying the health and safety system, is here tied to a competitive knowledge driven economy. This is a state sanctioned and preferred model. The Government approves of such a shift, and aligns itself with it. Thus, the text argues that the health and safety system must also change in order to complement this new economy. From the perspective developed in this thesis, this assertion is followed by what is perhaps the key phrase in the entire RHSSS document:

> We must recognise and promote the *contribution of a workforce that is 'happy, healthy and here' to productivity and competitiveness*. This is a workforce that *understands its own responsibilities* and benefits from a strong health and safety culture.

The phrase 'happy, healthy and here' signifies the 'ideal type' citizen that the Government wants to give shape to. A clear subject position is created for *all* employees. These individuals are happy, healthy, and at work, and they understand their responsibilities - both to themselves *and* to the Government's wider agendas. Because they are happy, they are motivated. Because they are healthy, they are more likely to be productive and able to withstand the pressures of working life. Because they are 'here', sickness absence costs are diminished. Thus, the negative costs associated with ill health diminish and productivity levels are maximised. These employees manifest the neo-liberal dream of a nation of motivated, self-governing and above all productive individuals. A happy, healthy and present employee is positioned as a *responsible* employee. The text makes the case for a moral imperative to stay motivated, healthy and fit for work, because those without these attributes are constructed as unable to contribute to productivity and competitiveness. The reward offered for adopting these favoured dispositions and behaviours is 'recognition'. Those unable or unwilling to occupy this position - that is unhappy, unhealthy or absent employees, are seen in the text as making no contribution to productivity or competitiveness, and thus do not deserve to be recognised. They are positioned as *irresponsible* and constructed as unproductive and lazy. Within this short extract we have a clear construction of what, for the state, being a *responsible* employee entails.

This positioning has significant implications for the analysis of the case study data: the extent to which different employee accounts match these criteria, and identification of the wider organisational influences upon the acceptance or rejection of this subject position will help to unravel the process of responsibilisation, and illuminate its relation to neoliberalism, risk and regulation. Thus, analytic topics for the case studies should include accounts of motivations, constructions of health in the context of work, and investigations into sickness absence management.

Through the RHSSS, the state delimits what its role and responsibilities are in relation to the health and safety system, and thus the health of employees. In this part of the strategy employees and employers are positioned as morally bankrupt if *they* don't take up responsibility for realising/accomplishing the targets. 'Happy, healthy and here', as a subject position, becomes particularly meaningful in the context of the systematic shedding of state responsibility accomplished in the previous sections of the RHSSS.

The RHSSS has strayed into territory which borders on moralisation. The suggestion is that an individual who is *un*happy, *un*healthy or simply absent from work, cannot contribute to the nation's or their own well-being, nor can they fully understand their responsibilities. The insinuation is that such employees are lazy, unproductive and irresponsible. It is here that the Government most clearly demonstrates a desire to enact a strategy of (de)responsibilisation. This includes the shedding of its own responsibilities, in an attempt to realise its core objectives of increased productivity and competitiveness, without which, the text would have us believe, there can be no strong health and safety culture.

> iv) There is a need for positive engagement of small firms, by promoting clear models of how they too can reap the benefits of effective health and safety management. We must commit to simplifying law that is over-complicated with their needs in mind, without compromising standards, and ensure that small firms are not deterred from seeking advice for fear of enforcement action. We must redouble efforts to bring pressure to bear through the supply chain, particularly in Government procurement.

The focus of the analysis within point four is upon the attempt to engage small firms, rather than upon the tangential concern with supply chains. This point

raises the issue of the relation of work-related ill health and injury to 'small firms', that is the 3.5 million firms with under 50 employees which comprise 98% of all enterprises and constitute 37% of the workforce - some ten million people (HSE website). There is an implication that small firms do not presently engage with the health and safety system, and this may be motivated by the perception that small firms currently cannot see how health and safety issues are relevant, or that they are perceived by small firms to be costly. The need identified here is for 'positive engagement of small firms, by promoting clear models of how they too can reap the benefits of effective health and safety management'. This assertion is based on the presupposition that there is a strong business case to be made for adopting good health and safety management, and infers the existence of 'models', which are available and appropriate to a wide range of workplaces and work cultures. These models are absent from the text. The RHSSS sets out the 'economic business case for further action' on workplace health and safety and makes strong claims supporting that case. However, Smallman constructs the problem differently:

> ..there is almost no science base for proving the case for OHS (Occupational Health and Safety) investment in large firms; making the case for SMEs (Small and Medium-size Enterprises) is doubly difficult, given their generally lower level of financial and managerial resources (Smallman, 2000:404).

The continued dominance of scientific and economic discourse in thinking about the relations between work and health is demonstrated. Other discourses, for example philosophical or moral ones, have less influence. Small firms are perceived to be in some way recalcitrant or resistant to health and safety discourse. The emphasis upon making the *business* case for health and safety is clearly aimed at work organisations and thus at employers, rather than employees. The text struggles to align the interests of labour with the interests of capital. From a more Foucauldian perspective, it is clear that the discourses of science and economics are the ones most powerfully evoked in the acts of persuasion manifested within the text. There is a clear attempt within the RHSSS to align the interests of small businesses with the interests of the state.

> v) The compensation, benefits and insurance systems must motivate employers to improve their health and safety performance, in particular

> by securing a better balance in the distribution of the costs of health and safety failures. When things do go wrong, employers must also be motivated to rehabilitate injured workers so as to maximise their future employability. The Government sees a case for reforming the arrangements for employers' liability insurance in pursuit of these goals.

Strategy point five again recognises the need of the state to engage employers in health and safety issues by presenting a 'business case', which involves the compensation, benefits and insurance systems. These systems are constructed as motivating employers to engage positively with the health and safety system. This point provides a further example of processes of governmental responsibilisation, informed by neoliberalism. As MacEachen demonstrates, compensation schemes can be seen as an embodiment of a key regulatory system, in which the shift from welfarist to neoliberal rationality may be seen to have consequences for individual employees. The pressure brought to bear on companies, by compensation, benefits and insurance systems, thought to motivate employers to improve their health and safety 'performance' is, according to MacEachen, further displaced onto the employees themselves. This increased persuasion may result in pressure being applied to employees to remain healthy, thus opening the door for increases in workplace monitoring and surveillance techniques and eroding the boundaries between work and leisure, the public and the private. There is often little agreement between private companies, the Government, trade unions and insurance companies as to the extent to which particular health hazards are directly related to employees' abilities to avoid work-related ill health. This demonstrates constraints on the Government in its attempts to manufacture particular forms of behaviour, and points toward a more decentred approach to regulation. An attempt is made to persuade employers to construct themselves as financially responsible for the aftermath of health and safety failures.

> vi) A more deeply engrained culture of self-regulation needs to be cultivated, most crucially in the 3.7 million businesses with less than 250 employees. We must demonstrate and promote the business case for effective health and safety management. We must provide financial incentives which motivate, and change the law to secure penalties which deter. This culture must be further supported through the full integration of health and safety within general management systems.

The sixth point further formulates the 'solution' to the 'problem' of employee health. There is the proposal that 'a more deeply engrained *culture of self regulation* needs to be cultivated' particularly in smaller firms. Here it is the term 'cultivating' which connotes a less direct and more decentred approach to regulating conduct. Black's reflections on decentred regulation are salient here, and helps to pull together the different strands of the analysis of the RHSSS.

Black's first point concerned the difficulties of establishing the causal and interactional factors which influence conduct. She claims that a decentred approach appreciates the complexity of the dynamic factors inherent in fields of behaviour. That the different actors within the field of employee health have different 'goals, intentions, purposes, norms and powers' (Black, 2002) is recognised within the RHSSS, and the strategy signals this complexity in its reluctance to take responsibility for addressing these factors. The second point Black makes concerns the 'fragmentation' of knowledge, power and control. That different workplaces and workforces may construct workplace health-risks in different ways, and approach their regulation in different ways (for example by disciplinary mechanisms or more negotiated solutions) is again recognised in the RHSSS. The RHSSS's proposed 'solution' to this complexity and fragmentation is to 'cultivate self-regulation'. Black's third point asserts that regulators recognise that actors will continue to act in the absence of regulation: in the absence of regulation, actors or systems will become self-regulating. The object of decentred regulation becomes to attempt to 'harness' the self-regulating capacities of organisations and individuals. The RHSSS aims to harness these capacities by constructing the *conditions* likely to lead to self-regulating behaviours and actions - behaviours and actions thought to be conducive to ensuring the continued good health of employees. Within the RHSSS there is an attempt to manipulate the conditions primarily through the introduction of targets, although these are supplemented by the threat of new penalties. Black's fourth point concerns the relations between social actors, and between social actors and government. Both sets of actors are perceived to have both needs and solutions, and are therefore constructed as 'mutually dependent' on each other for their resolution and use. The RHSSS emphasises partnership and attempts to align the needs of the different groups through powerful rhetorical strategies. Attempts are made to persuade companies of the

business case for a decentred approach to the regulation of employee health and to construct health as a primary site of concern for the responsible companies and employees. Black's final point concerns the collapse of the public/private distinction and the role of formal authority in governance and regulation. By constructing a subject position which stresses the interrelatedness of happiness, health, and productivity, distinctions between work and non-work become eroded. The self regulation aimed for is hoped to be achieved not primarily through legal sanction, but by its absence. However, 'authority' still has a role to play in regulation, but the responsibility for deciding whether and which authoritative sanctions are to be introduced in order to shape employee health behaviours, is largely devolved to the company. The RHSSS leaves it up to the company to decide the nature and extent of the power mechanisms to be introduced in order to cultivate the self-regulating employee at different workplaces.

Strategy point six demonstrates the belief that 'self-regulation', as a general principle to be adopted by both the individual and larger entities such as companies, is achievable and largely unproblematic. However, self-regulation has to coincide with (the employees'/company's) *self* interests. The rhetorical organisation of the RHSSS attempts to construct and manage those potentially diverse interests in a manner which suggests they are proximate, and which coincide with the interests of the state.

5.5 *The principle of responsibilisation*

In line with the theoretical and substantive concerns of the thesis, the discursive and governmental analysis of the RHSSS has attempted to identify instances in which this cultural text/technology has been shaped by neoliberalist political rationality, a decentred approach to regulation and the utilisation of the concept of risk. The overall aim of the analysis has been to reveal the attempts made within the RHSSS to *conduct conduct*.

Neoliberal rationality has manifested itself in the neoliberal technique of rendering calculable areas of socially problematic phenomena. This was evidenced most clearly in the emphasis upon costs and the setting of targets.

Many of the strategic solutions to 'health and safety failure' proposed in the text are compatible with the general neoliberal emphasis upon risk.

'Good regulation' is set up in the text as an opposition between, on one hand, decent standards and protection for everyone, and on the other, bureaucracy and red tape. Labour was traditionally seen as the party of centralised regulation and thus inimical to the interests of small business. Within the RHSSS New Labour attempt to position themselves as the party which is *for* deregulation and *for* small business, *despite* the emphasis upon targets, tougher sentencing, and the examination of innovative penalties for non-compliance. A central aim of the RHSSS was identified as the simplification and decentring of the regulatory system and of health and safety legislation - a simplification that is understood as a potential cost saving and is therefore constructed as in the interests of business - especially small business. The best way of realising good regulation, the text suggested, was to enable regulation to become absorbed into the culture and behaviours of the workforce. This intention was registered within the subject positions made available to employees within the text, which reflected the neo-liberal dream of the autonomous, self-aware, self-responsible and above all productive employee: the *happy, healthy and here* employee. The RHSSS contains a strong belief that 'self-regulation' - as a general principle to be adopted by both the individual and larger entities such as companies - is achievable and largely unproblematic. However, constraints on the Government in attempts to manufacture particular forms of behaviour were identified: self-regulation has to coincide with (the employee's and the company's) self-interests. The Government and the Health and Safety Commission recognise the complexity of health and safety regulation and construct the solutions needed in order to reach their targets as *localised* and therefore not their responsibility.

Through analysis, a clear guiding principle has been identified at the heart of the RHSSS. This clearly 'fits' with Osbourne's understanding of neoliberal rationality, which he suggests attempts to impose a principle intended to 'animate and regulate' overall strategies and particular targets: in short, the principle of 'responsibilisation' (Osbourne, 1997:185). Analysis shows that the RHSSS aims to conduct conduct through processes of (de)responsibilisation.

However, Black implies that analysis of contemporary forms of regulation should go well beyond the identification of government texts designed to realise their intentions. Analysis must be able to recognise and take account of the diversity of multiple and interacting factors which influence any regulative situation, especially those factors beyond the state. The utilisation of various techniques and technologies, for example techniques of numericisation and technologies of risk, should be identified in places external to the state, and subject to analysis. Awareness of these factors is used to guide analysis within the case study chapters.

Other significant topics for analysis in the case studies, identified within this chapter, include: the extent to which health and safety regulation becomes absorbed into the culture of the workforce; the problematic nature of deciding what actually counts as *work-related* ill health; the extent to which techniques of numericisation play a part in the regulation of health; the extent to which a risk based approach to employee health influences concrete instances of responsibilisation; the perceived blurring of the boundaries between public and private; the significance of accounts of the motivations of employees, employers and workplace health specialists; approaches to the management of sickness absence; and constructions of stress. These topics, in conjunction with the research themes and questions generated in Chapter Three, guide analysis of the case study data.

This chapter has identified some of the ways in which attempts are made at the macro level of the state to direct and control health related behaviours and understandings: attempts made to *conduct conduct*. The question remains as to how adequate the theoretical and methodological framework is for explaining what happens within 'real life', specific and concrete situations. By focussing *exclusively* upon texts which *aim* to achieve particular ends, which the policy as discourse and cultural technology approaches tend to do, those localised factors, which this thesis speculates may be of great significance, are overlooked. From within a broader Foucauldian perspective, analysis of the 'micro-dynamics of power' is understood to be vital in understanding social phenomena.

Cultural technologies such as the RHSSS are themselves both instruments and effects of power, and they combine with individual/collective agents who comply, resist, or more likely forge some kind of hybrid reaction to, such texts. In some instances the cultural technology may entirely 'miss' its intended audience. The case study chapters aim to establish the extent to which the preferred strategies for addressing workplace health and safety are realised or rejected, to establish whether the preferred subject positions given in the RHSSS are achieved in the ways anticipated within the text, achieved in other ways, or remain unfilled by particular subjects in particular spatial and temporal locations. As Black suggests, one of the principle aims of research into regulation should be to reveal regulation in previously unsuspected places, and thus 'unsettle our understandings of where the forces of legitimacy, authority and power are located in society' (Black, 2002:27).

6.1 *Introduction*

The Royal Mail has undergone many changes since its inception in 1860, and since the 1960s, political parties, market contexts and technological innovations have been forces for sometimes rapid and radical change. Lucio, Noon, and Jenkins (1997) characterise these changes chronologically as: 'modernisation' - concerned with administrative reorganisation; 'separation' - a period which saw the Royal Mail becoming a stand alone business; 'mechanisation' - which relates to the increased automation stemming from the introduction of new sorting machines, the construction of new sorting offices and the subsequent transformation of many employees' working practices; 'commercialisation' - the attempt to infuse the business with a more commercial disposition; and finally 'privatisation' - pressure from Government and internally to make the business operate more like a private sector organisation, thus becoming more sensitive and responsive to the market. A cumulative consequence of these changes has been the emergence of a concern with increased productivity and the measurement of performance, (Lucio et al, 1997:281-282) both at a business unit level and at the level of the individual employee. Its business and work practices reflect and are shaped by dominant political approaches to the management of the market. Throughout the 1990s the UK postal service has been involved in an almost perpetual process of change, mainly stemming from the influences of neoliberal policies and strategies concerned to make it increasingly 'commercially oriented'. In 2001 the Post Office Group became a plc and somewhat controversially became 'Consignia'[6]. The framework enabling these changes was the *Postal Services Act* 2000, designed primarily to create a more commercially focused company.

Consignia employs just over 200,000 people and comprises three main 'consumer brands' (business units):'Royal Mail', 'Parcelforce Worldwide' and the 'Post Office'. In addition to these 'big three' units, when the fieldwork was undertaken there were a further fourteen business units, nine focussed on 'key

[6] In November 2002 Consignia changed its name again and became the 'Royal Mail Group Plc', although as the fieldwork was undertaken while the company was known as 'Consignia', this is the name that will be used throughout the thesis.

markets' and the remaining five upon 'internal operations' such as property, services, and, significantly for this thesis, employee health. In the year 2001/2002 Consignia turned over around £7.5 billion, although it was widely reported to be losing over £1million per day.

In the last chapter it was suggested that the state, through the RHSSS, attempts to manufacture conditions in which companies will take responsibility for producing happy, healthy and present employees. These conditions are characterised by 'good regulation', which is thought to enable the regulation of employee health to become absorbed into the culture of the workforce. The principal form of regulation called for within the RHSSS is self-regulation. The RHSSS framed the problem of employee health as one in which the preferred solutions should align the interests of employees with the company, and the interests of the company with the state. Analysis of the RHSSS revealed a number of specific topics which are addressed within the case study chapters, namely: the significance of techniques of numericisation and technologies of risk; the process of deciding what counts as work-related ill health; the perceived erosion of the boundaries between work and non-work; approaches to sickness absence management; accounts of motivations; and constructions of stress. The structure of this chapter reflects these concerns.

The first part of the chapter is concerned with *conditions* and includes discussion and analysis of Consignia's Employee Health Services Department and the general approach to employee health and safety issues, and the wider conditions of the organisational influences on employee health, including the management style. The second part is concerned with practices and focuses upon techniques and technologies aimed at the regulation of employee health, including analysis and discussion of the Q-Health screening project, the sickness absence management system, and 'technologies of self', understood as those processes and practices which individual employees undertake in relation to their personal health and well-being. The third part subjects the various constructions of 'stress' encountered in the case study data to analysis, as this topic cuts across the wider concerns of the thesis, affording a deeper understanding of the relations between neoliberalism, risk, regulation, and responsibilisation.

Employee Health Services - delivering health

> EHS is a reliable 'one stop shop' for all Consignia employees, providing professional support and information for those experiencing physical, psychological or social problems .....Assessment, advice and guidance is provided on a wide range of personal and work-related problems (*Manager's guide to the Employee Health Services*, Consignia, 2002).

Established in 1997, the Employee Health Services (EHS) is the in-house occupational health and welfare service - all Consignia business units are encouraged to go to the EHS for advice and/or action on employee health and welfare issues. The health function is separated from the safety function which is handled separately, yet with mechanisms in place to give strategic advice where there are overlapping of Health and Safety issues. At time of writing they are hoping to become an independent business which will have commercial freedom to sell its expertise to other work organisations.

The EHS claims it is primarily concerned with providing all employees with free, expert advice and guidance on maintaining good health and well-being. They claim to be a 'one stop shop' which provides professional support and advice to employees and managers on all aspects of physical, psychological or social problems. The emphasis is upon professional support and the provision of information. They are also responsible for advising Consignia on ways to create 'positive' working environments, a significant theme within the RHSSS. It is stressed to all employees that, if they are experiencing problems at home or work, they may wish to receive initial support from their family doctor or line manager, but if this is inappropriate for any reason then the EHS is on hand. Managers may be advised on a range of health and well-being issues, from the suitability of someone to undertake particular tasks, to how best to manage sickness absence. Their sometimes conflicting responsibilities are brought to light in the various discourses articulated by EHS policies, within the accounts of EHS staff and employees.

Hierarchical in structure, EHS is led by the Director, Dr Steven Boorman, who is also the Chief Medical Advisor to Consignia. His role as Advisor is to help Consignia to identify its occupational health and welfare needs, develop policy for the organisation and to help it source those health needs. His role as Director of EHS is to be responsible for providing occupational health and welfare services to about 200,000 internal staff and 135,000 pensioners. Underneath him is a layer of Consultant Occupational Physicians. Below that are other health professionals including a Principal Welfare Coordinator and a Principal Nurse Coordinator, a Principal Occupational Therapist and a Principal Physiotherapist. Below that there are numerous Occupational Health Advisors, Welfare Advisors and a number of GPs. Finally, at approximately half of the Royal Mail delivery centres there are Fitness Suite Managers, although they are not necessarily employed directly by EHS. The EHS is supported by a wide range of administrative staff including a Customer Processes Manager, and it regularly makes use of the 'Post Office Research Group', as well as embarking upon collaborative ventures with other organisations, for example BUPA.

The next section discusses the working knowledges and practices of the EHS. Four EHS staff were interviewed in order to gain a small but broadly representative sample of the hierarchical structure of the RHS: from the EHS Head Quarters in Farnborough the Chief Medical Advisor/Director of Employee Health Services, and the Customer Processes Manager, and from a large sorting office, an Occupational Health Advisor and a Fitness Suite Manager.

The business of health

> During the last year Consignia has overhauled its approach to health and safety. A 'Revitalising Health and Safety' strategy means we will be moving from a purely reactive approach to health and safety management to a more proactive approach, with the active pursuit of improved health and safety as a real business goal. The policy, which is supported by new performance measures and procedures, aims to put health and safety firmly on every manager's agenda as an integral part of the job, bringing real and measurable improvements to the 'safety climate' and performance of the whole business. This year we will continue to encourage our employees' co-operation in this crucial area (*Consignia Annual Report 2001/2002*).

> The health and safety of individuals is the prime goal of this policy but Consignia plc believes that it also contributes to business performance through the prevention of losses due to injury and ill health (*Manager's guide to EHS*).

In the section of the *Consignia Annual Report 2001/2002* entitled 'supporting our employees', it is claimed that during the year 2000/2001 Consignia 'overhauled its approach to health and safety'. A new *Revitalising Health and Safety* strategy - Consignia's response to the RHSSS - states that Consignia emphasises a 'proactive' approach, and improved health and safety is thought of as 'a real business goal'. This is reflected in the introduction of improvable, measurable, performance targets. As a cultural technology and a governmental strategy, the RHSSS appeared initially to exert a profound influence upon the approach to employee health at Consignia. As with the RHSSS, the language used to talk about health in the annual report utilises many features of the discourse of neoliberalist managerialism: 'business goals', 'performance measures and procedures' and 'measurable improvements' are articulated onto the issue of 'health', moving health away from bio-medical, psychological, personal and recreational discourses. The strategy implies that on the ground, 'health-promoting' activities will be in abundance, and the latest proactive (anticipatory, preventative, long-term) health intervention techniques and initiatives would be widely practised.

It was envisaged that 'reactive' health practices - reacting to health problems as they arise - would comprise a less significant area of work for EHS staff at Consignia. This was profoundly not the view held by the Chief Medical Advisor/Director:

> Five years ago or so 20% of the work that was done by my unit was proactive in the sense of, if you like, in the interests of long term strategic needs, at the moment that's less than 5%, so there's been quite a significant shift and that's purely driven by the budget pressures.
>
> *Russell*: So because of the current climate that puts pressures on you to not deal with the more proactive, strategic stuff I guess?
>
> *Chief Medical Advisor/Director*: Yes, I mean I'm not saying that we don't do any of the longer term proactive stuff, but you know the organisation is going through a major, a major financial crisis at the moment and that quite clearly means that you know they're interested in today and not tomorrow.

Thus, within Consignia, despite the rhetoric of *their Revitalising Health and Safety* document and their *Annual Report*, and despite the rhetoric of the RHSSS, which aims to persuade companies of the business case for more *proactive* health measures, The Chief Medical Advisor/Director reported a shift *away* from proactive toward reactive measures[7]. A reason he cited for the shift *toward* a more short term, reactive approach to employee health was the difficulty of making the business case for the long term 'cost-benefits' of health interventions, within the context of the financial difficulties experienced within Consignia:

> *Russell*: What's the most frustrating thing about your job?
>
> *Chief Medical Advisor/Director*: That's interesting. Difficulty in developing firm business cases to support up-front investment.
>
> *Russell*: So making the business case for employee health?
>
> *Chief Medical Advisor/Director*: Yes, absolutely. At a time when there are financial stringencies then there needs to be very clear business cases for any proactive intervention, and it's quite difficult to show long-term cost benefits.

Within the RHSSS the Government attempts to argue that there *is* a business case for proactive health measures, at the same time as emphasising that companies should take responsibility for developing and implementing the business case. However, health experts within Consignia report that there are difficulties in making a long-term business case for proactive health and safety measures. The *theoretical* recognition of good health and safety practice as 'good business' is not matched by allocation of material resources. The relevance of the business case is recognised but is not currently being made or implemented, in spite of the rhetoric from the Chief Executive of Consignia for a shift toward proactive health interventions. The discourse of the 'business case' remains dependent upon providing a certain form of evidence - evidence of a scientific and economic nature which demonstrates a clear financial saving greater than the original investment. This fits with the neoliberal employee health theory identified in Chapter One which concerns itself with ensuring the costs of intervention should never exceed the costs of ill health.

---

[7] The Occupational Health Advisor also made clear that proactive health measures were not a priority and she felt that EHS could be 'much more proactive'.

The Occupational Health Advisor also saw the problem of 'short-termism' as one of the main stumbling blocks to delivering a good health service:

> *Occupational Health Advisor*: If you said to a manager 'well you pay that money now, if you pay your £10 now by the end of next week your staff will be fitter and more productive' yes, I think they could cope with that, but saying 'well in 5 years time or in 10 years time, if we encourage people in healthy eating and stopping smoking then their risk of heart disease will be lower', I don't really think they'll want to look at that, its too long term.

Within the RHSSS the term 'sustainable development' appears several times. The connotation was clearly that strategies introduced now should be sustainable and produce sustainable improvements in the health of the workforce. In the extracts above it is clear that the dominant understanding of 'business case' within Consignia means primarily *short-term*. If there was evidence to support the likelihood of short term 'pay offs', the business case would be easier to make. Health promotion becomes understood as something worthwhile through making a business case, and health becomes bound up with issues of productivity. The primary motive for improving the health of employees is here constructed as increasing 'productivity'. In this way, and in line with the RHSSS, the various discourses identified so far construct the view that a proactive, long-term approach to employee health is in the best interests of the employee - yet this remains in conflict with and entirely subordinate to the construction of increased productivity as a short-term priority. By devolving responsibility to companies to make the business case for health, the short-term profit interests of business tend to replace the state's longer-term health interests of its citizens.

Conflicts of interest

The way the EHS is set up means that they are required to meet the needs of the employees *and* the managers The EHS has a set of responsibilities beyond providing advice and support to employees and making the 'business case' for appropriate interventions. This concerns providing advice to managers, for example on the suitability of individual employees to undertake particular kinds of work, on deciding what counts as legitimate ill health, and deciding the extent

to which something can be considered to be work-related ill health. This has significant implications in the wider context of a targeted approach to employee health which emphasises the reduction of work-related ill health and the meeting of sickness absence targets. This potential conflict of interests means that the Occupational Health Advisor can be perceived by employees as working on behalf of Consignia, and therefore not necessarily in the best interests of the employee, or alternatively by managers as siding with the employee:

> *Occupational Health Advisor*: There are always ones I do that think you're biased, you know, they come, the individual says 'you're paid by the Post Office so you must be on their side'. If you advise alternative duties, managers say 'you're as bad as the employee, you're siding with them'.

The Occupational Health Advisor's knowledge claims are compromised by her position within the organisation. She constructs herself as being perceived to be neither worker nor manager, so, regardless of her claims to objectivity and expertise she demonstrates awareness of the *strategic* significance of her position. Significantly, this means that where there is contestation over the extent to which something may be perceived as legitimate ill health, or work-related ill health, the EHS is called upon to be the arbiter. This reinforces the importance of *localised strategic power relations* and the influence of the wider *conditions* upon them. Her account supports the view that strategic power relations are immanent within particular constructions. The point here is that the *conditions* - in this case the way the EHS is set up - influence both subjective understandings of expert knowledge *and* constructions of what counts as (work-related) ill health.

She recognises that her position may potentially detract from the positive impacts her assessments may have upon the well-being of individual employees. However, she is also aware of the potential advantages of her strategic position, specifically in the potential to 'make a difference' even outside the confines of the workplace. She states:

> So there's lots and lots and lots of things that Occupational Health Advisors can do, lots of intervention, lots and lots of support, and I think

> they're ideally placed to do a lot of things in the workplace, because you're fitting work and home together. What advice you give to somebody here they might take home and will impact on their family as well, so, help the health of everybody.

Her strategic position is here constructed as beneficial to employees. She clearly sees her expert knowledge as 'productive', in terms of modifying health behaviours and thus improving the quality of the employee's life. In this extract the position she occupies is constructed unproblematically as in the interests of the employee. Both the Occupational Health Advisor and the EHS construct their positions as benign toward the employee, their interests as primarily and unambiguously coinciding with the employee's. However, in terms of who uses the EHS and for what, the expressed claim of EHS to be there primarily for the employee is undermined by its actual usage. In the wider context of the pressure on managers to reach targets, for example on sickness absence levels, it is clear that contestations will arise. The Occupational Health Advisor states that:

> The majority of referrals are via managers, erm, or people can refer themselves, so the next one down is self-referrals. Management referrals in my area probably are about 80%, 75% of referrals, self referrals are about 20% roughly.

'Referrals' are sometimes understood to be used to 'threaten' unruly employees by managers. For the senior management, health is constructed as something which can reduce costs and aid productivity; for the Occupational Health Advisor, health is constructed as something which helps people, at work and home. Tensions arise in part as a consequence of constructing the EHS/Occupational Health Advisor as undertaking a policing role - as an assessor of truth claims. That the regulation of employee health occupies a strategic position is clear, but what are the wider influences on Consignia's approach to the regulation of employee health? The next section explores more closely the perceived relations between work and health, and begins to look at some of the ways in which the regulation of employee health and safety is constructed and understood within Consignia.

So far this chapter has used extracts from reports and guidelines, and extracts from the interviews with EHS personnel. The rest of the chapter continues in

this vein, but also uses extracts from the interviews with employees. A total of seven postal workers were interviewed, four from a large sorting office and three from a small delivery office. The analysis follows a brief summary of some of the salient characteristics of these interviewees.

From the sorting office: Dave is 31, single, and has worked there for 8 years; Jack is 45, married with two children and has worked there for 20 years; Martin is 27, recently separated and has a son; Arthur is 34, married, and has worked there for 17 years. They are all Postal Workers, which involves sorting and delivering duties, apart from Arthur who is a Bookroom Administrator.

From the delivery office: Ed is 31, single and has worked at there for 8 years; Tom is 31, single and has worked there for 10 years; Bill is 33, co-habiting, has a daughter and has worked there for 11 years.

6.3 *Workplace health risks*

This extract, from the *Manager's guide to the EHS*, states the general position of Consignia on employee health and safety:

> Consignia plc will ensure that the health and safety management system identifies hazards and assesses and controls risks to the health and safety of employees.
> Risk Assessment
> There must be documented procedures for the identification of hazards and for the assessment and evaluation of the associated work activity risks and there must be appropriate control strategies to reduce risks to an acceptable level.....Employees have a duty to co-operate in ensuring that both they and the company meet their respective legal duties. They can also contribute to ensuring the provision of a safe and healthy working environment for themselves and for other persons who may be affected by their work activities by setting a personal example to their colleagues in health and safety matters (*Manager's guide to EHS*).

The ways in which occupational health hazards and risks are constructed and understood has consequences for how employee health is approached. Selecting some practices, processes and environments over others, as being more or less 'risky', has significant implications for how employee health is regulated on a day-to-day basis.

Some hazards, for example exposure to certain substances, are heavily regulated and others, for example sitting down for long periods, less so. Two factors repeatedly referred to in the interviewee's accounts which have an impact on health, were the wearing of snow chains on shoes and the lifting and handling of mail bags. Weight restrictions have been in operation for a number of years now and I was curious to hear what employees made of the restrictions: whether everyone complied or if there were circumstances in which some employees did not, and if there were, under what conditions were regulations not adhered to, and how were transgressions accounted for. Ed, for example, asserts that health and safety is more strongly regulated than it was a few years ago. His account illuminates Consignia's position on the construction of responsibility for employee health within Consignia:

> *Russell*: Do you think that there's anything they could be doing for your health that would make your job a bit less hazardous?
>
> *Ed*: Two years ago I'd have said yes, but it's now a different job - there's weight limits on the bags, so you're not allowed to take too much weight out, if floors slippy they make you change straight away, even if it's only forecast with snow, *you've got to, you're supposed to, they make you* take your chains out so if you don't put them on it's down to you - so long as they supply them, they're covered, as far as they're concerned it's 'there's your snow chains - go and wear them' if you don't want to put them on it's down to you isn't it.

We can see here quite a complex construction of 'responsibility': it is not clear who actually takes responsibility for, in this example, the wearing of snow chains. On one level, the responsibility is clearly with the individual employee to comply with regulations but on another there is less clarity over the extent to which the wearing of snow chains is enforced or encouraged. In the next extract Ed is asked about the consequences of non-compliance with lifting regulations:

> *Ed*: If anybody sees you carrying more than one bag they shout at you, which is a good thing coz you're not supposed to, even if they are light bags, bad habits you've got to get out of.

Here we can see how the relationship between risk and responsibility is played out in terms of enforcement. The construction of the lifting and carrying of heavy bags as a health risk *and* a failure to comply with company regulations has been disseminated into the workforce, and the enforcement of compliance has

been absorbed into the culture of the workforce. There is a collective monitoring and surveillance of employees, not only by managers but among employees themselves. It appears that, in this context at least, there is a high degree of self-regulation. Asked what he thought of his colleagues who did not fully comply with health and safety regulations, who suffered ill health or injury as a consequence, Bill stated:

> It's their own, I mean *it's their own fault if they fall, well not their own fault*, but they should take more care. I mean one lad about 6 years ago he fell on some steps that were slippy and he smashed his elbow to pieces and he'd got no chains on or anything like that. *He can't be blamed for it* but *it's just unfortunate*, but if he'd had the proper footwear on maybe it wouldn't have happened.

Here we can see the introduction of the concepts of 'fault' and 'blame', which in this account have a complex relation to responsibility. Because the slippy surface is assessed as a risk, Consignia are able to absolve responsibility for the employee by issuing snow-chains: it becomes the 'fault' of the employee for failing to protect himself adequately. But because Bill also constructs this incident as an accident, as related to fate, the employee cannot be 'blamed' for it. Bill displays a reluctance to blame employees for injuries which arise as a result of their reluctance to take measures to protect themselves - it is seen here as 'just unfortunate' - yet at the same time there is a discourse of self-responsibility for health. The important factor here is how something becomes identified as a health risk - the extent to which something is considered an acceptable risk, or the extent to which measures should be taken to minimise the risk. At Consignia, once something becomes assessed as a health risk, and this is brought to the employee's attention, then it is the responsibility of the employee to ensure that ill health or injury does not arise as a consequence of exposure to the risk.

In the following extract an employee recounts his experience of an injury which could be argued to be clearly caused by working practices, but which gets couched in terms of 'unavoidability':

> *Russell*: Have you had any work-related ill health while you've been at the Post Office, was your back (problem) work-related?

Dave: No it weren't work-related. I did me wrist in..... I had 6 month off with it, I had to have me arm in a pot, that were through bag tying, lifting the bags, doing everything as you should be doing, but it just clicked like and tore the tendons in me wrist.

Russell: Was that, were you susceptible to that or?

Dave: No, there's quite a few related, you know like moving your wrist all the time, a lot of people get it, like elbows and that, most people get it.

Dave suggests that it is not uncommon for employees to sustain damage to their health through 'normal work practices' such as bag tying. It is constructed both by Consignia and employees as an acceptable risk, and something is done about it only after the event. While it may be difficult to establish an employee's susceptibility to harm from certain forms of work, and this appears to be acceptable within the culture of the workforce, the fact remains that this work practice could be constructed as involving a risk to health. Consignia mobilises an argument which suggests that because practices affect people in different ways it is reasonable not to change working practices.

Dave: They try and be very good with the health and safety like, really enforce health and safety like, *it saves them and it saves us* doesn't it.

The perceived motivations for regulative health and safety measures becomes apparent in this short extract: within this construction they are there to 'save' the employee from ill health - which in the previous extract it profoundly fails to do - and it 'saves' Consignia, as employers, from having to take responsibility for harm that is understood to be caused through work practices. Through regulating aspects of work practices and processes, and by insisting on employee compliance with the regulations, Consignia construct certain activities as hazardous to health. Through the practice of risk assessment certain activities are constructed as more risky than others. For example, walking in snow and lifting heavy bags are constructed as more hazardous than bag tying. The strategy identified within the RHSSS of absorbing regulation into the culture of the workforce is at least partially matched at Consignia, in that employees refusing to comply with certain health and safety regulations are 'pulled' by their colleagues.

The general approach to the regulation of health and safety within Consignia suggests that the instruments of modernist and neoliberal rationality - broadly the approach of identifying and quantifying risks to health *and* production - can be utilised in minimising the costs of ill health. Through the naming of certain risks the employee is encouraged and directed to ensure that harm arising from such risks is kept to a minimum - those ignoring the risks are both responsible for the consequences and subject to disciplinary action. Yet those practices or processes which are not constructed as hazards under the gaze of risk assessment, for example bag tying, and which clearly are understood to cause harm, are constructed by Consignia and individual employees as *acceptable* risks - as just unfortunate. In terms of responsibility it is clear that employees have a duty to avoid health risks wherever they have been constructed as such, although where work activities which are *not* explicitly constructed as health risks result in harm, Consignia is constructed as *not* responsible. It appears to be the case that whenever employees suffer ill health from work-related practices, because of the way hazards are constructed, Consignia is absolved of responsibility. Having a highly regulated approach to employee health and safety may well 'save' Consignia, but it does not necessarily 'save' the employee.

This section has examined the ways in which certain constructions of health and health risks create tensions in the way employee health is approached at Consignia. Contestation and competing understandings of the relations between fault, blame and responsibility become invisible through the practice of risk assessment. The key point established so far is that health can act as a site for the negotiation of strategic power interests and responsibilities, both between the state and the company (in terms of making a business case for proactive health interventions) and between the employer and the employee (in terms of constructing what 'counts' as a health risk or as legitimate ill health). The responsibility for managing and resolving these tensions appears to be located within the EHS generally, although responsibility for compliance with health regulations is located within the employee. The next section explores some of the wider organisational influences shaping Consignia's approach to the regulation of employee health, and picks up on the theme of 'motivated' employees identified in the RHSSS.

In a bid to 'improve customer services through greater reliability and predictability and improve competitiveness', 2001 saw the introduction of the 'biggest programme of change for 50 years' (*Annual Report 2001*:23). While the Chief Executive suggested in the *Annual Report* of 2001 that improving 'conditions for our employees through better pay and working hours' was also an objective of the restructuring, employee motivation and confidence in the future is reported to be at an all time low (*Guardian*, 21.03.03:21). These wider changes are identified by EHS staff as having a direct impact upon employee health.

The Chief Medical Advisor/Director of EHS is in no doubt about the relations between the ongoing changes within Consignia and the health of employees:

> *Russell*: Obviously there's been huge changes in Consignia - are the changes having any discernible impact on employee health issues do you think?
>
> *Chief Medical Advisor/Director*: Well I think that my business, as a business unit - wearing my Director's hat - is experiencing a significant upturn in demand so there clearly is an impact on health issues now: more people seeking occupational health advice as a result of the pressures and changes within the organisation.
>
> *Russell*: What, specifically, are those pressures?
>
> *Chief Medical Advisor/Director*: Huge organisational change, major restructuring, major changes in jobs, significant likely change in employee numbers, and major commercial pressures that have not been there in the past, so we have real competition directly in our market place, significant industrial unrest.
>
> *Russell*: Do you think job security has a direct effect upon health?
>
> *Chief Medical Advisor/Director*: Yes, definitely, and we've got good evidence for that within the organisation, and we are moving from a situation where working for the Post Office was a job for life to a situation where there's considerably less job security.

The Chief Medical Advisor/Director constructs a whole raft of issues stemming from organisational change as having the potential to impact negatively on employee health. However, such factors as organisational change and job

insecurity are not here considered as the kind of health-risks identified within the practice of risk-assessment. What *is* constructed as a health-risk clearly has significant implications for how health is understood and approached.

As well as job insecurity and organisational change giving rise to health concerns and having a de-motivating effect, another cluster of comments related to the role of 'time' and the idea of 'flexibility'. Interviewees constructed and positively evaluated past management actions as constituting a degree of 'real' flexibility: an attitude that meant if you had completed your duties then you were able to finish work early. New management techniques, emphasising productivity and targets, mean that the practice of 'give and take' has now all but been abandoned, causing a great deal of resentment among many in my sample.

> *Russell*: So you've worked here a long time and you'll have seen a few changes then?
>
> *Martin*: A lot of changes yes, a lot of changes, not all for the good either.
>
> *Russell*: I was going to say - what's got worse about it?
>
> *Martin*: I think the general attitude from the employer to the workforce basically. I mean we haven't got a bonus scheme as such that's any good, but what we have got is like sometimes you might be able to make a little bit of time at the end of the shift and they're picking at that, and they're not being encouraging, or they're not, you know, there's no like incentive - that's the word I'm looking for - to do better or better yourself, there's no real incentive there.

This account suggests that the targets which managers are expected to meet impact negatively upon employee motivation. Targets, rather than being a motivating factor, in this instance are understood to be counter-productive to the employee's sense of well-being and motivation at work. Martin identifies the lack of incentives as the root of employee disquiet. In particular the issue of flexibility is deemed to be of great significance to productivity and is subject to diverse constructions reflecting different interests. Erosion of flexible working practices, rather than the more traditional bargaining factors of pay and holidays, were of uppermost concern to the employees in my sample. The issue of 'poor management' came up repeatedly in the interviews. The next section examines employees' accounts of being managed, and the Occupational Health Advisor's

understandings of the relations between poor management and employee health. The general management style, and the actions of individual managers, are constructed as having significant implications for employee health and motivation.

Not managing very well

The decline in the standard of individual managers was frequently brought up by the interviewed employees. Their role and behaviour is constructed by employees and EHS staff as having a significant impact on the health and well-being of employees. There were competing constructions of the reasons for the inadequacies of some managers, ranging from inexperience, through wrong experience to 'power mad generals'. Some accounts manifested intense annoyance at the way some managers conducted themselves. In particular the constant visible surveillance perceived by employees to be undertaken by some managers was constructed as a significant cause of stress for some employees. There was a general perception that the productivity of a particular area or unit and the motivation of employees is intimately linked with the individual manager:

> *Russell*: Do you find for example a good manager or a bad manager has an impact on your colleagues?
>
> *Martin*: Absolutely, yes, you've hit the nail on the head there..... I think like when he's (line manager) not here - and he had this in writing - when he weren't here the performance in the area went right up and when he came back it dropped. People will work for a good manager, a manager that's not getting on with staff you can feel the atmosphere, people aren't going to work for him if he's going to crack the whip all the time - it's like flogging a dead horse.

The construction of certain managers as utilising inappropriate management techniques was consistent, yet it is not only motivation and productivity levels - reflected in the willingness of employees to 'work' for a good manager - that is constructed as being affected by unacceptable management techniques. It is claimed in relation to health that sickness absence and 'stress' are directly attributable to management styles.

Managers within Consignia have a clear responsibility to provide a duty of care to their employees. However there is a common perception that it can sometimes be the individual manager who contributes directly to employee ill health and absence. The Occupational Health Adviser claims a clear and explicit link between individual managers and both productivity and absence, claiming it is possible to 'trace' individual managers by correlating their location with absence and productivity measures. Motivation is here understood to be determined by the localised work conditions, which include the management style, rather than a state internal to the employee.

The next extract from the interview with the Occupational Health Advisor introduces issues around technology (in the literal sense) and technologies (in the governmental, monitoring and surveillance sense). Within the extract it can be discerned that managers are not exempt from the web of surveillance and monitoring available to large organisations like Consignia:

> *Occupational Health Advisor*: There are managers who manage well and there are managers who don't manage well and you can track their progress.
>
> *Russell*: You can almost see reflected in the well-being, the physical and mental well-being of the employees, the management style?
>
> *Occupational Health Advisor*: Yes.
>
> *Russell*: That's interesting,
>
> *Occupational Health Advisor*: I can have a little delivery office where I don't see people for months and months and months on end, and then suddenly I might see six people in a month and that makes me think 'what's changed? why are these people disgruntled?' Because not only will you get people presenting with health problems but they'll tell you their work problems as well. So somebody might present with a sprained ankle but then go on to tell you while here that, 'you know things are terrible in our office and so and so's complained and this is happening', so you get a general picture of not only the health but the culture of a management style, and performance, you know, problems within that office.

This extract is interesting in a number of ways, not only about the perceived link between managers and productivity/absence levels, but because it also gives us an insight into what is at stake in the *assessment* of health issues, and thus

understandings of the causes of ill health. A seemingly clear case of poor health may be complicated by factors external to the 'presenting' employee, for example a change in manager. From the perspective offered in this account it is unlikely that approaching employee ill health solely through the assessment of health-risks and the regulation of work practices are sufficient for protecting the health of the employee. The localised conditions, which Black stresses are an important factor in emerging forms of regulation, are born out by the data to be significant. Within Consignia, health has become associated with a multiplicity of factors outside of the risk and regulation approach preferred by the state and Consignia, which engage with subjective understandings of what constitutes health problems. A correlation is claimed by the Chief Medical Advisor between the wider organisational shift toward a more focussed concern with productivity and competitiveness and increases in reported employee ill health. The Occupational Health Advisor claims a link between poor management and employee ill health, which is supported by the subjective experience of the interviewed employees.

