



Extensions and intensions of management control—The inclusion of health

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ABSTRACT

Interest in management control of intangibles has grown remarkably during the last decades and now includes managing employee health. Research in this field is so far in the early stages: few empirical studies have been undertaken and fewer studies take into consideration the implications of such systems. In this paper we wish to contribute to the field with a qualitative study of instances of management control of health in ten Swedish organizations.

Many good intentions lie behind the idea of making health and ill-health a subject for management control and the expected results are very positive—lower sick-leave rates, reduction of costs and human suffering. Such intentions stand for an intension, i.e. the ideas, properties or state of affairs that are connoted by a word or symbol, in this case what can be connoted by the concept of management control of health, its conceptual position. An intension, however, is not given insofar as a word or concept may be associated to more than one. Thus we set out to interpret management control of health in terms of two conceptual positions, modernism and postmodernism, in order to bring forth two very different intensions of management control of health: one where the practice is seen as an investment with a purpose to visualize ill-health and increase efficiency by putting in place measures to increase employee health; the other where the practice is seen as a means to make the individual accountable in order to be able to intensify control and colonize leisure.

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1. Introduction

In the last two decades many researchers, practitioners, politicians and policymakers have recurrently stated that a substantial shift has taken place in society. Value creation, they hold, is no longer characterized by tangible investments (machines, properties, etc.). Instead, in what has come to be called knowledge society, investments in intellectual capital such as knowledge, customer and stakeholder relations, image, internal routines, organizational structures, R&D and most presently employee health are argued to be the most important resources (cf. Bjurström, 2007; Brookings, 1997; Drucker, 1988; Johanson and Mårtensson, 2006; Johanson et al., 2007; Marr, 2005; Stewart, 1997; Sveiby, 1997).

In consequence, management control of intellectual capital has been brought to the fore as organizations search to understand value creation—where it takes place, how it works and what it produces (Blair and Wallman, 2000; Lev, 1999, 2001; OECD, 1999). An ever incrementing number of studies has thus seen the light of day during the last 15 years. Results

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from OECD funded studies conducted already in the 1980s show that investment in intangibles and intellectual capital appeared to increase more rapidly than that in tangible assets and resources. Other studies, on the level of the firm present a positive relationship between investments in intangibles and rates of return above capital cost (Lev, 1999, 2001), between disclosure of social information and market reactions (Gray et al., 1995), between HRM quality and market value, between investments in competence development activities and performance, between training investments and profitability (Bassi and van Murren, 1999; Ottersten et al., 1999), and between investments in HR and abnormal return in knowledge intensive firms (Hansson, 1997; Hansson et al., 2004, 2007).

Thus “the term intellectual capital [...] continues to gain visibility in managerial literature. In the case of accounting much of the attention has been focused on measuring intellectual capital and reporting it in financial statements” (Fincham et al., 2005, p. 351). This development has also tended to include more and more aspects of intellectual capital, the latest of which, as argued in this article, is the inclusion of health as a subject of management control initiatives and practices (Bjurström, 2007; Johanson and Mårtensson, 2006; Johanson et al., 2007). As recently put forward in this journal, however, “[i]deas and proposals for intellectual capital have largely escaped the scrutiny of critical scholars and researchers” (Fincham et al., 2005, p. 351). Indeed, “to a significant extent [...] the practices themselves, as well as the thinking that underpins them” is unquestioned (Mouritsen and Roslender, 2009, p. 803) and “if the intellectual capital concept is as central as some claim it to be, it is vital that it is fully understood and exploited in the quest for social betterment” (*Ibid.*)

This article is a response to the call for more critical studies on intellectual capital and its consequences. We do this with an empirical study that illustrates one of the latest developments within the field of management control of intellectual capital: the inclusion of health. In effect, the interest in health, its management and measurement, can be understood as a bi-product as well as an extension of the attention intangibles aspects such as knowledge and intellectual capital have been awarded as subjects for management control initiatives that aim at visualizing and measuring through surveys, statistical analysis, bench marking, indicators, contracts between individuals and their managers, ownership of indicators and salary bonuses in order to improve the knowledge and understanding of the value creation process and to increase the ability to compete, grow and survive in the long term (Johanson et al., 2001a, 2001b).

1.1. Management control of employee health

Interest in occupational health and safety is not a new phenomenon and dates back to as early as 1700 BC (Åkerlind et al., 2007). Already in the 60s, for instance, Schultz (1961) introduced investments in health as an important facet of investments in human capital and argued that health enhances the qualities of the human resources while Becker (1965) held that morale and productivity was increased with improved employee physical and emotional health. Earlier proponents of such tendencies are described by Mayo (1933) who relates the quest for efficiency with the health of employees as epitomized by the British Health Munition Workers Committee and the Industrial Fatigue Research Board, which in 1930 became the Industrial Health Research Board. In the US similar concerns sparked interest to perform the Hawthorne experiments between 1927 and 1932. Even Taylor's scientific management, although heavily criticized, shows such tendencies insofar as one of its main ideas is that “the task [should] always [be] so regulated that the man who is well suited to his job will thrive while working at this rate during a long term of years and grow happier and more prosperous, instead of being overworked” (Taylor, 1998, p. 17).

The interest in occupational health has become even more acute (Johanson et al., 2007) at the turn of the century in so far as sick-leave rates and the cost of ill-health increased in Sweden (Marklund et al., 2005), the Netherlands and Norway (Palmer, 2005). This precipitated discussions on how to curb the trend (Holmqvist and Maravelias, 2006; Marklund et al., 2005), which resulted in countermeasures not only aimed at decreasing the length of sick-leaves—helping those who are already sick—but also to prevent sick-leaves altogether (Johanson et al., 2007). Among other things, in Sweden, several bills were passed that require organizations and municipalities to include sick-leave information on their annual reports (SFS, 2002:1062) and further co-financing of sick-leave costs (SFS, 2004:1237, 2006:1428). The argument in the legislature was to make it more profitable for employers to put measures in motion to decrease the rate and length of sick-leaves (Prop, 2004/05:21).

Concomitantly studies have focused on the relationship between ill-health and intellectual capital (Ahonen and Hussi, 2007) and found that investments in programs promoting health positively affect performance (Aldana, 2001). Along this lines some organizations have also begun to prioritize health as a key issue, envisioning health not only in the traditional acute sense of occupational health and safety that includes the prevention of work-related accidents and industrial diseases but also in a more holistic sense that includes the promotion of health in general and its connection to individual and organizational performance (Hart and Cooper, 2001). Occupational health measures are thus being put in place in the name of health, which stands as an emblem for quality of life and as an organizational resource for the efficient production of wealth in society (Arneson and Ekberg, 2005).

Management control of employee health is in the sense presented above as a practice that is underpinned by implicit ideals of rationality reflected by its explicit functioning and functions. In linguistic terms the practice could be denominated as an extension of an intension,¹ where extension is the set of things or objects in the world to which a word, phrase

¹ Not to be confounded with intention.

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