A significant factor which enables these claims to be made is the use of statistical information, gathered through monitoring and surveillance techniques, or to borrow Foucault's phrase, through 'technologies of power'. The information gathered about managers, employee ill health and injury, sickness absence levels and productivity measures, forms a 'grid of visibility' in which to identify patterns, aid understanding of phenomena, and inform decisions. The next section of this chapter is concerned with *practices* and explores in detail the use of various techniques and 'technologies' within Consignia. It assesses their significance for the regulation of employee health and the construction of responsibility.

6.3 *Practices*

Q-Health

Within the EHS new technology is utilised in novel ways with the aim of improving employee health and reducing sickness levels, thus improving productivity and competitiveness. This fits with the preferred strategy of the

state, which emphasises a transition from reaction to prevention to promotion of health, considered to be useful in the creation of motivated and productive employees. In the context of employee health, by far the most significant foray into new technology use by Consignia has been the 'Q-Health' project.

Between 1995 and 1998, the EHS, in conjunction with BUPA, undertook the largest ever UK employee health screening project. All eligible Consignia employees, some 220,000 at the time (now nearer 200,000), were invited to complete a voluntary lifestyle and health risk questionnaire which was sent to their homes. This asked about general health, personal and family medical history, diet, smoking and alcohol consumption. It included questions related to fitness and mental health, plus specific topics related to men and women. A total of 58,501 employees - 29% - completed and returned the questionnaire. The objective of the project, according to Penny Wilbourne, EHS Business Development Manager, was to

> improve the well-being of employees by promoting health and enabling individuals to make choices about lifestyle. The aim of the survey was to discover what was going on and work out how best to target resources (quoted in Hand, 2000).

The potential benefits to Consignia, namely reduced sickness absence costs and potential increases in productivity, remain absent from Wilbourne's statement.

Everyone who completed the questionnaire received a 'personal health profile' and an 'information manual'. BUPA provided a confidential helpline. The personal profile highlighted each participant's actual age in relation to their 'lifestyle' age, and their 'achievable' age - the age that would register if he or she adopted a healthier way of living. The manual highlighted risk factors and explained how people could modify their lifestyles to reduce these. BUPA collected the information on behalf of Consignia and prepared statistical reports for the EHS. This enabled EHS to identify geographically localised health problems in both Consignia as a whole, and within individual business units. These statistics allowed EHS to work with customers (other business units within Consignia) to target health education, health interventions and health

promotions. The Post Office Research Group (PORG), which exists to facilitate the use of new technologies within the organisation, invested in 'MineSet' software - a data-mining tool enabling the combination and visualisation of complex datasets. 'MineSet' allows complex three-dimensional images of datasets to be drawn. The images can be presented as 'maps' showing geographical differences or as 'tree diagrams', showing the links between different pieces of information.

EHS personnel were particularly interested in the data on '*modifiable* risk factors', such things as blood pressure and weight which can be influenced by lifestyle. The emphasis is clear: the point of the project was to focus upon those factors which the *employee* could, according to health promotion theory, control, rather than on identifying those risk factors which Consignia would be responsible for controlling.

The visualising software enabled staff at the EHS to explore the data in novel ways. It allowed key areas of health concerns to be pinpointed in order, so they claimed, to try and ensure that health initiatives could be closely targeted where they would be most effective. For example, campaigns about the dangers of smoking could be targeted in areas where the number of smokers is highest.

Significantly, with MineSet it became possible to overlay the basic visualised health information with, for example, sickness absence and productivity information, which enabled the identification of what EHS staff call 'hotspots': particular business units, particular occupations or particular illnesses that do not correspond to the national picture, or 'norm', and which may allow for previously unidentified proactive, targeted interventions. The project has been universally praised, winning numerous awards including the *Personnel Today HR Excellence Through Technology award*, and has been widely applauded and reported by various media and within the occupational health literature (for example *Occupational Health*, 2000:19-21; *IRS Employee Health Bulletin*, 2000:3-7).

It is possible to paint a rational, benign picture of the activities of the EHS, acting solely in the interests of individual employees by identifying potentially

harmful behaviours using technologies like Q-Health. However, there are clearly also more selfish, commercial benefits for Consignia, in terms of developing proactive interventions which should decrease sickness absence and potentially improve productivity. The basic premise of the Q-Health project was that self-knowledge of the employee's potential illnesses, or capacity for future ill health, will promote a feeling of increased personal awareness. This awareness, complemented by targeted advice, should in turn improve the potential for employees to exercise control over their health related behaviours. By encouraging employees to take steps to alter their own behaviour, and thus minimise the possibilities of future ill health, EHS health expenditure should be reduced and overall productivity increased. Assuming that employees respond favourably to their new 'self-knowledge' the kinds of desired behavioural changes hoped for include: reductions in smoking and excessive drinking; sensible eating and weight control; and regular exercise. Those employees who fell into 'high risk' categories were encouraged to participate in behavioural modification techniques such as quit smoking courses. Goss (1997) criticises Workplace Health Promotion discourse in general for operating as a 'form of control' supporting the 'extraction of higher levels of performance and commitment from employees'. The focus on risk within health promotion in general, and the Q-Health project in particular, brings to mind Castel's ideas about the potential for abstract factors of risk to comprise a powerful new form of social control (Castel, 1992).

Health-risk has come to be understood predominantly in terms of a positivistic scientific/medical/epidemiological discourse which determines how risk is defined and managed (Cheek and Willis, 1998:125). Throughout the Q-Health questionnaire health risks are conceptualised in terms of lifestyle factors - the individual employee is objectified and reduced to a series of measurements and tests. There is nothing which explores the individual's perceived quality of life, nor their social position: questions around, for example, working and housing conditions are absent. Excessive focus upon individual lifestyles can function as 'victim blaming' (Crawford, 1980). Another concern about the Q-Health project relates to the potential for new technology to act as a form of surveillance. Foucauldian notions of the 'panopticon', and 'surveillance' more generally, including the roles of 'confession' and 'examination' are relevant here, and it is

in relation to concrete, material practices that the significance and relevance of these concepts and understandings can be explored. As will be discussed in the next section, the Q-Health project displays an uncanny fit with these elements of Foucault's theorising.

Panoptic tendencies

Through the Q-Health project employees are 'examined' and encouraged to 'confess' aspects of their private lives which are then explored in minute detail. Although anonymised, Consignia gained privileged access to 60,000 of its employees' most intimate details which were previously hidden. Aspects of the employees' home lives are laid bare, blurring the boundary between home and working life. Conrad and Walsh, writing about employee health screening projects in the USA, suggest that:

> On one level, advocates of these corporate initiatives express widening and constructive concern for the health of employees and recognition of concerns felt by employees themselves. On another level, though, these developments taken together adumbrate a fundamental shift in accepted corporate jurisdiction over employee health and behaviour (Conrad and Walsh, 1992:99).

The ideal to be strived for in the Q-Health questionnaire is to achieve a 'vitality age' lower than one's chronological age. According to Armstrong, in his groundbreaking work on the emergence of a new form of medical surveillance - 'surveillance medicine' - there emerges a medical gaze which blurs the distinction between 'well' and 'ill'. The whole of the individual's life becomes subject to scrutiny for 'risky' behaviours which *might* impact upon quality of life in the present, or give rise to health problems in the future. 'Illness becomes a point of perpetual becoming' (Armstrong, 1995:402). Expert derived concepts of normality are brought to bear upon those individuals who - for whatever reasons - fall short of the constructed health 'norms', and they are encouraged to try and work toward them. Poster goes further to suggest that the technologies which enable projects like Q-Health can result in:

> a Superpanopticon, a system of surveillance without walls, windows or towers or guards. The qualitative advances in the technologies of surveillance result in a qualitative change in the microphysics of power

(Poster, 1995:87).

The experts' examination of individual employee capacities and behaviours involves the use of power in order to identify, classify, categorise and subject individuals to scrutiny as objects of examination, *all in the name of the interests of the employee*. Remaining hidden from view are the interests of BUPA (a private company with profits to generate), the State (wanting to cut health expenditure and increase individual productivity and competitiveness) and Consignia (who, losing over £1million each day, have an urgent need to save money and increase company competitiveness).

As discussed briefly in the Chapter One, what is deemed 'normal' in terms of health and illness varies historically and culturally, and is defined by powerful interest groups. As everyone responding to the Q-Health project is *potentially* at risk, a sense of uncertainty is fostered which creates a climate of anxiety and increases in self-surveillance. Self-surveillance is a key element of self-responsibility. Employees are encouraged by various means (in their health profile, personal health guide, various leaflets and other specific health interventions flowing from the Q-Health dataset) to discipline themselves to guard against what they may encounter in the future, as much as what they are at risk from now. The profiles and other documentation given to respondents do not dogmatically 'dictate' what a person must do in order to avoid unhealthy consequences, and the tone is courteous and positive throughout. However, in suggesting courses of action said to minimise harmful risk-inducing behaviours, 'technologies of self', or ways in which employees can discipline themselves to conform to pre-determined courses of action, can be discerned. These prescriptions for ways of living are at the heart of governmental power relations in that they are discourses - in the textual and practical sense - which have as their aim the direction of the conduct of individuals. The power to direct the behaviour of individuals is therefore in this instance not achieved by coercion, but by strategies which foster self-discipline via the creation of a 'need' for self-control. These forms of self control may be understood by the individual as acting in their own benefit, but they also serve the interests of the Scientific/Medical community, various Government Departments and the State

more generally, BUPA and Consignia, in spite of being framed as *primarily* in the interests of the *employee*.

The next section explains the way in which the Q-Health project - and the health promotion framework it exemplifies - impacts upon the way health is conceptualised and addressed in the day to day work of the Consignia health strategists and occupational health professionals within the EHS, and the ways in which the new information gleaned from the project was operationalised.

Utilising health technologies

Health strategists at different levels within the Consignia hierarchy were interviewed about the significance of the Q-Health project in developing new health interventions, managing sickness absence, and generally being used as a new management tool. The Chief Medical Advisor/Director of EHS, the Customer Processes Manager and the Occupational Health Advisor were asked about the Q-Health project within their interviews, and some of those responsible for ensuring the technology was usable by the health professionals were talked with informally at the EHS HQ.

By making the original Q-Health data more manageable and allowing that data to be supplemented by other data taken from existing records - for example data relating to sickness absence and business unit productivity measures - the scope for a range of possible interventions widens considerably. Instead of having a single dataset consisting solely of 'lifestyle behaviour' information, with the new software it became possible to supplement the dataset in increasingly complex ways and to work within a 'real time' frame. The scope for intervention enabled by developments in the techniques of numericisation used to analyse the Q-Health data has implications beyond purely health related matters. The Customer Processes Manager talked about some of the wider implications of combining Q-Health data with other datasets. In the following extract she talks about flu:

> *Customer Processes Manager*: One customer (business unit manager), they queried flu at certain times of year. When they actually looked at the information - and bear in mind that our professionals would say they've

> got real flu - they've been away for at least a week, look at sickness absence information, after seven days people off with flu reduces by quite a significant factor which suggests that a lot of those people, I mean it's quite obvious, a lot of people who say they're off with flu aren't off with flu. *It makes you query whether those people who were off for seven days were off because that's the length of time you can self certificate yourself.* Is it a way of, you know, if there's flu going on around the country *you can say you have flu to get some time off and not necessarily have to prove that they have some kind of flu*, and is it really an absence management problem rather than a flu epidemic or a health problem? So the work that we're doing now is helping us to determine whether or not, in this particular case, a flu vaccine program would actually be effective, and for us the answer is probably not, because *most of those people who are saying they've got flu probably haven't got flu.*

In this extract we can discern a clear shift from encouraging 'healthy lifestyle behaviours' toward a host of issues bound up with truth, legitimacy, assessment, policing and increased surveillance. New ways of regulating the health of the employees are emerging which are clearly not primarily in the interests of the employee but are rather developed in order to reduce absence. For example it is becoming increasingly unacceptable, in part as a consequence of the new technology, to claim that one has flu - to use flu as a legitimate excuse for not attending work. While risk factors may have originally indicated that certain employees may have been more susceptible to flu than others, once the risk based information has been supplemented by other forms of statistical information such as sickness absence data and productivity measures, then proactive interventions aimed at individual employees (in this case flu vaccines) may be replaced by reactive interventions such as stricter absence controls and logistical changes. The whole point of utilising the new technology, stressed to me over and again by those at the strategic level of EHS, and in line with company and national policy, was to help develop more *proactive* interventions aimed at improving the health of the workforce. The discourse of proactive health intervention in this instance contributes directly to gaining greater control over the business process.

Within Consignia there is no clear correspondence between the *intended* uses of health surveillance and monitoring technology and the *actual* uses to which it is put. On one hand, we have a trumpeting of the success of the Q-Health project, with awards being given and universal praise from the occupational

health community. On the other hand, claims were made about the potential of such projects to have 'superpanoptic' tendencies, able to usher in yet tighter forms of social control (Poster, 1995). The Q-Health project attempted to encourage those employees who responded to the initial survey to actively take more responsibility for their health by identifying behavioural health-risk factors. A variety of leaflets were produced on a range of lifestyle health-risk factors, to be handed out by EHS staff when the occasion arises. Within the Q-Health project there are clear links between regulation, risk and responsibility: a decentred form of regulation which emphasises personal responsibility, enabled by the identification of risk factors, aims to encourage individual employees to modify their own behaviour. However, there is no evidence to suggest it has led to the radical shift toward the proactive management of employee health which was the original justification. The main benefit to Consignia was identified as the development of measures designed to increase productivity and competitiveness. It also helped develop a more informed, strategic approach to sickness absence management. The next section looks at the way sickness absence is understood and managed at Consignia.

Regulating sickness absence

Occupational Health Departments and GPs play important roles in managing absence attributable to sickness, but over the last 15 years changes in legislation have altered these roles. When statutory sickness certificates were required from the first day of absence, GPs were inundated with patients with minor illnesses. People with high rates of sickness put considerable strain on their GP. 'Self certification' has changed that situation and the responsibility for deciding the seriousness of short-term sickness absences has shifted, particularly at Consignia, from a patient/doctor relationship to an employee/employer one. Absence due to sickness at Consignia has witnessed a dramatic rise in recent years. The disciplinary system developed for managing it - despite the lack of evidence for the effectiveness of 'disciplinary systems' aimed at reducing sickness absence (Briner, 1996) - is quite complex and involves placing employees on a number of 'stages', depending upon how much

sick leave they have taken[8]. Sickness absence is managed locally, in that day to day requests for sick leave and commencement of the disciplinary procedure is usually at the discretion of the line manager, but, as discussed earlier, the sickness records for all 200,000 employees are now computerised and stored centrally.

The Occupational Health Advisor claims some managers, under pressure from the targets outlined in Consignia's Revitalising Health document to reduce sickness absence, use the EHS as a disciplinary mechanism, as part of a strategy to ensure sickness absence is kept to a minimum. Again it is stressed here that the *conditions* in which regulatory measures evolve are of great significance. In the first instance it is the line manager who authorises sickness absence, but employees can be referred to Occupational Health Advisors or more senior EHS personnel if it is deemed necessary. According to the Occupational Health Advisor, this is one of the key problems in trying to deliver good health advice to those who need it. Managers and employees seem to be fighting a 'strategic battle' through her, which, she feels, benefits no-one, and frustrates her attempts to do positive work. In the following extract the Occupational Health Advisor constructs her role of advising employees on health issues as being compromised by the position she occupies:

> Sometimes there might be days where the individual doesn't want to see you, they've no intention whatsoever of taking any health advice, been sent by their manager. Whatever advice you can offer, they've no intention of taking it, don't really want to be there. Erm, managers not really being supportive, he's just going through the process of, you know, 'this is the process, this is a support service you've been offered that anyway now if you don't take it up I can get you later' kind of thing. Individuals turning up coz they think 'well if I go somebody's told me that it will stop me being put on the attendance procedure next time'. Which is quite frustrating, that I'm knowledgeable, trying to give them - I've got loads of information, give loads of leaflets out, try and be supportive to people when they don't really want it. That's quite frustrating, I do find that very frustrating. They say 'captive audience - at work Occupational

[8] Consignia sickness absence system consists of a series of 'Stages' at which employees will be 'encouraged' to improve their pattern of attendance to an 'acceptable standard'. Formal action is taken if an employee has in excess of: Stage 1: 4 absences or 14 days in a 12 month period; Stage 2: 2 absences or 7 days within the following 6 month period; Stage 3: 2 absences or 7 days within the following 6 month period. Employees are interviewed after the issuance of a stage warning. A Stage 1 interview is to warn the employee that his/her attendance is unsatisfactory and that he/she could be facing dismissal if an 'acceptable standard of attendance' is not maintained. A 2nd Stage Warning informs the employee that dismissal is being considered. A stage 3 Warning commences the dismissal procedure.

> Health Advisors have got a captive audience'. They might be captive but they don't always want a leaflet.

The question of whose responsibility it is to ensure sickness absence is minimised is highlighted in this extract. While mangers are held responsible for achieving absence related targets, the Occupational Health Advisor constructs some managers as exploiting her role in order to achieve those targets by threatening employees with a formal assessment by her. She interprets this as undermining her role as a provider of information and support, designed to maximise the health of employees. Whether and whose responsibility it is to decide if an employee's claim to sickness absence is legitimate or not, is contested as a result of the absence system and the wider localised conditions. The disciplinary nature of the absence system and the manager's need to reach absence related targets combine to produce conditions in which ill health becomes highly contested. In the context of the RHSSS, the need to provide statistical information about *work-related* ill health in order to achieve *its* targets, means that there are tensions inherent in systems of regulation that rely upon numericisation and target setting.

All the postal workers interviewed voiced concerns about the management of the sickness absence/attendance procedure.

> *Dave*: I think there should be better tactics actually in employing them stages, not just a manager himself - you give it to a manager, giving him that, our manager says 'well you've got to enforce so much stages this month', you've got to give them like, instead of reading it and actually going through it and thinking 'yes, it's a reasonable, we're not putting him on it', or, 'you've had too many one day absences, you're having it'. There's got to be a fair way to do it.

In this extract the view that the system is open to abuse by managers is put forward. Dave suggests that there is little consistency in how managers deploy 'stages'. The result is that the system is perceived to be unfair, which fuels resentment and may, somewhat ironically, exacerbate the problem of motivation associated with decreased productivity and increased sickness absence.

Another function of the Occupational Health Advisor is to try and get to the causes of absence by further exploration. Ed gives an account of this process:

Ed: They look into your background, they look into whether you've had problems at work with your gaffer. They look into stuff like that without the gaffer knowing which is a good thing.

Russell: Sounds pretty sensible really, sounds like a pretty reasonable way of dealing with it.

Ed: They might be off coz they don't like the manager, so they're off. It's work to find out if that is the case, and then she sits them down and says 'if that's the reason why, something can be sorted out, something can be done about it'.

Foucauldian notions of confession and examination are again of relevance here. Procedures for eliciting truth claims from subjects are linked to relations of power/knowledge - the key procedure is the confession. Foucault claims that the confession is the main ritual we rely on for the production of truth by individual subjects: the act of confession is part of the procedure of individualisation by power. In the context of exploring claims to legitimate time off, especially where there may be 'hidden' circumstances like the ones outlined above, it is clear that whoever is in a position to elicit truth is to some extent in a position to influence future power relations. The agency of domination, Foucault claims, does not reside within the one who uses their voice, but on the contrary within the one who listens. Occupying the position she does, the Occupational Health Advisor sometimes has unique access to explanations of wider issues which impact upon health which may otherwise remain invisible. So while it could be argued that both managers and employees use the EHS strategically - to serve their own interests - the Occupational Health Advisor also plays a central role in that power relation. The solutions to particular problems that she forms are based on the competing accounts offered by employees and managers, in addition to a range of expert knowledges that she brings to her role as Occupational Health Advisor. The relations between work and health from this perspective have more to do with Foucault's 'strategic games between liberties' than with formalised procedures of regulation. These 'games' involve actors who try to control the conduct of others, who in turn try to avoid having their conduct controlled.

It has so far been argued that at Consignia the concept of health has become a strategic and tactical factor in the competing truth claims of the various parties. This is exemplified in the issue of absence management. As Giddens (1998)

and Beck (1992) suggest, 'expert knowledge' plays a significant role in shaping and legitimating particular courses of action. Experts *are* often turned to, but not in a consistent manner. Expertise is often challenged, sometimes with a view to deceiving it, or exploiting it and using it for ends that are antithetical to its premises. The Fitness Suite Manager of the on-site gymnasium manifests another form of expert knowledge, this time of the relations between the physical body and those regimes designed to improve its level of fitness. He is in no doubt about what needs to be done with people who are often off sick. Improvements to their general health must be encouraged, but if it proves difficult to encourage them to take better care of themselves, then it should be enforced. The Fitness Suite Manager in the following extract makes an explicit link between issues of health and 'morality'.

> *Fitness Suite Manager*: The problem is getting the workforce in - people that regularly have time off sick. If you can't get them to come in and exercise then you know you can't drag them in.
>
> *Russell*: Do you think they (Consignia) should put more effort into that?
>
> *Fitness Suite Manager*: Yes. Personally I think that it's in the Royal Mail's benefits, or the Post Office's benefits, to make sure that they have a healthier workforce. Now, there's some guys down here that are really - take X for instance - who are really obese. You know, I can't see how they're a credit to a workforce. I personally think they should have six month/annual checks on their health, and if they're not, if they don't improve from one to the next, then there you are. I think they should, something should be done. If they're not at an acceptable level of fitness to work then how can you be, you know, how can you be a credit to a business, which has already got one of the worst sick records - or absenteeism - in the country.

The Fitness Suite Manager makes explicit the notion that good health should be a prerequisite for employment - a position that few would publicly voice. Nonetheless, it is a view compatible with the subject position offered within the RHSSS and within those discourses which suggest that controlling and improving the health of the workforce is a legitimate objective. Within the account of the Fitness Suite Manager there is an imperative for health, which echoes the moralising tone of the RHSSS: if employees are not healthy, then their absence levels are likely to reach an unacceptable level and they cease to be a credit to the company. From this perspective, like the one developed in the RHSSS, 'unhealthy' employees are positioned as irresponsible.

With so many explicit and implicit practices, regulations, and initiatives aimed at regulating the health of employees at Consignia, it should not come as a surprise to find that some of the employees interviewed did indeed make efforts to improve their health. The employees interviewed were all happy to talk at length about their general health, about the kinds of health behaviours they practice (or not) and about their motivations for 'taking care' of themselves. The next section explores these factors in an attempt to understand some of the links between the health related behaviour of some individuals, and their coincidence with the voluntarily participation in governmental objectives. Attention is also directed to the interrelation of the themes of self-regulation, the influence of the culture of the workforce, and the erosion of the work/non-work boundary.

Technologies of self

At the sorting office where four of the employees - Martin, Tom, Dave and Jack - were interviewed, there was a fitness suite/gymnasium, available for use by all staff for a small charge. They had all used the facility to varying degrees. The building is relatively new and it is interesting to note that when it was built most existing employees wanted a (alcoholic drinks) bar, but it was decided that there should instead be a low cost gymnasium to be available to all staff. Numerous employers now provide some kind of workplace facility to enable healthy activities. Access to the gym had had a sometimes profound influence on the health related behaviours of the employees. The four employees were full of praise for this facility.

> *Arthur*: To have something as good as the gym here you'd be a fool not to use it.

Despite a relatively low initial take up by the general staff, the facility has become increasingly popular. Arthur suggests his colleagues who do not use it are making a wrong choice, compared to his correct one. While two of the interviewees, Arthur and Dave, were casual about their use of the gym, two others, Martin and Jack, went into the gym five days a week. Martin was keen to talk about his health related behaviours and seemed to enjoy the exacting bodily regime that he imposes upon himself. As well as the physical

components of his regimen, his strict diet was also important to him. The role of a significant other - in this case his ex-wife - is constructed as influential in the development of his health-related behaviours, but in unexpected ways.

> *Martin*: Me diet's very strict at the moment - 5 days a week, cereal for breakfast when I get up, protein shake on top of it, then later on, first break, I'll be having tuna rice and sort of vegetables in that as well. Later on I'll have a protein shake again and fruit, and then later, tuna, rice and put some pickles in there. So it's protein 5 or 6 times a day and like just rice for carbohydrates twice a day.
>
> *Russell*: When did your interest in really looking after yourself form?
>
> *Martin*: Since we came down here really, I've been interested coz we had a gymnasium, coz we didn't have one where we used to work, and I started coming in not too often, might have made a few days and then not bother till the next week and then do it again. And then I got more and more into it, and it's last six months that's all I've wanted, that's it, I'm all gym - that's all I think about all the time.
>
> *Russell*: So what's that all about then?
>
> *Martin*: I don't know if it's got anything to do with separating from me wife, coz I've always trained. I like looking good, feeling good, eating healthily.

Martin constructs the catalyst for his strict regimen as the physical presence of the gym - he only started using a gym when he moved to this workplace. However, he also speculates that his use of the gym may in some sense be related to the break up of his marriage. His bodily regimen is constructed as having aesthetic and experiential elements: he likes to look good and feel good and understands his diet and training to be conducive to achieving these goals. Martin has a young son he looks after at home and works long hours to make up his pay - but, as he states, any spare time he has is spent in the on-site gym. It is clear that Martin highly values the degree of self-regulation afforded by the gym, and it is clear that by spending more time at work, including much of his non-working time, the boundaries between work and non-work are eroded. By providing the facility, Consignia achieves the objective of making some employees fitter, and therefore less likely to have time off sick. Reducing the cultural differences between work and private life helps to achieve the governmental goal of incorporating a concern with health and fitness into the general culture of the workforce/place.

It is interesting to note that a wide range of explanations were offered for the uptake of healthy behaviours, for example: looking good; feeling good; reaching a certain age; and enjoying sport. Dave, for a long time considered overweight, claims in the extract below that he cannot explain his desire to go to the on-site gym regularly, that it comes from 'inside'. An interesting technique to encourage him to attend was suggested by one his work colleagues:

> *Russell*: Do you feel any pressure generally to get a bit healthier, I mean you obviously do from somewhere, but where's that come from?
>
> *Dave*: I don't know, I think it's from inside, I fancy doing it.
>
> *Russell*: For yourself.
>
> *Dave*: Yes, I took a photograph and I thought 'no, that's not me'. One of the lads said 'take a photograph and then lose so much and then take another one', so I've done both. I looked at the first one and it really encouraged me to do it, you know like actually thinking 'that's what people see me as'.

The 'overweight Dave' could be seen as an embodiment of risk. He was inactive and sedentary until his friends encouraged him to take photographs of himself. The photo could be viewed as portraying a sense of guilt or even shame in his inactivity, which mobilised his desire for change. This process of psychologizing the experience of health may be related to what Rose calls 'government through the calculated administration of shame' (Rose, 1999a: 73). Shame or embarrassment signifies anxiety about the self and becomes linked to an injunction to become a self-responsible subject. Here, we see that shame has been produced primarily through the discourses of health, which individualises risk. Dave rejects the influence of external factors on his decision to improve himself. He posits an individualised self as the agent of change, and acts from the motivation of self-benefit. Dave makes no explicit reference to the availability of the gym at his place of work. This suggests that the preferred, state sanctioned, subject position offered to him at Consignia is taken up only when the appropriate conditions are in place. Again, the localised conditions profoundly influence the extent to which governmental objectives are realised. The practical upshot from Consignia's point of view is expected to be an increase in fitness for another employee, an increased ability to cope with work pressures and decreased absence costs.

Accounts of the motivations for healthy behaviours should not be seen as existing independently of working patterns. Factors such as age, weight, family, friends and the media are all cited as having significantly contributed to the employees' desire to take up healthy behaviours. However, it is important to recognise that working conditions also plays a fundamental role in determining their uptake. Other than having access to the gym on the work premises, another significant factor influencing whether healthy behaviours will be taken up or not is working patterns in terms of 'time'. Dave's use of the gym was not only brought about by the photos of himself:

> *Russell*: Did that (starting to use the on-site gym) coincide with when you started?
>
> *Dave*: Yes, I made sure it did like. I used to do overtime on nights and I stopped doing overtime on nights and got on to days instead, do a little bit of overtime, and get me sleep pattern better coz I was going home at like half past 3, 4 o clock in the morning, getting back up at 11 and coming back to work.

Ceasing to work nights not only meant that Dave could eat and sleep more regularly but it also acted as a catalyst for change - an opportunity that would otherwise be denied him. How employees respond to the provision of health related services - including physical, material objects such as gyms, less tangible factors such as advice and regulations or support or criticism from colleagues - cannot be determined in advance. The way that work and non-work factors hybridise each other makes it difficult to sustain a clear distinction between work and non-work, and between work-related and non-work-related ill health. This fundamental difficulty may be a significant contributing factor in the state's and company's reluctance to take responsibility for the health of employees. The state's desire to avoid taking responsibility for addressing this distinction was identified as a guiding principle within the RHSSS. Perhaps the clearest example of the problems associated with this difficulty is the issue of 'stress'. The complexity and tension over deciding the extent to which ill health is thought to be work-related is exemplified through an analysis of stress. The next section looks at the issue of stress within Consignia in order to explore how a particular health issue is 'played out'.

Individual stress assessment (ISA) adopts a confidential, systematic approach, based on questionnaires, to identify the causes of individual stress (i.e. issues at home and/or work) and develop the coping skills necessary to deal with it effectively. Managers should refer individuals they believe to be suffering from stress to EHS.

How to manage stress

Events which cause us stress are often outside our control. However, what we can do is learn to respond to these stresses in a more positive way.

Step One:

Become aware of the things which cause you stress and how you feel when you are stressed.

Step Two:

Develop relaxation skills. These can vary from vigorous exercise, competitive sports, listening to music or practicing relaxation techniques.

Step Three:

Take a positive and healthy attitude towards life, together with a healthy lifestyle. (*Manager's guide to the EHS*).

'Stress' has come to be an all pervasive feature of modern life. The Confederation of British Industry recently claimed that absence from work due to sickness is costing the UK £23 billion a year and that stress is a significant and growing cause of sickness absence. Yet the term itself, used in the context of human suffering, is relatively new. It was first coined by the Psychologist Hans Selye in his study *The Stress of Life* and only came into popular usage toward the end of the eighties and especially throughout the nineties.

In the context of work, it is claimed that stress is now second only to muskulo-skeletal disorders as a reported cause of absence from work (McGuinness, 2000). Over the last twenty years we have witnessed the formation of a veritable 'stress management industry', with many disciplines, largely from the 'human sciences', including medicine, psychology and sociology staking their claim to be bearers of legitimate knowledge relating to its origins, causes, effects and solutions. The number of experts claiming to be stress specialists has multiplied significantly in the last decade. Those who suggest stress has become a 'remarkably flexible notion' (Brown, 1999:24) or that it 'does not exist' (Briner, 1996) are at best reduced to the margins, at worst, totally ignored. There has been a discursive explosion around the concept of stress, offering sometimes competing understandings of what it is, what causes it and what

should be done about it. This has been accompanied by a rapid multiplication of its meanings in different contexts. The effects of these new and often contradictory knowledges around stress are manifold too, and may not always in the interests of the 'stressed' individual.

Despite the growth of the stress management industry there has been relatively little attention focussed on what it actually means to 'non-experts', or more specifically, *how* it means: how its meaning is constructed in day to day understandings and interactions. Research into employee understandings of the term stress appears to have been neglected. The various constructions of stress have profound implications both for individuals and wider society. How it is constructed and understood impacts enormously upon how it is dealt with and upon how it might be used strategically. The questions of 'what it is', 'where it is located', 'what should be done about it' and 'who should shoulder the responsibility for ensuring its negative effects are minimised', all have serious implications for employees and employers. In practice there is no clear agreement on what constitutes legitimate stress, nor on how to assess its severity or how to manage it.

What was immediately apparent from the data was the range of different influences cited as giving rise to employees' subjective experience of stress - in both work and personal life, or some combination of the two. Some employees, like Jack, related it to future events as much as events or conditions in the past or present.

> *Russell*: What do you think stress is?
>
> *Jack*: Just life's pressures really. You know, I think it's a mental problem, you know people just get hung up on things and store problems and it just comes out in different ways. You know, people can go and get depressed, they can get angry with other people and aggressive you know. So it can manifest itself in different ways really, that's how I see it.
>
> *Russell*: Do any of your colleagues, do you see any of your colleagues getting stressed?
>
> *Jack*: Oh yes. We had a - it seems to be a problem, it seems to be the new back pain, stress and depression - I think it's real. I think it's to do with work and that. Like at the moment we can't be assured we're going to have a job in five weeks time. We can't be assured this building's

> going to be here in five years time, you know, they might close it. So yes, people have got a lot to worry about.

In addition to the role of managers and the inflexible working patterns offered in earlier accounts, 'storing' problems, 'getting hung up' and the concerns over Consignia's future, are all cited as potential causes of stress. The Chief Medical Advisor/Director also gave an account of the problem of stress. He sees it as a legitimate area of concern, but one that should be treated no differently, in principle, to any other health issue. The positivist discourse of 'objectivity' and 'risk' frames his understanding:

> We have basically - instead of writing a separate mental health policy - have concentrated on the general approach which is to have a well-being policy, of which stress may be one issue that impacts on well-being. We approach stress no differently to any other health factor in the workplace and that is that, you know, it's a question of doing what we can to make an objective assessment of impact - effectively doing a risk assessment - and looking at what we can do to then control the, any risks that are identified.

Consignia claims to approach stress no differently to any other health factor and to have an 'holistic' approach to 'well-being'. There is the view that any factor which may impact negatively on well-being can be treated in a similar way, namely by undertaking an 'objective risk-assessment'. However, the difference between, say, ensuring adequate lighting or ensuring that employees are not badly managed is qualitatively different. Risk-assessment, as has been suggested elsewhere, lends itself to the assessment of some phenomena better than others. By collapsing the entirety of employee well-being into a single policy there is a danger of extending the extent to which employees' personal, private circumstances can be legitimately regarded as not only an area of concern, but also a potential site for intervention. From this perspective, influences outside the workplace may become conceptualised as risks. The following extracts make explicit the erosion of the boundaries between work and non-work. The Chief Medical Advisor/Director was asked how the EHS went about disentangling the causal chain that leads to feelings of stress, how it was possible to assess to what extent these feelings were caused by work or non-work factors.

Chief Medical Advisor/Director: It's an artificial distinction that doesn't really impact - so we provide deliberately, the welfare side of my service is around, you know helping with things like finance, helping with things like domestic distress, those sorts of things which may well be out of the workplace, but will still affect Postman Pat's productivity.

Here we see Consignia's response to the state's devolution of responsibility for deciding what qualifies as work-related health. A strategy is adopted of constructing the distinction between work and non-work as artificial, at least for *some* conditions widely understood to comprise ill health, such as 'stress'. By extending the corporate gaze out of the workplace, and examining *any* factor which may negatively affect productivity, the jurisdiction of the employer spreads to encompass the whole person and the whole of their private domain. The next extract quotes at length from the interview with the Occupational Health Advisor. It provides a fascinating insight into some of the factors which, in the context of employee health, are utilised to justify the introduction of techniques of responsibilisation.

Occupational Health Advisor: I think that everywhere, in the process of change everywhere, even within the work area, but outside the work area, technology, information, so many things seem to be changing very quickly, and some people just can't cope, they can't keep up with it. Some people don't appear to have the coping skills to manage change, I do personally I think people have had problems in their upbringing you know with more broken families, not had a role model, not developed coping skills as they've grown up, and then when they're faced with change, rapid change or repetitive change, they've got nothing to fall back on - they don't know how to cope they don't know what to do so they go off sick, and then when I see them and start talking about coping skills - 'what can you do?' - you know - and it's perhaps not even a health issue, it's not even health stuff. I think a lot of the time it's 'how can you cope, this is where you are, that's where you want to be, how do you get there? What action plan do you need?' and it's helping people to develop their own action plans and develop their own coping skills and coping mechanisms to deal with it.

Russell: You've talked a little bit about the causes of stress, I suppose my specific question is how can you tell, or how do you begin to try and assess if something is predominantly work-related stress or if something is predominantly home-related stress, how do you try and?

Occupational Health Advisor: Very very difficult

Russell: How do you deal with that?

Occupational Health Advisor: We do have a framework that Occupational Health Advisors and Welfare Advisors use, and we look at, I suppose it's a framework of looking at everything in a person's life and whether it's causing problems, because its been quite clear to me sometimes that once you start talking to somebody in-depth the thing that they think is their problem, and their presenting problem, when you actually get down to talking how work problems, home problems, how work affects home how home affects work, it's not actually the problem that they thought was the biggest problem - it's something else. So it's very difficult to sort of - I was going to say something like pulling the strands of spaghetti and straightening them out - to say you can't box things and say 'right that's work it's all work and nothing else' because life isn't like that is it.

Russell: Not at all. But that does have a bearing on the notion of occupational health?

Occupational Health Advisor: Yes, yes. Quite clearly there are a lot of things that are work-related - whether it is the actual work or whether it is the person's perception of their work that's causing them ill health. It can be both. People can feel out of control because they can't control their shift patterns or their working environment and see that work is the big problem, but really it's because they've got no control over it.

It is clear that the Occupational Health Advisor translates 'stress' into an inability to cope with the 'hectic pace of modern living' due to insufficient 'coping skills'. Many kinds of social hardship are cited as part of the causal antecedents of developing a lack of 'coping skills' which are constructed as the main cause of feelings of stress in later life. These include 'broken families' and 'lack of role models': factors to do with the decline of the nuclear family are introduced. The narrative of the 'the fast pace of modern life' has been around for at least 200 years (Brown, 1999). For the Occupational Health Advisor, once an employee sees themselves as 'stressed', this is a signal for her not to attempt to intervene in work practices or conditions, but for her to delimit the 'correct' kinds of conduct appropriate for people who get 'stressed'.

Control is emphasised, constructing subjects as rational actors who make rational choices in order to optimise their existence and control those external factors which impact negatively on their quality of life. The subjects at the heart of the Occupational Health Advisor's discourse are agents in control of their destiny and the problems they experience are constructed as arising within the socialisation process. If they could just develop coping skills, then they would be

able to master their destiny and control stress. The solutions to their problems are thus constructed as being located within the individual employees.

The Occupational Health Advisor asserts that it is her duty, as a good practitioner of forward thinking occupational health, to take the 'holistic' view and look at 'everything in a person's life'. The employee who feels stressed because they have to work nightshifts has to suffer the ignominious experience of having to expose their 'whole life'. This enables the Occupational Health Advisor to turn their reported desire not to work nights round into their need to develop coping skills and/or commence a rigorous physical training regime to make them more psychologically and physically robust. The processes of 'examination' and 'confession' again take on significance here. Should an employee 'present' with feelings of stress which they believe are solely related to working practices, they are submitted to a verbal examination. The objective of the examination is to extract information about their private lives which may impact negatively upon their productivity. Once the employee has 'confessed' that all may not be well outside the workplace (an inevitability for virtually everyone), then the Occupational Health Advisor, using her 'expert knowledge' is able to reconstruct the presenting problem as being due to non-work factors. The assumption appears to be that there are *no* instances in which it is *only* work that leads to employees feeling stressed.

> *Occupational Health Advisor*: They've got no control over it (shift patterns or the working environment) so that is the problem. Rather than tackling the things that they have got control over to make them feel better about themselves, to make them cope better, to cope at work, I've seen many people who, for example come in and say 'I can't cope any more with 3 shifts - I just can't work 3 shifts', or 'I can't work nights' and they might be, have a 101 things that, different pressures, you know going through a process of divorce or the kids are taking drugs, they're in debt or their partner's got drinking problems, lots of different things, but the big issue for them is they can't work shifts. This is quite common. *You can't change that* - there might not be anything I can do and I'll say to people 'I can't necessarily tell your manager that you're unfit to work a particular shift'.....So I think there's an issue about people's perception, I think there's an issue about people's expectations that 'the world owes me a living' and I find that more and more nowadays is that people seem to have been - not mollycoddled - but nursed along the way, that you know state benefits - and I'm not saying there shouldn't be any support - but 'the world owes me a living and I can't cope so outside things should

change', rather than having a look inside to see what I can do to influence things.

Again we see collapsed into a work-related problem - namely the problem of in/flexibility in the hours offered for work - a whole range of unrelated non-work issues. A range of counter arguments are mobilised within her account including the welfare dependency argument, which is aired despite the individuals being in full employment. The Occupational Health Advisor touches upon a significant consequence of the shifting power relations between employer and employee. By 'opening up' their private lives at the request of the Occupational Health Advisor in order to try and influence, in this example, the time that they work, employees demonstrate trust in EHS personnel to try and alleviate their difficulties. However, the trust is not necessarily reciprocated as the information gleaned from the employee's confession is used *not* to alleviate the original work-related problem perceived by the employee to be a significant contributing to their discomfort, but to introduce new techniques for living which are constructed as being compatible with ensuring the continued optimum productivity of the employee. The location of responsibility for making changes that are thought to result in a diminishment of 'feeling stressed' is spelt out in no uncertain terms:

> *Occupational Health Advisor*: We give advice on an individual basis you know when somebody knocks on the door and says 'I'm stressed can you give me advice' and I'll go through what is the problem. 'How can *you* influence that, how can *you* change things, how can *you* regain the feeling of control in some area of *your* work or home?' But there are also, we give seminars to managers, groups of staff on recognising symptoms, *coping skills, coping mechanisms, questionnaires to see what coping skills people are using and then information on how to develop the one's that they're not using.*

If an employee feels 'stressed', the Occupational Health Advisor, following the policy of EHS and Consignia in general, reconstructs it as the fault of the employee for failing to take measures to ensure that they can 'cope' effectively. It is as though structural factors - especially working conditions - have been banished: an attempt is made to persuade employees that the problems they face are internal to them, with their causes arising in the past, rather than the present.

Occupational Health Advisor: Intervention is necessary from somewhere, and perhaps occupational health professionals are best placed to do that because you're in between work and home.

Russell: is that a role you would welcome?

Occupational Health Advisor: Personally, yes, probably, yes. It's something that I'm getting more and more involved with, and perhaps looking at making an action plan for helping somebody, facilitate a personal action plan: 'where have *you* got control, where haven't *you*, what causes the most problems, is there anyway *you* can work differently to achieve the same results but to put less pressure on?' And it involves so many things like time management, *looking after yourself*, making sure *you're* taking breaks because its no good working 6 hours at a stretch with no break *because then you're not as productive*.

The techniques mobilised to combat employee stress demonstrate an uncanny fit with the techniques used in the RHSSS: 'action plans' are suggested which when combined with some rational calculative analysis, are thought to provide acceptable individualised solutions in which the responsibility for realising the goals is located within the individual. The explicit link between stress and productivity could not be more clearly made, and the responsibility for ensuring employees do not feel stressed (and therefore potentially reduce their productivity) is constructed as the employee's, albeit it with some 'expert' guidance from in-house health professionals. The Occupational Health Advisor and the Chief Medical Advisor/Director are reluctant to accept that *any* instances of stress can be legitimately considered as solely caused by work as this would require a radically different approach. Responsibility for resolving the problem would then be more difficult to place with the employee. Their response has been to develop a strategy which recognises and incorporates the concept of 'employee well-being' rather than 'health and safety'. Attempts to make stress a legitimate 'condition' has in part resulted in some employers, such as Consignia, becoming more interested in non-work factors which are perceived as impacting upon their employees' health and well-being. While this has the potential to be useful for some employees in some instances, it legitimates otherwise unwarranted incursions into employees' personal, sometimes intimate details, which they may justifiably not wish to disclose to employers.

6.5 *Conclusion*

For the Consignia employee there exists a great deal of health and welfare support which is uncritically promoted by EHS staff and Senior Consignia Executives as 'a good thing'. The work/non-work dichotomy is seen within approaches to health at Consignia as an 'artificial distinction'. In the name of the health of the employee, new strategies are developed to combat factors which impact negatively on productivity, such as stress. What we appear to be witnessing is a major shift in the responsibility for providing basic health and welfare support and advice - *away* from the state and the voluntary sector and toward the employer. There would appear to be a potential major conflict of interest in encouraging employers to take responsibility for their employees' well-being, rather than just their health, indeed, in collapsing health into well-being. On one hand, it makes good sense to encourage employers to really look after their employees, to try and ensure that their emotional, educational, social and welfare needs are met. On the other hand, significantly, there is the danger that if an employee's personal life can be seen to be having a negative impact upon their health, and thus their productivity, then some kind of intervention - be it welcome or not - may be imposed upon the employee. The boundaries between work and non-work are, for Consignia employees, being eroded. The data suggests that at Consignia, 'technologies of self' are encouraged and sometimes imposed upon employees who 'present' with what they consider to be primarily work-related ill health. They may have been 'sent' to an Occupational Health Advisor for assessment, who may then send them to the on site gym or encourage them to take control of their lives. They may be encouraged to learn techniques which help them to 'cope', and thus increase their resistance to the potentially harmful effects of working life.

We are witnessing the formation of a new strategic power relation between employer and employee, some of it enabled by the flexibility and contested nature of the meaning of stress. Employees are using the notion of stress to articulate a wide range of unsatisfactory work practices and conditions, whereas employers use it to legitimise attempts at the behavioural modification of employees, and to make incursions into their private lives. All power relations involve the potential to influence conduct in ways that are not necessarily in the

interests of the participants. The different constructions of stress demonstrate that power relations, indissoluble from certain knowledges and effects of truth, are materially productive. With the emphasis within the EHS very much upon *reacting* to health issues, current constructions of the causes of - and solutions to - employee ill health mean that working practices and conditions tend to be downplayed, and remain largely unaddressed and unresolved, in favour of a reconstruction of employee health and well-being problems that focuses more upon the personal circumstances and capacities of employees.

The decentred form of regulation preferred by the state, which encourages responsibility for health to be devolved and absorbed into the culture of a workplace/workforce, with the ultimate aim of producing motivated, self-regulating employees, appears to fit with Consignia's approach to the regulation of employee health. While Consignia, through its EHS and general approach to health and safety, still places an emphasis upon the identification of health risks - most clearly in the practice of risk assessment - the data suggests that what is thought to 'count' as a workplace health-risk is usually predetermined within conventional discourses of workplace health and safety. Such factors as poor management, inflexible working hours, organisational change, increased surveillance and job insecurity do not fit into the discourse and practice of risk assessment. The data demonstrates that, on one hand, Consignia appears to welcome the opportunity to take more responsibility for the health and welfare of its employees, but, on the other, the data suggests that the motives for this seemingly benign stance are often contaminated by self interest, especially in the desire for ever improving productivity and competitiveness. The response to many employees presenting with what they perceive to be work-related health and well-being issues is to encourage and persuade them to take more responsibility for their health and their lives, sometimes using disciplinary measures, such as the sickness absence system, to achieve this. Thus, attempts informed by the principles of decentred regulation and neoliberalism, as well as disciplinary and superpanoptic technologies, are made to conduct the conduct of employees in a way which aims to construct their self-interests in such a way that they align with the interests of both Consignia and the State.

7.1 *Introduction*

This case study commences with an overview of the differences between Consignia and the second case study - the web-design company the 'Byte'[9] - and a discussion of some of the key characteristics of the emerging 'knowledge driven economy' favoured by New Labour. The chapter then focuses upon the general approach to the regulation of employee health adopted at The Byte, includes, as with Consignia, a discussion of stress. The style of management is then analysed, along with some of the working conditions and practices this gives rise to. The chapter concludes by summarising the significance of these factors for understandings of risk, regulation and the process of responsibilisation in relation to employee health.

The Byte stands in almost complete opposition to Consignia: it is a small, non-unionised, newly established, private hi-tech company based in one physical location, employing a small number of predominantly young professionals. Consignia provides a public service via a state institution whereas The Byte provides a service for clients as a private company. For Consignia employees the workflow is constant with regular deadlines, at The Byte it is variable with intermittent deadlines. Consignia involves the physical movement of externally generated material goods, whereas work at The Byte involves the intellectual creation of 'virtual' objects. Instead of mainly unskilled, manual employees, The Byte employs highly skilled professionals. The Byte fits with 'the Government's vision for a competitive, knowledge driven economy' (RHSSS:18), and is an example of the type of company associated with the 'new knowledge economy'. It is suggested that the web-workers at The Byte share characteristics with a range of professional service organisations and industries which rely heavily upon individual and collective forms of intellectual capital. Many studies have demonstrated that the management of employees in such companies is different from that in more traditional manufacturing and manual service

[9] It should be noted here, that as confidentiality and anonymity were assured for this second case study, the location of the company has been concealed and the name of the company, along with the names of the individuals working there, have been changed.

companies (Greenwood, Hinnings and Brown, 1990; Hinnings, Brown and Greenwood, 1991; Alvesson, 1992, 1994; and Starbuck, 1992). As such, it was anticipated that The Byte case study would afford access to different constructions, understandings and practices of the regulation of employee health, from those at Consignia. Such contrasting companies present a challenge for the explanatory power of the theoretical and methodological framework adopted in this thesis.

The knowledge economy

The phrase 'knowledge economy' signifies an historical moment where the capital embodied within factories and machines has become of secondary importance to the knowledge of the workers (Ducker, 1993). It is also claimed that we have entered a 'new economy' where dynamic, flexible and non-bureaucratic network organisations employ workers who are empowered and treated as important strategic resources (Handy, 1984; Kanter 1989; Reich, 1993). It has been argued that in this 'new knowledge economy', the existing structure of work organisations has to be radically changed, in order to accommodate the new 'knowledge workers' who are inclined to work in their own interests (Deetz, 1995).

Deetz (1998) outlines what he believes to be some of the common characteristics of these new 'knowledge intensive' workplaces. Chief among them is that individual employees have high levels of autonomy and self-management. This is influenced by employee conceptions of autonomy entitlement, the specialised nature of their expertise, the lack of 'normative standards' for their product, the presence of work activity away from the main employment site, and the presence of alternative employment opportunities. The difficulty of observing and monitoring the work *process* itself further aids a sense of autonomous working, especially because it is often difficult to measure and attach financial rewards to specific product characteristics (Deetz, 1998:155). The picture painted is of a new form of economic reality in which companies are dependent upon the knowledge of workers, and where there is little tension or conflict of interest between employees and employers (Rasmussen, 2001:2). There is a belief that company and employee interests

coincide. The perceived absence of conflicts of interest between employees and employers sounds almost too good to be true, indeed, for Deetz it is. The question that some commentators raise is whether more relaxed, less hierarchical, 'flatter', team-work based management styles are in fact just emerging strategies aimed at making the worker take on more responsibility for their own subordination and work intensification (Milkman, 1998; Rasmussen, 2001; Deetz 1998). The question is, what happens to the regulation of health in these flatter, knowledge based companies?

The Byte

Founded in 1998, The Byte specialises in the development of new-media based solutions for clients and partners from public, voluntary and private organisations world-wide. The core of The Byte's team draw upon skills and competencies from a range of creative and technical backgrounds. Eleven people (including the four Directors) are employed full-time, with occasional short-term contracts given to specialist workers. The company and its employees undoubtedly fit the frame of highly entrepreneurial 'knowledge workers' in the 'new economy'.

Part of a complex of small companies specialising in 'new-media' based work, the offices are relatively new and open plan, with separate rooms for tea making and meetings. The first thing that struck me about The Byte was its relaxed and informal atmosphere. Each employee has their own desk and computer and some of the spaces are personalised with pictures and posters. On the first visit there was music and informal conversation, the second visit was quieter and more industrious. Everyone works in close proximity to each other, increasing the potential for easy and instant communication. Another thing which immediately struck me was the fact that this was a workplace populated by predominantly young people. The 'oldest' person there is 40, the majority of employees being in their twenties. The fieldwork practicalities and the rationale for selection of the interviewees was given in the methodology chapter. As a brief reminder, two days were spent at The Byte offices in July and August 2001 and two Directors and three employees were interviewed. Before analysis

commences, in order to give the interviewees a 'human face' a brief outline of their personal circumstances and role within the company is provided.

'Frank' is one of the founding partners and as such he is one of the Company Directors - the 'Creative Director' - as well as being a 'Multimedia Developer'. At 40, he is the oldest person working at The Byte. Frank was long-term unemployed before gaining a job at a university as a Multimedia Courseware Developer for two years, before starting The Byte with three friends in 1998. He has no 'formal' qualifications. He states that he enjoys reasonably good health.

'Phil' is also one of the founding partners and Company Directors - the 'Art Director' - and is a 'Graphics co-ordinator'. He is 32 and has a degree in Multimedia Graphics. He has a 'medical condition' - Ankylosing spondylitis - which primarily affects his spine. The joints and ligaments that normally permit his spine to move become inflamed and stiff. Some of the bones in his spine have grown together, causing his spine to become less flexible.

'Ruth' is 35 and is the 'Office and Finance Manager'. She has a business degree. She states she is in generally good health, but occasionally suffers from Irritable Bowel Syndrome.

'Steve' is 22 and is an 'Assistant Programmer'. He started work for The Byte in 2000. Although without formal qualifications, he has much experience of computer programming and sound and video production. He states that he enjoys good health.

'Ken' is 23 and is a 'Designer'. He also started work for The Byte in 2000. He has received formal training in illustration and animation and, prior to working for The Byte worked as a freelance artist. He, too, states that he enjoys good health.

In line with the theoretical and methodological framework, all the interview texts are treated as accounts of subjective understandings and experience. The first area to be discussed is the general approach to health at The Byte.

7.2 *Work and health at The Byte*

RSI and VDUs

Smaller companies such as The Byte are notorious within occupational health and safety discourse for implementing few of the formal Health and Safety practices and policies that larger companies have in place. This situation was constructed as a core concern within the *Revitalising Health and Safety Strategy Statement*, which, it was argued in Chapter Five, characterises this phenomenon as stemming from fear of bureaucracy and failure to appreciate the 'business case' for prioritising health and safety. The Byte did not confound these expectations. The seemingly relaxed attitude to work extended to occupational health needs and beliefs. It was clear that 'health issues', although of concern, were not a priority at The Byte. This first extract from an interview with one of the directors, Phil, makes this clear:

> *Russell*: Is there anybody here who is sort of has an interest in the health side of the business at all?
>
> *Phil*: For themselves or for people in general?
>
> *Russell*: For the company in general.
>
> *Phil*: Not really no. It is something that we've been trying to cover for quite some time now, getting lots of health and safety stuff in place you know, but, well there is the office manager - she's the one pressing to get this stuff in place - but there's always something else that crops up that seems to be more important and it gets pushed aside.

Initially then, it can be seen that health and safety concerns are here considered a low priority by directors. There is always 'something else that crops up', although it is recognised that unspecified measures should be taken. The Office Manager is identified as the person most keen to put such measures in place. She constructs the main obstacle as financial pressure:

> *Ruth*: I have a really bad back, I mean I have arthritis, so I'm constantly, I get up and walk around a lot, even if it's just to the kitchen to give my back and neck a rest and, my seat's terrible - I need a good chair but can't afford one so I don't get one.

Ruth explains the lack of an adequate chair as due to financial constraints. The general context in which decisions about the provision of health and safety equipment are made, then, is constructed initially as a business one. New technology workers are prone to a category of occupational hazard that has become the primary cause of ill health in the UK's workforce: muskulo-skeletal disorders. This term denotes a range of disorders which include bad backs and a form of 'occupational injury' which is especially prevalent among web-workers: Repetitive Strain Injury (RSI). MacEachen (2000) alerts us to the significance of RSI in relation to neoliberalism. Her research shows that managers perceive RSI to be particularly prevalent among those workers 'who lack (self)discipline'. She found that, once education and information designed to minimise RSI has been given to employees, those who go on to develop it can then be held personally responsible. In attempting to decide the extent to which RSI could be said to be work-related, there is an extension of surveillance and monitoring techniques into the employee's private, home life, comprising an expansion of the corporate jurisdiction of worker's bodies (MacEachen, 2000).

Everyone interviewed at The Byte was asked about RSI. The interviewees responded with varying understandings of what it is, what causes it, and how to prevent it, although most claimed they had at some time or other experienced it. One of the Directors, Frank, talked about his experience of RSI, which illuminated further The Byte's 'policy' on work-health issues:

> *Frank*: I've had RSI which sort of comes and goes, but when it does come on it's pretty bloody painful, you don't get any warning. You can be working for ages absolutely no sign of it and the next day it's just like shooting pains all up your arms and that's sort of quiet a common sort of illness I think for what we do.
>
> *Russell*: Yes, is there stuff you do to try and minimise that at all, or is it left to people to manage it?
>
> *Frank*: Well there's a couple of people who've suffered from it this year so we try and, well we basically we *just* said 'anybody who wants to look into'. We suggested certain things you know like gel wrist rests, like you can get different types of mice and like *just* people to be aware of posture, monitors for eye level. Basically anything that anybody wants to get because they feel they might be troubled by it, *just* say, '*just* tell us what you want and we'll buy it' basically, because that's more important than people being fucked.

RSI is constructed by the directors and employees as an 'occupational hazard'. Frank's use of the word 'just' here marks a stretch of talk as defensive. It is used to disclaim blameworthiness and to justify the company's (in)action. It is taken for granted that employees will encounter RSI at some point but there is no formal policy in place for dealing with it. The informal policy consists of suggesting which equipment may minimise its harmful effects and encouraging employees to make requests for such equipment. The initiative for the solution is passed to the employees. The basic policy is thus fundamentally one of encouraging personal/self-responsibility for the identification and management of this occupational health issue. Ruth, the Office Manager, described the 'policy' in a slightly different way from the directors, but the principle remained the same:

> *Russell*: Do you have a formal responsibility for things health and safety?
>
> *Ruth*: Yes, I have to make sure that they're aware of the VDU regulations, that they're aware that they can request ergonomic keyboards and stuff like that if they want to, they know how high their seating should be, so yes, all of that stuff because we need to be covered for that.
>
> *Russell*: It's good that they're aware of all the correct procedures and that but inevitably...
>
> *Ruth*: If they choose to ignore them, then that's fine.

The employers are constructed as responsible only for making resources available and providing information. Beyond this, it is up to the employee to assess for themselves the extent to which they feel they may need additional resources or information. The employees are positioned as rational actors who are capable of 'choosing' to accept or 'ignore' the advice offered to them. A primary motivation for communicating existing health and safety regulations to employees is here constructed by Ruth as having to be 'covered', rather than protecting the employee. Again, the emphasis is placed upon the employee to decide the extent to which they comply with the regulations. The rationale for this approach to occupational health risks and needs becomes clear in the following extract from the director, Frank:

Frank: Some people take it a bit more seriously than others and I think *some people just get complacent about it* and just think 'well it's not going to happen to me because I feel fine'. But that's a danger with it because you don't get the warning and then one day you're fine and the next day you can hardly move your hands.

Russell: But it's not something you insist upon: 'you must do'

Frank: No. We haven't done at this stage, although, I don't know. Because not everybody's comfortable with, like *even though they know how they should sit, what they should use and stuff, they're not always comfortable doing that.* So I'm sort of pretty aware of a lot of it but I still catch myself out with like contortionist sort of positions.

Russell: On the phone, and looking at the computer and talking to somebody else?

Frank: Yes, so *I don't think it's something you can really insist on.*

The stated desire to encourage self-directed, autonomous behaviour, or put another way, the desire to *avoid* autocratic, hierarchical, authoritarian behaviour here manifests itself in a recognition that 'everyone is different'. It is claimed by both directors that all staff at The Byte 'know' what measures should be taken to avoid suffering from RSI, for example good posture, correct layout of work station etc., and that if there was anything at all that staff wanted (in order, for example, to lessen the likelihood of experiencing RSI) then all they had to do was 'ask'. The responsibility for taking the initiative on measures to avoid identified health risks is thus laid firmly at the feet of employees. The expressed desire not to 'insist' on any health and safety measures is interesting in the context of the theme of 'motivation'. Frank does not want to discipline or restrict in any way the employees. This is mobilised to justify a lack of responsibility regarding their protection. This is a strongly libertarian position and introduces a certain conception of freedom which may be highly valued at The Byte.

Despite the claim made by both directors and the Office Manager that employees would be bought any specialist health-related equipment they requested, and the claim that health regulations were explained to them, the accounts offered from some employees contradicted this. Ken, who uses a 'pen' (a mouse which looks and feels like a real pen) was unfamiliar with the concept of RSI, but was familiar with other subjectively experienced physical discomforts stemming from continual proximity to his PC.

Russell: The other thing that seems to come out of the research, especially in design companies, is RSI - do you have any experience of that?

Ken: I don't really understand the full RSI thing - what it actually does. I know, is that the problem where your hand doesn't quite?

Russell: Yes, repetitive strain injury, eventually you can get feelings of numbness or shooting pains up your arm, you become incapacitated through recurring use of the same bit of your hand.

Ken: Well I don't have problems - I've not had them kind of problems coz I use, generally use the pen that you saw which is probably coz I'm quite used to. It's more natural thing for me coz I sort of came from an art sort of education rather than the design side. So I mean I don't really get any problems at all from that. But I do get the odd, if I've been staring at the screen for too long or if it's something quite meticulous, if I have to look at a lot of text rather than graphics it, I find that when I go outside or when I come away from the screen it's a bit heavy, perhaps get bad headaches for a few minutes. Yes, that's probably a bit worrying - try and tend not to sit as close to the screen, sometimes I find myself like my nose is virtually touching the screen. Plus I've got quite good eyesight so sometimes the, just the screen really irritates my eyes and so yes, but then I suppose it would anyone's eyes.

Ken here constructs his working practices as involving an acceptable, inevitable degree of harmful impact. He suffers from headaches which he attributes to spending too much time close to his screen, and finds the potential health risks 'worrying'. Despite understanding the correlation between close proximity to a screen and the potential for harm, he still finds himself too close.

The narrative of continuity

Some interviewees claimed that other companies insist upon a utility which freezes the screen for ten minutes out of every hour, thus ensuring compliance with health and safety good practice. In the next extract Ken is asked how he would feel about this:

Ken: I was chatting to a girl down the corridor and she said that they've got one of them sort of things and she thought it was good, she'd had the RSI thing, *but I think I'm pretty clued up on it really, I tend not to get too, you know, I tend to usually sit right and everything.* I think if that was, if it was imposed I'd probably get a bit, well, yes, get a bit pissed off with it. I tend to, well I suppose everyone gets quite into their work but, if you're right in the middle of something and you have to stop for ten minutes,

then you'd be really pissed off with it. Then when I came back I probably wouldn't be able to do it as well.

Ken here constructs a seemingly benign health and safety measure as undermining productivity and as a perceived threat to his autonomy. He constructs himself as an 'expert of the self' (in terms of knowledge about work/health practices), and cites his expertise as a form of credentialing to strengthen his argument against the imposition of health and safety measures which are critiqued as interrupting the flow of work. Everyone claimed to be aware of the positive effects of setting up and using equipment correctly, for example taking regular breaks from their work and adopting 'good posture'. However, this knowledge was undermined by a 'narrative of continuity' which Ken, Steve and the two directors expressed as being of fundamental importance in the execution of their work. The introduction of health and safety measures designed to protect health is constructed as subordinate to the need to produce high quality work. There is a prioritisation of the right to work in whatever way, and at whatever pace, they see fit. The two discourses, of work and health, here become hierarchically conjoined: factors perceived to impact negatively upon the work process, and thus productivity, are constructed as secondary to health concerns.

The director Phil also constructs the problem of taking regular breaks as an imposition which impacts negatively on the work process. In this next extract he articulates the perceived dilemma between 'imposing' measures conducive to good health, and 'allowing' the individual employee to make those choices for themselves:

> *Phil*: We do let people work at their own pace and what have you because it just, if we're telling people to 'right they should be doing this every twenty minutes' or something like that then, er, it's, er, the fluidity is just broken you know? I mean if you're saying 'right OK you're sitting in front of a computer screen, you need to spend 10 minutes out of every hour looking away' you come back, you've lost the flow, you know, you forget what you were doing and that type of thing.

The work undertaken at The Byte is here constructed as creative, as flowing and fluid. A fear is expressed that once the 'flow' has been disrupted it may be difficult to rejoin it. Walking away or taking a break is seen to jeopardise the

quality of the work, and productivity and creativity become difficult to separate. Another employee, Steve, was also aware of the health 'risks' of spending too long at the computer, but he too constructed 'concentration' as an indefinite 'flow', disruption of which impacted negatively upon the quality of work:

> *Russell*: Some companies that are not too dissimilar insist that you have, you know, ten minutes off every hour and all these sorts of things.
>
> *Steve*: I'm quite good at imposing fag breaks on myself, but again that's another health hazard in itself, yes. I don't like, another company next door has this annoying utility on their computers that imposes a micropause on you and freezes up the computer so that you don't work on it, which I really don't like the look of just because I think it would interrupt my flow of concentration. But I do make an effort to take regularish little breaks and make sure that I do get out of the office for at least half an hour everyday, that kind of thing - which not everyone does.
>
> *Russell*: So all things considered you're generally happy with a more flexible way of working in relation to health, rather than having it imposed?
>
> *Steve*: I'm always, *I do want to kind of invent my own ways of sorting things out.*

Here Steve positively evaluates the autonomy afforded by the working style at The Byte, and embraces the opportunity to demonstrate self-regulation. The discourses which comprise localised configurations of power/knowledge which Byte staff turn to and/or deploy in relation to the work/health nexus, tend to be experiential and anecdotal, although they are largely consistent with occupational health expert's views. All the staff recognise that to avoid regular breaks from their work station is to risk headaches, eye irritation and muskulo-skeletal disorders, RSI in particular. However, all prioritise and legitimate the view that it is not 'worth' the 'loss of continuity' - the 'fluidity' which is constructed as essential for producing high quality work. Each staff member appears to have taken on the responsibility for undertaking their own, small scale, localised and individualised risk-assessment, framed in terms of 'risk to health' against 'risk to the quality (and presumably quantity) of work' they produce. The responsibility for making this calculation is placed firmly with each individual, although it is claimed that anyone wishing to deviate from this 'norm' (anyone who wants extra equipment, to take regular breaks etc.) is welcome to do so if they so choose. In contrast to Consignia there are no formal monitoring or

surveillance measures in place. A high degree of self-regulation and self-surveillance exists. At The Byte it is the responsibility of the self to continually monitor one's bodily and mental well-being and to continually calculate the 'cost-benefit' of particular working practices. Staff at The Byte appear to legitimate those discourses which encourage the evaluative calculation that risks to productivity are more important than risks to health, at least in the short-term. In contrast to MacEachen's findings, there was no suggestion that the directors perceived RSI to be particularly prevalent among those workers 'who lack (self)discipline'. Nor was there any suggestion that there was *any* monitoring or surveillance of employees, within or without The Byte.

Another common phenomena seen as problematic by everyone at The Byte was 'stress'. The next section examines the data for constructions of stress.

Stress

At Consignia we saw how stress was deployed differently for strategic ends by employees and health professionals. Employees deployed their stressed state to try and achieve a change in working conditions. The Occupational Health Advisor constructed the term as being overly loaded with sometimes contradictory meanings to be of any practical use in an evaluation of employee health, and instead took it as a signifier of an 'inability to cope'. The solution proposed to the stressed employee at Consignia was to direct them to take up adequate coping mechanisms, which sometimes included an attempt to modify their bodily behaviours and improve their physical resilience. At The Byte the term stress, its causes and solutions, was also contested by the interviewees. Everyone interviewed agreed that from time to time stress was much in evidence, both in themselves and their colleagues. Ken echoed the difficulties voiced at Consignia in trying to unravel the relative influences of work and non-work factors which give rise to subjective feelings of stress:

> *Russell*: What do you think are the factors that lead to feeling stressed out?
>
> *Ken*: People's expectations on you, pressure on you, I think for me it'd be a time when if I've got a lot of work on, but then I've got people outside work. Say I've got a girlfriend and I've got a lot of work on, I'll have the

stress here and then she'll be pissed off coz I've got to spend time at work, so that you can't really win.

Ken posits that feelings of stress arise through the sometimes conflicting expectations of others. It is not the long hours *per* se which are constructed as a causal factor, but rather a conflict of interests between work and non-work. A further construction by Ken involved the view that working in a stressful environment can be a useful experience.

Ken: I think that for me it's been good for me to do this, it elevates the stress levels but definitely got better at taking it.

Here Ken constructs stressful situations as conducive to improving coping skills, a position which greatly contrasts with much 'expert' knowledge on stress. There are no formal mechanisms in place to deal with feelings of stress at The Byte, unlike at Consignia where a formal policy on stress is in place. Steve constructed stress as the biggest health risk at The Byte:

Steve: The worst hazard is stress, but it's something that I can partly very much enjoy as well, because it, I have, I do occasionally feel quite stressed out and do get a bit run down, but I do find that the sense of achievement when I've finished something more than makes up for it in some ways.

Here we have an example of a justificatory strategy for tolerating difficult working conditions. Becoming 'run down' minimises the significance of the problem and constructs it as a short-term one, rather than a long-term or more permanent one. For Steve, health considerations are not seen to be as important as other factors; a decline in health is constructed as being sufficiently compensated by his 'sense of achievement'. In trying to establish what Steve thought the causes and solutions to stress should be, the theme of deferred rewards emerges:

Russell: So it's mainly work pressure, deadlines, that causes the stress?

Steve: So most of it's self-inflicted.

Russell: Do you think there are measures that you could take or want to take, or that other people could take to reduce that - or would you want to reduce that stress? Difficult question.

Steve: Difficult question. I don't know. I think for the next few years at least I think I'm quite happy with it, as long as I do manage to give myself, kind of make some efforts to enforce a bit of time out on myself, make sure that I do do things like taking holidays and just relaxing rather than not taking holidays and running around manically. But I don't know. A couple of years down the line I'll probably want to stop for a while and go and pursue some other, other interests and other ambitions.

In this exchange the working conditions, such as deadlines and long hours, previously constructed by Steve to be the main cause of stress, are reconstructed as being 'self-inflicted', which suggests that he has internalised the responsibility for both the causes and solutions to stress. Here we can again discern a strategic deployment of health status but, rather than using it to attempt to change existing working conditions as at Consignia, possible sacrifices in health status are accepted here by individuals as to do with making 'investments' in their future. Steve can 'put up' with feeling stressed now, as long as he keeps hold of the longer-term view which involves rewards in the future. Rather than seeing stress as arising from unhealthy working conditions, he frames it as something which is a personal choice - he 'chooses' to have some stress now in order to minimise it in the future.

One factor agreed to increase subjective feelings of stress is the long hours worked in order to meet deadlines. Phil, one of the directors, is no exception to this and perceives a clear correlation:

Russell: Is there a correlation between stress and deadlines for example?

Phil: Oh yes, absolutely. I mean it might be one of the things that actually helps us to meet all our deadlines - I mean we've met every one so far but it does involve a serious amount of hair pulling and stuff you know. I mean if we realised if that we have 2 days to do what we think is 4 days work, we'll get it done, but at that point everybody almost becomes unapproachable.

The perception that The Byte is a relaxed place to work is contradicted here by Phil's claim that everyone becomes 'unapproachable' when racing to meet a deadline. Here there is a strong association between working practices and subjectively experienced feelings of stress. The interviewees largely accept this

It is accompanied by a sense of shared responsibility for work processes, which may reinforce commitment to, and norms of behaviour within, The Byte.

At The Byte, to claim that you are stressed will not produce an 'examination' in which you are invited to 'confess' your problems. Nor are you likely to be subjected to the proposal that you should increase your 'coping skills' or modify your behaviour. However, stress (however it is conceptualised) is consistently constructed as a significant problem with health implications. There are no formal mechanisms in place at The Byte to deal with it, which may be explained in part by the desire for autonomy and the willingness to demonstrate self-regulatory behaviour.

Work practices widely understood to be 'unhealthy' have become 'normalised' at The Byte. As Goss (1999) and Haunschild (2001) hypothesise, informal pressure to conform to workplace norms appears to have become activated. Particular constructions of the relations between work and health have become a part of the everyday culture of the workplace/force, but in ways unanticipated by the Revitalising Health and Safety Strategy Statement. The decentralised *de*regulation of health and safety measures at The Byte, and the indirect pressure on employees to take responsibility to manage workplace health risks - and thus become self-regulating - results in this instance in *acceptance* of the potential for harm to arise as a consequence of work. The truth-effects of particular power/knowledge constellations are from time to time subjectively experienced as harmful by Byte directors and employees. This does not give rise to the modification of either work practices nor behaviours, rather to a 'calculation' that short term health risks are an acceptable price to pay for undertaking the work they want to, in a manner they desire.

The deregulated approach to health at The Byte, which appears to complement self-directed working practices, and the devolution of responsibility toward employees for the making of significant decisions which have consequences for their motivation, health, and productivity, is indicative of the wider managerial strategy. The next section focuses upon the management style at The Byte.

7.3 *Management style*

A hierarchy exists at The Byte, but in many ways it is far less discernible than the hierarchy at Consignia. The four directors are better paid and ultimately perceived to be fundamentally responsible for the continued operation of the company, the generation of profit and, at least in legislative terms, the health and well-being of their employees. In practice the organisation is extremely 'flat', in many ways seemingly non-hierarchical. All staff (the term 'staff' is used to denote both directors and employees) have specific and clearly delineated areas of expertise, although inevitably there is a small degree of overlap. The spatial elements of the work environment including the layout and proximity of staff to each other means there are no visible hierarchical markers. Everyone can see and communicate with everyone else. Staff can request formal or informal meetings with anyone else at any time, although most of the important strategic communication takes place either at the weekly meetings or, more usually, informally over their desks or during coffee/cigarette breaks. This, combined with the almost continuous music and occasional highly informal conversation, gives The Byte - certainly in comparison to the conditions encountered at Consignia - a relaxed and open feel.

The above factors all contribute to reducing the perceived differences between managers and managed, as does the absence of formal surveillance and monitoring systems. The only mechanisms that appear to be in place for the measurement of performance are informal, experiential ones. These factors may contribute to the perception of a reduction in some of the conflicts between managers and managed which accompany many workplaces, such as Consignia. The non-hierarchical nature of The Byte does, however, mean that there are far more shared responsibilities than one would normally encounter in more traditional workplaces. For example, all staff are involved in deciding which new equipment or technology to invest in and personal training and development needs are identified by individuals. This *shared* responsibility could be conceived as more of a *shift* in responsibility - away from the managers and onto the employees, as we have already seen in relation to a range of health and safety issues. In addition, career development is seen very much the responsibility of the employee: if they want to go on a course or

develop new skills, then it is up to them to make a case. However, rather than being seen as problematic, the shared or shifting responsibility, and sense of a collective fate, seems to be positively welcomed by employees and managers alike. This is most visible in notions of flexibility in working practices.

Flexibility

Flexibility is perhaps one of the key 'technologies' through which The Byte management style is realised, not simply in the times and hours worked - although this is certainly significant - but also through a tolerance of people's 'styles' of working, and a commitment to allowing employees freedom of expression and freedom to use Byte equipment for personal use. Directors and employees share the perception that there exists a great deal of 'flexible working' at The Byte. Frank and Phil - the two Directors - outlined the company's ethos on flexible working:

> *Russell*: What about the working patterns of you and your team or whatever you want to call them, is it sort of nine 'til 5, 5 days a week or?
>
> *Frank*: Not at all. Depending, it's all to do with deadlines really and us - probably still because we're a fairly new company - still underestimating schedules and stuff, so when a deadline comes up we tend to find there's still shitloads to do, and days turn into sort of 13, 14 hour days and working weekends quite often, so. Sort of getting better at judging time but it's also I think because we try to keep a good quality of work - you could say 'fuck it' and just send it out as it is but everybody is quite into quality of work.

Here Frank justifies the very long hours worked by employees as being due in part to managerial inexperience but ultimately acceptable to them because both Directors and employees are keen to produce high quality work. He legitimates poor managerial estimation of the time pieces of work take to complete by saying it is because they are a new company. Thus, faulty estimates by the management become downplayed and a collective concern with quality of work is emphasised.

> *Russell*: So is everybody on hourly rate or weekly wage or?
>
> *Frank*: Sort of monthly wage, and we do 6 monthly bonuses depending on how well the company is doing overall. We're not really in a position to

start offering double time for overtime, so it's just weighing up. But I don't think they would do it if they just thought they were getting ripped off, because there's some incentive there, they know they're going to get a nice Christmas present or something.

Russell: So there's probably a great deal of flexibility?

Frank: Yes. You know, if people need to come in or have a couple of hours off in a morning because there's something they need to do or whatever, then that's alright as well, because it kind of works both ways - it's OK because nobody takes the piss.

Phil: It does seem to work better for us having, you know saying to people 'right we start work at 9 'o'clock, if you're half an hour late don't worry about it, you know that's fine. If you want to do any extra time that's fine as well, after 5 o'clock you can stay behind, use the equipment to do your own thing if you like'.....I think if you ask anybody they all enjoy working here, probably mostly because of the way we work.

The employee's perceived willingness to work long hours is explained by the directors as due to the existence of a system of rewards comprising: the payment of occasional bonuses (if the company is doing well); allowing personal use of the equipment; and letting people come in a little late occasionally. These factors are constructed as being a sufficient incentive for employees to work the expected long and unsocial hours. These factors are mobilised as both evidence of the flexible management practices *and* as an example of the rewards that the employees enjoy as a result of their flexibility, even though the long hours are constructed by the directors themselves as caused at least partly by their faulty estimations.

The way flexibility operates at The Byte however also includes an informal 'requirement' for employees to be flexible enough to work for up to 14 hours a day and occasional weekends, sometimes for several weeks in succession, although the data suggests that this was not constructed as problematic by the employees, who had come to expect to have to put in long hours as deadlines approached. The employee Ken articulated a favourable evaluation of the flexible approach to work at The Byte:

Ken: It's not a case of a place of work where you have to sneak out for a tea break or whatever. So it's, it's quite good like that. What I mean to say like you still got to, still like, I do a lot of overtime now and then if it's

needed, so I suppose it evens out in a way. But I think that's good, it's good, you know it works both ways.

Ken suggests the need for working long hours 'evens out' and 'works both ways'; he constructs the exchange as fair and implies that his needs are met at The Byte. Steve was also positive in his appraisal of the way flexibility is manifested at The Byte. Steve highly valued the opportunity to pursue his interests in music and video editing afforded by the use of the specialised equipment available at The Byte, to which he would otherwise not have access:

> *Steve*: I'm quite into my music and art and stuff as well. It would be quite nice to build up some resources and then just kind of run off for six months, go travelling, take lots of photographs or something and kind of live an easy life for a bit.

Steve's willingness to work long hours in sometimes stressful conditions is here justified in part by an appeal to a deferred reward. Steve can be seen to be using The Byte 'strategically', that is not only as a place of relatively secure employment doing something he enjoys in a manner evaluated positively by him, but also as a place to learn new skills, experiment with his creativity, and 'build up some resources'. The 'investment' of working long hours now, at the beginning of his working life, in order to open up spaces of potentiality in the future, seems to be a common theme for directors and employees alike. It can be seen to match the preferred qualities of the state sanctioned neoliberal subject who takes responsibility for taking measures to optimise their employment potential in the future.

In this context the 'flexible' working practices are seen to have a strategic element. Frank also talked of using his involvement with The Byte strategically, as a means to an end rather than an end in itself:

> *Frank*: There is a possibility that we might make quite a lot of money at this and my aim is to retire and enjoy it at some point. I don't want to do this for the rest of my life basically, and he's (another director) of the same opinion.

Frank assured me these views are shared openly with his colleagues and are a part of the 'culture' of the organisation. The long hours are constructed

universally as an *investment*, either in terms of acquiring enough money to retire or simply gaining enough skills and experience to open up further personal and career opportunities in the future. However, the construction that long hours are an investment in future potential is particularly significant here. This construction has a disciplinary effect: it functions to provide incentives to employees and directors alike to work very long hours. This keeps them in the workplace longer, reducing the boundaries between work and non-work, and it increases their individual and company productivity and competitiveness. It also serves to encourage a culture in which self-regulation is highly valued.

Before critically discussing the wider implications of the management style at The Byte, attention is briefly focussed on another unregulated element of the working conditions which is perceived as trust inducing, yet which also has a self-regulating, disciplining function: the approach to sickness absence management.

Sickness absence

Sickness absence at The Byte is perceived by everyone to be unproblematic: Consignia would no doubt be envious of the very low absence levels, especially in view of the non-existence of a formal absence system. However, the high level of informality at The Byte, fostered in part by the lack of clear hierarchical signifiers, may be a significant contributing factor to low absenteeism. The informal pressure to be present helps to produce a sickness absence system which is self-regulating. Thus the potentially costly and time consuming introduction of a formal procedure, which may also diminish the sense of freedom experienced at The Byte, is inhibited. The 'presenteeism' encountered at The Byte, achieved in part through a highly deregulated approach to sickness absence, and thus devoid of any bureaucracy or 'red tape', would no doubt be positively evaluated within a framework which was primarily concerned with target measures.

Taken together, the above factors point to a working environment where internal conflicts are perceived to be minimal and everyone seems to be working and behaving broadly in their own *and* everyone else's interests. We have seen how

the various discursive constructions of such things as flexibility and the management style operate to create the perception that the individual's desires appear to coincide with the interests of the company.

7.4 *Discussion*

Strategies of self-subordination

Some commentators are critical of these kinds of emerging working conditions and practices. Deetz, for example, warns that the values of 'self-management, lattice structure and autonomy' may be 'to the long-term detriment of both the employee and the company' (Deetz,1998:158-159). The 'loyalty' of The Byte employees and their lack of resistance to the long hours worked could be thought of as a kind of 'consent' given to arbitrary institutional arrangements which are far from 'natural' and 'incontestable'. The 'consent process' is described as when someone actively, although unknowingly, accomplishes the interests of others in a faulty attempt to fulfil his or her own. Deetz suggests that employees 'instrumentalize and strategize' themselves through self-surveillance and control of their bodies, feelings, dress and behaviour. He suggests that this self management benefits managerial interests more than company or employee ones, and that the 'strategized subordination' occurs as employees subordinate themselves to obtain money, security, meaning or identity. The danger arises because these factors could or should be realised through the work process *without* the requirement for subordination. The outcomes to this subordination may not turn out to be what the employee expected:

> The employee 'strategizes' the self toward increases in power and money, but since these are themselves simply more instrumental means and not ends the quest is never complete. The future is deferred and the quest endless. While there is an expectation and even some appearance of gain, significant hidden costs accrue to both the corporation and employees (Deetz, 1998:164).

Deetz (1998) suggests that, when employees strategize their own subordination for the sake of private gains, they surrender whatever power they have to change their conditions. In effect they give their consent to domination - the conflicts which could produce contestation are suppressed leading to a sense of

false autonomy. In a more 'traditional' work discourse such as that found at Consignia, the principal conflicts are expressed as employee versus management interests. Management expresses a desire for more control of the work process and increased production combined with decreased labour costs. Employees express the desire for better working conditions which include increased pay and a higher degree of autonomy in their work. There is a sense of solidarity within their respective groups. Deetz's point is that consent rearranges these relations and realises significant potential detriment to the employee. Employees - like those at The Byte - don't express a concern that they are required to work long hours. 'The enemy is no longer the manager's expectations' and the company becomes integrated into the employee's 'self'. In this logic, Deetz suggests, work is not supposed to be *for* 'body sustenance' and 'support of external relations', rather the reverse: 'the body and social relations are positive only in so far as they support work' (Deetz, 1998:166). Competing identities and needs are suppressed and considered as potentially intrusive and capable of leading to inefficiencies.

Deetz's characterisation of the voluntary subordination found increasingly in employees within the new economy paints a bleak picture. What appears to be a relaxed and non-hierarchical place to work is reduced, from this perspective, to an example of the growth of an 'insidious means of control'. The method of control outlined here stands in almost complete opposition to that identified at Consignia - employers at The Byte have no desire to measure performance, to get 'inside' and attempt to modify the employees' physical and mental capacities, nor to instil techniques designed to withstand work pressures. However, according to Deetz, the overall effect of the methods of control encountered at The Byte is that *employees control themselves on behalf of others*. The 'rules' are not set by management but are self-devised by employees for their own 'success'.

If Deetz's thesis is correct, and the data analysis does largely seem to support it, then there may be profound implications for the health and well-being of Byte employees and Directors alike, as both perceive existing working practices to be beneficial, conducive and in their long-term interests. Analysis of the interview texts has revealed some of the ways in which the health and well-

being of all the staff could be compromised by their willingness to strategize their self-subordination. Some of the ways in which processes of self-regulation and responsibilisation - not just of health - are discursively constructed, justified and achieved have been highlighted.

The managerial strategy at The Byte can now be seen as partly to do with discursively constructing a minimal need for the regulation of work and health practices and processes, which affords a perception of maximum autonomy and freedom for each and all. In short, the way in which work is constructed at The Byte serves to create an environment which appears to be unlike 'conventional' work. Perhaps the most dizzying manifestation of this was articulated by Phil:

> *Phil*: You know, we have a guy who's a programmer back there, he can't seem to do his job without being stoned. So you know, we don't encourage it but we say 'yes, if you want to nip out, fine, no problem'. So we sort of think here that more towards just making it comfortable for people you know - 'do whatever you like'. Whether that's a good thing or not I don't know, but it helps with producing the work.

What is 'good' or 'bad' is constructed as a member's concern. All staff are encouraged to develop their own particular ways of working: they are encouraged to discover their own 'best' way of managing the pressures and problems encountered in the work environment. The management seem keen to foster (and exploit) ways of working which make work seem as little like conventional work as possible. Behaviours which are barely tolerated in wider society, indeed, behaviours which are illegal and widely understood to be detrimental to health, if seen as conducive to making employees feel comfortable, and if they appear to contribute positively to productivity, are deemed acceptable.

Unlike many of the understandings encountered in the data from Consignia, there is a reluctance here to make any moral judgements about employee behaviour. As long as the work continues to be produced to a high quality, little else seems to matter. Behaviours understood to be unhealthy are neither ridiculed nor evaluated. This does not express an *absence* of morality, nor the deliberate exploitation of employees, rather it articulates a certain ethos: an ethos in which *freedom from regulation* (for example of behaviours deemed

risky in other contexts) *and freedom of choice* - freedom to work and behave in ways that are formulated by the self - is of paramount importance. In terms of risk, the allowing of risky, sometimes illegal activities may in fact connote a certain solidarity between directors and employees which marks them as a group in which 'Others' are composed of those external to the company who are perceived to embrace more conventional understandings of work, health and risk. This model of existence, involving freedom of choice, freedom to self-assess risks and benefits, a lack of moralising about behaviours, freedom from regulation and the consequent acceptance of responsibility *is* the subject position offered by the underlying rationality of neoliberalism. In terms of workplace health risks, if an employee at The Byte is made ill through their work, there is no-one to blame *but themselves*. The wider conditions which give rise to working practices at The Byte become perceived to be beyond the influence of employers or employees.

Short-term/long-term

Much of the discussion in the Consignia case study was concerned with the opposition between short-term and long-term health benefits, with the Occupational Health Advisor and Director of the Employee Health Services frustrated in their attempts to 'make the business case' deemed necessary to ensure adequate consideration of the longer-term health needs of their employees. Using Deetz's framework, the health risks to individuals at The Byte are one of the main unacceptable costs to be paid for strategies of self-subordination. However, in the constructions of the fundamentally neoliberal employees at The Byte, these health risks - constructed by employees as predominantly short-term - are calculated by them as the 'price' to be paid for potentially longer-term benefits. By investing the self in demanding and potentially hazardous work with clear health risks now, as a means to increasing their human and material capital, staff at The Byte are 'gambling' that their longer-term prospects - in terms of financial security and quality of life (which includes health needs) - will be greatly improved. However, to suggest that *all* employees *fully* embrace the subject position afforded by the approach to health and work at The Byte is not consistent with the data. Dissatisfaction with the existing work/health arrangements at The Byte came from Ruth, the

Office Manager, and Steve, who when asked if he suffered from RSI, responded:

> *Steve*: Oh right, I do get a bit of that - I tend to swap mice quite regularly, I've got a few. Occasionally, there was one time when it did get rather kind of, I started to feel some pain regularly in my right hand and ended up just swapping hands and mousing with my left hand for a while, which did help a bit. I mean they've been very kind of open to getting me new toys and new things to try and help *me* sort it out
>
> *Russell*: Is that an arrangement you're completely comfortable with?
>
> *Steve*: yes, *just about, I might, I don't know, I perhaps should say more*, about perhaps things like chairs and desks, coz I haven't got exactly long legs, does tend to be a bit of a high desk for me. But *I'll* get these things worked out at some point I guess.
>
> *Russell*: Are you a bit reluctant to?
>
> *Steve*: I don't know, *I'm just a little bit reluctant to ask for things* but that's just kind of the way I am I guess.

Ruth's acceptance of the company's inability to afford a chair for her, which she believes would help protect her back, and Steve's reluctance to 'say more' or to 'ask for things' (which he believes would help to protect his health), support the position of Deetz. Steve's *healthful* 'self', it could be argued, has become 'subordinated' by a strategy designed by Steve to realise his personal goals of enjoyable, creative employment, of using The Byte's facilities to 'build up resources', and thus investing in his future through gaining valuable work experience. Because responsibility for health is devolved to Steve, he becomes accountable for failing to protect himself against harm. This could signify self-incompetence, and not 'sorting it out', from within this context, becomes irrational. Because there is a lack of visible authority/hierarchy to question or challenge, there are practical constraints on his choices within the conditions found at The Byte. It becomes Steve's responsibility to negotiate health and safety issues with his managers, the directors - a position he feels uncomfortable with. The reasons for not 'sorting out' his workstation become individualised. The 'cost' of accepting the existing conditions is exposure to potential harm, but this is a price that he, positioned as a free, rational, calculating and choosing subject, is prepared to pay. The extract above

demonstrates that he struggles to make sense of this within the discursive conditions at The Byte.

The preceding section has looked at the health/work nexus at The Byte, and has utilised Deetz's thinking on strategized self subordination to illuminate the relations between risk, regulation and the neoliberal subject working within the new knowledge economy. This final section discusses some of the wider - yet still work-related - conditions which impact upon the health of those at The Byte.

Technologies of self

All of the staff at The Byte express an appreciation of the importance of being and staying 'healthy', although it was only Ruth - the Office Manager - who regularly took measures thought to be conducive to good health. For the other interviewees expending time, energy and resources on behaviours understood to be conducive to good health was not a priority. They generally saw activities solely dedicated to improving health as not enjoyable or, for some, a waste of time. However, Ken and Steve did express an interest in taking up such behaviours, but outlined some of the difficulties in achieving this aim:

> *Ken*: Yes, I'd like to do that (go to a gym). When you see friends who've done it and it benefits them, it seems like a good idea. I suppose it's not always easy finding the time for stuff like that, especially, you know, if you've just finished, you've just done a long day at work, you don't want to spend an hour swinging on a bar or whatever.
>
> ---
>
> *Steve*: I do think I should get some more exercise, go out, go swimming a bit more or something, but I mean a lot of it is that I don't have the time and energy at the moment.

The culture of long hours is here implicitly constructed as an obstacle to undertaking exercise for Ken and Steve: lack of time and energy meant that they were both disinclined to spend time at the end of the day undertaking bodily regimes. Again we see the culture of the workplace/force tending to inhibit the uptake of behaviours understood to be healthful. One particularly illuminating account in terms of the wider relations between health, risk and the neoliberal subject, was offered by one of the directors, Phil.

The ethos of freedom at The Byte, of minimal government of others and maximum government of self, is exemplified by Phil. Earlier accounts offered by Phil state that he believed everybody enjoys working at The Byte, 'mostly because of the way we work'. The highly valued ethos of freedom at The Byte posits a subject position in line with that of neoliberal discourse: a rational, self-reflexive agent endowed with ability to make cost/benefit calculations and correct choices. However, the following account challenges this neoliberal - and a particular (post)modern sociological - characterisation of the subject. It should be remembered Phil suffers from a degenerative condition which means that without a strict bodily regimen of stretching exercises his condition is expected to worsen rapidly. It is worth quoting at length.

> *Russell*: Are there things that you do which are not beneficial for your health shall we say?
>
> *Phil*: Oh yes, absolutely, smoking drinking, I don't always eat well, I don't always eat regularly, I don't do enough exercise. I should be stretching, that sort of thing, everyday, and some days I get up late and I don't do it - I know I should be doing it everyday, you know, working here, you know I'm sitting at the chair all day every day.
>
> *Russell*: That's something I'm going to come on to, muskulo-skeletal stuff, I suppose it's particularly salient in your case. What about drug taking - do you indulge every now and again?
>
> *Phil*: I indulge every now and again yes, I used to do more in my earlier days.
>
> *Russell*: didn't we all.
>
> *Phil*: Yes, but I mean class A drugs like coke and speed and stuff like that, they just do me a lot of damage, yet I still do them every now and again you know. It's now more like once every other blue moon you know, it's very infrequently, but I feel it straight afterwards and I'm struggling for 2 weeks afterwards but it doesn't stop me.
>
> *Russell*: So you would like to change some of these activities, but feel compelled for whatever reasons to indulge?
>
> *Phil*: Yes, I don't even question it so much any more because I've never really worked out why I don't do all the right things, yes.
>
> *Russell*: You mentioned that occasionally you do things which are more proactive about your health.

Phil: Yes I do. I mean when I remember I do a lot of yoga type stuff, just to try and keep supple, you know. I try to do a bit of walking every now and then. But I can spend three or four weeks without doing anything remotely connected to exercise, you know.

Russell: Are there barriers which could be removed that would enable you to do a bit more do you think?

Phil: (long pause) *I don't really know. I don't know why I don't just get off my arse and do some. I just don't. That's the answer really.* Nothing ever seems, I mean, a classic example is I was told - it was stressed to me - by my rheumatologist that I had to do this 'making myself supple', you know yoga type things. I didn't do it for six months and then I found out on my next check up that two more of my vertebrae had fused together purely because I couldn't be arsed to do it. And even that still doesn't make me do it regularly. *I don't know why*. I don't know whether I'm just lazy or what. I mean generally I know I'm not lazy because I can work like a Trojan when I have to, you know, that type of thing, it doesn't really bother me. But for some reason nothing seems to be urgent enough.

The notions of risk and self-responsibility are here dramatically conjoined. Phil 'knows' what the expert risk knowledge/guidance is about his condition. He states that he wants to do what is required to minimise the harmful effects of his condition, but simply 'does not know' why he fails to take appropriate measures. Indeed, he reports that he feels compelled to indulge in those activities which he understands to be harmful.

The 'model' of the modern citizen posited both by neoliberalism and by many social theorists, including Beck and Giddens, is that of a rational self-reflexive actor endowed with an ability to make rational choices about the most appropriate forms of conduct. Within this framework, it is clear that Phil is acting 'irrationally'[10]. It is clear that different contexts and different discourses produce different understandings of what it means to be rational. What 'counts' as a rational, responsible subject, and what counts as truth is here seen to be highly individualised. This exposes a fundamental contradiction within neoliberal discourse, namely, that as rational actors we are expected and thus responsibilised into making rational choices about appropriate forms of action,

[10] Unless, that is, we view his behaviour as symptomatic of a strategy which involves risking his embodied self in the short term in order to, as Deetz suggests, realise a 'strategy of self-subordination' *consistent with the requirements of the neoliberal order*. By this I mean that aspect of neoliberalism which rewards unbridled entrepreneurialism unbounded by 'bureaucratic' health discourses and regulatory 'red tape', although this is not how Phil's account constructs the problem.

although occasionally - or perhaps more pervasively - there is a high degree of subjective *uncertainty* involved in all human action, manifested in competing discourses and discursive practices, for example the widely differing approaches to the relations between work and health encountered in the two case studies.

This is manifested in Phil's uncertainty about the 'correct' reasons for his 'faulty choices'. For Phil these 'reasons' are presently unknowable and consequently uncertain, so his attempts to rationalise his behaviour finish up, like Steve's, with the potential for self blame. He constructs his situation as a profoundly *individual* problem, with *individual* solutions, thus constructing his failure to act rationally as an *individual* failure. Within neoliberal employee health discourse, ways of regulating employee health are uncoupled from the state and its agencies, and are placed, via companies, firmly within the 'choice' of the individual. While this may suit Phil up to a point, he is clearly uncomfortable with the responsibility for rationalising and meeting the conflicting needs of work and health. For Phil, these needs *do* conflict (for example time to exercise versus time to meet deadlines). This fundamental conflict of interests *now placed within the individual* is played down in the state's emphasis upon companies making a business case for good workplace health standards. Phil's account, like Steve's, struggles to make sense of his behaviour partly because it does not fit with the dominant neoliberal discourse which posits rational, self-reflexive, risk-minimising agents of choice. The truth-effects hoped for by neoliberal discourse - that Phil is best placed to use expert and self knowledge in order to rationalise and modify his own behaviour in a way that complements the objectives of increased individual and company productivity and competitiveness, and thus make the 'correct' choices concerning his health and work-related behaviour - are here exposed as highly problematic.

7.4 *Conclusion*

At The Byte, health status is constructed as one element of a person's human capital which may be used strategically - by the self to benefit the self - within the context of deferred rewards and long term investment in the self. Staff at The Byte reconstruct workplace health risks as offering a potential 'shortcut' to a

better existence in the future. At The Byte, the question 'is it acceptable for employees to harm themselves in the process of their daily work practices?' is 'yes'. It is largely acceptable to both employees and directors. The answer to the question 'where is responsibility for the health of The Byte employees located? is a resounding 'within the employee'. While responsibility for many aspects of work at The Byte is shared, it is up to the individual to decide whether the existing working practices - which involve a significant 'risk' to health - are acceptable or not, although the data suggests that no-one was inclined to challenge them.

It could be argued that staff at The Byte are 'trading' aspects of their health for a particular form of freedom. A form of freedom in which autonomy is highly valued and the desire to be free of as many 'rules and regulations' as possible means that self-regulation, and thus self-responsibility, is the price to be paid. This form of freedom includes the freedom to engage in unhealthy, risky behaviours, especially if those behaviours are themselves used for strategic aims.

Both Giddens (1998) and Beck (1992) claim we are all now self-reflexive citizens who actively shape our own conduct and our relations with others by becoming dependent upon a wide range of experts who we actively use to regulate everyday life. It is suggested that we are confronted with a complex array of alternatives, especially in relation to lifestyle, and that governance of all manner of institutional domains - including health and work - are now organised around risk management rather than moralised enforcement. Governance, they claim, is increasingly future orientated and more focussed upon risk prevention, risk minimisation and risk distribution. We are supposed to be preoccupied with insecurity and this insecurity in turn leads to an insatiable demand for new knowledge, knowledge designed to limit the riskiness of everything. Society, it is argued, is characterised by the management of risks.

Staff at The Byte make this view highly problematic. First, they are certainly not dependent on a range of experts for guidance about their health and work-related behaviours. Second, risk *is* important to Byte staff, but not in the ways anticipated by Beck and Giddens - some risky activities such as the refusal to

take breaks and working long hours, and in one case, illegal drug use, are positively valued within the context of deferred gratification and productivity. Third, there was little evidence that staff at The Byte are presently preoccupied with insecurity. In fact, the opposite appears to be true in that some of them explicitly stated they feel more secure than they ever have, although it could be argued that the desire for long-term security motivated many of their choices and behaviours. Finally, there was nothing in the data to support the view that Byte staff are continually seeking out new knowledges on which to base their actions. While The Byte may be an exceptional workplace in many respects, it does provide much evidence for the modification of some influential and powerful recent social theorising. The legitimacy and dominance of the model of the individual which posits a self-reflexive, rational and self-responsible choice-maker, means that some people struggle when they find themselves doing things that are difficult to rationalise. The individualising tendencies of this model, and lack of alternative explanations, can lead to self-blame.

The directors and employees at The Byte largely escape the 'grid of visibility' cast over society. They are largely unmonitored, not subject to surveillance nor techniques of examination and confession. At first sight it appears to be a Foucauldian utopia, a space devoid of panoptic and disciplinary effects. There exists a managerial strategy of disengagement at The Byte, employees can do what they like, however they like, as long as the work gets done. However, panoptic surveillance and disciplinary management is replaced by self-regulation and self-surveillance. Panoptic surveillance differs from self-surveillance in that even though both comprise self-surveillance, the motivations for this behaviour have been radically altered. In the panoptic sense, self-surveillance is undertaken because it is thought that someone or something else may be watching. In the 'post-panoptic' conditions experienced at The Byte, it is taken that no-one and nothing are watching.

In terms of responsibility for health, the *overall* result is the same both at The Byte and at Consignia. Employees continue to subjectively experience health problems that they understand to be caused by work, but are positioned as responsible for failing to take adequate measures to protect themselves. The key difference is that at The Byte this is achieved *in the absence of any*

recognisably regulatory measures, and without the use of any recognisable technologies of power or disciplinary mechanisms, and thus *in theory* employees are able to be more productive and competitive. Calculations of risk exist but are devolved to employees. That there are 'costs' associated with occupying this position is not lost on directors and employees. The costs are self-assessed within a framework of long term investments against what they hope are short term discomforts: the 'personal business case' for (self) regulatory health measures remains unmade. The motivations, values and beliefs of The Byte staff are mobilised as justificatory strategies for working long hours and subjectively experiencing a range of health disorders including stress, headaches, back-ache, RSI and eye irritation. While those at The Byte appear to make largely rational calculations about the extent to which they are willing to strategically subordinate aspects of their self, the appeal to freedom does, nonetheless, continue to serve the interests of capitalism, and helps to achieve the state's preferred neoliberal subject position. The responsibilities encountered at The Byte are profoundly individual ones. The mode of (de/self)regulation identified at The Byte, is thoroughly decentred.

8.1 *Introduction*

This thesis utilises a range of theories, concepts and analytic methodologies informed by the works of Foucault. An attempt has been made to combine Foucauldian theory with literature developed since his death, particularly the governmentality and policy-as-discourse literature. Foucauldian influenced methods of Discourse Analysis have been employed in order to say something about relations of power encountered in the regulation of employee health, and about subjective experiences. An attempt has been made to reveal the mechanisms and processes of government and regulation, and to examine the roles and understandings of the state, companies, health professionals and employees within them. By situating the analyses within a Foucauldian frame it has been possible to explore some of the links between political power, health knowledge and expertise, organisational dynamics, and subjective understandings and behaviours, in order to increase our understanding about emerging forms of regulation.

In line with the stated aims, this thesis has explored the influence of an underlying neoliberalist political rationality upon emerging forms of regulation, through an investigation into the different ways in which employee health is problematised at various sites. At the level of the state, a fundamental problematisation has been identified: *companies and individuals are understood to become more productive and competitive as a consequence of a reduction in the costs of work-related ill health*. At the level of the company, there is evidence of a diversity of localised problematisations of employee health, with little consistency in approaches to its regulation. Evidence which demonstrates the influence of the underlying political rationality of neoliberalism upon these problematisations has been foregrounded.

A rhetoric of a governmental shift toward ill health prevention has been identified. 'At risk' groups and individuals (including employees) are targeted with the aim of protecting society from the costs of population ill health. An attempt to disperse the state's preventative function into the workplace has

been identified. However, the *responsibility* for achieving a reduction in the societal costs of ill health is increasingly individualised. Strategies of power, as we have seen, do not necessarily realise their intended outcomes. How people actually respond to the external discourses and strategies that attempt to shape them has been a key theme of this thesis. A Foucauldian framework has been useful in trying to explicate the inter-relationship between the imperatives of health management expressed at the national, institutional and organisational levels, and the ways in which individuals respond to them in their everyday lives. The main focus has been on local techniques and micro-powers. Some of the subjugated knowledges which inform everyday behaviour and understanding can be seen to play a major role in the interrelation of institutionalised and localised power.

This final chapter has two parts. The first part addresses the substantive issues, the second part the methodological and theoretical issues. The findings of each empirical chapter are summarised and discussed, where relevant through recourse to the research themes and questions developed in Chapter Three relating to: the institutional/organisational context; panoptic tendencies - monitoring and surveillance; subjective understandings and experiences; self-responsibility; and neoliberalism. Concluding remarks are made which conjoin the substantive and theoretical issues.

8.2 *Substantive findings*

Revitalising Health and Safety Strategy Statement

If we take Ericson's (2000) characterisation of neoliberalism as a model for governance 'beyond the state', we can see how the five basic assumptions, namely, the minimal state, the centrality of the market, the importance of risk and the emphasis on individual responsibility and individual choice, are all reflected within the RHSSS, and are implicated in what Black (2002) refers to as 'decentred' regulation. Analysis of the *Revitalising Health and Safety Strategy Statement* revealed it to be a thoroughly neoliberal document. The reluctance to take responsibility for the imposition of 'bureaucratic' regulations aimed at identifying workplace health-risks, which may stifle the 'choices' which

companies are encouraged to take about how best to approach employee health, and which results in individualisation of responsibility, is consistent with neoliberal assumptions.

The RHSSS is a manifestation of neoliberalism's attempt to expand the economic form to apply to the social sphere. Economic 'analytical schemata', and criteria for economic decision making - in the RHSSS the emphasis upon target setting and the making of a 'business case' - are transposed onto employee health concerns. The emphasis upon making the business case for employee health and safety measures encourages a market oriented system of action. As well as the stated aim of reducing the *rates* of work-related accidents and ill health, there is a clear and explicit emphasis upon increased productivity and reduction of the 'bill' generated from work-related accidents and ill health.

The preference for decentred regulation is demonstrated most clearly in the RHSSS by the rejection of centralised risk management. The responsibility for assessing workplace health risks is dispersed to companies. The neoliberal approach to employee health attempts to erase risky behaviours, provided the costs do not compromise increased productivity and competitiveness. Analysis of the RHSSS reveals that the object is to target employees as a 'risky population', and to transform their status into individuals/groups capable of managing their own risks.

Analysis reveals a problematisation of employee health within the RHSSS designed to justify a strategy of decentred regulation. The RHSSS goes further than this, though, by actively creating preferred subject positions for companies and individual employees. Companies are positioned as responsible if they recognise and make the business case for employee health. Employees are positioned as responsible if they remain motivated, fit for work and productive: *happy, healthy and here*. Companies and individuals who deviate from these positions are deemed irresponsible within the terms of the RHSSS.

The general employee health strategy at Consignia is to collapse health into well-being and to regulate some work activities, such as lifting and handling and walking on snow and ice, for example by imposing limits and insisting on the use of specialised equipment. Failure to comply effects disciplinary action. Similarly, a disciplinary approach to sickness absence was identified. A range of motivations and justifications are offered by senior executives, the Chief Medical Advisor/Director of the Employee Health Services, the Occupational Health Advisor and the Fitness Suite Manager, for becoming involved in the health and well-being of employees. At the broadest level, the negative impact upon productivity that work-related ill health may have was made explicit by them all.

Consignia's response to the *Revitalising Health and Safety Strategy Statement*, evidenced in their *Annual Report*, suggests a shift *toward* a more targeted, proactive approach, with the 'active pursuit of improved health and safety as a real business goal'. However, even though managers are encouraged to realise health and safety targets, the trend at Consignia is identified as a move *away* from proactive health measures toward reactive ones. Evidence suggests that the desire of health professionals at Consignia to take more proactive health measures is thwarted by the difficulties associated with making a business case. Managers claimed that the business case for health initiatives was difficult to make, due to the dominance of short-term interests. Other motivations identified in the accounts ranged from wanting to improve employee 'coping skills' to making workers 'a credit to the workforce', although these motivations acted as justificatory strategies for attempting to improve employees' fitness to work.

At Consignia health professionals play a key role in shaping health strategies and in directing the health-related behaviours of employees. The Occupational Health Advisor directs the health-related behaviours of employees by identifying the need for some employees to improve their physical and psychological selves. Employees are positioned as in need of disciplinary health regulatory measures, in order to ensure safe working practices and minimal sick leave.

In addition to centralised monitoring of sickness-absence, work-related accidents and ill health, there is evidence of a range of more sophisticated monitoring and surveillance technologies. These include the 'superpanoptic' Q-Health project, which aims to produce a high degree of self-surveillance and self-responsibilisation for non work-related health. Evidence supports the view that these technologies utilised at Consignia enable information about employees' private lives to become available - albeit in anonymised form - to Consignia. This furthers the 'corporate gaze' into areas of employees lives previously considered outside the jurisdiction of the company. In addition to monitoring and surveillance, a number of other factors suggest erosion of the boundaries between work and non-work. For example, the provision of an on-site gymnasium means employees in my sample are inclined to spend some of their non-work time at their workplace. The collapsing of health into well-being, and the provision of in-house welfare services, means that all Consignia employees are encouraged to divulge details of non-work-related problems to Consignia. For the Chief Medical Advisor, the work/non-work dichotomy is seen as an 'artificial distinction'. Employees presenting to the Occupational Health Advisor are encouraged to submit to an examination and to 'confess' that all is not well outside work.

The employees interviewed generally accept the need for health regulation and evaluate positively Consignia's overall approach to health. Employees broadly accept the need for a disciplinary approach to sickness absence management, although it is recognised that some employees are perceived to fall foul of the system through no fault of their own. It is generally accepted that regulations are designed to act in the interests of employees. Evidence suggests that regarding some behaviours, for example lifting and handling, health and safety concerns have become absorbed into the culture of the workforce. Employee's monitor their colleagues and their own behaviour, thus partially realising an important element of the state's preferred strategy on employee health. Those perceived to be 'resisting' health strategies are admonished by managers and fellow employees.

However, if the meaning of workplace health strategy is broadened to include the Occupational Health Advisor's approach to stress management, for

example, a different picture emerges. One could, for example, speculate that some employees presenting with stress and requesting a decrease in night duties may dispute the prognosis of the Occupational Health Advisor that they need to increase their coping skills. The cause of the subjective experience of stress would be contested, although the solutions offered all arise within the neoliberal rationality. Further, despite the size of the Q-Health screening project, two-thirds of Consignia employees could be conceptualised as 'resisting' involvement with it.

At Consignia, because of the perception that hazardous working practices are heavily regulated, when ill health is understood to arise as a consequence of work, employees tend to accept that Consignia is absolved of responsibility. Regulations with disciplinary consequences enforce the process of responsibilisation. Once employees are made aware of workplace health risks, it is their responsibility to avoid them. At Consignia, employees are encouraged or disciplined into agreeing to a range of normalising, therapeutic training measures, designed to empower, enhance and optimise their performance, and to transform them into risk-calculating subjects.

The Byte

At The Byte, in contrast to Consignia, a strategy of providing minimal health information and intervention is adopted. Employees are encouraged to identify their own health needs and make requests for specialised equipment designed to minimise harm. There is no evidence for *any* health regulatory measures, and there is an informal approach to the management of sickness absence. A range of motivations and justifications are offered for *not* becoming involved in the health concerns of employees. Health measures are constructed as unwelcome impositions, and financial constraints is offered as a justification for making health concerns a low priority. The concept of a business case for health is not recognised at The Byte and there is no evidence to suggest any influence of in-house health expertise.

Employees at The Byte are positioned as highly autonomous and capable of identifying their own health risks and needs, evidenced in part by the absence

of monitoring and surveillance technologies. Much of the literature (Goss, 1997; Haunschild, 2001; Deetz, 1992; Cheek and Willis, 1998) emphasises the role of panoptic monitoring and surveillance technologies in disciplining employees into adopting healthy behaviours. However, their absence at The Byte is interesting in that it demonstrates that panopticism does not constitute a *necessary* element in the regulation of employee health and the process of responsibilisation.

At The Byte the boundaries between work and non-work are also highly corroded, but in a very different way from Consignia. The Byte is made to seem as little like a conventional workplace as possible. Highly informal communication, personalised workspaces and a lack of 'clock watching' contribute to an experience of work which is unlike traditional conceptions. The workplace culture positively evaluates the long hours that are worked which are justified through appeals to dedication, quality of work and deferred rewards.

At The Byte the non-interventionist approach to health is broadly welcomed by employees, and contributes to the sense of autonomy and freedom experienced there. Some health practices - for example the introduction of screen freezes - were constructed by interviewees as having the potential to detract from the quality of work. However, evidence suggests some employees are uncomfortable requesting equipment they feel would minimise harm to their health. While broadly welcoming the extension of autonomy into health considerations, it is clear that some employees do not request equipment designed to protect their health. It is difficult for some employees to make sense of this. Because employees can work in whatever manner they like, as long as the work gets done, to 'resist' the (lack of) regulation is to *insist upon* regulatory measures. Because of the workplace culture and the ethos of freedom, Byte employees are reluctant to challenge existing arrangements.

All the interviewed employees at both case studies made connections between work and health status. Many have subjectively experienced ill health that they perceive to be a direct consequence of working practices. At The Byte, when ill health is perceived to arise as a consequence of work, it is constructed as acceptable because the benefits of working there are constructed as adequately

compensating for it, or that their own interests are subordinate to the needs of the company. In both case studies, in very different contexts, the data demonstrates that employers, the state, and its agents, are absolved of responsibility for employees' subjectively experienced ill health, even when it is understood to be primarily work-related. This is highly significant in the wider context of the withdrawal of the welfare state.

Evidence supports the view that all employees are encouraged and/or directed, to some extent, to become self-responsible for their health. Indeed, analysis from all three empirical studies shows that processes of (de)responsibilisation are at the heart of emerging approaches to the regulation of employee health. At The Byte, self-responsibility is achieved in an altogether different way from Consignia. Here it is the *lack* of regulation, and lack of employer provision of specialist equipment and expertise, that results in a (sometimes reluctant) acceptance of self-responsibility for health. The responsibility for the identification of health risks at The Byte is with the employee, and is no longer a matter of scientifically informed production of truth by professionals. Rather, it enters into the space of 'negotiated settlement' (Dean, 1999:169).

Having summarised the main substantive findings from the three empirical chapters, the discussion widens and becomes more critical, making the links between the different elements involved in the regulation of employee health more explicit. Two recurring key terms/concepts are understood to be of great significance in the problematisation of the regulation of employee health: risk and stress. The chapter continues through discussion of the significance of these terms/concepts.

Risk and stress

Within the *Revitalising Health and Safety Strategy Statement* (RHSSS), risk acts as a central organising principle, with the identification and management of risks seen as essential to reduce rates of work-related accidents and ill health. At Consignia, the practices of risk assessment and risk management are claimed to be fundamental in the approach to employee health. At The Byte, in practice each employee becomes responsible for undertaking their own

informal, localised risk-assessment - although it is not conceptualised by staff in this way.

Within the RHSSS companies are encouraged to take responsibility for the identification and regulation of workplace health risks. Evidence demonstrates that contestation and competing understandings of the relations between fault, blame and responsibility become difficult to articulate or are made invisible through the practice of risk assessment. At Consignia, Bill struggled to articulate coherently the relations between fault, blame and responsibility when one of his colleagues fell on ice. Once something is formally identified as a health risk at Consignia, such as icy surfaces, it becomes the responsibility of the employee to ensure that ill health or injury does not arise as a consequence of exposure to it. The Q-Health project centres risk, with the focus upon those risk factors which the employee can, according to health promotion theory, control. The Chief Medical Advisor states that stress is approached through undertaking a risk-assessment, although data suggests a very broad meaning of risk in this context. Risk is here used to justify and legitimate examination of *any* factor which may impact negatively on productivity and to attempt modification of the behaviour of employees. The account of the Occupational Health Advisor makes explicit reference to non-work factors she constructs as having the potential to detract from employee productivity. Evidence also suggests that what is thought to 'count' as a *workplace* health-risk, is defined within the terms of workplace health and safety discourse. Poor management, for example, constructed by employees and the Occupational Health Advisor as having the potential to impact negatively on health, falls outside of workplace health risk discourse.

At The Byte, responsibility for identifying and taking measures to avoid health risks is laid firmly at the feet of employees. Each staff member takes on the responsibility for undertaking their own, small scale, localised and individualised 'risk-assessment', framed in terms of risk to health, against risk to the quality (and presumably quantity) of work they produce. Staff at The Byte legitimise those discourses which encourage the evaluative calculation that risks to productivity are more important than risks to health.

Fox's (1999) models of risk outlined in Chapter Two are relevant here. The 'constructionist' conception of risk suggests hazards are real but risks are constructed, that value laden judgements are mapped onto the hazards. So, for example, if people fail to protect themselves from risk they may be positioned as culpable. This was found to be the case at both case studies. At Consignia, employees failing to avoid risks are subject to victim blaming and disciplinary regulation. At The Byte, employees are subject to self blame. The 'postmodern' model of risk suggests both hazards and risks are constructed. This is useful in understanding that judgements about what constitutes a hazard or a risk occur within localised conditions. At The Byte, for example, autonomy is highly valued, which contributes to acceptance of responsibility for deciding what is considered an acceptable work-related health risk. At Consignia, certain practices, for example lifting heavy bags, are considered hazardous, and others, for example bag tying, are not. Because these conceptions of what constitutes a hazard or risk are contingent, dependent upon a complex nexus of localised conditions, we can agree with Fox when he states that the 'subjectivities which are created around risk, health and work are relative, and grounded in discursive fabrications of what is to be positively or negatively valued' (Fox, 1999:216). Evidence from The Byte also suggests agreement with Beck's assertion that

> experts dump their conflicts and contradictions at the feet of the individual and leave him or her with the well intentioned invitation to judge all of this (information) critically on the basis of his or her own notions (Beck, 1992:137).

The processes involved in deciding what elements of existence are considered risky are of great significance to understandings of regulation. Truth, power and the subject become linked in the discursive practice of risk-assessment. The truth-effects of particular constructions become far reaching. Once something is defined as a risk, then subjects who take measures to avoid them are positioned as responsible, those who do not, as irresponsible. Clearly a conflict of interest arises when the power to define what counts as a work-related health risk is dispersed into companies. For example, the desire for increased productivity and competitiveness, inflexible working hours, increased surveillance and monitoring, organisational change and job insecurity are unlikely to be considered work-related health risks by companies. This particular

conflict of interest is one which the state, through its problematisation of employee health, actively sanctions.

In addition to the increasing centrality of risk, over the last twenty years a multitude of diverse experiences and practices have been regrouped under the general rubric of 'stress'. Since the general appearance of the term in the 1980s employees began to recognise (literally 're-cognise', re-think) themselves as 'stressed'. Once the term became widespread and linked to work, all the different interested parties began to stake a claim in defining and tackling it[11].

It was hypothesised that once a person thinks of themselves as stressed, not only might they negatively evaluate their own well-being and ability to cope with work's pressures, potentially seeing themselves as somehow inadequate, but also, because of the State's preferred approach to employee health, they may be increasingly placed at the mercy of their employer. At The Byte, feelings of stress, especially when a deadline looms, have become normalised and are constructed as acceptable, so there is no formal strategy for addressing it. At Consignia, evidence suggests that there is every likelihood that the *cause* of the subjectively experienced stressed state will be located by a health professional as lying within the employee themselves, in their lack of general coping skills and/or lack of physical and psychological resilience, rather than within the working practices dictated by the employer.

The preferred strategy of the state, made explicit through analysis of the RHSSS, is to place responsibility for the definition, identification and resolution of stress with companies. From within the state's, and individual company's problematisations of employee health, feelings of stress are now widely perceived to be a consequence of health risks - although only rarely exclusively work-related ones. As a consequence, companies claim legitimate incursions into employees' private lives or encourage employees to become more self-

[11] The medical establishment and various disciplines - especially psychology - could claim expertise, utilising the prestige that accompanies it; pharmaceutical companies could market new products aimed at its relief; politicians could claim they were doing everything they could to fight a new epidemic; Government Departments and agents could demand increases in resources needed to research and combat it; stress management experts could market new techniques for minimising its harmful effects; occupational health professionals could claim more resources were needed to tackle it, and, evidence suggests, could more easily justify interventions into every aspect of employees' lives; unions could subsume a whole raft of other work grievances within it; employers could themselves go on, and send their managers on, a range of 'courses' designed to minimise its harmful effects and increase their company's productivity; and perhaps most significantly, though not always to their advantage, employees in every sector of work and at every workplace could now think of themselves as 'stressed'.

responsible for their health. This critique of stress is not to deny the reality of a problem, but to demonstrate further the influence of particular problematisations upon the regulation of employee health.

As neoliberal governance tends to focus on risk minimisation, the riskiness of everything comes into focus. In the context of stress, almost anything may be constructed as the cause, and the demand for new knowledge about possible causes - and solutions - increases exponentially. If virtually everything can be conceptualised as containing a possible risk, and under neoliberal rationality responsible government and subjects want to minimise risk, then the demand for knowledge relating to risks becomes insatiable. The new knowledge generated adds awareness to yet more sources of risk, and the risk-knowledge process becomes self-perpetuating (O'Malley, 1996).

Regulation

Analysis provides evidence of a decentred approach to regulation, which utilises the concept of risk, in order to enable an overall strategy of (de)responsibilisation: in the field of employee health, attempts are made to conduct conduct primarily through strategies of (de)responsibilisation.

The 'best' way of realising 'good regulation', the RHSSS suggests, is to enable regulation to become absorbed into the culture and behaviours of the workforce, that is, to responsibilise the workforce. The data from both case studies demonstrates that this objective has, in very different ways, already been largely achieved. Despite this, employees continue to report experiences of work-related ill health. The subject position made available to employees within the RHSSS, which reflects the neo-liberal dream of the autonomous, self-aware, self-responsible and above all productive employee - the *happy, healthy and here* employee - is *not* realised through contemporary problematisations of employee health. While employees at The Byte embrace the opportunity for self-regulation, the data suggests that *health* considerations are a low priority for these highly autonomous, 'self-regulating' subjects. They claim to be 'happy', and are rarely away from the workplace, but accounts suggest regular bouts of subjectively experienced work-related ill health. There is little motivation to

regulate their own health when confronted with what they perceive to be a choice between subjective experiences of freedom at work *or* the imposition of regulatory health measures. Subjective experiences of freedom *and* good health, within the discursive conditions of The Byte, are largely mutually exclusive. In the absence of any health monitoring, any work-related ill health experienced at The Byte is unlikely to be recognised within state targets.

Through decentred regulation, formal authority over employee health is devolved to companies. Consignia is positioned as 'free' to 'choose' a highly regulatory and disciplinary approach to employee health. The Byte is 'free' to 'choose' to reject this model of governance. The Byte exemplifies the view that in decentred analyses, regulation is what happens in the *absence* of formal legal sanction: regulation here becomes the product of local conditions rather than of the formal authority of government. Regulation, in the context of employee health, is shown to be primarily conceptualised in terms of the localised management of risks, rather than being explicitly concerned with serving the best interests of employees.

We are now in a position to suggest that analysis of the data demonstrates support for Black's expanded and updated definition of regulation:

> *Regulation is the sustained and focused attempt (manifested in the RHSSS/Consignia's approach to health) to alter the behaviour of others (companies and employees) according to defined standards (best practice) or purposes (risk reduction) with the intention of producing a broadly defined outcome or outcomes (at 'worst', reductions in rate of work-related ill health, at 'best', 'happy, healthy and productive' employees), which may involve mechanisms of standard-setting (targets), information gathering (of data on work-related ill health) and behaviour-modification (health 'improving' responsibilisation).*

We are in a position to agree with Black's suggestion that developing a 'decentred conceptualisation of regulation' helps to increase our understanding of 'contemporary socio-political relations', and 'unsettle our understandings of where the forces of legitimacy, authority and power are located in society' (Black, 2002:27). Evidence suggests the emergence of significant shifts in the relations between employees, companies and the state, with an extension of power (conceptualised as the ability to conduct conduct) granted to companies.

The way employee health is problematised enables the imposition of a neoliberal principle intended to 'animate and regulate' overall strategies and particular targets: in short, the principle of 'responsibilisation' (Osbourne, 1997:185).

From the perspective developed in this thesis, regulation becomes understood as *the production of (de)responsibilisation*. The objective of decentred regulation is shown to be individualised responsibility. The concept of responsibility is used strategically as a powerful persuasive trope, designed to change - or maintain - certain behaviours. However, one of the most interesting findings is that *the principle of responsibilisation can still be achieved in the total absence of formal regulatory systems.* Responsibility for health has been successfully implanted into companies and employees through modification of localised discursive conditions.

8.3 *Theoretical and methodological concerns*

Problematisation

At the broadest level, 'problematisation' has been utilised to conceptualise the 'practical conditions' which transform something into an object of knowledge. These practical conditions include accounts and understandings, documents, techniques and technologies, health and working practices, physical conditions and styles of management. These problematisations, these discursive practical conditions, are conceived as both limiting and enabling particular forms of subjectivity. Following O'Doherty and Willmott, it is contended that Foucault's concern was to explore and explain how it is that individuals become tied to an arbitrary sense of self, becoming subjects in the double sense: subjects who achieve actions, make choices etc. *and* who are simultaneously subject to something or someone (O'Doherty and Willmott, 2001:471). One of the implications stemming from this view, in the context of employee health, is that obligations, responsibilities, and health-risks are always constructed, experienced, and lived in specific social practices. This suggests a relational ontology rather than an individualistic, legalistic one. Moral and ethical

considerations are formed in situated practices which are themselves tied to the procedures used in their invention.

The utility of other concepts taken from Foucault in identifying relations of power is demonstrated through recourse once again to the issue of stress. This provides us with a good example of the 'truth-effects' of Foucault's 'Knowledge/Power' relations. New forms of knowledge, which claim to be 'true', yet which can be contradictory, result in powerful material effects. The Health and Safety Commission's response to the problem of 'stress' is to direct employers to 'take reasonable action to mitigate its effects'. But, as we have seen, the stress 'discourse' is saturated. It means many things to many people. The disputes over its causes and solutions have been foregrounded. Stress becomes a new 'object of knowledge' which shapes organisational, management, and employee practices, processes and behaviours, which in turn influence the way that stress is approached and understood.

Embodied in the discourse around stress (but also in other areas, for example sickness absence management) is an example of what Foucault terms 'power relations as strategic games between liberties' (Foucault, 1994a:299). The different interests (the Government and its agencies, health professionals, managers and employers, unions and employees) attempt to 'make stress mean' in particular ways, utilising different knowledges from different disciplines (for example psychology, sociology, biology, medicine) in order to gain acceptance of their particular view. For example, in the RHSSS stress is constructed as a risk to the effectiveness of the modern workplace; for our Occupational Health Advisor it is characterised largely as an 'inability to cope'; for employees it may be characterised as a consequence of 'job insecurity' or 'intensive working practices'; for managers it may be conceptualised mainly in terms of a negative impact upon productivity; and for the neoliberal rationality, something that is a 'cost' to society.

The methods adopted for dealing with stress at Consignia demonstrate the value of Foucault's thinking on the practices of examination and confession. The examination 'objectifies' the employee, reducing them to a complex of quantifiable variables over which the examiner can exercise their judgement in

developing responses. The confession extracted from the employee 'subjectifies' them and opens up areas for 'legitimate' intervention. The measures developed as a consequence of the employee's confession subjectifies them further. The employee, in the practice of stress management, is both objectified and subjectified, both processes contributing to their 'subjectivization' and 'individualization'.

Governmentality

The concept of governmentality draws attention to the reciprocal constitution of power techniques and forms of knowledge. The linking of governing (gouverner) with modes of thought (mentalite) suggests technologies of power cannot be studied without also analysing the underlying political rationality. Government both defines a discursive field in which exercising power is 'rationalized' (concepts are delineated, objects are specified, arguments and justifications are given) *and* it also structures specific forms of intervention (Lemke, 2001:191). 'Political rationality' gives rise to thinking about problems in particular ways which in turn leads to the implementation of political technologies aimed at addressing the problem. In this thesis the focus has been one problem for neoliberalism, namely, the social, economic and political costs of employee ill health and the political and localised technologies developed and aimed at its improvement.

The Foucauldian conception of government as the 'conduct of conduct' broadens understandings of where what we think of as regulation may arise, and brings the added dimension of self-regulation into view. It also provides a correction to the often voiced criticism of Foucault's work that it is too localised and context specific. The governmentality perspective widens the object of analysis so that underlying influences, such as neoliberalism, can be discerned. One objective of adopting insights from the governmentality perspective is to make clear the forms of thought implicated in problematisations of social phenomena. Accepting that the directing of conduct always includes some kind of 'technology' affords the exposure of a range of mechanisms utilised in regulation. Technology in this context refers to mechanisms and instruments through which governing is accomplished. For example, in addition to targeting

and other general techniques of numericisation, within neoliberal rationality great emphasis is placed upon the technology of the 'action plan'. This is evidenced in the RHSSS, but also within the Occupational Health Advisor's recommendation that employees presenting with stress develop their own action plan. These transposable technologies and techniques are foregrounded within the governmentality perspective.

At the level of the state, policies and strategies may be understood as technologies (for example the RHSSS), and at the level of the organisation, the practices of monitoring and surveillance. But from a governmentality perspective there are also technologies of the self, which include actions taken upon oneself in order to try and shape one's own conduct. Using the concept of technology it has been possible to show how processes of responsibilisation are achieved. From this perspective, both regulation and risk can be understood *themselves* as 'technologies of government'. Viewing risk as a technology, deployed governmentally in everyday practices and processes by a wide range of agents (including some employees such as those at The Byte who 'risk' their health in order to take a 'risk' on a better future), rather than viewing risk as a fundamental condition of society, as Beck does, means it is easier to view risk as aiming to achieve something other than simply a reduction in exposure to a hazard. For example, we have seen how risk is implicated in processes of responsibilisation. A focus on techniques and technologies emphasises practical features of government, for example ways of collecting and utilising information, types of training, kinds of calculation and the organisation of space. By paying careful attention to these features, which comprise a significant element of the 'conditions' of government, analysis has shown how regulation relies upon a range of practical factors. To achieve its ends, government must use technical means.

The theoretical strength of the governmentality perspective is that it sees neoliberalism not just as ideological rhetoric or a political-economic reality, but above all as a political project which endeavours to 'create a social reality that it suggests already exists' (Lemke, 2001:203). Neoliberalism is seen as a political rationality that tries to render the social domain economic and to link a reduction in (welfare) state services to the increasing call for personal responsibility and

'self-care'. The governmentality perspective allows us to identify the neoliberal labour that goes into attempts to manufacture individual and collective bodies which are 'motivated', 'lean', 'fit', 'flexible' and 'autonomous', that is, 'healthy'. Neoliberalism *itself* can be seen as a technique of power. The focus, from within an employee health context, has been the construction of an integral link between the health of the state, the health of companies and the health of individual employees. Some of the effects that neoliberal rationality has in terms of (self)regulation and domination have been brought to light. Using Foucualt's ideas, the thesis has attempted to demonstrate some of the ways in which the 'autonomous' individual's desire and capacity for self-control is linked to forms of political rule and exploitation.

Analysing discourses

As stated in Chapter Four, Foucault was reluctant to codify any particular methodological approach. So it was decided to identify and combine appropriate elements of discursive psychology, critical discourse analysis and the policy as discourse/cultural technology approach, with the broad theoretical framework in order to tackle the research questions. The analytic concepts and linguistic tools offered by these approaches proved to be productive. During analysis it was established that the boundaries between these approaches to discourse are unclear. For example, the concept of subject position is taken from Foucault and is utilised by all three approaches. Foucault never undertook the kind of detailed textual analysis undertaken in this thesis. His primary textual material was historical. There is no evidence to suggest he ever undertook analysis of transcribed interviews. However, by combining the governmentality perspective with forms of critical discourse analysis it has been possible to elucidate the mechanisms of decentred regulation and to identify those discursive strategies which justify, motivate, sustain or reject particular constructions of the regulation of employee health. Detailed analysis of texts reveals how socially constructed understandings of, for example, autonomy and flexibility can be used to justify particular practices, to justify activity or inaction, in particular contexts.

From the theoretical and methodological analytic position adopted in this thesis, the subject and truth, discourse and agency and relations and effects, are all immanent in each other. The capacity for action exists at the interface between subjects' sensibilities/moral choices and the discourses/institutions that surround them. Attention is focussed upon what can and cannot be thought or said within particular discursive conditions. Employee accounts sometimes demonstrated the difficulties of articulating particular understandings. At The Byte for example, Phil's discomfort with being positioned as accepting responsibility for rationalising and meeting the conflicting needs of work and health is clear. By situating the accounts in relation to the preferred subject position of neoliberal approaches to health, for example the *happy, healthy and here* employee, we can understand Phil's discomfort in his inability or reluctance to occupy neoliberalism's preferred position.

The explanatory power of the governmentality perspective, combined with the methods of discourse analysis, has helped to explore the empirical data and illuminate the processes of responsibilisation which lie at the heart of emerging forms of regulation. The mechanisms of such emerging forms of regulation have been exposed. Analysis has shown how these are influenced by neoliberalism, and reveals how specific problematisations give rise to certain constructions. It has been demonstrated that individual subjects sometimes struggle to make sense of their actions within the dominant conditions they find themselves in.

8.4 *Concluding remarks*

Traditional Health and Safety, within the terms of the RHSSS, is seen to be failing. Small companies are seen as incorrigible in their seeming lack of concern for the health of their employees and the stressed employee has become highly visible in society. Attempts to programme behaviour induce particular 'effects in the real' such as distinctions between true and false, between liability and responsibility, between acceptable and unacceptable risk, all of which are implicit in the ways people direct, govern or conduct themselves and others. Public policy, health and safety, and professional and personal discourses, under the influence of neoliberal rationality, highlight the individual as the most important site for determining health related practices and

behaviours. It is the individual who is constructed as ultimately responsible for deciding the extent to which particular health risks are avoided or minimised and, in some cases, what is to be identified as a risk.

The 'demand' for more autonomy, individual control and self-determination - more freedom - encourages the response of 'supplying' individuals and collectivities with the possibility of actively participating in the solution of specific problems which had hitherto been the domain of the state, special agencies, or expert institutions specifically empowered to undertake such tasks (Lemke, 2001:201). This process is exemplified at The Byte where maximum autonomy and self-determination accompany a virtually total elimination of employee health related costs.

Rather than adjusting the macro-economic policy, New Labour is concerned to reform the conduct of individuals and institutions to make them more competitive and productive. Active participation in health and safety establishes local sites of self government that can be indirectly managed by the new technologies of performance. New Labour make an appeal to freedom: companies, groups and individuals are positioned as responsible and autonomous agents who, if regulated at all, are subject only to the principles of decentred regulation.

The state and those companies which shape emerging forms of regulation, as this thesis demonstrates, systematically downplay those multiple structural factors which remain completely outside the control of individual employees, for example job insecurity, the generalised increase in the use of the concept of risk and the shift away from a centralised state - all of which have profound implications for the choices that can be made and the extent to which differently placed individuals are able to secure health and happiness. These significant factors are made invisible within their neoliberal discourses. No matter how self-responsible modern subjects become, there are inevitably going to be times when factors outside their control are going to determine, to some extent, their experience of health and happiness. These factors, although often difficult to discern, should not be confused with 'inappropriate' choices nor individual moral failure.

A sense of freedom at work is surely something to be highly valued, and some of the interviewees explicitly claim this. But Rose might ask if it is best characterised as a 'choice' or an 'obligation' for those at The Byte to assemble their own identities as a matter of their freedom. Following Rose (1999a), this thesis asks if there are costs associated with The Byte employees' sense of freedom, and answers with a resounding 'yes'. Evidence supports Rose's (1999a) hypothesis that the productive subject is to be governed as a citizen, as an individual striving for meaning in their work, seeking identity in work, whose subjective desires for self-actualisation are to be harnessed to the firm's aspirations for productivity, efficiency and the like (Rose, 1999a:244). In short, it is asserted in support of Rose's hypothesis, that employers and employees at The Byte are indeed to a great extent 'governed through their (sense of) freedom'. Staff at The Byte are the ideal citizens imagined by neoliberalism. They are self motivated, self regulating, highly productive and self governing. They remain productive and present at work without any recognisably regulatory measures. The subject position made available to them in neoliberal approaches to employee health is embraced by them, but doing so sometimes makes it difficult for them to understand certain of their own (in)actions. At The Byte there are no visible hierarchies, and a huge sense of freedom and autonomy. This makes it very difficult to suggest that this state of affairs is unacceptable, as it is clearly acceptable to The Byte employees.

The epistemological position developed in this thesis is problematic in terms of evaluating behaviours or developing practicable interventions. The classic criticism of those adopting a Foucauldian position, voiced explicitly by Haunschild (2001) in the context of employee health, is that it may not be possible to say whether anything is 'good or bad'. It remains very difficult, from within a Foucauldian perspective and a broadly social constructionist epistemology, to say if any of these practices, processes, constructions or understandings are actually 'good or bad' for individual employees. However, clearly the study has been critical of certain elements of existing problematisations of employee health. For example, it has been suggested that a clear conflict of interest arises when the power to define what counts as a work-related health risk is dispersed into companies. It is argued that neoliberalism gives rise to unwarranted moralisation and potentialities for

(self)blame and victimisation. It is further suggested that increasing self responsibility for health effects a movement of concern over working conditions toward a concern with the health and resilience of individual employees. It could be implied that individual employees exist in a 'false state of consciousness', that they are duped into acting in the interest of others at the expense of their own, and that therefore existing approaches to the regulation of employee health are simply 'bad' for employees. But from a Foucauldian perspective we cannot stand outside power-relations. We cannot stand 'on the side of freedom' to make the judgement that employees are wrong to accept these conditions. It is not up to me to suggest how employees should react to their conditions, it is a dilemma for the participants, a 'member concern', a concern that evidence suggests they struggle with. As we have seen, employees at The Byte are uncomfortable with elements of the approach to health there. To stand on the side of 'freedom', against 'the tyranny of domination and exploitation', is problematic within the Foucauldian view, for as the evidence shows, freedom is itself implicated with power-relations.

But there is a problem with this kind of analysis. Because employees are treated as discursive subjects they are positioned neither as duped nor agentic. The analysis does not make a case for *more* government or regulation, any more than it makes a case for *more* freedom. This tension exists within a broadly social constructionist epistemology. However, what we are able to point to and comment upon is the way power is exercised in contemporary society: power relations exist in, and are modified within, localised conditions. This does not condemn us to some nihilistic relativism. Analysis has identified a number of 'costs' to The Byte staff's sense of freedom: they are expected to work very long hours; they report very high levels of stress; and they ignore potentially long-term health problems for the promise of deferred reward[12]. From within the subject position that Byte staff occupy, if anything goes wrong, from profit failure to ill health, it is entirely the individual's fault.

And what of the more 'traditional' space occupied by Consignia employees - are there costs associated with working in an environment that is relatively heavily regulated, supposedly in their interests? Again the answer is 'yes' - costs not

[12] In Phil's case there is an apparent rapid decline in health.

only in terms of the physical harm that some practices produce, but also costs in terms of their sense of insecurity, in terms of the consequences of an intensification of work, in terms of the contempt for the strict hierarchal management structure, and for some, in terms of a profound sense of disillusionment and lack of hope for the future: all of which, the evidence suggests, have the potential to impact negatively on their health and well-being.

The 'government' of employee health has been identified, not only at the level of national policies and campaigns, but also within professional and discipline bound groupings, through organisational contingencies and within individual employees themselves. Attempts to guide the health related conduct of employees are manifold, with an array of responses elicited at the organisational and individual levels. The fact that so much of our behaviour can be conceptualised in terms of 'health impact' alerts us to contemporary conceptualisations of what it is to be human. The emphasis upon being self-responsible (as opposed to being responsible for others), flexible (when the 'flexibility' often works against one's own interests), and 'risk-aware' (when the constant incitement to worry about multiple aspects of existence can be counter productive), is currently highly valued by different sectors of society (politicians, health professionals and a wide range of other professions, and especially employers and directors in work organisations) and codified in their policies and strategies. These emerging values have implications for each of us, for our working, family and community 'identities' and relations, and for wider society.

From a Foucauldian perspective, ways of being are always tied to the motives and operations of power interests. The focus has been on the interrelationship between the imperatives of bodily management expressed at the institutional level, and the ways that people engage in conduct in their everyday life. The framework has allowed for notions of subjectivity which acknowledge a fragmented and contradictory self, pulled between many imperatives and desires - especially the desires to stay happy, healthy and wealthy which, as we have seen, under present conditions can be difficult to negotiate. The subject, caught within competing problematisations, can struggle to achieve an 'authentic' self. The study has shown how neoliberal informed approaches to the regulation of employee health have been recognised, ignored, contested,

translated or transformed, in the context of every day experience. An attempt to reframe working conditions as issues around responsibility for health has been identified. Whether responsibility is imposed or chosen has not been the question, rather, how, and under what conditions, is responsibility achieved? Emerging regulatory discourses penetrate the mind and body of employees, imposing disciplines of thought and behaviour, in the name of a neoliberal rationality hungry for ever increasing profitability.

Althusser, L. (1977) Ideology and Ideological State Apparatus in Althusser. L. *Lenin and Philosophy and Other Essays*. London: New Left Books.

Alvesson, M. (1992) Leadership as social integrative action: a study of a computer consulting company, *Organisation Studies*, 13(2),185-209.

Alvesson, M. (1994) *Management of Knowledge-intensive Companies*. New York: de Gruyter.

Alvesson, M. & Deetz, S. (1996) Critical Theory and Postmodernism: Approaches to Organisational Studies in Clegg, S., Hardy, C. & Nord, W.R. (eds) *Handbook of Organisation Studies*. London: Sage.

Armstrong, D. (1995) The Rise of Surveillance Medicine, *Sociology of Health and Illness,* 17, 393 – 404.

Bacchi, C. (2000) Policy as Discourse: what does it mean? where does it get us? *Discourse: Studies in the Cultural Politics of Education*, 21(1), 45 - 56.

Barker, J. R. (1993) Tightening the Iron Cage: Concertive Control in Self-managing Teams, *Administrative Science Quarterly*, 38, 408-37.

Barrett, M. (1980) *The Politics of Truth: From Marx to Foucault.* Stanford: Stanford University Press.

Barry, A., Osbourne, T. & Rose, N. (1996) *Foucault and Political Reason.* London: UCL Press.

Baumann, Z. (1996) On communitarians and human freedom: or, how to square the circle, *Theory, Culture and Society*, 13(2), 79-90.

Bauman, Z. (2001) *Community: Seeking Safety in an Insecure World.* Cambridge: Polity Press.

Baumann, Z. & May, T. (2001) *Thinking Sociologically, 2nd edition*. Oxford: Blackwell.

Beattie, G. & Doherty, K. (1995b) *Living the Troubles: A discourse analytic approach to understanding the reaction to violence in North Belfast.* Proceedings of the British Psychological Society, 3(1),17.

Beck, U. (1992) *Risk Society:Toward a New Modernity*. London: Sage.

Beck, U., Giddens, A. & Lash, S. (1994) *Reflexive Modernization: Politics, Tradition and Aesthetics in the Modern Social Order.* Cambridge: Polity Press.

Beck, U. (2000) Risk society revisited: theory, politics and research programmes in Adam, B., Beck, U. & Van Loon, J. (eds) *The Risk Society and Beyond: Critical Issues for Social Theory*. London: Sage.

Bendle, M. F. (2002) The crisis of 'identity' in high modernity, *British Journal of Sociology*, 53(1), 1-18.

Bennett, T. (1992) Putting Policy into Cultural Studies in Grossberg, L., Nelson, C. & Treichler, P. A. (eds) *Cultural Studies*. New York: Routledge.

Billig, M. (1987) *Arguing and Thinking. A Rhetorical Approach to Social Psychology.* Cambridge: Cambridge University Press.

Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D. & Radley, A. (1988) *Ideological Dilemmas. A Social Psychology of Everyday Thinking.* London: Sage.

Black, J. (2002) *Critical Reflections on Regulation.* London: London School of Economics and Political Science.

Brenot, J., Bonnefous, S. & Marris, C. (1998) Testing the cultural theory of risk in France, *Risk Analysis*, 18(6), 729-739.

Briner, R. B. (1996) ABC of work-related disorders: absence from work, *British Medical* Journal, 313, 874-877.

Brown, S. D. (1999) Stress as regimen: critical readings of self-help literature in Willig, C. (ed) *Applied Discourse Analysis: Social and Psychological interventions*. Buckingham: OU Press.

Bryman, A. (2001) *Social Research Methods*. Oxford: Oxford University Press.

Bunton, R., Nettleton, S. & Burrows, R. (eds) (1995) *The Sociology of Health Promotion*. London: Routledge.

Burchell, G., Gordon, C. & Miller, P. (eds) (1991) *The Foucault Effect: Studies in Governmentality*. Chicago: The University of Chicago Press.

Burman, E. & Parker, I. (1993) Introduction - discourse analysis: the turn to the text in Burman, E. & Parker, I. (eds) *Discourse Analytic Research. Repertoires and Readings of Texts in Action.* London: Routledge.

Burrell, G. (1988) Modernism, Postmodernism and Organisational Analysis 2: The Contribution of Michel Foucault, *Organisation Studies*, 9(2), 221-235.

Calas, M. B. (1999) Barry Turner for the ages of living dangerously: Risk, 'New capitalisms', and life in the coming century, *Organisation Studies*, 20(4), 683-694.

Castel, R. (1991) From Dangerousness to Risk in Burchell, G., Gordon, C. & Miller, P. (eds) *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press.

Chan, A. (2000) Redirecting Critique in Postmodern Organisation Studies: The Perspective of Foucault, *Organisation Studies*, 21(6), 1059-1075.

Cheek, J. & Willis, E. (1998) Health risk analysis and sociomedical technologies of the self: Private health insurance gets into health promotion, *Australian Journal of Social Issues*, 33(2), 119-132.

Clegg, S. (1998) Foucault, Power and Organisations in McKinlay, A. & Starkey, K. (eds) *Foucault, Management and Organisation Theory.* London: Sage.

Conrad, P. & Walsh, D. C. (1992) The new corporate health ethic: lifestyle and the social control of work, *International Journal of Health Sciences*, 22(1), 89-111.

Cooper, C. & Williams, S. (eds) (1994) *Creating Healthy Work Organisations.* Chichester: Wiley.

Coveney, J. (1998) The government and ethics of health promotion: the importance of Michel Foucault, *Health Education Research*, 13(3), 459-468.

Crawford, R. (1980) Healthism and the medicalisation of everyday life, *International Journal of Health Services*, 10, 365-388.

Crawford, R. (1993) A cultural account of health: control, release and the social body in Beattie, A., Gott, M., Jones, L. & Sidell, M. (eds) *Health and Wellbeing: a Reader.* London: MacMillan.

Crotty, M. (1996) *Phenomenology and Nursing Research.* Melbourne: Churchill Livingstone.

Dale, K. & Burrell, G. (2000) What Shape Are We In? Organisation Theory and the Organized Body in Hassard, J., Holliday, J. R. & Willmott, H. (eds) *Body and Organisation.* London: Sage.

Danna, K. & Griffin, R. G. (1999) Health and Well-Being in the Workplace: A Review and Synthesis of the Literature, *Journal of Management*, 25(3), 357-384.

Daunton, M. J. (1985) *Royal Mail: The Post Office since 1840.* London: Athlone.

Daykin, N. (1998) Workplace health promotion: benefit or burden to low-paid workers? *Critical Public Health*, 8(2), 153-166.
Daykin, N. & Doyal, L. (eds) (1999) *Health and Work: Critical Perspectives.* Basingstoke: Macmillan Press.

Deacon, R. (2000) Theory as practice: Foucault's concept of problematization, *Telos*, 118, 127-142.

Dean, M. (1999) *Governmentality: Power and Rule in Modern Society*. London: Sage.

Dean, M. & Hindess, B. (1998) Introduction: Government, Liberalism and Society in Dean, M. & Hindess, B. (eds) *Governing Australia: Studies in Contemporary Rationalities of Government.* Melbourne: Cambridge University Press.

Deetz, S. (1992) Disciplinary Power in the Modern Corporation in Alvesson, M. & Willmott, H. (eds) *Critical Management Studies*. London: Sage.

Deetz, S. (1995) *Transforming Communication, Transforming Business: Building Responsive and Responsible Workplaces*. Creskill, NJ: Hampton Press.

Deetz, S, (1998) Discursive Formations, Strategized Subordination and Self Surveillance in McKinlay, A. & Starkey, K. (eds) *Foucault, Management and Organisation Theory*. London: Sage.

Department of Health (1995) *Improving Health is Everybody's Business* (last modified 11 August 2000) http://www.signupweb.net/backup/Statement_ Intent/Satement_Intent.htm (accessed 19 February 2000).

Doherty, K. & Anderson, I. (1998) Talking about rape: perpetuating rape supportive culture, *The Psychologist*, 11(12), 583-587.

Doherty, P., Forslin, J. & Shani, R. (eds) (2002) *Creating Sustainable Work Systems: Emerging Perspectives and Practices.* London: Routledge.

Donzelot, J. (1979) *The Policing of Families: Welfare versus the State.* London: Hutchinson.

Donzelot, J. (1991) Pleasure in work in Burchell, G., Gordon, C. & Miller, P. (eds) *The Foucault Effect: Studies in Governmentality.* Chicago: University of Chicago Press.

Douglas, M. (1966) *Purity and Danger.* London: Routledge.

Dougals, M. (1992) *Risk and Blame: Essays in Cultural Theory.* London: Routledge.

Drucker, P. F. (1993) *Post-Capitalist Society.* Oxford: Butterworth Heinman.

Du Gay, P. (1996) *Consumption, Identity and Work.* London: Sage.

Eakin, J. M. & MacEachen, E. (1998) Health and the social relations of work: a study of the health-related experiences of employees in small workplaces, *Sociology of Health and Illness*, 20(6), 896-914.

Edwards, D. (1997) *Discourse and Cognition.* London: Sage.

Edwards, D. & Potter, J. (1992) *Discursive Psychology.* London: Sage.

Ericson, R., Barry, D. & Doyle, A. (2000) The moral hazards of neo-liberalism: lessons from the private insurance industry, *Economy and Society*, 29(4), 352-558.

Ewald, F. (1999) Foucault and the contemporary scene, *Philosophy and Social Criticism*, 25(3), 81-91.

Fairclough, N. (1989) *Language and Power.* London: Longman.

Fairclough, N. (1992a) *Critical Language Awareness.* London: Longman.

Fairclough, N. (1992b) *Discourse and Social Change*. London: Polity.

Fairclough, N. (1995) *Critical Discourse Analysis*. London: Polity.

Fairclough, N. (2000) Language and neo-liberalism, *Discourse and Society*, 11(2), 147-148.

Fairclough, N. & Wodak, R. (1997) Critical discourse analysis in van Dijk, T. (ed) *Discourse as Social Interaction: Discourse Studies: a Multidisciplinary Introduction*. London: Sage.

Findlay, P. & Newton, T. (1998) Re-framing Foucault: The case of performance appraisal in McKinlay, A. & Starkey, K. (eds) *Foucault, Management and Organisation Theory*. London: Sage.

Flick, U. (1998) *An Introduction to Qualitative Research*. London: Sage

Foucault, M. (1970) *The Order of Things: An Archaeology of the Human Sciences*. London: Tavistock.

Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. London: Allen Lane.

Foucault, M. (1979) Governmentality, *Ideology and Consciousness*, 6, 5-21.

Foucault, M. (1980) *Power/Knowledge*. Edited by Colin Gordon. Brighton: Harvester.

Foucault, M. (1981) *History of Sexuality. Volume 1 An Introduction*. London: Pelican.

Foucault, M. (1983a) Afterword: The Subject and Power in Dreyfus, H. L. & Rabinow, P. (eds) *Michel Foucault: Beyond Structuralism and Hermeneutics, 2nd edition*. Chicago: University of Chicago Press.

Foucault, M. (1983b) On the Genealogy of Foucault. An Overview of Work in Progress. Interview in Dreyfus, H. L. & Rabinow, P. (eds) *Michel Foucault. Beyond Structuralism and Hermeneutics.* Chicago: University of Chicago Press.

Foucault, M. (1984a) Nietzsche, Genealogy, History in Rabinow, P. (ed) *The Foucault Reader.* New York: Pantheon.

Foucault, M. (1984b) What is Enlightenment? in Rabinow, P. (ed) *The Foucault Reader.* New York: Pantheon.

Foucault, M. (1988) *History of Sexuality. Volume 2 The Uses of Pleasure.* London: Penguin.

Foucault, M. (1990) *History of Sexuality. Volume 3 The Care of the Self.* London: Penguin.

Foucault, M. (1991) *Remarks on Marx.* New York: Semiotext(e).

Foucault, M (1994a) *Essential Works Volume 1: Ethics, Subjectivity and Truth,* edited by Rabinow, P. New York: New York Press.

Foucault, M (1994b) *Essential Works Volume 2: Aesthetics, Method and Epistemology*, edited by Rabinow, P. New York: New York Press.

Foucault, M (1994c) *Essential Works Volume 3: Power*, edited by Faubian, J. D. New York: New York Press.

Fox, N. J. (1993) *Postmodernism, Sociology and Health.* Buckingham: Open University Press.

Fox, N. J. (1999) Postmodern Reflections: Deconstructing 'Risk' 'Health' and 'Work' in Daykin, N. & Doyal, L. (eds) (1999) *Health and Work, Critical Perspectives.* Basingstoke: Macmillan Press.

Fullagar, S. (2002) Governing the healthy body: discourses of leisure and lifestyle within Australian health policy, *Health: An Interdisciplinary Journal for the Study of Health and Medicine*, 6(1), 69-84.

Gabe, J. (ed) (1989) *Medicine, Risk and Health*. Oxford: Blackwell.

Gergen, K. (1985) The social constructionist movement in modern psychology, *American Psychologist*, 50(3), 266-275.

Giddens, A. (1984) *The Constitution of Society*. Cambridge: Polity Press.

Giddens, A. (1993) *Sociology*. Cambridge: Polity Press.

Giddens, A. (1998) *The Third Way: the Renewal of Social Democracy*. Cambridge: Polity Press.

Goss, D. (1997) Healthy Discipline? Health Promotion at Work, *Electronic Journal of Radical Organisation Theory*, 3(2), http://www.mngt.waikato.ac.nz /depts/sml/journal.

Grinyer, A. (1995) Risk, the real world and naive sociology in Gabe, J. (ed) *Medicine, Risk and Health.* Oxford: Blackwell.

Hall, S. & Jacques, M. (eds) (1983) *The Politics of Thatcherism*. London: Lawrence and Wishart.

Hall, S. & Jacques, M. (eds) (1989) *New Times: The Changing Face of Politics in the 1990s*. London: Lawrence and Wishart.

Hand, J. (2000) Data visualization helps save lives, *Synergy Magazine*, Spring.

Handy, C. (1984) *The Future of Work*. Oxford, Basil Blackwell.

Hatchuel, A. (2002) The Sources of Intensity in Work Systems: Cognitive and Relational Limits of Self-management in Doherty, P., Forslin, J. & Shani, R. (eds) *Creating Sustainable Work Systems: Emerging Perspectives and Practices.* London, Routledge.

Haunschild, A. (2001) Humanization Through Discipline: Foucault and the Goodness of Employee Health Programmes. *Paper submitted to 2nd International CMS Conference*, Manchester, July 11-13, 2001.

Health and Safety Executive (1999) *The costs to Britain of workplace accidents and ill health in 1995-1996.* London: HSE Books.

Higgs, P. (1998) Risk, Governmentality and the reconceptualization of citizenship in Scambler, G. & Higgs, P. (eds) *Modernity, Medicine and Health.* London Routledge.

Hinnings, C. R., Brown, J. & Greenwood, R. (1991) Change in an autonomous professional organisation, *Journal of Management Studies*, 28, 375-93.

Henriques, J., Hollway, W., Urwin, C., Venn, C. & Walkerdine, V. (1984) *Changing the Subject: Psychology, Social Regulation and Subjectivity.* London: Methuen.

Hollway, W. (1983) Heterosexual Sex: Power and Desire for the Other in Cartledge, S. & Ryan, J. (eds) *Sex and Love: New Thoughts on Old Contradictions.* London: The Women's Press.

Hook, D. (2001) Discourse, Knowledge, Materiality, History: Foucault and Discourse Analysis, *Theory and Psychology*, 11(4), 521-547.

Hopper, T. N. & Macintosh, N (1998) Management Accounting Numbers: Freedom or Prison - Geneen versus Foucault in McKinlay, A. & Starkey, K. (eds) *Foucault, Management and Organisation Theory.* London: Sage.

Gabe, J. (ed) (1995) *Medicine, Health and Risk - Sociological Approaches.* Cambridge: Blackwells.

Goodwin, N. (1996) Governmentality in the Queensland Department of Education: policies and the management of schools, *Discourse*, 17(1), 65-74.

Gordon, C. (1991) Governmental rationality: an introduction in Burchell, G., Gordon, C. & Miller, P. (eds) *The Foucault Effect: Studies in Governmentality.* Chicago: University of Chicago Press.

Grant, C. B. & Brisbin, R.E. (1992) *Workplace Wellness: The Key to Higher Productivity and Lower Health Costs.* New York: Van Nostrand Reinhold.

Greenwood, R., Hinings, C. R. & Brown, J. (1990) P2-form strategic management: corporate practices in professional partnerships, *Academy of Management Journal*, 33, 725-55.

Grundemann, R. W. M. & Van Vuuren, C. V. (1997) *Preventing Absenteeism at the Workplace: European Research Report.* Dublin: European Foundation for the Improvement of Living and Working Conditions.

Guttman, N. & Ressler, W. (2001) On being responsible: ethical issues in appeals to personal responsibility in health campaigns, *Journal of Health Communication*, 6(2), 117-136.

Health and Safety Executive (1999) *Work accidents and ill health cost society billions* http://www.hse.gov.uk/press/e99207.htm

Health Canada (1986) *The Epp Report: Achieving Health For All - A Framework for Health Promotion.* Ottowa: Health Canada.

Higgs, P. (1998) Risk, Governmentality and the reconceptualization of citizenship in Scambler, G. & Higgs, P. (eds) *Modernity, Medicine and Health.* London: Routledge.

Institute of Personnel and Development (1995) *The IPD Guide on Occupational Health and Organisational Effectiveness.* London: Centurian.

Institute for Public Policy Research (2000) *The Future of Work.* London: IPPR.

Jaworski, A. & Coupland, N. (eds) (1999) *The Discourse Reader.* London: Routledge.

Jones, C. & Porter, R. (eds) (1994) *Reassessing Foucault: Power, Medicine and the Body.* London: Routledge.

Kanter, R.M. (1989) *When Giants Learn to Dance: Mastering the Challenges of Strategy, Management and Careers in the 1990s.* New York: Simon and Schuster.

Knights, D. & Willmott, H. (1989) Power and Subjectivity: From Degradation to Subjugation in Social Relations, *Sociology*, 23(4), 535-558.

Knights, D. & Willmott, H. (1991) Corporate Strategy, Organisations, and Subjectivity: a Critique, *Organisation Studies*, 12(2), 251-273.

Lane, K. (1995) The Medical Model of the Body as a Site of Risk: A Case Study of Childbirth in Gabe, J. (ed) *Medicine, Health and Risk - Sociological Approaches.* Cambridge: Blackwells.

Lash, S. (1990) *Sociology of Postmodernism.* London: Routledge.

Lemke, T. (2001) 'The birth of biopolitics': Michel Foucault's lecture at the College de France on neo-liberal Governmentality, *Economy and Society*, 30 (2), 190-207.

Lewis, G., Gewitz, S. & Clarke, J. (eds) (2000) *Rethinking Social Policy.* London: Sage.

Lewis, R. A. (1952) *Edwin Chadwick and the Public Health Movement 1832-1854.* London: Green and Co.

Loyal, S. & Barnes, B. (2000) Agency as a Red Herring in Social Theory, *Philosophy of the Social Sciences*, 31(4), 507-524.

Lloyd, M. & Thacker, A. (eds) (1997) *The Impact of Michel Foucault on the Social Sciences and Humanities*. Basingstoke: Macmillan.

Lucio, M. M., Noon, L. & Jenkins, S. (1997) Constructing the Market: Commercialization and Privatization in the Royal Mail, *Public Administration*, 75, 267-282 .

Lucio, M. M., Noon, L. & Jenkins, S. (2000) The flexible-Rigid Paradox of Employment Relations at Royal Mail, *British Journal of Industrial Relations*, 38(2), 277-298.

Lupton, D. (1992) Discourse analysis: a new methodology for understanding the ideologies of health and illness, *Australian Journal of Public Health,* 16(2), 145-150.

Lupton, D. (1993) Risk as moral danger: the social and political functions of risk discourse in public health, *International Journal of Health Services*, 23(3), 425-435.

Lupton, D. (1994) Consumerism, commodity culture and health promotion, *Health Promotion International*, 9(2), 111-18.

Lupton, D. (1994) *Medicine as Culture: Illness, Disease and Culture in Western Societies*. London: Sage.

Lupton, D. (1995). *The Imperative of Health: Public Health and the Regulated Body*. London: Sage.

Lupton, D. (1999) *Risk*. London: Routledge.

McGillivray, D. (2002) Health promotion in the workplace: a missed opportunity? *Health Education*, 102(2), 60-67.

McGillivray, D. (1999) Work and leisure - an evaluation of corporate provision for employees, *Leisure Studies Association Newsletter*, 52, 20-39.

McGuinness, P. (2000) *New Work New Stress.* London: Industrial Society.

McKinlay, A. & Taylor, P. (1998) Through the Looking Glass: Foucault and the Politics of Production in McKinlay, A. & Starkey, K. (eds) *Foucault, Management and Organisation Theory*. London: Sage.

McKinlay, A. & Starkey, K. (eds) (1998) *Foucault, Management and Organisation Theory.* London: Sage.

MacEachen, E. (2000) The mundane administration of worker bodies: from welfarism to neoliberalism, *Health, Risk and Society*, 2(3), 315 - 327.

Malcolmson, R. W. (1973) *Popular Recreations in British Society: 1700-1850.* Cambridge: Cambridge University Press.
Marx K. & Engels, F. (1976) *The German Ideology, 3rd edition*. London: Progress.

May, T. (1998) *Social Research: Issues, Methods and Process*. Buckingham: OU Press.

Melucci, A. (1992) Liberation or Meaning? Social Movements, Culture and Democracy in Pieterse, J. N. (ed) *Emancipations, Modern and Post-Modern*. London: Sage Publications.

Midha, A. (1997) *Contradictions in health promotion and workplace health promotion with particular reference to Wales*. Unpublished thesis for Ph.D., Swansea University, 49-3008.

Midha, A. & Sullivan, M. (1999) Conflicting rationales for promoting health in the workplace, *Critical Public Health*, 9(3), 44-57.

Milchman, A. & Rosenburg, A. (2001) Marxism and Governmentality Studies: Toward a Critical Encounter, *Rethinking Marxism*, 14(1), 132-142.

Milkman, R. (1998) The New American Workplace: High Road or Low Road? in Thompson, P. & Warhurst, C. (eds) *Workplaces of the Future.* London: MacMillan.

Mills, S. (1997) *Discourse*. London: Routledge.

New Labour (2000) *United Kingdom Employment Action Plan For 2000.* London: Department for Education and Employment.

Newton, T. (1998) Theorizing Subjectivity in Organisations: the Failure of Foucauldian Studies? *Organisation Studies,* 19(3), 415-447.

Nettleton, S. & Burrows, R. (1997) Knit Your Own Without a Pattern: Health Promotion Specialists in an Internal Market, *Social Policy and Administration*, 31(2),191-201.

Noon, L., Jenkins, S. & Lucio, M. M. (2000) Fads, Techniques and Control: The Competing Agendas of TPM and TECEX at the Royal Mail, *Journal of Management Studies*, 37(4), 499-520.

O'Doherty, D. & Willmott, H. (2001) Debating labour process theory: The issue of subjectivity and the relevance of poststructuralism, *Sociology*, 35(2), 457-476.

Oechsler, W.A. (2000) Workplace and Workforce 2000+: The Future of Work, *International Journal of Occupational and Environmental Health*, 73, Supplement, June 2000 S28-S32.

O'Malley, P. (1996) Risk and responsibility in Barry, A., Osborne, T. & Rose, N. (eds) *Foucault and Political Reason. Liberalism, neo-liberalism and rationalities of government.* Chicago: University of Chicago Press.

Osbourne, T. (1997) Of Health and Statecraft in Petersen, A. & Bunton, R. (eds) *Foucault, Health and Medicine*. London: Routledge.

Parker, I. (1997) Discursive psychology in Fox, D. & Prilleltensky, I. (eds) *Critical Psychology. An Introduction.* London: Sage.

Parker, I. (ed) (1998) *Social Constructionism, Discourse and Realism.* London: Sage.

Petersen, A. R. (1996) Risk and the regulated self: the discourse of health promotion as politics of uncertainty, *The Australian and New Zealand Journal of Sociology*, 32(1), 44-57.

Petersen, A. R. (1997) Risk, governance and the new public health in Petersen, A. R. & Bunton, R. (eds) *Foucault, Health and Medicine.* London: Routledge.

Petersen, A. R., Barns, I., Dudley, J. & Harris, P. (1999) *Poststructuralism, Citizenship and Social Policy.* London: Routledge.

Philips, L. & Jorgenson, W. (2002) *Discourse Analysis as Theory and Method.* London: Sage.

Poster, M. (1992) *Critical Theory and Poststructuralism.* Cornell: Cornell University Press.

Poster, M. (1995) *The Second Media Age.* Cambridge: Polity Press.

Poster, M. (1996) Databases as Discourse: or, Electronic Interpellations in Lyon, D. & Zureik, E. (eds) *Surveillance, Computers, and Privacy.* Minneapolis: University of Minnesota Press.

Potter, J. (1996) *Representing Reality: Discourse, Rhetoric and Social Construction.* London: Sage.

Potter, J., Edwards, D. & Wetherell, M. (1993) A model of discourse in action, *American Behavioural Scientist*, 36(3), 383-401.

Potter, J. & Wetherell, M. (1987) *Discourse and Social Psychology: Beyond Attitudes and Behaviour.* London: Sage.

Potter, J. & Wetherell, M. (1992) *Mapping the Language of Racism: Discourse and the Legitimation of Exploitation.* London: Harvester Wheatsheaf.

Potter, J. & Wetherell, M. (1994) Analyzing discourse in Bryman, A. & Burgess, R.G. (eds) *Analyzing Qualitative Data.* London: Routledge.

Potter, J., & Wetherell, M. (1995) Discourse Analysis in Smith, J., Harre, R. & Van Langenhove, L. (eds) *Rethinking Methods in Psychology.* London: Sage.

Punch, K. F. (1998) *Introduction to Social Research.* London: Sage.

Ransom, J. S. (1997) *Foucault's Discipline: The Politics of Subjectivity.* Durham, NC: Duke University Press.

Ransome, P. (1999) *Sociology and the Future of Work.* Aldershot: Ashgate.

Rasmussen, B. (2001) New Workers in a New Economy? *Paper to Work Employment and Society conference.* University of Nottingham.

Rasmussen, B. (2001) The gendered construction of a greedy organisation: Decentralisation of responsibilities in services. *Paper to Rethinking Gender, Work and Organisation conference.* Keele University.

Reich, R. (1993) *The Work of Nations.* London: Simon and Schuster.

Robertson, A. (2001) Biotechnology, political rationality and discourses on health risk, *Health*, 5(3), 293-309.

Rose, N. (1996) *Inventing Our Selves: Psychology, Power, and Personhood.* Cambridge: Cambridge University Press.

Rose, N. (1999a) *Powers of Freedom.* Cambridge: Cambridge University Press.

Rose, N. (1999b) *Governing the Soul, 2nd edition.* London: Free Association Books.

Rose, N. & Miller, P. (1992) Political Power Beyond the State: Problematics of Government, *British Journal of Sociology*, 43(2), 173-205.

Scambler, G. & Higgs, P. (1998) *Modernity, Medicine and Health.* London: Routledge.

Schlenker, B. R., Britt, T. W., Pennington. J., Murphy, R. & Doherty, K. (1994) The triangle of modern responsibility, *Psychological* Review, 101(4), 92-96.

Scott, S. & Freeman, R. (1995) Prevention as a Problem of Modernity: the example of HIV and AIDS in Gabe, J. (ed) *Medicine, Health and Risk.* Oxford: Blackwell.

Scottish Office (1999) *Towards a Healthier Scotland - a White Paper on Health.* London: The Scottish Office.

Selye, H.H.B. (1956) *The Stress of Life.* New York: McGraw Hill.

Sennett, R. (1998) *The Corrosion of Character.* London: W.W. Norton.

Sevenhuijsen, S. (2000) Caring in the third way: the relation between obligation, responsibility and care in 'Third Way' discourse, *Critical Social* Policy, 20(1), 5-37.

Shumway, D. R. (1989) *Michel Foucault.* Charlottesville: University Press of Virginia.

Simons, J. (1995). *Foucault and the Political.* London: Routledge.

Smallman, C. (2001) The Reality of 'Revitalising Health and Safety', *Journal of Safety Research*, 32, 391-439.

Smith, D. (1999) The civilising process and the history of sexuality: comparing Norbert Elias and Michel Foucault, *Theory and Society*, 28(1), 79-100.
Stake, R.E. (1995) *The Art of Case Study Research.* London: Sage.

Starbuck, W. (1992) Learning by knowledge-intensive firms, *Journal of Management Studies*, 29, 713-40.

Starkey, K. & Hatcheul, A. (2002) The Long Detour: Foucault's History of Desire and Pleasure, *Organisation*, 9(4), 641-656.

Taylor, C. (1984) Foucault on Freedom and truth, *Political Theory*, 12(2), 152-183.

Townley, B. (1993) Foucault, power/knowledge, and its relevance for Human Resource Management, *Academy of Management Review*, 18(3), 518-545.

Townley, B. (1994) *Reframing Human Resource Management.* London: Sage.

Turner, B. S. (1995) *Medical Power and Social Knowledge.* London: Sage.

Turner, B. S. (1996) *The Body and Society, 2nd edition.* London: Sage.

Wandel, T. (2001) The Power of Discourse: Michel Foucault and Critical Theory, *Cultural Values*, 5(3), 368-382.

Watson, J. S. (1996) Lay theorising about 'the body' and implications for health promotion, *Health Education Research*, 11(2), 161-72.

Watson, S. (2000) Foucault and the Study of Social Policy in Lewis, G., Gewitz, S. & Clarke, J. (eds) *Rethinking Social Policy.* London: Sage.

Wetherell, M. (1998) Positioning and Interpretive repertoires: conversation analysis and poststructuralism in dialogue, *Discourse and Society*, 9(3) 387-412.

Wetherell, M., Taylor, S. & Yates, S. (eds) (2001) *Discourse Theory and Practice: a Reader.* London: Sage.
Williams, C. (2001) *Contemporary French Philosophy.* London: Athlone Press.

Wilkinson, I. (2001) Social Theories of Risk Perception, *Current Sociology*, 49(1), 1-22.

World Health Organisation (1987) Ottowa Charter for Health promotion, *Health Promotion International*, 1(1), ii-v.

Wray-Bliss, E. (2002) Abstract Ethics, Embodied Ethics: The Strange Marriage of Foucault and Positivism in Labour Process Theory, Organisation, 9(1), 5-39.

Wynne, R. & Grundemann, R. (1999) *New Approaches to Improve the Health of a Changing Workforce*. Dublin: European Foundation for the Improvement of Living and Working Conditions.

Yin, R. (1994) *Case Study Research: Design and Methods, second edition.* London: Sage.

Appendix A - Analysis of the 'Healthy Workplace Initiative' Statement of Intent

Statement of Intent

In "Our Healthier Nation", the Department of Health has identified the 'workplace setting' as a key component in working to improve public health in England.

Work can make major contributions - both positively and negatively - to people's health. The work of the Health and Safety Commission (HSC) and Health and Safety Executive (HSE) - which has responsibilities across Great Britain - has, in recent years, increasingly focused on identifying and tackling the issues of work-related ill-health, particularly through its Good Health is Good Business Campaign.

Through this Statement of Intent, the Department of Health and the HSC/E express their shared aims, and recognise the opportunities for joint action in England. They acknowledge the benefits of an holistic approach to peoples' health and well-being, which identifies the benefits to the individual and the workplace.

Statement of Intent

Improving Health is Everybody's Business

The Healthy Workplace Setting of Our Healthier Nation is a key component in improving people's health. A new vision of a healthy workplace that benefits people will only be realised if health gets in to the business and organisation mainstream. This means that health issues, including the duty of employers to protect the health and safety of their employees, and others who might be affected by their work, need to be addressed through:

- the culture of an organisation, which ensures that it actively promotes a healthy workforce, and recognises the benefits of better health for worker productivity, and for the business prospects of the organisation.

its management practices, including work design, to ensure that:

- it recognises what individuals bring to the workplace, including their health needs or limitations

- exposure to risk is minimised and the control of risk is maximised.

These arrangements may include access to occupational health advice and support

By this statement of intent, we will seek to work with others to secure and improve

the health of people at work by:

- identifying and promoting examples of good practice for handling key workplace health issues, such as backpain, and disseminating the results in usable forms.

- making available appropriate and up to date information which reflects available evidence and uses all forms of media.

- encouraging better access to services and helping to provide a bridge between prevention, treatment and rehabilitation.

- helping to promote compliance with relevant workplace legislation.

Furthermore, we believe that:

- Improving health is everybody's business.

- This partnership between Department of Health, HSC and HSE, is the best way of effecting such improvements in the workplace at Government level, with (or in co-operation with) other government departments.

- This statement provides a basis for realising the wider aims of OHN in the workplace, which are to improve the overall health of the population and to narrow the health gap.

Analysis

Launched in March 1999 the 'Healthy Workplace Initiative' is a joint initiative between the Health and Safety Commission/Executive and the Department of Health. It is part of the Department of Health's wider 'Our Healthier Nation' strategy. This strategy identified three settings (workplaces, schools and neighbourhoods) that 'present an opportunity to drive against health inequalities and improve health overall'. The basic 'purpose' of the initiative is to 'empower firms, businesses and workplace organisations to see how they can help themselves'. The fact that the text under analysis is taken from the Department of Health's website is not particularly relevant, as it has been circulated mainly in paper form. The Department of Health now attempts to put all of its information onto its website. Though of interest, this is not deemed to be of significance in this particular analysis. It was chosen as a key cultural technology in that it explicitly identifies the workplace, and thus employees, as

capable of being transformed through specific targeted interventions. Its aim is to regulate behaviour, to direct the conduct both of companies and individual employees. As such, it represents a prime example, in the field of employee health, of a governmental (and cultural) technology, and is thus particularly salient to the concerns of this thesis.

The method and style of analysis of this text is based *solely* on Foucauldian principles. Despite the reservations about the difficulties associated with utilising and developing a recognisably exclusively Foucauldian methodology, it is thought useful to attempt it as this may highlight some of the practical difficulties associated with such an endeavour, or alternatively demonstrate its utility.

According to Foucault, discourses can be viewed as ways of constituting knowledge, which claim to be truth and which result in practices which produce forms of subjectivity. Power is exercised within discourses in ways that constitute and govern individual subjects. A 'discursive field' contains relations between language, institutions, subjectivity and power. Though impossible to comprehensively delineate, the text under analysis refers directly or indirectly to the discursive fields of employment, science and health. The text contains competing discourses that have as their aim the 'regulation of behaviour'. There is an attempt to produce a specific mode of subjectivity in a particular subject position: the 'healthy employee'. The analysis will try to explore how this is achieved, who benefits from it and how.

Initially, the 'pre-conditions' or 'conditions of possibility' that enable the text should be explored. These are potentially very broad as the statement of intent continually makes 'intertextual' references to many ideas and concepts, all of which cannot be traced here. For example work, health, well-being, responsibility, benefits, safety, risk, and culture are all complex concepts with different definitions in different contexts, yet they are used in the text unproblematically, without definition. For example 'health' itself is continually contested and can encompass bodily, sexual, emotional and psychological aspects, and issues of (in)security. It is clear from the title of the initiative, 'Improving health is *everybody's* business' (the phrase appears three times in the text) along with the emphasis upon partnership and the implied pooling of

resources, that the 'ownership' of the initiative is to be vague and widely dispersed. This has implications in terms of responsibility, in particular that 'good health' is (equally) *everybody's* responsibility, when clearly it is not (for example some people are born and remain - through no 'fault' of their own - 'unhealthy' in some way). The contested and ambiguous nature of the term 'health' which impacts upon the conditions of possibility for this text, appears to have been taken advantage of.

In discussing the relations between discourse and power, Foucault formulated a number of 'rules' which lend themselves well to analysis of this particular text (Foucault, 90, pp92-103), the first of which is the 'rule of immanence'. This draws attention to the relations between power and knowledge, specifically how power is extended and reinforced by the knowledge gained about particular subjects. The main subjects *alluded* to in the text are 'unhealthy employees'. A wide range of providers of knowledge are referred to, including HSC and HSE, occupational and other specialist health workers, and all employers. It is asserted that the knowledge gleaned through the increased surveillance necessary for the discovery of 'examples of good practice' will be made widely available. Individual employees will be both the 'objects of' this new knowledge, and 'subject to' it. While unhealthy workers exist, and certainly an alleviation of work-related ill health seems a noble objective, the attempted uniform constitution of the 'healthy worker' as an *essential* component of the workplace may have negative consequences for those people whose health is unable to be improved by good practice. Much has been made of Foucault's thesis that many discourses have as their main goal the 'production of useful and docile bodies'. It might be claimed here that the production of 'healthy *and therefore more productive* yet docile bodies' is the main subjectivity the text is trying to construct.

Secondly, Foucault refers to the 'rules of continual variation'. This suggests that particular discourses are only ever a cross section of wider 'matrices' and are continually changing. Our attention is brought to particular groupings of interested parties who attempt to influence the trajectory of discourses at a particular moment. The particular constellation of groups we find here are all seemingly concerned with 'health'. But all have other 'discursive' interests; the

government requires a flexible and healthy workforce to ensure continued economic success; the HSC/HSE require a healthy workforce and 'good relations' with the Government to ensure continuation of their own professional/economic interests; occupational health experts too have a professional interest in claiming a position of expertise in relation to workplace health. Further, the challenge of more radical health discourses, which emphasise the structural and ethical factors associated with work-related ill health and minimise the role that individual responsibility should play, are excluded from the text, along with the voices of any employees or employee representatives. While the initiative claims to be about partnership and making health *everybody's* business, it is clear that some groups have more involvement in - and control over - the process than others. Worker representatives such as Trade Unions have traditionally articulated issues around health at work, yet this group makes no appearance in the initiative. It seems that, despite claims to be inclusive and concerned with partnership, the text is founded on significant exclusions.

The 'rule of double conditioning' draws our attention to the strategic balance of power across society. Power is not seen simply to be imposed from above in a general strategy - in this context for example, the 'Our Healthier Nation' strategy - nor solely activated within the local encounter between, say, an occupational health worker and an employee. Rather, the different levels are neither seen as 'discontinuous' nor 'homogeneous'. The notion of 'double conditioning' suggests that power works through institutions at an individual level as part of a specific local tactic itself enabled by the wider strategy. It should be possible to trace some of the connections between the different levels of influence in the case study chapters. The 'employer' does not *represent* the state by demanding good health of their employees in order to increase 'productivity' and improve the 'business prospects of an organisation', yet the conditions of possibility afforded by the nature of work organisations allows for a strategy which entails precisely the potential rejection of unhealthy workers. The tension in the text between the individual and strategic approaches to, responsibility for and levels of, health is also highlighted.

The final rule is that of 'the tactical polyvalence of discourses'. It is asserted that it is within discourses that power and knowledge are joined together. It is clear that meanings are never fixed, merely more or less stable. This (in)stability is a consequence in part of the way particular discourses are put to particular uses in particular contexts. The same linguistic elements exist within all discourses, yet 'single' discourses can contain contradictory elements. A central contradiction within this text can be found in notions of 'shared responsibility' ('health is *everybody's* business') yet the ownership of health is situated within the individual (individuals 'bring *their* health needs/limitations' to the workplace). Also, the initiative has to grapple with the incompatibility of improving the health of *everyone* (the 'health of the nation') with improving economic efficiency, which under the present system entails an uneven distribution of resources. Unlike most of the rest of Europe, in the UK the gap between rich and poor, and (consequently) between 'healthy' and 'unhealthy', is still steadily increasing. The text has trouble managing its different 'tactical functions', manifested in its desire to be many things to many people. To employees it simply wants to help them be healthy; to businesses it wants to make them more productive; to health professionals it wants to enable them to work together and pool resources; for the Government themselves the initiative wants to ensure they are perceived to be doing the right things for the right reasons, whilst steering the economy in a manner consistent with economic growth.

The text seems to be struggling to be inclusive and above all fair to everyone, with a variety of incentives offered to all who feel able to join in. 'Real benefits' and 'better prospects' are the outcomes on offer from an 'holistic approach to people's health and well-being'. However, no definitions of health nor well-being nor what an 'holistic' approach entails (for example, such things as issues of pay and conditions and the nature of capitalist relations) are offered, and there is no mention of any of the potentially negative consequences of failure to comply. Further, there is no explicit mention of any of the 'hidden' benefits to various parties, for example the potential to cut overall health costs afforded by this initiative, and the extra funding, prestige and influence that the HSC/E and workplace health experts may attract. The shift toward a strategy of self-responsibilisation, and the introduction of a more decentred approach to regulation for health, remains implicit and well concealed.

Despite the above analysis, there may well be grounds for optimism. One cannot tell in advance the consequences of initiatives such as this, only become sensitised to some of its potential dangers. As *everything* is *potentially* dangerous it would be easy to become hyper-pessimistic and totally negative about virtually all new initiatives and strategies. This is why it is important to complement analyses of these kinds of texts with other analyses, for example, explorations of how the concept of 'work-related ill health' is conceptualised and problematised in particular workplaces, and how particular occupational health professionals and individual employees conceptualise work-related health issues. These perspectives too constitute 'texts', but will be approached in a very different manner to the preceding analyses.

Appendix B - Interview schedules

Appendix B1

Byte Staff - questionnaire [confidential and anonymous]

Aide memoir

Time available, what I am, research interests, stage of research, confidentiality, interviewee's expectations.

Interview [totally confidential and anonymous – company/individual won't be named].

About general health and health and work – no right or wrong answers – point is to see what you think about health and what actually happens at work concerning health.

Section 1 - Profile

What's your job?
How long have you done this?
How old are you?
Are you married?
Do you have children?

Section 2 - General health

Would you say you enjoy good health?

Have you had any major illnesses?

Is there anything you do that is bad for your health?
[Drinking/smoking/drugs/diet]

Would you like to or do you plan to change any of these activities?

Are there things you do that are good for your health?
[Exercise/gym/sport/walking/diet/relax]

Section 3 – Work-related health - general

Tell me a little about where you work – how many people work there, flexible working [fixed hours/contracts etc.]

Is there anybody who is specifically responsible for employee health?

Do you have any practices or policies at work, which explicitly concern health?

What happens when someone goes off sick? [Doctor's note/length of time /trust etc]

Do you receive much literature about health from external sources?

Are there other things that you do, or is there anything you would like to be doing for your employees' health? [What are the obstacles to this?]

Section 4 – Work-related health - specific

Are there any work-related health hazards?

Have you had any work-related ill health while you've been working at the Byte?

What do you think of RSI?

What do you think of stress?

Do you think there are measures which can be taken to minimise the possibility of stress?

Have you or any of your colleagues ever suffered from work-related stress?

Do you feel any pressure generally to become healthier? [If so, from where/whom?]

Do you think there is anything that the Government could or should be doing for your health?

Is there anything else you wish to say in relation to your health?

Appendix B2

Consignia Employee - questionnaire [confidential and anonymous]

Aide memoir

Time available, what I am, research interests, stage of research, confidentiality, interviewee's expectations.

Interview [totally confidential and anonymous – company/individual won't be named].

About general health and health and work – no right or wrong answers – point is to see what you think about health and what actually happens at work concerning health.

Section 1 - Profile

What's your job?
How long have you done this?
How old are you?
Are you married?
Do you have children?

Section 2 - General health

Would you say you enjoy good health?

Have you had any major illnesses?

Is there anything you do that is bad for your health that you would like to change?
[Drinking/smoking/drugs/diet]

Would you like to, or do you plan to change any of these activities?

Are there things you do that are good for your health?
[Exercise/gym/sport/walking/diet/relax]

Have you always been concerned about your health? [If no, what changed]?

Section 3 - EHS

How long have you worked for the post office?

What do you think of Employee Health Services?

Have you ever had any contact with EHS? [Tell me about it]

Do you think there is anything that EHS could or should be doing for your health?

Do you remember the Q-Health project, which involved BUPA?

Have you ever been on any courses or received any training related to health?

Section 4 – Work-related health

Are there any work-related health hazards?

Have you had any work-related ill health while you've been working at the Post Office?

Do you ever get stressed? What do you think of stress? What is it? What causes it?

Do you think there are any measures that could be taken to minimise the possibility of stress?

Have you or any of your colleagues ever suffered from work-related stress?

What would happen if you were to go on the sick with work-related ill health?

Do you feel any pressure generally to become healthier? [If so, from where/whom?]

Do you think there is anything that the Government could or should be doing for your health?

Is there anything else you wish to say in relation to your health?

Appendix B3

Interview with Occupational Health Advisor, 27th November 2000

Aide memoir

Time available, what I am, research interests, stage of research, anonymity, confidentiality, interviewee's expectations.

SECTION 1 – GENERAL

1.1 Role of interviewee

What is your role and how do you fit into the EHS unit?

1.2 Employee Health Services

Would you tell me a little more about the EHS unit?

Organization
Components

What kinds of health issues do you deal with?

Lifestyle related
Work-related
Grey areas
Female and Male health problems
[Come back to stress]

What would you like the EHS to do in an ideal world?

Shift toward prevention
Specialized targeted interventions
Lifestyle
Health Promotion v Occupational Health

What are the main barriers to achieving this?

1.3 Delivery of health initiatives

How are health initiatives delivered? Talk me through the process

Extent of targeting by: [Geographical area] [North v South]
[Unit location]
[Occupation]
Uptake of initiatives
Voluntary or compulsory
Health Promotion v Occupational Health
Difficulties in delivery

What health related facilities and programmes does the Post Office offer?

Gymnasium/canteen

Are health interventions/initiatives evaluated in any way?

Dissemination/good practice/Mechanisms of evaluation

Is 'new technology' used in any way?

Any other similar databases in the U.K.

SECTION 2 – Q-HEALTH PROJECT

2.1 General

Would you tell me a little bit about the Q-Health?

Impetus for approach/ownership of project/overall responsibility
Relation to BUPA – team/individual staff
Development of questionnaire

Were you involved in it in any way?

2.2 Outcomes

What do you think has been the practical upshot: did anything change as a result of the project?

Costs [*and savings*] – internal market/outsourcing
Feedback into new initiatives

Are you aware of any other major initiatives in the pipeline?

SECTION 3 – STRESS

3.1 Prevalence

Do many employees suffer from stress? Is it increasing?

Monitoring

3.2 Stress initiatives

How is employee stress dealt with?

Assessment/Counselling/Leaflets

3.3 Causes

What do you think are the main cases of stress?

How is it decided if work or non-work factors causes stress?

Life/work balance

If stress is caused by non-work factors, how is this addressed?

SECTION 4 - CHANGE

4.1 Changes in the EHS unit

What changes do you foresee within the EHS?

Big changes in PO – impact on health initiatives
Costs [more employer responsibility]
Need to be profit accountable by 2001

4.2 Wider changes in the Post Office

Have any factors emerged recently that might impact either positively or negatively upon employee health?

Big changes in PO – impact on health initiatives
Costs [more employer responsibility]
Need to be profit accountable by 2001
Govt.'s new Occupational Health and H&S strategies – impact
Extent of keeping health concerns 'in-house'
Other health information gathering techniques/methods for establishing health needs

SECTION 5 – OTHER

5.1 Dilemmas

Your work must be challenging sometimes. What sort of dilemmas do you encounter?

Practical
Moral/ethical

Is there anything else you feel may be relevant to my research?

I'll be interviewing Dr. Boorman before Christmas. Everything you have said to me today will be kept confidential. However, if you could ask for anything or suggest anything to either of them, what would it be [apart from a pay rise]?

Offer to pass copy of transcribed interview to OHA.

Notes:

Post Office has 200,000 staff of which 160,000 are in the Royal Mail. Between 1995 and 1998 QH gathered health related information from 30% of staff [60,000] on; Demography; physical and psychological health; health and lifestyle; and health screening.

Respondents were given a health profile, health education pack and [sometimes] -specific advice.

Appendix B4

Q-Health interview with Customer Processes Manager: Thursday 19th October, 2000.

Aide memoir

Welch et al [1999] *Variations in self-reported health by occupational grade in the British Post Office*: The Q-Health Project in Occupational Medicine vol.49 No.8 pp491-497

The British Occupational Health Research Foundation Newsletter 1999 Issue No.13

Post Office has 200,000 staff of which 160,000 are in the Royal Mail. Between 1995 and 1998 QH provided info from 30% of staff [60,000] on; Demography; physical and psychological health; health and lifestyle; and health screening.

Were any staff excluded from the invitation to complete the QH questionnaire, and are any excluded from the interventions that have been taken as a consequence of it?
Who oversaw/oversees the QH project? Who has responsibility for it now?
What other screening/surveillance/monitoring techniques are there in relation to employee health?
Were the findings passed to employees/Unions/Managers who were then involved in deciding interventions or were there a team of staff who worked out the interventions from the results?
What types of interventions have been taken as a consequence of the QH project?
Staff completing QH offered health profile and health education manual [can I have copy please?]
Results used to develop initiatives throughout the PO. and develop strategic planning.
Are there any other similar databases in the U.K?
How is employee health dealt with in the P.O.
Is it possible to delimit individual and non-individual health interventions?
Health and lifestyle/behaviours bit included info on drinking, smoking and exercise – how are initiatives in these areas delivered?
Does term 'psychosocial' get used much?
How are interventions that stem from Q-Health framed? Voluntary or compulsory? Negotiated?
Are there any negative effects of the Q-Health project that you are aware of?
I understand that the QH database interfaces with absenteeism rates and local productivity measures – how does this work, and what might be a practical consequence of combining this information?
Are all interventions evaluated in a standardised way?
Are examples of good practice widely disseminated throughout the PO?
What about the 70% of non-respondents – do they have particular characteristics regarding their health?
Are the 30% that responded perhaps a healthier subset?
How is the working relationship with BUPA managed?

What other methods are used to establish the health needs [and interventions] of the workforce?
In lower grades angina, CHD, blood pressure, obesity, smoking and arthritis all more prevalent?
The psychological wellbeing of the sample was worse than that of the national average; what specific measures have been taken to address this?
Are there ***any*** circumstances in which the details an individual employee might be accessed?
Are there any employee health implications from the new Postal Services Act?
When cause of absence - say of stress - is ambiguous does that influence sick pay?
I understand all PO business units have to be profit accountable by 2001 – how are you and Employee Health Services [as 1 of 34 units] going to achieve this?
Is there an internal market for health interventions?
Who is the new head of Health and Safety and how do I contact him?
Employee Health Services are a business unit , are they therefore 'under threat'?
Any [recent] changes in Government Policy to make employers more responsible for employee health?
Do the new Occupational Health and Health and Safety strategies impact upon PO health interventions?
Postcoded data allows for geographical interventions – anything major?
Anything relating to Sheffield/South Yorkshire?
Health Ed initiatives have a long history in P.O.
Are individual managers in particular units/locations now absolved from the responsibility of employee health?
Health and Safety, Occupational Health, Job design, Employee Health Services...how does it all fit together? What are main areas of overlap?
Are employees ever advised to go to their own GP? Is there an In-house GP?
To what extent is general ill health addressed internally?
Do different employees in different businesses/locations have a different experience of health interventions?
Stress – Does Q-Health allow for looking put for stress?
PO response to stress appears to be counseling?
Counsellors used to find main cause of stress – if it is work what happens?
Are staff given stress management courses?
Any new initiatives aimed at tackling stress?
Does stress differ from other health related problems? Employee Assistance Programs?
Are all health costs generated internally [at work] contained within .P.O?
What is the extent of employee participation in choosing WHP initiatives?
What is the extent of employee participation in WHP initiatives? [voluntary/compulsory?
How else is new technology used to impact positively on employee health?
Is it fair to say that most health behaviour initiatives are aimed at lower level staff?
The objective of having healthy workers is good: are there any new strategies currently being adopted by the P.O.?

Appendix B5

Interview with Chief Medical Advisor/Director of Employee health Services

Aide memoir

Dr Richard Welch, CstJ, MSc, FFOM, DIH, Director, Employee Health Services, The Post Office, UK

A graduate of Glasgow University, Dr Richard Welch was a General Practitioner for six years with part-time appointments in Occupational Medicine. In 1979 he was appointed Medical Officer at Chrysler Car Plant in Linwood and in 1981 Regional Medical Officer for The Post Office in Colchester. Since 1987 he has been Chief Medical Adviser to The Post Office with responsibility for the provision of Occupational Health Services. Since the merger of OHS with Employee Support in 1997 he has also been Director of Employee Health Services.
Dr Welch is the author of a number of articles on the Employment of Diabetics, is past President of the Occupational Medicine section of The Royal Society of Medicine and regularly lectures on a variety of subjects connected with Occupational Medicine. Involved in lots of health-related stuff outside the PO.

Role

What is your role?
What exactly is it that you're trying to deliver?
What's the best thing about the job?
What's the worst thing about the job?
What is most frustrating about job?
How do you disentangle health from safety – easy?

Employee Health Services

What is main aim of EHS?
Talk me through the line of responsibility for delivering employee health?
How much is strategic intervention?
How much is reactive intervention?

Q-Health and technology

Very excited about Q-Health when I first heard about it
When I came to EHS last October it seemed to be down played
What was good about it – what have you learnt from it?
What was bad about it, why wasn't it the success you'd hoped for?
Last time I was here there was a bit of excitement around new visualising technologies – technology capable of bringing together many databases [absence, productivity etc.] and exploring potential new interventions
Screening/monitoring etc – must be much new potential?
What do you think about the potential for new technology to help deliver better managed health interventions?

Health Priorities

What are your current health priorities/ Areas targeted/ Areas targeted?
Have you any new initiatives?
Health behaviours targeted?

Stress

What is your take on it?
Real?
Work/home causal chain?
Solutions?
Legal problems?

Changes at the PO

Big changes
Flexibility
EHS
Future
outsourcing
Independence from PO
Help other businesses?

Governmental strategies

Tackling work-related stress
Revitalising health and safety
Securing health together – long term OH strategy
Entry into EU

Future of employee health

Will employers be more or less responsible for their employees health in the future?
Will the 'business case' for improved occupational health be won?
What will be the big employee health issues of the future?

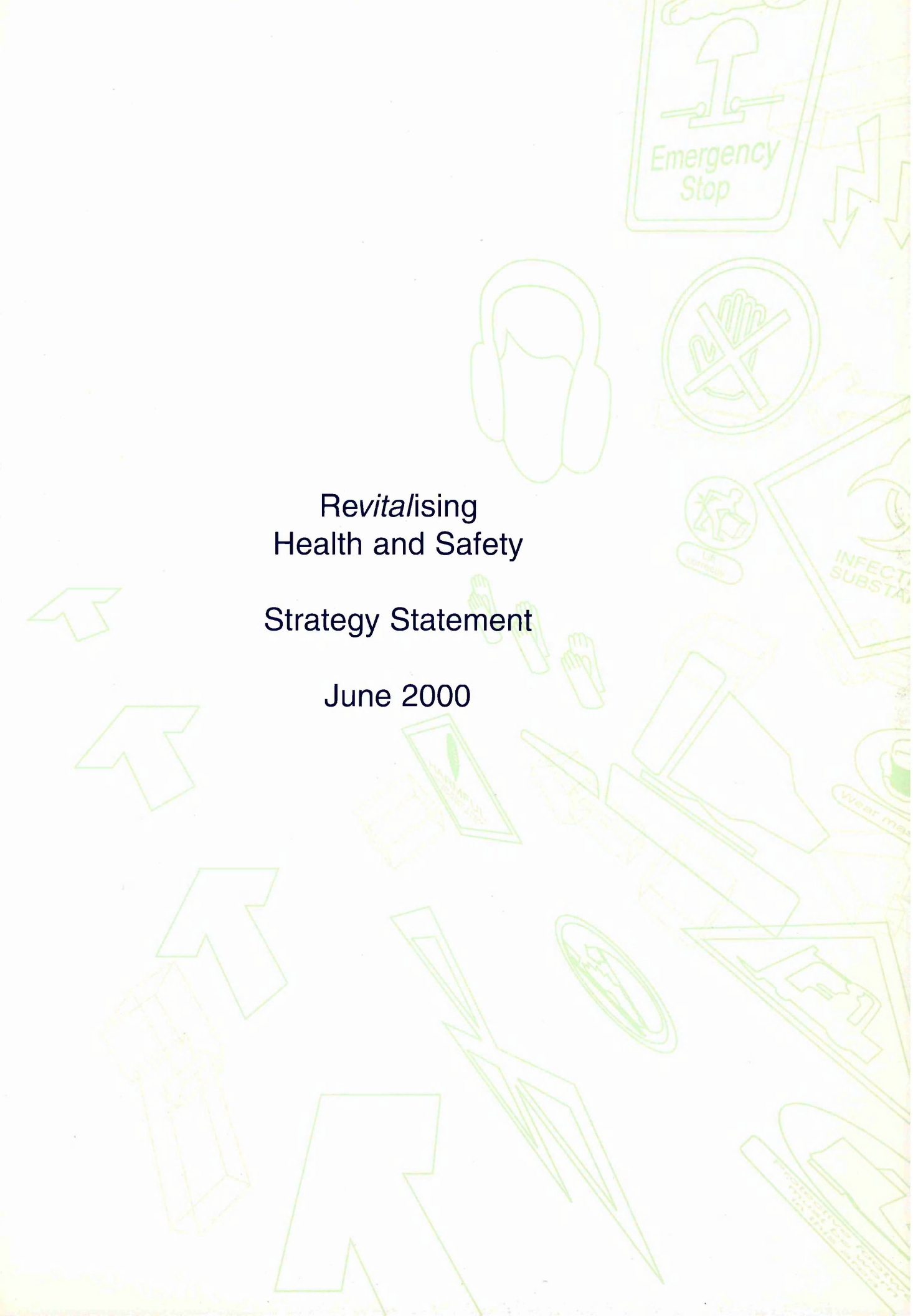
HSC
Health & Safety
Commission

DETR
ENVIRONMENT
TRANSPORT
REGIONS

Revitalising Health and Safety

Strategy Statement

June 2000



Re*vital*ising Health and Safety

Strategy Statement

June 2000

Department of the Environment, Transport and the Regions
Eland House
Bressenden Place
London SW1E 5DU
Telephone 020 7944 3000
Internet service http://www.detr.gov.uk/pubs/index.htm

Further copies of this report are available from:
Department of the Environment, Transport and the Regions
Free Literature Service
PO Box 236
Wetherby
West Yorkshire
LS23 7NB
Tel: 0870 1226 236
Fax: 0870 1226 237

Published by the Department of the Environment, Transport and the Regions. Reprinted in the UK, March 2001 (00SCSG1479) on paper comprising 80% post-consumer waste and 20% TCF pulp.

Product code OSCSG0390.

Foreword by the Deputy Prime Minister

Revitalising Health and Safety is about injecting new impetus to better health and safety in all workplaces.

The Health and Safety at Work etc Act 1974 was a landmark in making Britain's workplaces safer. For the first time all employers were required to keep their workplaces healthy and safe. The Act provides a strong framework for good, effective regulation and has transformed Britain's workplaces. We can see the results – the number of deaths at work today is a quarter of the 1971 level.

But 25 years on, it is time to give a new impetus to health and safety at work. Too many deaths still occur at work. Each death or serious injury in the workplace is a tragedy; a tragedy that causes devastation for workers, their families and loved ones; a tragedy which, perhaps, could have been avoided in the first place.

Society as a whole pays when things go wrong. We estimate that the total cost to society of health and safety failures could be as high as £18 billion **every year**. We can and should do something about this.

That's why, last year, I announced our *Revitalising Health and Safety* Initiative, a strategic appraisal of our health and safety framework, building on the hard work of the last quarter of a century and setting the agenda for the first 25 years of the new Millennium. Our aim is to reduce the impact of health and safety failures by 30% over 10 years.

Transport safety is not covered in this statement. Nor does it seek to anticipate in any way the outcome of Lord Cullen's public inquiry into the tragic rail accident at Ladbroke Grove junction.

Revitalising Health and Safety reflects the changing world of work and the need for our regulatory system to match it. It also acknowledges that certain areas of work, such as construction, still have a high accident rate and that we must work hard to combat this.

The work of the Health and Safety Commission and Executive will be vital in making *Revitalising Health and Safety* a success. Preventing accidents and ill-health, rather than dealing with the consequences, must be their priority.

Revitalising Health and Safety foreshadows tougher sentences for health and safety offences, and also an examination of new, innovative penalties.

We want this initiative to succeed. That's why I'm committing the Government to show clear leadership as an employer, procurer and policy maker. I hope this will inspire others right across our diverse economy to commit to new action and share in the benefits of good health and safety management.

I believe that the *Revitalising Health and Safety* initiative will bring about a real change in workplace culture – a change that will blaze a trail for effective partnership between employers and workers in all aspects of working life.

John Prescott

Foreword by the Chair of the Health and Safety Commission

The importance of good health and safety is evident to anyone who has seen the consequences of health and safety failure. Those who suffer most are the injured, the ill and the bereaved. But all of us lose from poor health and safety: employers and employees, consumers, and the providers of public services. Society and the nation at large cannot escape the £18 billion bill every year.

The Health and Safety Commission warmly welcomed the initiative taken by the Deputy Prime Minister last year when he launched the consultative document *Revitalising Health and Safety*. This exercise has helped raise the profile of health and safety. Action and achievement are now the watchwords. We need nothing less than a step change improvement in health and safety over the next decade.

So the challenging targets to reduce health and safety failures that we publish here must engage all the stakeholders in the health and safety system: employers, workers, Government, local authorities, employers' associations and trade unions, professional bodies and safety charities, and many others.

In the coming year I shall be asking all our stakeholders to draw up their own action plans in order to meet these targets. I particularly welcome the Government's commitment to show clear leadership as an employer, as a major purchaser of goods and services, as an investor and as policy maker.

The partnership approach of the Health and Safety Commission has achieved much over the last 25 years. But a new world of work poses new challenges and we must never be complacent.

We shall rise to these challenges and meet the targets set out here if we all continue to work in partnership.

Bill Callaghan

Contents

Overview

1 The *Revitalising Health and Safety* initiative was announced by the Deputy Prime Minister on 30 March 1999 to inject new impetus and relaunch the health and safety agenda, 25 years after the Health and Safety at Work etc. Act 1974.

Aims of Revitalising Health and Safety

- to inject new impetus into the health and safety agenda;
- to identify new approaches to reduce further rates of accidents and ill health caused by work, especially approaches relevant to small firms;
- to ensure that our approach to health and safety regulation remains relevant for the changing world of work over the next 25 years; and
- to gain maximum benefit from links between occupational health and safety and other Government programmes.

2 The Government considers that the basic framework set by the 1974 Act has stood the test of time. This provides for goal setting law, taking account of levels of risk and what is 'reasonably practicable', with the overriding aim of delivering good regulation that secures decent standards and protection for everyone.

3 The 1974 Act confers a wide range of functions on the Health and Safety Commission and Executive, including proposing new law and standards, enforcing health and safety legislation, investigating accidents and complaints, conducting research, and providing information and advice. In certain premises, including retail, entertainment and offices, health and safety legislation is enforced by local authorities.

4 The Deputy Prime Minister launched a consultation on 1 July 1999, jointly with the Health and Safety Commission, seeking stakeholders' views and ideas. Almost 1,500 responses were received, containing many valuable insights and suggestions. **Section 1** gives details of the consultation, and an analysis of responses is at **Annex A**.

5 The Government's approach has been to focus on ideas capable of adding value to the current system without threatening its overall balance. For example, while appropriate enforcement and deterrence is crucial, this must not be at the expense of promoting voluntary compliance and models of excellence. The Government wishes to build on 25 years of successful partnership between employers, employees, trade unions and consumers on the Health and Safety Commission.

6 This **Strategy Statement** sets out how the Government and Health and Safety Commission will work together to revitalise health and safety. At its heart are the first ever targets for Great Britain's health and safety system:

- to reduce the number of working days lost per 100,000 workers from work-related injury and ill health **by 30% by 2010;**
- to reduce the incidence rate of fatal and major injury accidents **by 10% by 2010;**
- to reduce the incidence rate of cases of work-related ill health **by 20% by 2010;**
- achieve **half** the improvement under each target by **2004.**

7 Details of the new targets are given in **Section 2**. These are underpinned by the **10-point Strategy Statement** in **Section 3**, which sets the direction for the health and safety system over the next 10 years. This statement highlights the importance of *promoting better working environments* to deliver a more *competitive economy*, *motivating employers* to improve their health and safety performance, and *simplifying over-complicated regulations*.

8 Delivery of the new targets will depend crucially on the *commitment of stakeholders* to pioneer new action. To lead the way, **Section 4** sets out an **Action Plan** which the Government and Health and Safety Commission will take forward, where appropriate in partnership with the Scottish Executive and the National Assembly for Wales. Scottish Minister for Enterprise and Lifelong Learning, Henry McLeish, has signalled his commitment to this initiative. It also has the support of Mrs Edwina Hart, the National Assembly for Wales' Finance Secretary, who also has lead responsibility for health and safety issues in Wales.

9 The **Action Plan** incorporates many ideas suggested in the consultation and focuses, in particular, on what more Government can do over the short to medium term to support the Health and Safety Commission's existing programme of work. The **Action Plan** includes measures:

- to ***motivate employers***, through a *Ready Reckoner* to drive home the benefits to industry of a good health and safety regime, a new *challenge to industry on annual reporting* and commitments to *legislate to make the punishment fit the crime* when health and safety standards are flagrantly ignored;
- to ***engage small firms*** more effectively, through the new *Small Business Service* in England and equivalent structures in Scotland and Wales, a programme of *tailored sector-specific guidance* and development of a *grant scheme*;
- to ***put the Government's own house in order***, through a *Ministerial checklist*, *removal of Crown immunity* and action on *procurement*;
- to promote coverage of ***occupational health*** in local Health Improvement Programmes in England and co-ordinated Government action on ***rehabilitation***;
- to secure greater coverage of ***risk concepts in education***, including changes this year to the *National Curriculum in England and Wales* and action on risk education for *safety-critical professionals*.

Section 1

Consultation

10 The *Revitalising Health and Safety* initiative was announced by the Deputy Prime Minister on 30 March 1999. In answer to a Parliamentary Question, John Prescott outlined his intention to:

> "...take forward a strategic appraisal of health and safety to mark the 25th anniversary of the Health and Safety at Work etc. Act 1974... to inject new impetus and relaunch the health and safety agenda...and to reduce the rate of workplace accidents and ill health still further."

He promised that a public consultation document would be launched in the summer to open up a debate on this important issue.

Preparing the ground

11 An inter-Departmental Steering Group was set up in April 1999 to oversee and co-ordinate work. The Steering Group commissioned a programme of exploratory meetings with stakeholders, for example on service delivery, engaging small firms and targeting industry sectors. These involved, amongst others, the **Confederation of British Industry**, the **Trades Union Congress**, small firms representatives such as the **Federation of Small Businesses**, the **British Chambers of Commerce** and the **Forum of Private Business,** the **Health and Safety Executive/Local Authority Enforcement Liaison Committee (HELA)** and the **Association of British Insurers**.

12 In addition to the Department of the Environment, Transport and the Regions and the Health and Safety Executive, all Government Departments with direct responsibility for aspects of health and safety at work were represented on the Steering Group, including:
Department of Health – on public health issues;
Department of Social Security – on the Industrial Injuries scheme;
Department for Education and Employment – on education in health and safety skills and risk management;
Department of Trade & Industry – on competitiveness and small firms;
Ministry of Agriculture, Fisheries and Food – on health and safety in agriculture and forestry;
Lord Chancellor's Department – on penalties; and
Cabinet Office – on regulatory impact.
HM Treasury, the **Scottish Executive and Welsh Administration** were also represented. The **Ministry of Defence**, **Home Office**, **Inland Revenue** and **HM Customs & Excise** were consulted on relevant issues.

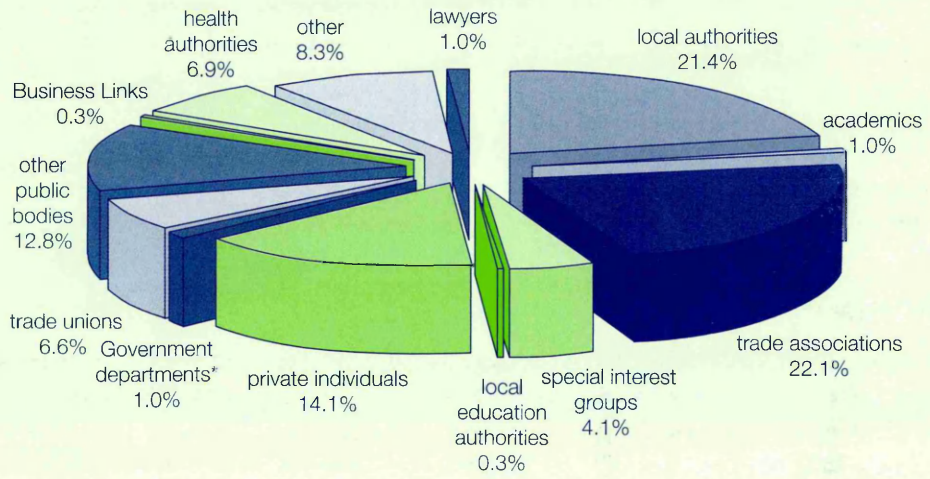
Collecting views

13 The *Revitalising Health and Safety* consultation document was launched jointly by DETR and the Health and Safety Commission on 1 July, 1999. It set out the economic business case for further action, and sought views on what more could be done to make the Government's vision for higher standards a reality. In addition to the main document, three summary leaflets were produced to target employers, workers and small and medium-sized enterprises. Over 7,000 copies of the main document and 40,000 leaflets were distributed.

14 The consultation period closed on 24 September. 1,478 responses were received:

- 290 were responses to the main Consultation Document. Figure 1 shows the source of these responses;
- 194 were responses to the Employer leaflet;
- 860 were responses to the Worker leaflet; and
- 134 were responses to the Small and Medium-sized Enterprise leaflet.

Figure 1: Sources of responses to Main Document



*Source: *This figure refers only to those Government Departments submitting a formal response to the consultation document. Paragraph 12 lists all the Departments who have been actively involved in the Revitalising Health and Safety initiative.*

Identifying key themes

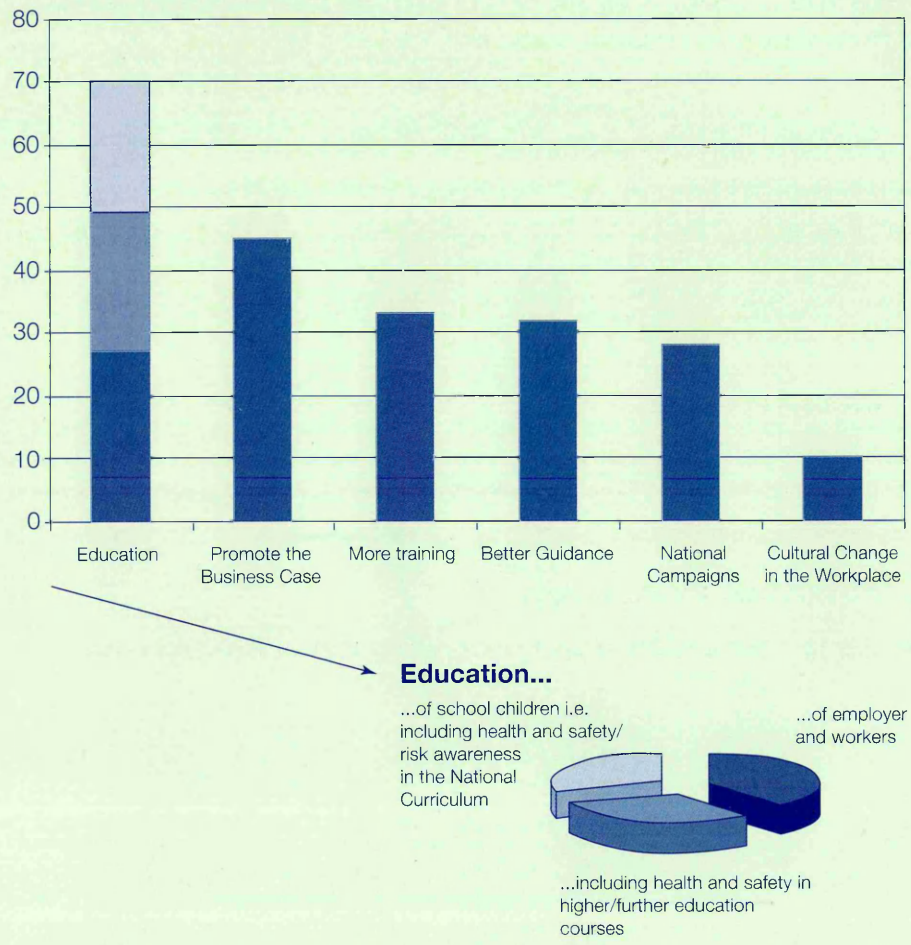
15 Almost everyone who responded thought that more could, and should, be done to raise health and safety standards in every sector and every type of business, right across Great Britain. The open nature of the consultation inspired a broad range of ideas for how further improvements might be made.

16 A detailed analysis of the responses is at **Annex A**. This section summarises the views of respondents to the main consultation document on how further progress can be made in reducing accidents and ill health caused by work. The seven key themes to emerge from the 265 responses that specifically addressed this issue are as follows:

i. Raising Awareness of Health and Safety

17 Almost two thirds of responses focused on the need to raise awareness of health and safety – among employers, workers and the general public. Opinion was split on the most effective method of awareness raising, with many suggesting that several methods should be deployed at once. **Figure 2** shows the most popular suggestions.

Figure 2: Suggestions for Awareness Raising



ii. Enforcement Action

18 Enforcement issues were mentioned in over a third of responses. The most popular suggestions were:

- more inspections;
- increased funding for regulators;
- stiffer penalties;
- more energetic enforcement of existing legislation (some made the point that this would be easier to achieve if the legislation was clearer); and
- greater attention to the recording and reporting of incidents (for example through a National Safety Audit requiring companies to produce audited annual reports on their health and safety performance and plans).

iii. Boardroom Issues

19 A quarter of responses suggested that ensuring health and safety was a boardroom issue would be a key factor in making further progress. The most important issues were felt to be:

- covering health and safety in company annual reports;
- indicating publicly which Director holds responsibility for health and safety;
- including health and safety on the agendas of Board meetings;
- clarifying the position on corporate responsibility.

iv. Role of the Insurance Industry

20 A tenth of responses suggested that the insurance industry needed to play a more proactive role in promoting health and safety awareness, and that health and safety performance needed to be reflected more sharply in the level of insurance premiums.

v. Safety Representatives

21 A tenth of responses highlighted the important role of safety representatives in managing health and safety at work. The majority of these called for enhanced powers, such as the Provisional Improvement Notice powers granted in some Australian States. Such Notices allow representatives to serve notice on their employers of breaches of health and safety law and to require action to deal with them.

vi. Occupational Health and Rehabilitation

22 Almost a tenth of responses called for better access to occupational health services for all workers, including a new focus on the provision of rehabilitation services for injured and sick workers.

vii. Financial Incentives

23 Around 1 in 12 responses called for financial incentives to motivate employers to act.

The next three Sections give details of new **Targets for Great Britain**, a **Strategy Statement** and **Action Plan**. Together these form the response of the Government and the Health and Safety Commission to the ***Revitalising Health and Safety*** consultation, designed to inject new impetus into the health and safety agenda for the new Millennium.

Section 2

Targets for Great Britain

24 Health and safety is central to sustainable development and securing a better quality of life for all:

- raising workplace standards will promote better public health and *social progress which recognises the needs of everyone*;
- reducing the £18 billion[1] annual bill for health and safety failures will contribute to *maintaining high and stable levels of economic growth and employment*;
- controlling harmful substances in the workplace will help to *protect our environment*.

25 We must grasp every opportunity to promote higher health and safety standards through wider sustainable development initiatives. For example, the Government hopes that health and safety will feature in the new Queen's Award for Sustainable Development. We look to the devolved administrations, and to regional and Local Agenda 21 partnerships, to play their part in promoting the health and safety message through programmes aimed at furthering sustainable development.

26 Amongst the indicators set out in *A strategy for sustainable development for the United Kingdom*, published in May 1999, are working days lost through illness, work fatalities and injury rates. A stated aim of the *Revitalising Health and Safety* initiative is to bring down rates of accidents and ill health caused by work.

27 In *Saving lives: Our Healthier Nation*, the Government set tough but attainable targets for England in priority areas such as death rates from cancer, coronary heart disease and stroke[2]. Over two thirds of respondents to our main consultation supported setting targets for health and safety at work to give new purpose and direction for all who needed to act.

28 The Government and the Health and Safety Commission have now decided, for the first time, to set targets for Great Britain on health and safety at work to drive forward this new strategy. Their delivery is dependent on the commitment of all stakeholders in the health and safety system to act to secure higher standards. That includes crucially action by Government at national, regional and local level – and action by dutyholders under health and safety law.

1. *Costs to Britain of workplace accidents and work-related ill health in 1995-1996*, HSE 1999
2. *Better Health – Better Wales* and *Towards a Healthier Scotland* set similar targets.

29 Our aim is for all stakeholders, working together, to:

- reduce the number of working days lost per 100,000 workers from work-related injury and ill health **by 30% by 2010**;
- reduce the incidence rate of fatal and major injury accidents **by 10% by 2010**;
- reduce the incidence rate of cases of work-related ill health by **20% by 2010**;
- achieve **half** the improvement under each target **by 2004**.

30 To deliver these challenging new targets, we will need:

- implementation of the new **Strategy Statement** and **Action Plan,** set out in the next two sections of this document;
- delivery of the **Health and Safety Commission's Strategic Plan –** an updated Plan rolling out this initiative will be published later this year including, wherever appropriate, development of supporting sectoral and risk-specific targets, to be agreed in partnership with stakeholders and then driven down into the workplace;

The Health and Safety Commission's Strategic Plan for 1999/2002 sets out five strategic themes supported by key programmes:

- to raise the profile of occupational health;
- to improve health and safety performance in key risk areas;
- to develop health and safety aspects of the competitiveness and social equality agendas;
- to increase the engagement of others and promote full participation in improving health and safety;
- to improve the Health and Safety Commission and Executive's openness and accountability.

The **Strategy Statement** and **Action Plan** set out in this document are designed to build on and further these themes.

- the **commitment of stakeholders** to share in our aspirations and contribute to their delivery, for example by devising and publishing their own supporting targets.

31 In formulating these targets, account has been taken of responses to the Health and Safety Executive discussion document *Developing an occupational health strategy for Great Britain* which invited comment on a target of reducing work-related ill health by 20% by 2010. Account has also been taken of forecast changes in the labour market over the next 10 years, and of the Health and Safety Commission's experience in formulating outcome targets for some specific sectors such as the rubber and paper industries. A focus on tackling the most serious cases first, together with improved arrangements for rehabilitation, will be key to delivery of the first of these targets. The Health and Safety Executive will now develop baselines for these measures, make arrangements for discussions (involving the social partners) on contributory targets, and for monitoring progress.

Section 3

10-point Strategy Statement

32 The 25 years since the Health and Safety at Work etc Act 1974 have seen steady but, in the recent past, slowing reduction in levels of health and safety failures. This has been a tribute to the strengths of the 1974 Act and the analysis that underpinned it. The rate of fatal injury to workers in Great Britain is less than half that in Germany.

33 In striving to achieve maximum preventative effect, the Health and Safety Executive and local authorities have sought to balance their duties to give advice, inspect, undertake enforcement action and investigate complaints and accidents. There is no need to change this basic approach, but there is a pressing need for constant vigilance and further action to raise standards.

34 That is why the Government has significantly increased the resources available to health and safety – additional resources of some £63 million were made available to the Health and Safety Commission and Executive in the three year Comprehensive Spending Review in 1998. As a result, the annual number of regulatory contacts the Health and Safety Executive has with employers and duty holders (including inspections) is estimated to have risen to 188,000 in 1999/00. The number of prosecutions for health and safety crimes has been rising each year and is estimated to have reached 1900 in 1999/00.

35 A fair, decent and safe society depends on good regulation where alternative approaches, such as guidance, cannot secure the same outcome. Good regulation is about decent standards and protection for everyone, not bureaucracy and red tape. The Health and Safety Commission and Executive are committed to helping business – small firms in particular – by simplifying and clarifying health and safety law and guidance; improving the enforcement regime by ensuring it is consistent, proportionate, transparent and targeted; and cutting red tape by removing unnecessary forms and paperwork requirements.

36 The 1980s and 1990s have been characterised by significant legislative activity, much of which has been driven by the European Union. It is now recognised by many, including our European partners, that the legislative framework is broadly complete. The challenge is to convert legal standards into real changes in culture and behaviour in the workplace, since only this can deliver continuous improvements in standards. We must also be alert to new areas of risk and the forces behind them, and be ready to develop strategies to tackle them. People management issues, such as stress, change and violence, continue to pose a threat to the effectiveness of the modern workplace.

37 Many of the findings of Lord Robens' committee[3], which paved the way for the 1974 Act, remain valid today. Partnership between Government, employers, employees and unions remains crucial, as does self-regulation based on goal setting law. But there is a need for new energy and a new strategic direction. This **10-point Strategy Statement** sets the framework for further action over the early part of the 21st century:

3. *Safety and Health at Work*, Report of the Committee 1970-72, Chairman Lord Robens, HMSO Cmnd. 5034

i) The health and safety system needs to do more than just prevent work-related harm. It must **promote better working environments** characterised by motivated workers and competent managers. This will require a shift in focus from minimum standards to best practice. In so doing, we will make an active contribution to the wider Government agendas of competitiveness, sustainability, public health and social inclusion.

ii) The changing world of work means we must adjust our approach to health and safety regulation. The health and safety system must complement the Government's vision for a competitive, knowledge driven economy. We must recognise and promote the **contribution of a workforce that is 'happy, healthy and here' to productivity and competitiveness**. This is a workforce that understands its own responsibilities and benefits from a strong health and safety culture.

iii) **Occupational health** must remain a top priority if a real break-through is to be made. The next significant step will be to take forward the Health and Safety Commission's new occupational health strategy. This will include better compliance with health law, innovative arrangements to secure continuous improvement, and having the right knowledge and skills available with appropriate occupational health support.

The Health and Safety Commission will launch an occupational health strategy for Great Britain in July 2000. The new strategy will take a wide view of occupational health considering not only the preventative side of controlling effects of work on health, but also how health impinges on work, and the contribution that occupational health can make to rehabilitation.

iv) There is a need for **positive engagement of small firms**, by promoting clear models of how they too can reap the benefits of effective health and safety management. We must commit to simplifying law that is over-complicated with their needs in mind, without compromising standards, and ensure (for the reasons set out in paragraph 96) that small firms are not deterred from seeking advice for fear of enforcement action. We must redouble efforts to bring pressure to bear through the supply chain, particularly in government procurement.

v) The compensation, benefits and insurance systems must **motivate employers** to improve their health and safety performance, in particular by securing a better balance in the distribution of the costs of health and safety failures. When things do go wrong, employers must also be motivated to rehabilitate injured workers so as to maximise their future employability. The Government sees a case for reforming the arrangements for employers' liability insurance in pursuit of these goals.

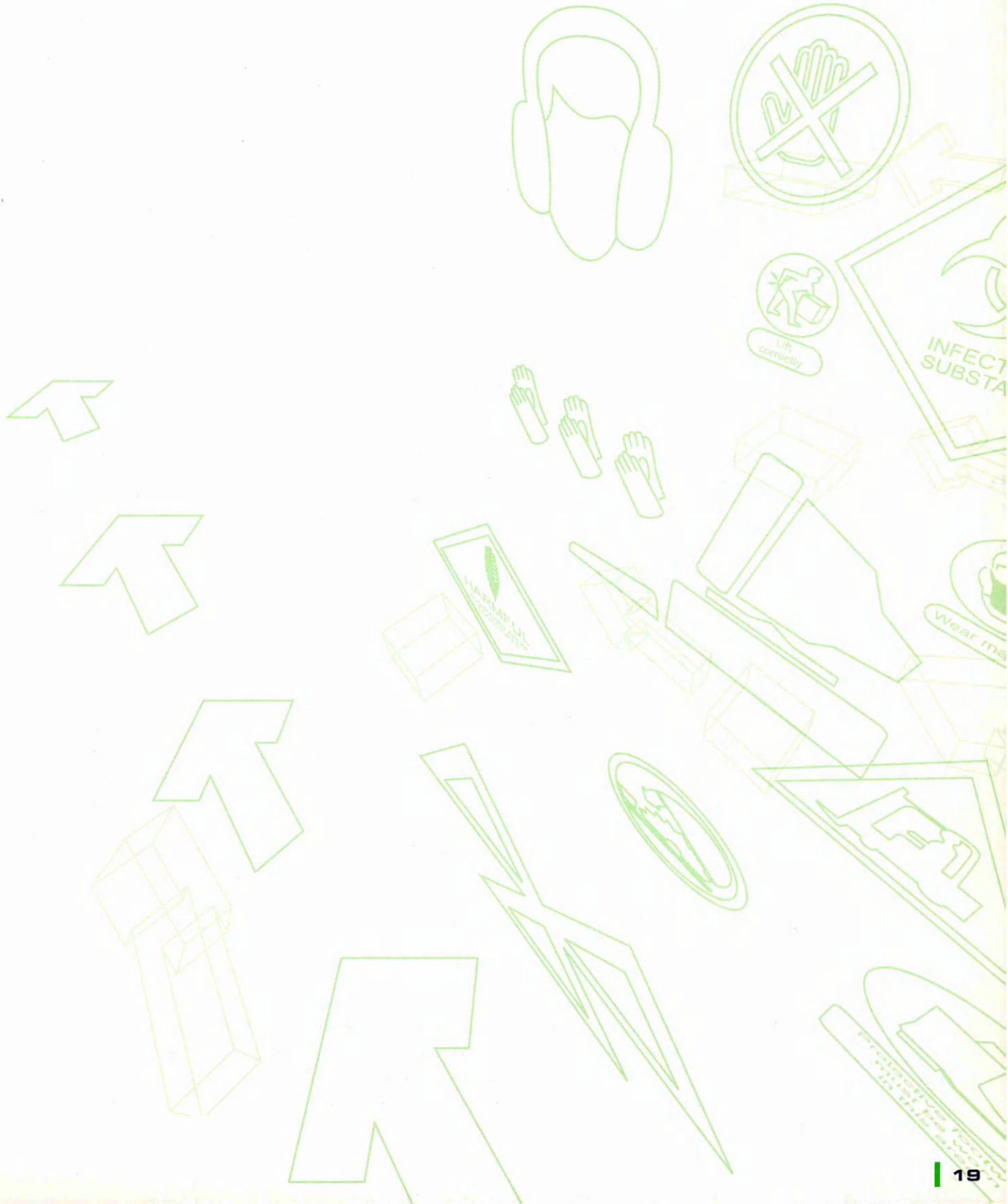
vi) A more deeply engrained **culture of self-regulation** needs to be cultivated, most crucially in the 3.7 million businesses with less than 250 employees. We must demonstrate and promote the business case for effective health and safety management. We must provide financial incentives which motivate, and change the law to secure penalties which deter. This culture must be further supported through the full integration of health and safety within general management systems.

vii) The full potential of Robens' vision for worker participation in health and safety management at individual workplaces is yet to be realised. An innovative response is needed to the challenges presented by the changing world of work. **Partnership on health and safety issues** can lead the way for the Government's wider agenda on partnership between employers and workers. Indeed, effective partnerships between all stakeholders in the health and safety system, including central, regional and local government, are crucial.

viii) **Government must lead by example.** All public bodies must demonstrate best practice in health and safety management. Public procurement must lead the way on achieving effective action on health and safety considerations and promoting best practice right through the supply chain. Wherever possible wider Government policy must further health and safety objectives.

ix) Most health and safety failures are due to poor management and ignorance of good practice, rather than direct malicious intent. **Education** at every level, starting in primary school, in health and safety skills and risk management is key. Significant steps forward have been made, but there is much more still to do. Coverage of risk issues in engineering, design and general management education remains weak.

x) The best way to protect workers' health and safety, particularly where more complex contractual structures are involved, is to **'design it in'** to processes and products. The Construction Design and Management Regulations have pioneered this approach with considerable success. The same principles must now be applied in other areas where there is heavy reliance on contracting.



Section 4

Action Plan

38 In order to deliver the ambitious targets we are now committing to, we must take forward the new strategic direction through concrete action in the shorter term. This section sets out the first steps – a **44-point Action Plan**. Some actions fall to the Health and Safety Commission, in consultation with stakeholders, and will be carried forward into their later Strategic Plans. Others are commitments from government designed to raise further the profile of the Health and Safety Commission's work.

Motivating employers

Ready Reckoner

Action point 1
The Health and Safety Commission will publish and promote a Ready Reckoner supported by case studies to drive home the business case for better health and safety management.

39 We are grateful to the insurance industry for agreeing in principle to circulate these documents with employers' liability insurance renewals. They will also be made available to trades unions, safety representatives and employees.

40 The idea of the Ready Reckoner is to provide employers with a straightforward tool to facilitate assessment of the potential financial benefits of further action to improve health and safety management. This will take the form of a short awareness-raising leaflet supported by a software package, which will also be made available to workers and their representatives.

Over £180 million a year could be saved in work-related illness costs in the construction industry alone. "Rethinking Construction", the report of the Construction Task Force published in 1998, indicated that some leading clients and construction companies had achieved reductions in reportable accidents of 50-60% in two years or less, with consequent substantial reductions in project costs.

BIP Group, a plastics company with annual sales of £75m, made health and safety a priority. It is the first item at board meetings, and Chairman Keith Sansom organised raffles to mark improvements. Accidents resulting in a worker taking three days or more off work have been reduced from 18 to less than one a year, and the company's insurance premiums have reduced by 60%.

41 The experience of companies such as South West Water demonstrates that a strong health and safety culture contributes significantly to profitability. South West Water saved £2.5 million over a six-year period through action to prevent accidents. They also expect to save £0.9 million over a ten-year period through a programme to prevent just one type of work-related ill health (upper limb disorder). Yet our consultation revealed that many organisations continue to doubt whether the 'good health and safety is good business' message really does apply to them in hard financial terms. The aim of the Ready Reckoner is to address this communication failure.

- In October 1999, the Health and Safety Executive published new data on the costs to Britain of workplace accidents and work-related ill health in 1995-1996.
- Work-related accidents and illness cost 2.1-2.6 per cent of gross domestic product each year – equivalent to between £14.5 billion and £18.1 billion.
- The cost to employers is estimated at between £3.5 billion and £7.3 billion a year – 4 to 8 per cent of all gross company trading profits.

Reporting

Action point 2

The Health and Safety Commission will promote publication of guidance, by March 2001, to allow large businesses to report publicly to a common standard on health and safety issues. The Government and the Health and Safety Commission challenge the top 350 businesses to report to these standards by the end of 2002, and will then work to extend this to all businesses with more than 250 employees by 2004.

42 An analysis of health and safety coverage in the annual reports of companies in the FTSE 100 was carried out by the charity 'Disaster Action' in 1996. This showed that roughly half of these reports covered health and safety in some way, with wide variation in the quality of reporting.

43 In line with the approach adopted on environmental reporting, where there are some excellent examples, Ministers wish to seek to encourage more widespread reporting on a voluntary basis in the first instance. However, Ministers are minded to move to a compulsory regime if good progress is not made against this action point.

44 It is anticipated that the new guidance on annual reporting will encourage companies to include details of their health and safety policies, numbers of reported incidents and details of any enforcement action. Ministers attach particular importance to details of prosecutions, fines and statutory notices being made public. Many of the unions responding to our consultation argued for auditable standards for reporting the costs of health and safety failures and the benefits of health and safety interventions. The feasibility of this proposal will be considered in working up guidance.

45 The Royal Society for the Prevention of Accidents is taking forward a new initiative called *Director Action on Safety and Health (DASH)*. One aspect of this work is to be a consultation on encouraging best practice in measurement and reporting (both internally and externally) of health and safety performance and plans.

46 The Company Law Review, which includes within its remit an examination of the legal framework for company accounting, reporting and disclosure, may also make proposals relevant to company reporting on health and safety. The Review, which was launched by the Department of Trade and Industry in 1998, is overseen by a Steering Group of independent experts. It is due to make its final report in Spring 2001.

Action point 3

The Health and Safety Commission will undertake a fundamental review of the health and safety incident reporting regulations.

47 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) came into force in April 1996. These Regulations simplified injury definitions, introduced new plain English report forms, and enabled the Health and Safety Executive to pilot arrangements for telephone reporting of accidents in Scotland. Plans are being laid, subject to resources being made available, for an integrated call centre which will enable all employers to report incidents by telephone, fax or Internet.

48 While nearly all workplace fatalities are reported, only 47% of reportable incidents generally are reported to the Health and Safety Executive or local authorities. The review of the reporting regulations will look in particular at the needs of the Health and Safety Executive and local authorities for the information currently collected; investigate why employers do not report accidents and the near misses they are required to report; and the possibilities for 'joined up' information and communications strategies with others in the public service to get across the reporting message to employers.

49 A related issue is the quality of investigation by employers when incidents occur, to ensure that lessons are learned and risks are better controlled in future. The Health and Safety Commission has recently sought views on the introduction of a specific duty on employers to investigate accidents. It is considering a consultative document with specific proposals to change the law. Leading-edge employers, large and small, already conduct detailed investigations of all incidents, including near misses, as a powerful catalyst for improved future performance. Our vision for the future is far wider propagation of such best practice approaches.

How well are we doing?

Action point 4

The Health and Safety Commission will advise Ministers what steps can be taken to enable companies, if they wish, to check their health and safety management arrangements against an established 'yardstick'. This work will include examination of the implications for small firms and the role standards can play in addressing their needs.

50 Two thirds of responses to our consultation saw wider adoption of accreditation schemes as a means of raising health and safety standards. At present there is no health and safety management standard to which companies can seek accredited certification. This is at odds with the position on environmental and quality management standards, and may mean that health and safety is given less attention. Although health and safety does feature in the most recent 'Investors in People' standard, it is unlikely that this element within such a broad standard can realistically acquire sufficient prominence to achieve the impact we are seeking.

51 A certifiable standard could provide a clear benchmark and help to promote supply chain initiatives. It could also provide a useful input to the SIGMA Project[4], which aims to create a strategic management framework for sustainability by developing the next generation of sustainability management tools and standards. It is for consideration whether any of the existing non-certifiable health and safety standards would provide a good starting point.

52 Work currently underway in the International Labour Organisation and in other international bodies will need to be taken into account. The EC Advisory Committee on Safety, Hygiene and Health Protection at Work has recently agreed a helpful statement of principles. It is critical, though, that the needs of smaller firms and their workforces are taken into account, which is why we are making a commitment to examine how standards can help to promote health and safety in small firms. This work will need to involve representatives of small firms and their employees from the outset.

4. Run in partnership by the British Standards Institution, Forum for the Future and the Institute of Social and Ethical Accountability, and involving the Department of Trade and Industry and the Department of the Environment, Transport and the Regions.

We welcome – and encourage organisations to participate in – health and safety benchmarking programmes, such as the Confederation of British Industry's CONTOUR management tool. CONTOUR allows companies to measure their environment, health and safety performance against their competitors, with a view to enhancing competitiveness.

Involving insurers

53 Many consultees suggested that the insurance industry could do more to promote higher health and safety standards. The 10-point Strategy Statement indicates that the Government sees a case over the medium term for reforming the compensation, benefits and insurance systems to motivate employers more effectively to raise standards and rehabilitate victims. The Government attaches importance to involving the insurance industry in the development of health and safety policy, for example through the Health and Safety Commission's advisory structures.

Action point 5

The Health and Safety Commission will consider how best to involve the insurance industry more closely in its work, including the possibility of representation on the Commission's advisory committees.

54 The insurance industry has indicated that introduction of auditable management standards would assist them in encouraging better health and safety performance from their customers for employers' liability insurance, particularly if a suitably tailored scheme could be introduced for small firms. Some insurers, particularly in higher hazard sectors, do already load premiums by as much as 50% according to risk, and offer discounts of up to 20%. Insurers also offer free advice on risk management, together with health and safety training and consultancy services.

55 Key issues for further consideration are how insurers might exert greater pressure on very poor performers; and how the current practice of adjusting premiums and providing advice to larger businesses in higher hazard sectors might realistically be transferred to lower hazard sectors and smaller businesses.

56 For example, the Association of British Insurers is looking to develop a recommended questionnaire on health and safety, the purpose of which will be to ensure that health and safety information is presented in a uniform and user-friendly fashion, leading to better informed assessment of risks and the measures necessary to control them. Such a questionnaire should make insurers' expectations on health and safety standards very clear to companies purchasing insurance, while facilitating adjustment of premiums according to risk and performance.

57 The Government is eager to secure the highest possible levels of compliance with the Employers' Liability (Compulsory Insurance) legislation, so that all workers benefit from the full protection intended by the law. At present, only a restricted number of Health and Safety Executive inspectors have responsibility for enforcing this legislation.

Action point 6

The Government will work with the Health and Safety Executive to ensure that a larger number of inspectors have powers to enforce the Employers' Liability (Compulsory Insurance) legislation.

Penalties

Action point 7

The Government will seek an early legislative opportunity, as Parliamentary time allows, to provide the Courts with greater sentencing powers for health and safety crimes. The key measures envisaged are to extend the £20,000 maximum fine in the lower courts to a much wider range of offences which currently attract a maximum penalty of £5,000; and to provide the courts with the power to imprison for most health and safety offences.

Action point 8

The Health and Safety Executive will monitor and draw public attention to trends in prosecution, convictions and penalties imposed by the Courts, by publishing a special annual report. This will 'name and shame' companies and individuals convicted in the previous twelve months. This information will also be available on the Health and Safety Executive's Website.

58 The consultation document stated that the Government was considering whether to make imprisonment available to the courts for all health and safety offences, and whether the maximum fine for breaches on summary conviction should be increased for offences under the 1974 Act. The overwhelming view of consultees was that the general level of penalties imposed by the courts is inadequate: only 7% considered that the current framework for penalties was satisfactory. Many also argued that more publicity needed to be secured for successful prosecutions. In the light of future trends in sentencing, the Government will consider a referral of health and safety offences to the independent Sentencing Advisory Panel.

59 The Government sees a strong case for strengthening the sentencing powers available to the courts and intends to legislate for this as soon as Parliamentary time allows. A Government handout Bill (the Health and Safety at Work (Offences) Bill), following this session's Private Members' ballot, has already been introduced in Parliament which would increase the maximum lower court fines and make imprisonment more widely available. The Bill would also increase the penalty for the main offence under the Employers' Liability (Compulsory Insurance) Act 1969, and extend the time limit on bringing prosecutions for such an offence.

Marking the launch of the joint TUC – British Safety Council report on health and safety penalties in December 1999, the Lord Chancellor said:

- "I am confident that the Criminal Courts will play a full part in generating greater public awareness of the importance of health and safety issues; and in ensuring that the Courts come down hard on those who breach health and safety legislation."

While stressing that only the magistrates and judges could do justice in the particular circumstances of the cases before them, the Lord Chancellor said that they should not flinch from using the maximum penalties, including imprisonment where appropriate.

Action point 9

The Health and Safety Commission will advise Ministers on the feasibility of consultees' proposals for more innovative penalties.

60 Many consultees suggested that a more innovative approach to penalties might be more effective in changing companies' behaviour. Among the specific proposals which the Health and Safety Commission will consider are:

- fines linked to the turnover or profit of a company;
- prohibition of Director bonuses for a fixed period;
- suspension of managers without pay;
- suspended sentences pending remedial action;

- compulsory health and safety training;
- penalty point system on the drivers' licence model;
- fixed penalty notices for specific offences;
- deferred prohibition notices on welfare issues.

61 A further popular suggestion was that community service related to health and safety might be an appropriate penalty in some cases. Community service orders can, and have been, imposed by the courts following health and safety convictions. The Health and Safety Commission will consider as part of this project what effect the community service approach has had and whether there might be scope for its wider use.

Action point 10
The Government will consider an amendment to the 1974 Act (when Parliamentary time allows) to enable private prosecutions in England and Wales to proceed without the consent of the Director of Public Prosecutions.

62 The Law Commission published a report on 20 October 1998 entitled *Consents to Prosecution*. This report found anomalies in the list of offences requiring the consent of the Director of Public Prosecutions, arguing that these made substantial inroads into the ordinary individual's right to set the criminal law in motion. Though health and safety offences were not intended to be within the scope of the report, the same principles have a bearing on the position under the 1974 Act.

63 The Law Commission recommended that consent provisions should exist only for three categories of offences: where a defendant could contend that prosecution would violate the European Convention on Human Rights; where national security or an international element is involved; or where there is a high risk that the right of private prosecution will be abused and cause the defendant irreparable harm. The Law Commission concluded against pursuing their provisional proposal for consent provisions where civil proceedings are available in respect of the same conduct.

64 The Law Commission recommends that all consent provisions, which fall outside these categories, be dispensed. The powers of the Attorney General to prevent vexatious proceedings from commencing or to terminate them, and the powers of the Director of Public Prosecutions to take over and discontinue proceedings, remain. The Director of Public Prosecutions has to date received no more than a handful of applications in relation to health and safety offences, all of which have been rejected. Such a reform would, though, need to guard against any vexatious prosecutions skewing action away from protection of the most vulnerable.

Corporate responsibility and the role of Directors and responsible persons of similar status

65 There has been growing public concern that the existing offence of corporate manslaughter is flawed. Following the Southall rail crash in 1997 which resulted in 7 deaths and 151 injuries, Mr Justice Scott-Baker ruled that a charge of manslaughter could not succeed because of the need to "identify some person whose gross negligence was that of Great Western Trains itself". Similarly, prosecutions against 7 individuals and the company following the Herald of Free Enterprise disaster in 1987 failed because "the various acts of negligence could not be aggregated and attributed to any individual who was a directing mind". In the history of English law there have been only three successful prosecutions for corporate manslaughter, all against small companies.

66 The Law Commission recommended that a special offence of 'corporate killing' should be created. In cases where management arrangements had failed to ensure the health and safety of workers or the public, a death would be regarded as having been caused by the conduct of the corporation. Individuals within a company could still be liable for the offences of reckless killing and killing by gross carelessness, as well as the company being liable for the offence of corporate killing. Directors and managers can also be prosecuted under section 37 of the Health and Safety at Work etc Act 1974 if an offence is committed with their consent or connivance, or is attributable to neglect on their part.

67 The Home Office published on 23 May 2000 a consultation document on involuntary manslaughter, with a view to implementing the Law Commission recommendations on a new 'corporate killing' offence in England and Wales. The consultation document covers the issue of corporate liability and the extent to which Directors should be personally liable. The Scottish Executive will consider whether, in the light of proposals in England and Wales, any changes are needed to Scottish law.

68 Many consultees considered that greater prominence for health and safety issues at board level was the key to raising standards. Responses from health and safety practitioners pointed unanimously to the perception of a low profile for their profession with little support from senior management.

Action point 11
The Health and Safety Commission will develop a code of practice on Directors' responsibilities for health and safety, in conjunction with stakeholders. It is intended that the code of practice will, in particular, stipulate that organisations should appoint an individual Director for health and safety, or responsible person of similar status (for example in organisations where there is no board of Directors).
The Health and Safety Commission will also advise Ministers on how the law would need to be changed to make these responsibilities statutory so that Directors and responsible persons of similar status are clear about what is expected of them in their management of health and safety. It is the intention of Ministers, when Parliamentary time allows, to introduce legislation on these responsibilities.

69 Health and Safety Executive guidance confirms that, in organisations that are good at managing health and safety, health and safety is a board room issue and a board member takes direct responsibility for the co-ordination of effort. Ministers and the Health and Safety Commission attach importance to ensuring that organisations appoint an individual director for health and safety, or a responsible person of similar status.

The Royal Society for the Prevention of Accidents (RoSPA) launched a new initiative called *Director Action on Safety and Health (DASH)* on 27 October 1999. This will seek to co-ordinate a programme of activities involving key stakeholders aimed at encouraging more effective involvement of Directors.

70 Health and safety management needs to be set firmly in the wider context of corporate governance and corporate social responsibility. Guidance on the internal control requirements of the Combined Code on Corporate Governance, developed by a working party under the chairmanship of Nigel Turnbull, was published by the Institute of Chartered Accountants in September 1999 (ISBN 1 84152 010 1). The guidance is intended to ensure that the board is aware of the significant risks faced by their company and the procedures in place to manage them. Boards of directors are called on to review regularly reports on the effectiveness of the system of internal control in managing key risks, and to undertake an annual assessment for the purpose of making their statements on internal control in the annual report.

We're doing our bit

71 Many responses to the consultation suggested that there was considerable scope for government – at central, regional and local level – to improve its own performance as an employer, to demonstrate excellence in health and safety management as a model for others to follow. This will be key to reducing levels of sick absence and early retirement on grounds of ill health in the public sector.

The average days lost due to work-related illness in the nursing profession is one of the highest for any occupational group.

Source: Survey of Self-Reported Work-Related Illness 1995

The Human Resources Framework 'Working Together – Securing a quality workforce for the NHS' has set a target for all NHS employees in England to have access to occupational health services by April 2000.

The occupational health and safety services strategy for NHS Scotland staff 'Towards a Safer Healthier Workplace', published in December 1999, fulfils the commitment in the NHS in Scotland Human Resources Strategy to developing a fully integrated, comprehensive, accessible and inclusive Occupational Health and Safety Service, which is consistent throughout Scotland. Key aims are to involve staff fully in developing and determining standards, implement policies and procedures to minimise and prevent accidents and incidents, and to benchmark standards for occupational health.

Action point 12

Ministers and the Health and Safety Commission will endorse a health and safety checklist along the lines of the one at Annex B, subject to consultation with the relevant trades unions and other relevant stakeholders, for circulation to all Government Departments and all public bodies, including local authorities and health authorities, as a catalyst for improvement. Ministers will be advised of the results of this exercise.

Action point 13

All public bodies will summarise their health and safety performance and plans in their Annual Reports, starting no later than the report for 2000/01.

Action point 14

The Department of the Environment, Transport and the Regions, in partnership with the Health and Safety Executive, will pioneer a High Level Forum to provide leadership on health and safety management issues within the Civil Service.

Action point 15

The Government will seek a legislative opportunity, when Parliamentary time allows, to remove Crown immunity from statutory health and safety enforcement. Until immunity is removed, the relevant Minister will be advised whenever Crown censures are made.

72 Crown bodies have always been exempt from provisions in health and safety law for prosecutions and statutory prohibition/improvement notices. The Health and Safety Executive currently enforces health and safety in Crown bodies by means of non-statutory improvement and prohibition notices. When, but for Crown immunity, the Health and Safety Executive would have prosecuted, there are agreed arrangements for recording a Crown censure against the Crown body concerned.

73 The Health and Safety Commission will advise Ministers on the range of options for introducing statutory health and safety enforcement against Crown bodies. The Food Safety Act 1990 offers a possible model. This provides for statutory improvement and prohibition notices against Crown bodies and, in lieu of prosecution, the power to seek a High Court (or, in Scotland, Court of Session) declaration of non-compliance. In the meantime, the Cabinet Office in consultation with the Health and Safety Executive is to issue new guidance to departments and agencies on the procedures for enforcing health and safety requirements in Crown bodies.

The modern world of work

74 One of the key aims of *Revitalising Health and Safety* is to ensure that our approach to health and safety regulation remains relevant for the changing world of work over the next 25 years. Responses to our consultation highlighted the need for further action to protect workers in untraditional employment arrangements and to secure the positive engagement of small firms.

75 This section sets out action designed to deliver protection for all. For example, where approaches to individual employers alone cannot hope to succeed, we will need to work more energetically through the supply chain, with central and local government leading the way. True partnership will be key, both between employers and workers, whatever the employment framework, and more widely between all stakeholders in the health and safety system, including government.

Action point 16

The Health and Safety Commission will consider further whether the 1974 Act should be amended, as Parliamentary time allows, in response to the changing world of work, in particular to ensure the same protection is provided to all workers regardless of their employment status; and will consider how the principles of good management promoted by the Construction, Design and Management Regulations approach can be encouraged in other key sectors. Ministers will be advised accordingly.

76 A large majority of respondents to our consultation saw a need for clear and simple guidance to ensure better understanding of health and safety responsibilities in contractual chains. Only 19% considered themselves to be clear on who held health and safety duties in contractual chains. 81% felt there was a need for clarification or clearer guidance, with about a tenth of these commenting that the law was only clear where the Construction, Design and Management (CDM) Regulations applied.

The CDM Regulations seek to ensure that health and safety is managed effectively throughout all stages of a construction project – from conception and design through to site work and subsequent maintenance and repair. It is enshrined in the principles of good management practice in which all those involved understand fully their own obligations and those of others, and work co-operatively to achieve a healthy, safe, cost efficient and highly productive project.

77 The Health and Safety at Work etc Act 1974 places general duties on employers in respect of their employees, and on employers and the self-employed in respect of persons other than their employees. There has been concern that this framework may not be able to deal adequately with rising numbers of the 'apparently self-employed' – those who are self-employed for tax purposes but whose level of control over working conditions is difficult to distinguish from that of employees in the same sector. Homeworkers, peripatetic workers and volunteers may also give rise to misunderstanding of the legal position.

78 The Health and Safety Commission consulted on this issue in 1996 and concluded at that time that no immediate change in the law was needed. A programme of work has gone forward to consider the needs of vulnerable workers but, despite this, the *Revitalising Health and Safety* consultation suggests that widely-held concerns remain. The National Minimum Wage legislation may provide a new model to follow.

79 The Government is committed to plugging any gaps in current arrangements, in particular to ensure that responsibility never falls between two stools. While considering changes that may be necessary to the 1974 Act in the light of changing patterns of employment, the Health and Safety Commission will also consider whether there are other changes, over the last 25 years, that suggest that amendment of the Act would now be helpful.

80 The Government sees a good case for modernising the Industrial Injuries scheme. The scheme now compensates people working under a contract of employment who are disabled by an accident or by diseases known to be a risk of work. The aim of the Government, in reviewing the scheme, is to reflect better the needs of today's labour market, and to improve incentives for prevention and rehabilitation.

Workplaces with trades union safety representatives and joint health and safety committees have significantly better accident records – over 50% fewer injuries – than those with no consultation mechanism[5].

81 Key to delivering health and safety in the workplace is effective engagement of the workforce themselves; that in turn means effective representation of the workforce in decisions relating to the safety regime. Ministers and the Health and Safety Commission attach great importance to the role played by safety representatives in securing good standards of health and safety. Every opportunity has been taken to encourage more businesses to recognise the role of safety representatives. The Health and Safety Commission published a discussion document on 8 November 1999 on the options for promoting greater worker participation, particularly in the context of a changing labour market and limited trade union presence in many cases. Options canvassed in the document included the introduction of roving safety representatives, giving safety representatives greater powers, and new steps to widen employee participation in non-unionised workplaces. The Health and Safety Commision will advise Ministers on these options and will publish a consultative document setting out proposals for change.

82 The £5 million Partnership Fund announced by the Prime Minister in May 1999 will support workplace projects which foster partnership between employers and employee representatives. The Government attaches great importance to promoting partnership on health and safety issues, recognising that co-operation on health and safety can provide the building blocks for co-operation on other matters.

83 We welcome the work of the Trades Union Congress and the Confederation of British Industry in promoting partnership in health and safety, with the particular aim of ensuring that employers see safety representatives as partners in risk management rather than a group of people whom they are formally required to consult. Developing wider partnerships with other key stakeholders, including government at central, regional and local level, is also crucial.

84 As part of the work of the Trades Union Sustainable Development Advisory Committee, the Government commissioned a report to explore the options for increasing the involvement of trades unions in workplace environmental issues. The committee is continuing to consider this issue.

Action point 17

The Government will ask the Learning and Skills Council, in consultation with the Health and Safety Commission, to undertake an early review of the funding and provision of training for safety representatives. In light of the conclusions of this work, the Scottish Executive and the National Assembly for Wales will consider whether to change the arrangements in Scotland and Wales.

85 The 1977 Safety Representatives and Safety Committees Regulations entitle trade union appointed safety representatives to time off with pay to undertake training. The Trades Union Congress and individual unions run courses. This training used to be publicly funded through the Trade Union Training and Education Grant, but this was phased out by 1996. At present, funding rules prevent Further Education colleges running courses lasting less than 4 days, whereas it would often be more convenient for workers and employers alike to attend shorter courses.

Action point 18

The Health and Safety Executive will take further action to publicise the right of workers to contact them, particularly in the context of the new protection provided by the Public Interest Disclosure Act 1998.

5. *Unions, Safety Committees and Workplace Injuries*, Reilly, Paci and Holl. British Journal of Industrial Relations 33.2, June 1995 0007-1080

86 The Public Interest Disclosure Act 1998 provides additional protection for 'whistleblowers'. It is only right that people who come forward to expose the practices of irresponsible employers are afforded every possible protection from victimisation.

87 Listening to workers' concerns and ensuring that incidents are properly reported to the enforcing authorities should be integral to employers' health and safety arrangements. But all workers have the right, where they feel that their employers have not paid proper regard to their health or safety, to contact their health and safety enforcing authority. Workers can make their views known in confidence, if they wish, and the enforcing authorities will do everything possible to protect their anonymity. Workers' right to contact enforcing authorities is publicised in the new Health and Safety Law poster and leaflet, and on the Health and Safety Executive's website. The Health and Safety Executive will continue to seek further opportunities to publicise this message, for example in other relevant publications and leaflets.

88 More than 30,000 workers contacted the Health and Safety Executive last year. Around half of these complaints were found to be justified on investigation. The results of the 'whistleblowers' pilot telephone line indicates that about a quarter of such justified complaints involve serious risks to health and safety requiring priority action.

Supply chain pressure

89 It is now widely recognised that, just as organisations stand to benefit from improved productivity when they improve health and safety management systems, so procurers stand to secure better value for money when their contractors do the same. Avoidable accidents trigger unforeseen costs and delay.

90 It is important that Government departments and the wider public sector make legitimate and relevant health and safety requirements a significant factor in their procurement decisions, within the framework of the Government's policy of basing all public procurement of goods, services and works on value for money and the EC procurement rules.

91 For example, contract specifications should make explicit reference to health and safety requirements wherever appropriate. Companies who have performed poorly on previous contracts, for example in compliance with health and safety law, may be excluded from tendering opportunities, unless they can demonstrate positive action taken to achieve compliance.

92 We believe that the construction sector should be the immediate focus for action, as it is here that the impact is likely to be greatest. *Rethinking Construction*, the report of the Construction Task Force published in July 1998, is bringing about a sea change in attitudes to construction procurement. The Government has launched the *Movement for Innovation* initiative to take this work forward. An important part of this is promotion of the *Respect for People* agenda. A key goal must be to get the design stage right and to set the right tone from the outset.

93 Work must also start on rolling out similar approaches to Government procurement in other sectors. In the same way that the new construction *Clients' Charter* is to be an industry-wide initiative, the Government will look to industry to follow its lead in other sectors.

Action point 19

The new Clients' Charter to be launched later in the year as part of the Movement for Innovation in the construction industry, will include targets on health and safety to drive up standards. Government Departments and their sponsored bodies will sign up to the Charter as part of their Achieving Excellence action plans and in demonstration of their support for the Health and Safety Commission's Working Well Together campaign. The Government will consider how this approach can be rolled out to other areas of procurement.

Action point 20

The Local Government Construction Task Force will consider how health and safety issues can be most effectively factored into construction procurement by local government.

Action point 21

The Health and Safety Executive will produce guidance for Government Departments and other public bodies on how best to achieve exemplary standards of health and safety in construction projects with which they have an involvement.

A positive approach to small firms

94 The Health and Safety Commission has long recognised the need to develop links with intermediaries with the aim of engaging small firms and communicating the benefits of effective health and safety management. However, the consultation response suggested that many small firms have difficulty understanding their legal duties and are unclear about the action they should take.

Action point 22

The Health and Safety Commission will take action, consulting the new Small Business Service in England, to improve arrangements for ensuring that the views of small firms are fully taken into account in policy formulation; and will seek to identify areas of regulation that affect small firms and can be simplified without lowering standards.

Action point 23

Within the framework set by the Nolan procedures for public appointments, the Government will seek to enhance representation of small firms on the Health and Safety Commission.

Action point 24

The Health and Safety Commission and the new Small Business Service will work in partnership to secure an effective profile for occupational health and safety within the Small Business Service both centrally and at local level. Similar work will also be taken forward in partnership with Scottish Enterprise, Highlands and Islands Enterprise, the Scottish Executive and the Business Connect network in Wales.

95 Between June and September 1999, the Department of Trade and Industry carried out a public consultation on its plans for a new Small Business Service, tasked with acting as a voice for small business at the heart of Government; simplifying and improving the quality and coherence of Government support for small businesses; and helping small firms deal with regulation and ensuring small firms' interests are properly considered in future regulation.

96 A key aim of the Small Business Service, effective from April 2000, is to provide a one-stop shop for information and advice, free from any threat of enforcement action. Our consultation revealed strong demand for this form of service, so it will be important to ensure that a full range of appropriate material on health and safety issues is available to small firms through this channel.

Effective guidance

Action point 25

The Health and Safety Commission and Executive will promote positive models of how small firms can benefit from effective health and safety management, through a range of information products including clear, straightforward sector-specific guidance supported by case studies.

97 Over three-quarters of respondents to our small firms leaflet suggested that realistic and relevant advice tailored to the specific needs of their organisation is not currently available. Respondents called for clear, straightforward, sector-specific advice written in plain English. The Health and Safety Commission and Executive have paid close attention in recent years to the content and presentation of guidance documents, and many of the 400 free leaflets the Health and Safety Executive produces are aimed at small firms and have won awards for plain language. Nevertheless, the Health and Safety Executive's experience reflects the views of consultees that small firms sometimes have difficulty finding the publications they need.

98 To address this difficulty, the Health and Safety Executive is undertaking a fundamental review of its guidance, identifying gaps in provision and the reasons why small employers can't find what they need. The outcome will be a full portfolio of guidance products reflecting the needs of small firms and other customers. These will include sector-specific introductory guidance for small firms, supported by case studies of best practice, available on the Health and Safety Executive's website.

99 The guidance will point out the hazards and risks in the sector, spell out key actions necessary to comply with the law and indicate where more detailed guidance can be found, including links to relevant downloadable material elsewhere on the site. This initiative will need to be drawn to the attention of, and linked appropriately to, the information systems of key intermediaries such as local authorities and the new Small Business Service.

The Occupational Safety and Health Administration in the United States have a website specifically for small businesses (www.osha-slc.gov/SmallBusiness). The website offers interactive computer software that can be downloaded, free on-site consultation and guidance on specific US standards.

Financial incentives

Action point 26

The Health and Safety Commission will advise Ministers on the design of a grant scheme to encourage investment by small firms in better health and safety management.

100 80% of respondents to our small firms leaflet supported a grant scheme or tax incentive to encourage small firms to invest in better health and safety. 20% of respondents expressed a particular preference for a grant scheme, while 10% favoured the tax incentive route. Respondents said that the most important consideration in designing a new scheme was to keep it simple and non-bureaucratic. The two most popular suggestions were subsidising training, publications, videos and consultancy advice, and giving a financial reward upon accreditation to a recognised standard.

101 Given consultees' preference for grants over tax incentives, together with the conclusion of exploratory work that grants are likely to enable more effective targeting, we have agreed that the Health and Safety Commission will advise Government on the design of a grant scheme in the first instance. This work will include consideration of whether the Environmental Technology and Energy Efficiency Best Practice Programmes could provide a model for Government support on health and safety issues.

102 Small Firms Training Loans are administered by the Department for Education and Employment. These provide low-cost credit through the high street banks for training that support achievement of a firm's business objectives, including health and safety training which meets this criterion. Health and Safety Executive and local authority inspectors have been asked to draw the scheme to the attention of companies they visit where appropriate. We would also look to key intermediaries such as accountants, banks and training providers to seek to raise awareness of this scheme.

Regulatory activity by local government

Action point 27

The Health and Safety Commission will work with local authorities to propose an indicator against which the performance of local authority enforcement and promotional activity in England, Scotland and Wales can be measured.

103 97% of responses to the question about whether more could be done to raise the profile of health and safety within local government answered yes. The most popular suggestions were to revisit the role of local authorities to ensure recognition of their occupational health and safety work, and to review the funding and performance management arrangements for this function.

104 The Health and Safety Commission is conscious of the need for local authorities to demonstrate best value. It will therefore review the guidance, made under Section 18 of the Health and Safety at Work etc. Act 1974 and arrangements for monitoring and evaluating the effectiveness of local authority enforcement activity. The Health and Safety Executive and Local Authorities Enforcement Liaison Committee (HELA) will also bring forward proposals for a programme of inter-authority auditing to demonstrate compliance.

In recognition of the effectiveness of partnership working, the Health and Safety Executive and local authorities have developed the Synergy Programme. This programme will test new, more flexible, ways of working at the boundary of Health and Safety Executive and local authority enforcement, to encourage collaborative approaches, speedier responses and better targeting of enforcement effort.

Occupational health and rehabilitation

105 *Saving Lives: Our Healthier Nation* emphasised that effective action on health in the workplace by employers and employees will improve competitiveness, by reducing sickness absence and improving the health of the local communities which provide the workforce.

106 The most prevalent forms of work-related ill health in this country are (a) musculoskeletal disorders (an estimated 1.2 million people were affected in 1995[6]), including back problems or "RSI"; and (b) stress (an estimated 0.5 million people were affected in 1995). Both conditions accounted for over three-quarters of people suffering from an illness caused by their work in 1995. Significant numbers of people were suffering from a lower respiratory disease in 1995 (an estimated 200,000), including asthma and ear conditions (an estimated 170,000), including deafness, which were caused by their work.

The ***Back in Work*** programme was launched by the Minister for Public Health and the Minister for Health and Safety in May 1999 to tackle back pain as part of the Healthy Workplace Initiative. The programme is supporting and evaluating a series of pilot projects to show what works in this field and how it works.

107 By far the worst work-related health and safety disaster of the 20th century has been exposure to asbestos. Asbestos-related disease caused by exposure between 15 and 60 years ago claimed at least 3,000 lives in 1997, and an upward trend in fatality rates is anticipated over the early years of this century. A ban on the importation, marketing and use of white asbestos came into force on 24 November 1999 (except for a few safety critical uses where no suitable substitute is available). The use of blue and brown asbestos has been illegal since the mid 1980s. Use of all forms of asbestos in Great Britain is now largely illegal.

Action point 28

The Health and Safety Commission will work with a range of Government departments and other partners to promote and implement fully the new Occupational Health strategy for Great Britain.

108 For the last three years, the Health and Safety Executive has been working with stakeholders to develop a new occupational health strategy for Great Britain. This strategy, to be published in July 2000, will complement the public health strategies for England, Scotland and Wales and other key Government policies including Welfare to Work, the New Deals, sustainable development and Modernising Government. It will take a wide view of occupational health considering not only the preventative side of controlling effects of work on health, but also how health impinges on work, and the contribution that occupational health can make to rehabilitation.

6. This and the other figures in this paragraph are taken from the Self-Reported Work-Related Illness Survey in 1995.

109 Following the launch of the joint Department of Health and Health and Safety Commission's *Healthy Workplace* initiative in March 1999, over 30,000 organisations have 'signed up' to the vision of a holistic approach to working people's health and well-being. This includes the need for access to occupational health advice and support.

Action point 29

The Government will encourage better access to occupational health support, and promote coverage of occupational health in local Health Improvement Programmes and Primary Care Group strategies in England, as recommended by the Health and Safety Commission's Occupational Health Advisory Committee.

The Corporation of London and London Chamber of Commerce and Industry are piloting an Occupational Health Helpline. The Helpline acts as a free confidential referral service to assist London based businesses with their workplace health issues.

Getting it right when things go wrong

Action point 30

As part of the next stage of the New Deal for Disabled People, the Government is considering how best to strengthen retention and rehabilitation services for people in work who become disabled or have persistent sickness.

110 Each year some 160,000 people are forced to give up work through long-term illness or disability. The Employment Service already helps just under 5,000 a year to remain in work. For many thousands of people, their problems arise as a direct result of industrial accidents or occupational diseases. The current arrangements for co-operation between employment, health and social services are patchy and are not often focused on helping the person concerned to return to work. Consideration is being given to developing better models for retention and rehabilitation as part of the wider strategy to ensure people with disabilities, or long term sickness, can play their full part at work.

Action point 31

The Health and Safety Commission will consult on whether the duty on employers under health and safety law to ensure the continuing health of employees at work, including action to rehabilitate where appropriate, can usefully be clarified or strengthened. For example, organisations might be required to set out their approach to rehabilitation within their health and safety policy.

111 There is a strong economic, social and legal case for taking all practicable steps to rehabilitate workers suffering from injury or ill-health, even where this is not directly work-related, including making reasonable adjustments to working arrangements so that they can return to work. This principle is reinforced by the Disability Discrimination Act 1995 and by the Government's Welfare to Work programme, in particular for disabled people.

112 Effective rehabilitation has much to contribute to the Government's objectives on combating social exclusion. Manual workers make up 42 per cent of the workforce but experience 72 per cent of reportable injuries. Manual workers are more affected by health and safety failures, not only because they have a higher incidence of injury, but also because there is a greater probability that any injury will impede their ability to continue their duties.

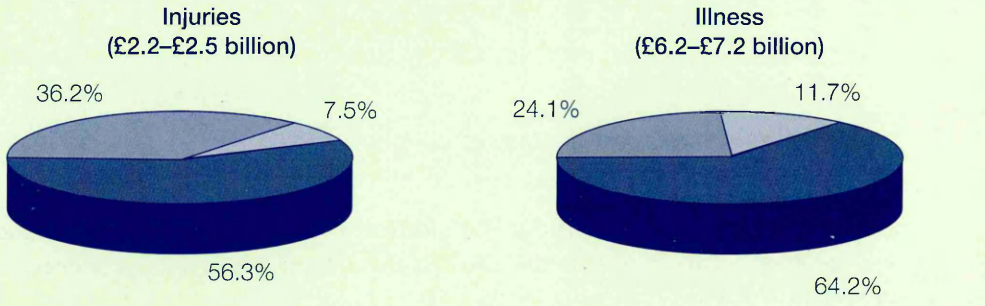
113 In the US, well-targeted rehabilitation has been shown to have a cost benefit ratio of 1:2. A Finnish study in the metal processing industry showed a 10:1 return on investment[7]. Benefits were measured in terms of reduced early retirement and sick leave, and increased productivity. While some of the rehabilitation costs were borne by the Finnish Social Security system, the intervention would still be profitable for the company without this subsidy.

7. *The Dalbo Project: Economics in Maintenance of Work Ability* O Nasman and G Ahonen of the Fundia Wire Co, presented at the International Commission on Occupational Health Workshop, The Hague, 22-24 April 1999

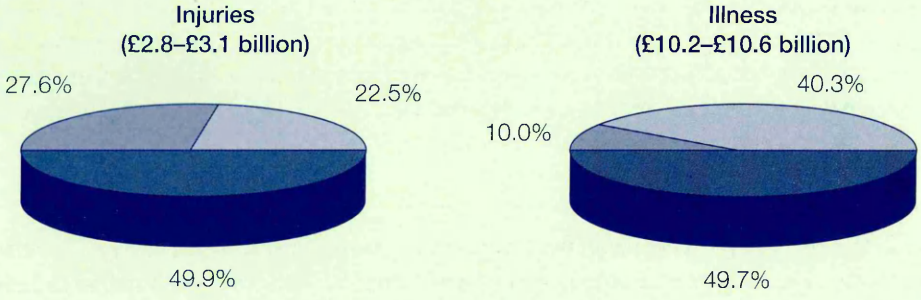
114 The Trades Union Congress have published a discussion document on how greater use of rehabilitation can be made in this country. The *Second UK Bodily Injury Awards Study* sponsored by the International Underwriting Association of London and Association of British Insurers was published in October 1999, including a new Code of Best Practice for insurers and claimants' lawyers.

115 The issue for Government is what further action can be taken to deliver an effectively co-ordinated rehabilitation policy, across all the public bodies potentially involved, to complement the work already underway in the private sector. The Strategy Statement makes clear that the compensation, benefits and insurance systems must motivate employers to improve their health and safety performance and to rehabilitate injured workers, including retraining where appropriate. The chart below shows who pays under current arrangements for work-related injury and ill health.

Figure 3: Relative costs of injuries and illness for 1995/96



Relative costs of injuries and illness for 1995/96 plus net present value (NPV) of future costs



Key:

Costs to employers society | Costs to individuals | Costs to the rest of society

Source: The Costs to Britain of workplace accidents and work-related ill health 1995/96, HSE 1999

116 Major reform of the compensation, benefits and insurance systems presents the prospect of a powerful new lever to raise health and safety standards. This can be achieved by increasing the proportion of costs borne by those responsible for health and safety failures, thereby strengthening their motivation to raise standards. Moreover, employers' financial motivation to keep victims in work would also be strengthened.

117 The rehabilitation of injured and sick workers could place a heavier burden on small firms than on larger firms, who are more likely to have or be able to afford occupational health services. Small firms may look for additional help and incentives to help them provide rehabilitation. This will need to be taken into account in pursuing action point 26 on the design of a grant scheme to encourage investment by small firms in better health and safety management.

Taxation policy

118 A number of consultees raised the concern that, where employers provide rehabilitation services, in some circumstances these can be subject to a tax charge because they are treated by the Inland Revenue as a benefit provided by the employer to the employee.

> The Inland Revenue announced on 19 November 1999 that the Government is to exempt general welfare counselling provided by an employer from tax and National Insurance contributions, and is to consult relevant organisations on the arrangements for this.

119 Other rehabilitation services, including private medical treatment, are exempt from tax if they relate directly to something which has happened in carrying out the employment.

Equal treatment for the disabled

Action point 32

The Health and Safety Commission will work in partnership with the Department for Education and Employment and the Disability Rights Commission to ensure that health and safety law is never used as a false 'excuse' for not employing disabled people, or continuing to employ those whose capacity for work is damaged by their employment, for example by highlighting this point in relevant publications and guidance.

120 This work will be taken forward as part of the Health and Safety Commission's 3rd Strategic Theme 'to develop health and safety aspects of the competitiveness and social equality agendas'. It is important that health and safety law should not present an inappropriate bar to the employment of disabled people. As part of this work, the Health and Safety Commission will collaborate with the Department for Education and Employment on the production of a planned revised Code of Practice for the elimination of discrimination in the field of employment against disabled persons, following the recommendations of the Disability Rights Task Force report 'From Exclusion to Inclusion'.

Better education in risk concepts

Action point 33

The revised National Curricula in England (from September 2000) and Wales (from August 2000) will include more extensive coverage of risk concepts and health and safety skills at every level.

121 An overwhelming majority of respondents thought that raising awareness of health and safety issues through education was one of the keys to making further progress. 65% of respondents specifically mentioned that more should be done in schools, with a third of these suggesting greater coverage in the National Curriculum. This will not only enable children to understand potential workplace hazards, but also – as consumers – to purchase goods which are fit for purpose and meet the required health and safety standards: an issue raised in the recent Consumer Strategy White Paper[8].

122 The Department for Education and Employment and the National Assembly for Wales have consulted on proposed changes to their National Curricula this year. One significant change will be the approach to health and safety. Instead of treating this topic as a matter of following rules, pupils will where appropriate be taught to understand hazards and risks and how they should be managed. This better reflects the nature of society, where we all face a multitude of risks and need to know how to cope.

8. *Modern Markets: Confident Consumers*, DTI, 1999

123 Risk concepts will receive significantly more prominent coverage in the new curriculum in both England and Wales. In England the non-statutory framework for Personal, Social and Health Education (PSHE) also covers these issues. In Wales, the non-statutory framework for Work-Related Education (WRE) offers pupils the opportunity to develop their understanding of employees' rights and responsibilities and the importance of following correct, safe, working practices, supporting the non-statutory Personal and Social Education (PSE) framework's emphasis on being healthy and safe.

124 In Scotland, schools are encouraged to follow the Health Education for Living Project (HELP), which includes a progressive approach to safety in the environment, including aspects about safety in the workplace.

The joint Department of Health/Department for Education and Employment 'Healthy Schools' Programme, launched in October 1999, seeks to improve both the health of young people and their educational achievement. Key standards required include ensuring that members of the whole school community are aware of their roles and responsibilities, and the appointment of a health and safety representative to carry out regular risk assessments.

Action point 34

The Government and Health and Safety Commission will act to ensure that safety-critical professionals such as architects and engineers receive adequate education in risk management. This will be delivered through a programme of direct approaches to relevant higher and further education institutions and professional institutions.

125 Over a third of respondents to the main consultation specifically mentioned the importance of covering health and safety issues in further and higher education. Many highlighted the particular importance of educating engineers, architects and designers. One of the key barriers to further progress on standards in construction is thought to be that health and safety considerations are not properly taken into account at the design stage.

126 The Health and Safety Executive has recently produced a report entitled *Education of Undergraduate Engineers in Risk Concepts* which will inform discussions with the Engineering Council, the professional institutions and the universities about incorporating defined learning outcomes in relevant curricula. The Health and Safety Executive is also exploring whether chartered status of professional institutions can be made conditional on prescribed levels of health and safety competence.

127 It is already the case that all National Training Organisations are required to pay attention to health and safety in developing national occupational standards and in making proposals for National and Scottish Vocational Qualifications frameworks based on these standards.

Scotland, Wales and the English regions

128 Occupational health and safety is a reserved matter, but it is crucial that the right links are made with policy development on devolved issues and those being progressed at regional level. At the same time, policy making for Great Britain must reflect national and regional considerations and views. We are delighted that Henry McLeish, Scottish Minister for Enterprise and Lifelong Learning and Mrs Edwina Hart, the National Assembly for Wales' Finance Secretary, who also has lead responsibility for health and safety in Wales, have signalled their commitment to the *Revitalising Health and Safety* initiative.

129 We underlined at the outset the centrality of occupational health and safety within the wider sustainable development agenda, and we look to the Regional Development Agencies to take this into account in taking forward programmes to further sustainable development. Attention is drawn to this point in the Government's *Guidance on Regional Sustainable Development Frameworks* published in February 2000[9] and in the Government's formal responses to the Regional Development Agencies' first strategies published in January.

9. Regional Sustainable Development Frameworks are to be developed and completed by December 2000.

Action point 35

The Health and Safety Commission will work with the Scottish Executive, the National Assembly for Wales and Regional Development Agencies in England to ensure that:

- ***health and safety considerations are taken into account in policy making at national and regional level, for example in economic policy and public health initiatives; and***
- ***national and regional interests are appropriately reflected in the Health and Safety Commission's work.***

Action point 36

In line with the requirement of the Modernising Government White Paper, the Health and Safety Executive will consider the feasibility of reorganising its regional structure in England so that it is co-terminus with that of the Regional Development Agencies, with the aim of facilitating more effective regional and sub-regional liaison.

Action point 37

Within the framework set by the Nolan procedures for public appointments, the Government will seek to ensure a balance of representation on the Health and Safety Commission from Scotland, Wales and the English Regions.

Modernising Government

130 The *Modernising Government* White Paper highlights the importance of delivering policies and services, which are co-ordinated for the convenience of the customer, not for the convenience of the agencies involved. This demands a customer-based outward-looking focus.

131 The Government and the Health and Safety Commission recognise and value the expertise of the Health and Safety Executive's staff and of local government enforcers. It will be crucial to safeguard this resource in taking forward a programme of modernisation, and indeed to overcome current difficulties in recruiting and retaining staff in key specialisations.

132 The Health and Safety Commission has adopted as a strategic theme improving their openness and accountability, in particular through preparation for the Freedom of Information Act and the adoption of Service First principles of public service delivery.

Action point 38

The Health and Safety Commission will hold some meetings in public each year.

Action point 39

To enable greater openness, the Health and Safety Commission aims to take the opportunity presented by powers in the Freedom of Information Bill to remove restrictions on disclosure of information imposed by Section 28 of the Health and Safety at Work etc. Act 1974.

133 The Health and Safety Executive has a policy of openness with health and safety information except where the law prohibits disclosure or where significant harm would result, for example to the ability to regulate and enforce the law. At present, moves towards greater openness in line with this policy are constrained by the blanket statutory restriction on disclosure of certain information imposed by Section 28 of the Health and Safety at Work etc. Act 1974. Powers in the Freedom of Information Bill enable these blanket restrictions to be removed or amended, and its provisions allow a policy of withholding information only where release would cause significant harm.

Action point 40

The Government will develop proposals for sharing with health and safety regulators information about business start-ups held by other authorities, by March 2001.

134 A number of consultees underlined the importance of getting the health and safety message across to small firms at the earliest possible stage, for example through comprehensive but straightforward start-up packs. Health and safety regulators have noted that they are hindered in this task by the absence of data on new business start-ups, even though this is held by other Government authorities. Sharing of this data, subject to resolution of any data protection and commercial considerations, would fit well with the *Modernising Government* agenda.

Action point 41

The Government will incorporate health and safety guidance into the new Cabinet Office integrated policy appraisal system, and establish a 'virtual health and safety network' of key Whitehall contacts to enable rapid electronic dissemination of information.

135 The Health and Safety Executive is developing guidance for policy makers across Whitehall on the need to consider occupational health and safety implications of their own policy measures. The intention is to promote synergies with other regulatory measures, which can increase the impact of health and safety across the system. The guidance will be available electronically and will form part of the Cabinet Office composite advice to policy makers on regulatory development.

The Inter-Departmental Liaison Group on Risk Assessment (ILGRA) is one of the several mechanisms by which the Health and Safety Executive:

- ensures that its risk-based approach is in step with wider cross-Departmental initiatives that shape and underpin the Government's approach to the regulation of risk; and
- uses its expertise to help other Departments develop their frameworks for managing and regulating risks.

The Health and Safety Executive is taking forward a project called *Sharing Agendas in Agriculture* which will seek to agree shared targets for Government intervention in the agricultural sector.

Action point 42

The Health and Safety Executive and the Government will act in partnership to increase the number of staff secondments arranged between the Health and Safety Executive and central or local government, industry or trades unions.

Action point 43

In implementing this Strategy Statement, the Government and the Health and Safety Executive will ensure that all sections of society – including women, ethnic minorities and disabled people – are treated fairly; and will work in partnership with the Cabinet Office to pilot a new approach to gender mainstreaming.

Information age government

136 The Health and Safety Executive's website – www.hse.gov.uk – is a key source of occupational health and safety information in the UK and beyond. It provides immediate access to a wide range of information, including the Health and Safety Executive's free guidance publications. The Health and Safety Executive will continue developing the site, which in 3 years has grown from about 100 to 3,000 pages of information. Use of the site has increased from about 1,000 to over 145,000 'hits' a week, and is now doubling every five or six months.

137 The Health and Safety Executive's e-commerce site (www.hsebooks.co.uk) was launched as a pilot in January 1998 and provides an electronic catalogue and ordering facility for both free and priced publications. The site will be developed to include a facility for customers to pay for and download anything from the site (further downloadable material is available free of charge on the main website).

138 The Health and Safety Executive also manages the UK pages on the website of the European Agency for Safety and Health at Work (www.osha.eu.int) which provides access to a wide range of European and broader international information.

139 For the future, planned developments include:

- **a legislative database** in partnership with a commercial publisher, to provide online access to all primary and secondary legislation and related guidance on health and safety, together with additional guidance and information from Government and other sources;
- **'Electronic Essentials'** in partnership with Royal Sun Alliance and a software developer – an online product based on the popular *Essentials of Health and Safety at Work* publication;
- **'COSHH Essentials'** is being further developed as an online product to provide easy access to information about hazardous substances;
- **business start-ups** will be able to access a point on the website to find out how to get started in health and safety; and
- **discussion group/chat forum pilots** including more dynamic stakeholder consultation.

Organisational issues

140 Without changing the broad current legislative structure, we have identified five areas where there may be a case for organisational change within the Health and Safety Commission and Executive in order to deliver this Action Plan:

- In the section on engaging small firms, we pointed to the reluctance of small firms to contact the Health and Safety Executive or local authorities for advice, for fear of enforcement action. The new Small Business Service is intended to go at least some way to addressing this problem, by providing a one-stop shop for advice and information, entirely separate from any Government enforcement function. However, there may also be a case for organisational separation within the Health and Safety Executive of information and advice services from inspection and enforcement functions;
- The Government is considering, in the context of its Transport Safety Review, whether there is a case for greater separation between investigative and regulatory functions in the transport sector. This review will not be concluded until after the Cullen Report, but has wider implications for health and safety. The aim of greater separation would be to ensure that investigators do not shy away from any valid criticism of the regulator. There may be a case for a clearly differentiated 'Investigation Unit' to investigate major incidents in other industrial sectors for which the Health and Safety Executive has safety responsibility, able to draw in expertise from the regulator, the private sector and academics;
- The respective roles of the Commission and Executive are still not sufficiently understood. The Government recognises that greater clarity is required, and that the Commission's capacity for strategic policy development should be strengthened;
- Some have voiced concern that current arrangements, whereby inspectors themselves prosecute cases through the courts, may not provide for the most efficient use of inspectors' valuable time. Others would argue that, as a matter of principle, the functions of investigation and prosecution should be separate. The Government sees no easy way of addressing this issue in the short term, but believes that alternative arrangements may warrant further consideration;
- The Government are concerned at the relatively low level of prosecutions and have asked the Health and Safety Commission and Executive to consider how their existing prosecution system can be strengthened, taking into account the approaches of other regulatory bodies such as the Environment Agency.

Action point 44

The Government and the Health and Safety Commission and Executive will work together to explore options for organisational change to address these issues.

International dimensions

141 A high proportion of standards set in the field of health and safety at work result from the work of international bodies, including the European Commission, the United Nations, the Organisation for Economic Co-operation and Development, and the International Labour Organisation (ILO). Many of the health and safety regulations in Great Britain are founded on European Union Directives. Ministers will continue to support high standards of health and safety at work, based on risk assessment approaches, in the deliberations of the EC Councils of Ministers and in bilateral and multilateral discussions with counterparts in Europe and elsewhere. The European Agency for Safety and Health at Work, now fully established and having an ambitious work programme, is likely to be an increasingly influential shaper of opinion. The UK (Government and social partners) will continue to play a major role in shaping the debate in the EU on health and safety standards, and to spread good practice through our work in the ILO, the European Agency and other bodies.

142 The Health and Safety Commission and Executive will continue to pursue active policies to influence and assist these international bodies, in consultation with stakeholders including local government representatives, both to explain UK procedures and to learn lessons from approaches taken elsewhere. These will include a programme of secondments of Health and Safety Executive staff to international bodies, and playing an active role in the EC Advisory Committee of Safety, Hygiene and Health Protection at Work and initiatives such as the ILO's SafeWork Programme. The Health and Safety Executive will continue to act as the UK's "Focal Point" to support the European Agency and maintain a national network of bodies able to help the Agency's work. In support of this work the Health and Safety Executive will continue an internal programme of training to assist staff working with other nationalities and cultures, including language training.

143 A central objective of the Government in approaching arrangements for agreeing European laws in the field of health and safety at work is to achieve acceptable standards that are implemented and enforced on an equal basis throughout the whole of the European Union. This ensures a level playing field in terms of competitiveness and that the standards of health and safety protection for workers in all EU countries is as high as those achieved in the UK.

Annex A

Analysis of Consultation Responses

1. Main document

This annex highlights the key issues raised in responses to the themes and questions raised in *Revitalising Health and Safety*. Of the overall total of 290 substantive responses, there was an average of 147 responses to each numbered question.

Reducing Accidents and Tackling Health Problems

I. Two-thirds of respondents thought that further progress could be made in reducing accidents and ill health caused by work by raising awareness of health and safety, specifically through:

- education and training;
- direct campaigns; and
- simpler, more accessible and targeted guidance from regulators.

II. In addition to general awareness raising, almost a third suggested that health and safety standards in poorer performing sectors and regions could be raised by more targeted inspection and enforcement activity, supplemented by harsher penalties. One in five respondents thought that incentives, such as tax reductions, grants or more free advice, would encourage better performance; and a further 14% called for more partnerships between companies and other intermediaries, such as trade associations.

III. Over 80% agreed that there should be different approaches to tackle occupational health problems. Again, calls for education, training, publicity and guidance featured strongly. Almost half thought it essential that both employers and workers should have access to occupational health services and sources of advice, in particular, it was suggested that:

- a new focus should be given to occupational health in the National Health Service, for example by giving more training to general practitioners, and including occupational health specialists on Primary Care Groups; and
- employers should fund more health-screening and rehabilitation programmes.

IV. Respondents recognised the importance of addressing the problem of violence in the workplace. Over half thought that the best approach was to raise awareness of the issue by providing more guidance to employers, and also training staff in conflict management and dealing with difficult people.

V. 87% of respondents broadly or fully agreed with the analysis of the trends which might be expected over the next 25 years and their implications.

VI. There were a variety of recommendations for adjusting today's approach to raising health and safety standards in anticipation of the likely trends over the next 25 years. Key responses (at around a third of respondents each) included:

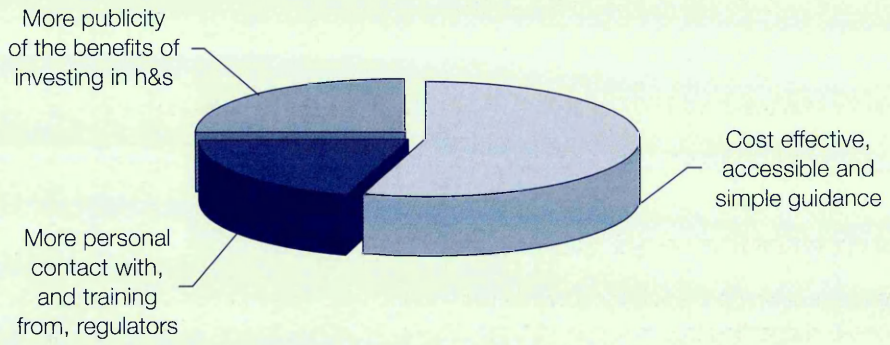
- more education and training; and
- better guidance and more advice, publicity and awareness raising.

There were also calls for more enforcement, financial incentives to invest in health and safety and more support for safety representatives.

Engaging Small Businesses

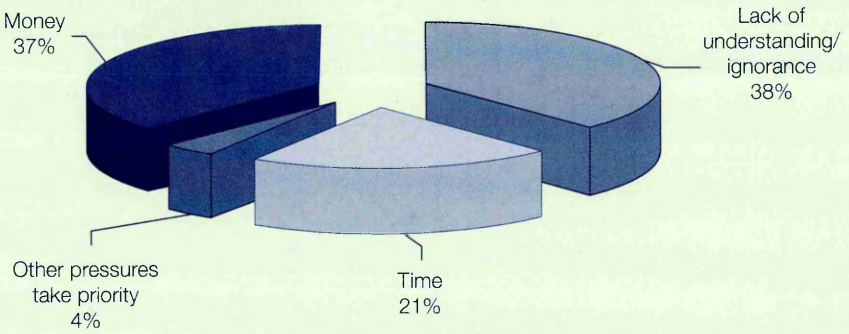
VII. The majority of respondents (over two thirds) thought that the best way of engaging small businesses on health and safety issues was to ensure that employers in small business understood what was required of them under health and safety legislation. There were different suggestions as to what would be the most effective way of achieving this (as shown in the graph below):

Figure 4: Helping small businesses understand their health and safety responsibilities



VIII. The following chart shows what prevents small businesses from taking the opportunity to improve their competitive position through better health and safety management:

Figure 5: Barriers seen aspreventing small business from improving health and safety management



In suggesting how these barriers could be overcome, the largest number (two in every five) said that more publicity should be given to the benefits of investment in health and safety, together with more information about the costs of health and safety failures. Two other suggestions (both mentioned in around one fifth of responses) were:

- more simplified, accessible, timely and targeted guidance; and
- incentives to encourage investment in health and safety, such as linking insurance premia to health and safety management.

Clarifying Responsibilities

IX. The vast majority of respondents (81%) called for clarification and clearer guidance of the law on who holds health and safety duties in a chain of principal and sub-contractors.

X. Few gave direct answers on what new systems or approaches would improve communication between contractors to promote effective health and safety management. Nevertheless, around half of those who did respond highlighted the need for better clarification of responsibilities, such as requiring responsibilities to be outlined in contracts.

XI. In the absence of traditional contracts of employment, the three main suggestions on how to ensure proper management of health and safety (at around a third each) were:

- making clear that the principal contractor / client / person paying the bill is responsible for all those working to them;
- providing better and clearer guidance; and
- changing the law to:
  - widen the definition of an 'employee' in health and safety legislation; and
  - require details of health and safety responsibilities to be included in employment contracts.

Competence and Accreditation

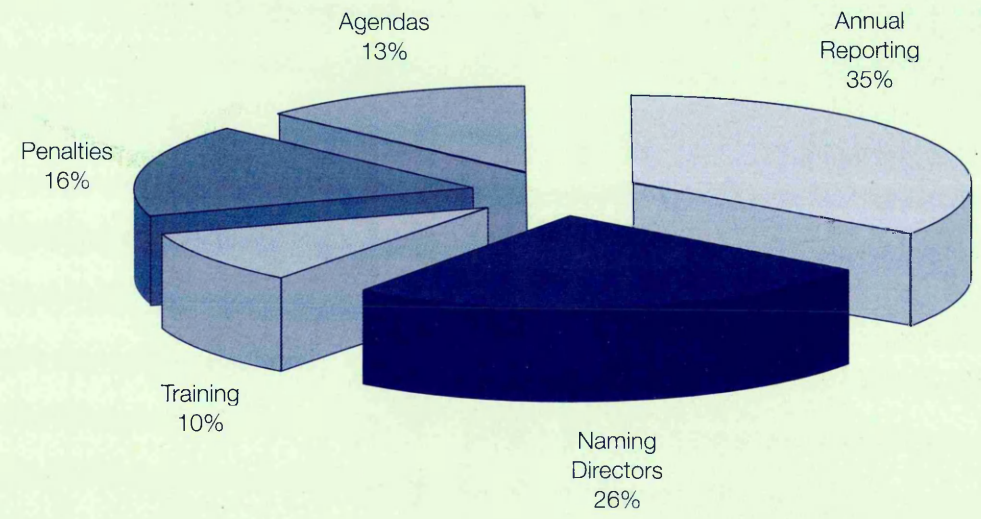
XII. There was significant support for accreditation schemes in the responses, with around two in every three responses suggesting that they can be beneficial in raising health and safety standards. However, many caveated their answers that, in order to be of benefit, schemes should be widely accepted, more than paper exercises, focused on management competence and training, and voluntary.

Action by Employers

XIII. The overwhelming majority (over 90%) thought that supply chain initiatives should be more widely adopted. It was suggested that the Health and Safety Commission's Good Neighbour scheme should be further developed and promoted; and that Government should set an example in its conduct as a client.

XIV. There were several suggestions as to how health and safety could gain a higher profile at Board level. The graph below shows the split of those mentioning annual reporting; naming a responsible director; training for directors; including health and safety on board agendas; and increasing penalties against directors, including raising fines and clarifying the law on corporate manslaughter:

Figure 6: Raising the profile of health and safety at Board Level

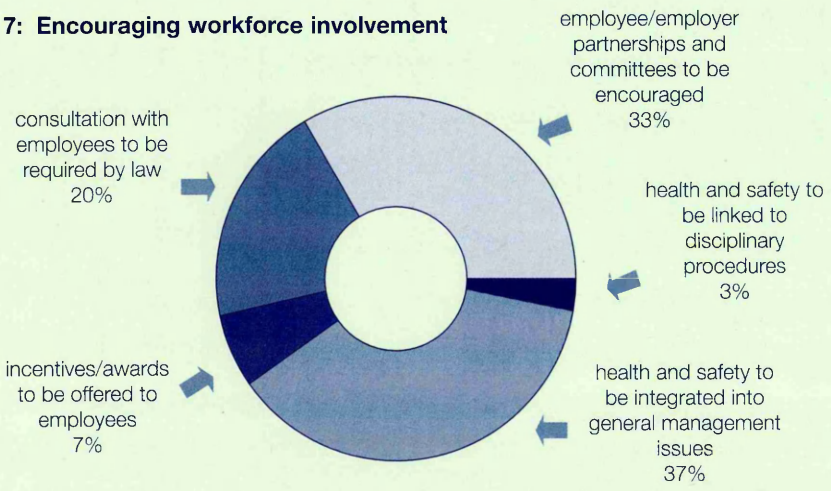


Action by Workers

xv. Over two-thirds said that workers would take greater personal responsibility for their own health and safety and that of colleagues if they understood more about the benefits of good practice and the potential consequences of irresponsible action. Suggested remedies included more training, better education, general awareness raising and a sharper focus on personal responsibility under health and safety law. Other popular responses were that workers should be encouraged to get involved with health and safety matters in the workplace, and that there should be better training and support for safety representatives, possibly with Provisional Improvement Notice powers on the Australian model.

xvi. In responding to the question of how workplace involvement in improving health and safety standards could be encouraged, over half said that there should be greater consultation with workers on health and safety issues. Of those, the key suggestions are shown in the following graph:

Figure 7: Encouraging workforce involvement



Action by Designers

xvii. There were three key messages on how further improvement in designed-in safety standards in equipment, substances and management systems could be secured, each were mentioned in around 1 in 4 responses:

- there should be more focus on health and safety during design courses;
- standards required for CE and other 'kite' markings should be clarified; and
- there should be more enforcement of design standards.

Action by Health and Safety Regulators

xviii. Almost half suggested that more effective outcomes would be produced if health and safety regulators concentrated more on giving advice, for example through campaigns, working with intermediaries, and simpler, more practical guidance. A further quarter thought there should be more proactive, preventative inspections, so that companies would receive a personal visit from an inspector who could give 'hands-on' advice. More enforcement action, more investigation of accidents and more publicised prosecutions were highlighted in around a third of responses.

xix. The question of what penalties should be faced by those who breach health and safety law received the highest number of responses. The overwhelming message was that the current level of penalties is inadequate (only 7% considered the current system to be satisfactory).

Agreeing Targets

xx. Over two-thirds broadly supported setting aspirational targets, but some caveats were mentioned e.g:

- sufficient resources should be allocated to monitoring performance (details of which should be published);
- targets should be achievable, and the proposed means of their delivery should be clear.

The Trades Union Congress, supported by five other unions, called for a National Safety Audit to be carried out, which would include aspirational national targets, against which companies would be required to publish progress in their annual reports.

Health and Safety from the Public's Perspective

xxi. Almost half of respondents felt the split of responsibilities within Government across wider health and safety issues appeared confusing to the public. Particular concern was raised about the difficulties that face members of the public seeking assistance, with almost a quarter suggesting the existing arrangements could be better publicised, for example through:

- a simple leaflet;
- a single national inquiry line;
- more information in the Yellow Pages and libraries; or
- a single Internet gateway.

xxii. In response to the question of whether health and safety regulation could be more effectively co-ordinated with other Government regulatory activity, over half of respondents thought that there should be more co-ordination – particularly with environmental (15%), transport (8%) and fire (6%) regulation. About a tenth considered better communication and liaison as the answer; while about the same proportion advocated an integrated enforcement body.

XXIII. Almost all respondents (97%) believed more could be done to raise the profile of health and safety within local government. In addition to general education and awareness campaigns, over a tenth felt Government needed to be more proactive in stipulating standards and targets for health and safety enforcement, as is the case with food safety.

Links to other Government Agendas

XXIV. Nearly two-thirds of respondents felt Government could do more to highlight health and safety aspects of wider policy areas. Amongst a wide variety of suggestions, ideas included:

- a proactive communications strategy, to move away from the widely held perception that too much media coverage was reactive;
- a joined-up agenda on rehabilitation of injured workers;
- making health and safety integral to all policy formulation and presentation; and
- getting Government's own house in order as an employer and procurer, including removal of Crown immunity.

XXV. Respondents held diverse views on what they hoped to see from better links and joined working in Government policy. The main themes included:

- identification and elimination of overlapping legislation, and integration of risk assessment concepts across Government (20%);
- integration of health and safety into all aspects of policy making (8%);
- better promotion of occupational health through the health services and a new focus on rehabilitation (6%).

XXVI. There was overwhelming support for greater coverage of risk management in all levels of the education system. Over two thirds considered it crucial to introduce health and safety issues, including first aid and fire safety, into schools. Over 40% specifically mentioned the importance of coverage in further and higher education. Several suggested mandatory health and safety modules in the National Vocational Qualifications framework, particularly for engineers, architects and designers.

The International Dimension

XXVII. More than a half considered that the Government could take further steps to influence the European legislative agenda on health and safety by raising the profile of health and safety amongst Members of the European Parliament, and involving industry, health and safety professionals and Non-Government Organisations more frequently in European work. Over one third thought that the UK should seek to ensure parity of implementation and enforcement of health and safety legislation across the EU, so as to secure a level playing field.

XXVIII. Almost a third suggested Scandinavia as a useful model for consideration in formulating health and safety policy in Great Britain, particularly for their approach to securing worker involvement/partnership and their occupational health services.

Other suggestions (in descending order of frequency were):

- Australia/New Zealand, for their compensation/rehabilitation systems, Provisional Improvement Notices issued by safety representatives, and occupational health clinics (20% of responses);
- USA, for their approach to designed-in safety, occupational health/rehabilitation systems, and 'sunset clauses' which prevent legislation becoming life-expired; and
- Germany, for their insurance system, equipment 'MOTs', occupational health services and approach to occupational road risk.

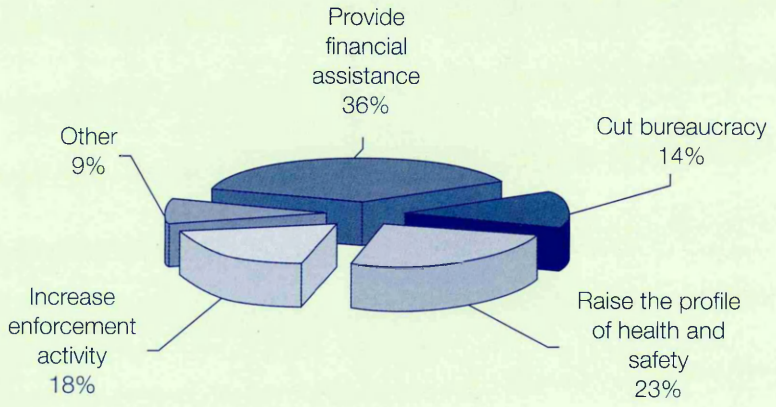
Employer Leaflet (194 responses)

I. Three consistent messages emerged from responses on what prevents employers taking further action on health and safety:

- cost, particularly of training and Heath and Safety Executive publications (mentioned in 85% of responses);
- time and competing pressures (75% of responses);
- lack of knowledge and awareness (two-thirds of responses).

The graph shows the suggested ways in which Government could help:

Figure 8: What Government could do to raise health and safety standards



II. Over 95% responded positively that they knew where to obtain health and safety advice. However, some mentioned that they feared that asking the Health and Safety Executive for advice could lead to a subsequent inspection visit.

III. 60% seemed aware of their responsibilities in contractual chains, but a quarter thought that clarification was needed.

IV. Over two-thirds of respondents called for government to do more to prevent accidents and ill health. One in four responses suggested that subsidising training was the most suitable method.

V. When buying (or hiring) new equipment, almost all respondents thought that improvements were needed to demonstrate whether it had been designed with health and safety in mind. Suggestions included:

- introducing rigorous controls over CE marking and other standards;
- issuing guidance on the value/level of assurance provided by standards.

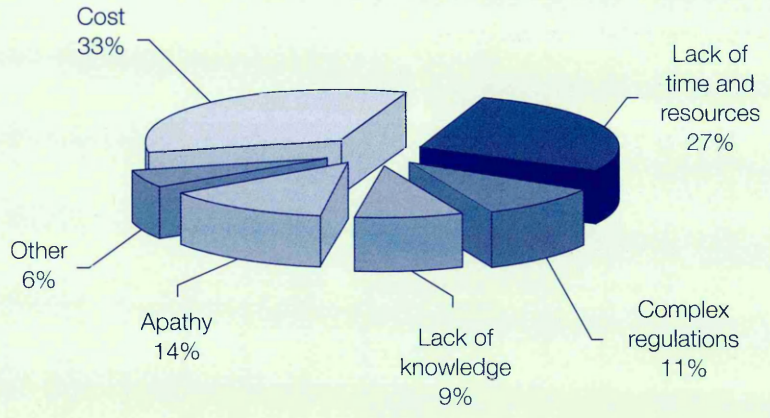
VI. The following table shows that the vast majority of respondents already take significant steps to improve health and safety standards in the workplace, or would consider doing so:

Figure 9	Already do	Would consider
Making health and safety a standing item on your Board agenda	75%	14%
Making health and safety the responsibility of a named Director	84%	5%
Publishing details of health and safety performance in your Annual Report	56%	31%
Setting targets for further health and safety improvements	70%	23%
Participating in the Health and Safety Commission's 'Good Neighbour' scheme	19%	58%
Making sure your health and safety systems meet a recognised standard, such as BS 8800	30%	55%
Making sure your staff have a trained safety representative	82%	10%

Small and Medium-sized Enterprises (SME) Leaflet (134 responses)

I. The following chart indicates the key reasons that emerged from the responses as to what stops SMEs from taking further action on health and safety:

Figure 10: Factors preventing SMEs from taking further action on health and safety



II. Over three-quarters asked that Government should provide clear and relevant guidance, tailored for the needs of SMEs. One in four suggested more awareness raising campaigns, or better use of the Internet.

III. Over a third of responses mentioned either the Inland Revenue or Customs & Excise as the two Government organisations they deal with most often, but three-quarters felt these organisations should not involve themselves with health and safety matters. 25% thought that only the Health and Safety Executive/local authorities should deal with health and safety issues to ensure consistent and expert advice.

IV. Over 80% warmly supported the introduction of a grant scheme or tax incentive to encourage small firms to invest in better health and safety, particularly to fund training or to help with purchasing safety equipment.

Worker Leaflet (860 responses)

I. The overwhelming majority of respondents (90%) said that they had a workers' safety representative and had their say on health and safety.

II. Around half thought that cost and resource implications stopped their employer doing more about health and safety. Others considered a general attitude of management apathy to be a significant factor.

III. Workers received advice from many different sources, particularly in-house health and safety officers, worker representatives and line managers/personnel. It was suggested that more commitment from management, improved consultation and increasing powers of safety representatives would improve advice.

IV. Over half thought they did not have sufficient training in occupational health and safety. It was suggested that this could be rectified by providing financial support for training and broadening the range of training issues to incorporate, for example, violence at work, lone working and stress.

V. Almost two-thirds felt that Government could, and should, do more to publicise health and safety, either through high profile media campaigns or accessible and cheaper literature.

VI. Priorities for action by employers were seen as:

- ensuring that all equipment is safe, and that they, and staff, are fully aware of risks related to their jobs;
- complying with legislation; and
- ensuring effective consultation with staff, safety representatives and the Health and Safety Executive.

Priorities for Government included:

- more enforcement and stiffer penalties;
- improving communication with unions and industry;
- providing financial incentives;
- empowering safety representatives; and
- simplifying the structure of existing legislation.

Annex B

Ministerial Health and Safety Checklist

1. How are health and safety plans and priorities established?

2. Are you satisfied your safety policy and assessment of risks conform to legal requirements, with clearly identified managers responsible for health and safety?

3. Who holds responsibility for health and safety at a senior level? How is the senior management's commitment to health and safety communicated to staff?

4. What steps do you take to safeguard members of the public who visit your premises?

5. What are your methods for health and safety monitoring, review and audit? Do you use benchmarks?

6. How do you consult and inform staff about health and safety issues?

7. How do you motivate and train staff in health and safety?

8. Do your risk assessment and control measures take adequate account of individual capabilities including gender, age and physique?

9. How many RIDDOR reportable injuries/diseases/dangerous occurrences has your organisation reported in the last 12 months?

10. Are adequate records kept on e.g. risk assessments, training and accidents, near miss reporting, both on individuals' staff files and centrally?

11. Are all incidents investigated so that lessons are learnt and relevant risk assessments reviewed?

12. Do the same health and safety standards apply to other relevant areas of management e.g. premises, contract management and bodies in receipt of grant payments?

Annex C

List of Action Points

Action point 1
The Health and Safety Commission will publish and promote a Ready Reckoner supported by case studies to drive home the business case for better health and safety management.

Action point 2
The Health and Safety Commission will promote publication of guidance, by March 2001, to allow large businesses to report publicly to a common standard on health and safety issues. The Government and the Health and Safety Commission challenge the top 350 businesses to report to these standards by the end of 2002, and will then work to extend this to all businesses with more than 250 employees by 2004.

Action point 3
The Health and Safety Commission will undertake a fundamental review of the health and safety incident reporting regulations.

Action Point 4
The Health and Safety Commission will advise Ministers what steps can be taken to enable companies, if they wish, to check their health and safety management arrangements against an established 'yardstick'. This work will include examination of the implications for small firms and the role standards can play in addressing their needs.

Action point 5
The Health and Safety Commission will consider how best to involve the insurance industry more closely in its work, including the possibility of representation on the Commission's advisory committees.

Action point 6
The Government will work with the Health and Safety Executive to ensure that a larger number of inspectors have powers to enforce the Employers' Liability (Compulsory Insurance) legislation.

Action point 7
The Government will seek an early legislative opportunity, as Parliamentary time allows, to provide the courts with greater sentencing powers for health and safety crimes. The key measures envisaged are to extend the £20,000 maximum fine in the lower courts to a much wider range of offences which currently attract a maximum penalty of £5,000; and to provide the courts with the power to imprison for most health and safety offences.

Action point 8
The Health and Safety Executive will monitor and draw public attention to trends in prosecution, convictions and penalties imposed by the Courts, by publishing a special annual report. This will 'name and shame' companies and individuals convicted in the previous twelve months. This information will also be available on the Health and Safety Executive's Website.

Action point 9
The Health and Safety Commission will advise Ministers on the feasibility of consultees' proposals for more innovative penalties.

Action point 10
The Government will consider an amendment to the 1974 Act (when Parliamentary time allows) to enable private prosecutions in England and Wales to proceed without the consent of the Director of Public Prosecutions.

Action point 11
The Health and Safety Commission will develop a code of practice on Directors' responsibilities for health and safety, in consultation with stakeholders. It is intended that the code of practice will, in particular, stipulate that organisations should appoint an individual Director for health and safety or responsible person of similar status (for example in organisations where there is no board of Directors). The Health and Safety Commission will also advise Ministers on how the law would need to be changed to make these responsibilities statutory so that Directors and responsible persons of similar status are clear about what is expected of them in their management of health and safety. It is the intention of Ministers, when Parliamentary time allows, to introduce legislation on these responsibilities.

Action point 12
Ministers and the Health and Safety Commission will endorse a health and safety checklist along the lines of the one at Annex B, subject to consultation with the relevant trades unions and other relevant stakeholders, for circulation to all Government Departments and all public bodies, including local authorities and health authorities, as a catalyst for improvement. Ministers will be advised of the results of this exercise.

Action point 13
All public bodies will summarise their health and safety performance and plans in their Annual Reports, starting no later than the report for 2000/01.

Action point 14
The Department of the Environment, Transport and the Regions, in partnership with the Health and Safety Executive, will pioneer a High Level Forum to provide leadership on health and safety management issues within the Civil Service.

Action point 15
The Government will seek a legislative opportunity, when Parliamentary time allows, to remove Crown immunity from statutory health and safety enforcement. Until immunity is removed, the relevant Minister will be advised whenever Crown censures are made.

Action point 16
The Health and Safety Commission will consider further whether the 1974 Act should be amended, as Parliamentary time allows, in response to the changing world of work, in particular to ensure the same protection is provided to all workers regardless of their employment status; and will consider how the principles of good management promoted by the Construction, Design and Management Regulations approach can be encouraged in other key sectors. Ministers will be advised accordingly.

Action point 17
The Government will ask the Learning and Skills Council, in consultation with the Health and Safety Commission, to undertake an early review of the funding and provision of training for safety representatives. In light of the conclusions of this work, the Scottish Executive and the National Assembly for Wales will consider whether to change the arrangements in Scotland and Wales.

Action point 18
The Health and Safety Executive will take further action to publicise the right of workers to contact them, particularly in the context of the new protection provided by the Public Interest Disclosure Act 1998.

Action point 19
The new Clients' Charter to be launched later in the year as part of the Movement for Innovation in the construction industry, will include targets on health and safety to drive up standards. Government Departments and their sponsored bodies will sign up to the Charter, as part of their Achieving Excellence action plans and in demonstration of their support for the Health and Safety Commission's Working Well Together campaign. The Government will consider how this approach can be rolled out to other areas of procurement.

Action point 20
The Local Government Construction Task Force will consider how health and safety issues can be most effectively factored into construction procurement by local government.

Action point 21
The Health and Safety Executive will produce guidance for government departments and other public bodies on how best to achieve exemplary standards of health and safety in construction projects with which they have an involvement.

Action point 22
The Health and Safety Commission will take action, consulting the new Small Business Service in England, to improve arrangements for ensuring that the views of small firms are fully taken into account in policy formulation; and will seek to identify areas of regulation that affect small firms and can be simplified without lowering standards.

Action point 23
Within the framework set by the Nolan procedures for public appointments, the Government will seek to enhance representation of small firms on the Health and Safety Commission.

Action point 24
The Health and Safety Commission and the new Small Business Service will work in partnership to secure an effective profile for occupational health and safety within the Small Business Service both centrally and at local level. Similar work will also be taken forward in partnership with Scottish Enterprise, Highlands and Islands Enterprise, the Scottish Executive and the Business Connect network in Wales.

Action point 25
The Health and Safety Commission and Executive will promote positive models of how small firms can benefit from effective health and safety management, through a range of information products including clear, straightforward sector-specific guidance supported by case studies.

Action point 26
The Health and Safety Commission will advise Ministers on the design of a grant scheme to encourage investment by small firms in better health and safety management.

Action point 27
The Health and Safety Commission will work with local authorities to propose an indicator against which the performance of local authority enforcement and promotional activity in England, Scotland and Wales can be measured.

Action point 28
The Health and Safety Commission will work with a range of Government departments and other partners to promote and implement fully the new Occupational Health strategy for Great Britain.

Action point 29
The Government will encourage better access to occupational health support, and promote coverage of occupational health in local Health Improvement Programmes and Primary Care Group strategies in England, as recommended by the Health and Safety Commission's Occupational Health Advisory Committee.

Action point 30
As part of the next stage of the New Deal for Disabled People, the Government is considering how best to strengthen retention and rehabilitation services for people in work who become disabled or have persistent sickness.

Action point 31
The Health and Safety Commission will consult on whether the duty on employers under health and safety law to ensure the continuing health of employees at work, including action to rehabilitate where appropriate, can usefully be clarified or strengthened. For example, organisations might be required to set out their approach to rehabilitation within their health and safety policy.

Action point 32
The Health and Safety Commission will work in partnership with the Department for Education and Employment and the Disability Rights Commission to ensure that health and safety law is never used as a false 'excuse' for not employing disabled people, or continuing to employ those whose capacity for work is damaged by their employment, for example by highlighting this point in relevant publications and guidance.

Action point 33
The revised National Curricula in England (from September 2000) and Wales (from August 2000) will include more extensive coverage of risk concepts and health and safety skills at every level.

Action point 34
The Government and Health and Safety Commission will act to ensure that safety-critical professionals such as architects and engineers receive adequate education in risk management. This will be delivered through a programme of direct approaches to relevant higher and further education institutions and professional institutions.

Action point 35
The Health and Safety Commission will work with the Scottish Executive, the National Assembly for Wales and Regional Development Agencies in England to ensure that:
- *health and safety considerations are taken into account in policy making at national and regional level, for example in economic policy and public health initiatives; and*
- *national and regional interests are appropriately reflected in the Health and Safety Commission's work.*

Action point 36
In line with the requirement of the Modernising Government White Paper, the Health and Safety Executive will consider the feasibility of reorganising its regional structure in England so that it is co-terminus with that of the Regional Development Agencies, with the aim of facilitating more effective regional and sub-regional liaison.

Action point 37
Within the framework set by the Nolan procedures for public appointments, the Government will seek to ensure a balance of representation on the Health and Safety Commission from Scotland, Wales and the English Regions.

Action point 38
The Health and Safety Commission will hold some meetings in public each year.

Action point 39

To enable greater openness, the Health and Safety Commission aims to take the opportunity presented by powers in the Freedom of Information Bill to remove restrictions on disclosure of information imposed by Section 28 of the Health and Safety at Work etc. Act 1974.

Action point 40

The Government will develop proposals for sharing with health and safety regulators information about business start-ups held by other authorities, by March 2001.

Action point 41

The Government will incorporate health and safety guidance into the new Cabinet Office integrated policy appraisal system, and establish a 'virtual health and safety network' of key Whitehall contacts to enable rapid electronic dissemination of information.

Action point 42

The Health and Safety Executive and the Government will act in partnership to increase the number of staff secondments arranged between the Health and Safety Executive and central or local government, industry or trades unions.

Action point 43

In implementing this Strategy Statement, the Government and the Health and Safety Executive will ensure that all sections of society – including women, ethnic minorities and disabled people – are treated fairly; and will work in partnership with the Cabinet Office to pilot a new approach to gender mainstreaming.

Action point 44

The Government and the Health and Safety Commission and Executive will work together to explore options for organisational change to address these issues.