Corporate Social Responsibility

What's Weight Got to Do with It?

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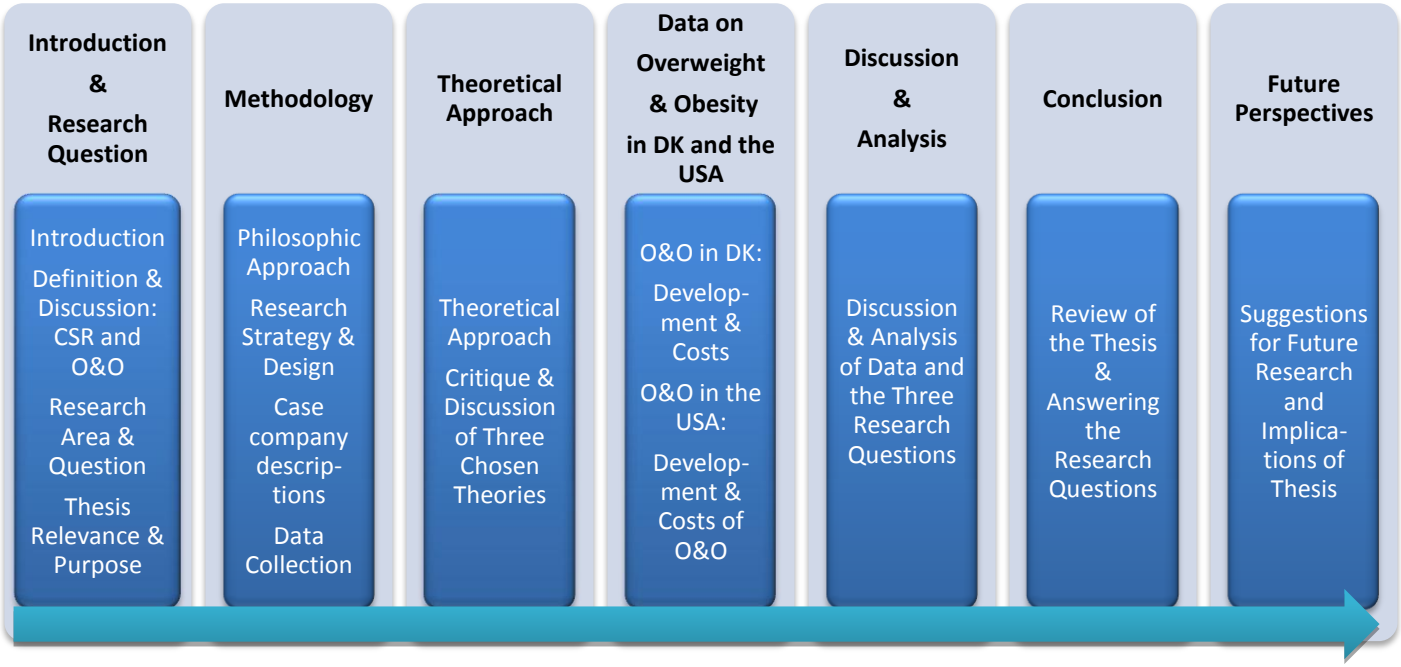
Introduction

Humanity has the ability to make development sustainable – to ensure that it meets the needs of the present without compromising the ability of future generations to meet their own needs[1]

The definition is from the Brundtland report - one most can agree to because it is "true" but, also because it is vague enough for everybody to attest to. Under the umbrella of sustainability is where this thesis has its relevance focusing on the development and prevalence of overweight and obesity (O&O) and Corporate Social Responsibility (CSR): blending factors of what it means for businesses in terms of increased absenteeism and presenteeism[a] and the burdens it places on not just the overweight or obese employee but also on the firm as employer. The thesis is a comparative study of Denmark (DK) and the USA, using two case companies Novo Nordisk (Novo) as a representative of the Danish business community and St. Jude's Medical (SJM) as a representative of the American one.

The thesis divided into seven parts, as is seen below. The following introduces the topic and defines CSR and O&O followed by the problem statement and the three research questions (RQ) after which the methodological and theoretical background is presented. A separate chapter describes the development of O&O over time in DK and the US and the financial costs that are accrued. The discussion & analysis looks at the data and via the use of theory works towards answering the RQs. The thesis concludes with implications for future research.



[a] Presenteeism: productivity loss at work

But first, CSR is defined and discussed in the thesis context and the issues there are with CSR as a tool and a business concept are brought forth. Second, O&O definitions, inherent issues and sequelae are debated. Being a new topic I have decided to elaborate extensively on CSR and O&O to ensure that there is no ambiguity. The chapter concludes with problem area, RQs, and a short summary.

What is Corporate Social Responsibility?

CSR is not a new concept; it is, however, one that has gained momentum the past decades and is used in many fora, such as academia and the business world. However, while they look at CSR from different points of view, business tool or concept, the question remains: *What* exactly is CSR? Apart from the fact that most can agree to the issue of business and their responsibilities within the, large and somewhat shapeless area of the "Triple Bottom line" (TBL) or the Three Ps: people, planet and profit – nobody can agree on the scope nor scale of the responsibilities, not even a common definition of CSR is reached. So how does a firm use CSR and make it benefit not just the environment, the stakeholders but also the aforementioned financial bottom-line? The many pros and cons of CSR have been discussed, however, business is business; it does not exist without, at least to some extent, profit - and without business there are no jobs, and without content customers and employees there is no business. Firms know this. But it is not just the business community and NGOs that are involved with CSR; governments are also entering the picture. Effective January 1, 2009 the Danish government passed a new law that the 1100 largest companies in DK must account for CSR in their annual reports[2] and in 2008 the "Action Plan for Corporate Social Responsibility" (DAP) promoting CSR and helping Danish companies "reap the benefits from being at the global vanguard of CSR"[3] was presented. These government incentives have helped place CSR on the map in DK, signalling to firms and the public alike that it must be taken seriously. Still, there is a downside - that CSR reporting now is a must it has also augmented scepticism: *Why* do companies engage in CSR – because the *want* to or because they *have* to? The answer is probably a bit of both. CSR is lauded as a voluntary concept, but that is compromised when governments pass laws. The EU too is making a concerted effort in promoting CSR defining it as "the responsibilities of enterprises for their impacts on society"[4]. The EU also highlights the voluntary nature of CSR, but continue that "certain regulatory measures create an environment more conducive to enterprises voluntarily meet their social responsibility"[5]. A policy that DK follows with the DAP and legislation. The EU pleads for making CSR strategic to strengthen competitiveness and emphasises that it can bring benefits in terms of risk management, cost savings, customer relationships, human resource management, and innovation capacity.

However, before settling on a definition of CSR further elaboration is needed. In 2011 Adeyeye identified three issues at the heart of CSR[6]: whether corporations have broad responsibilities other than profit

maximisation, whether CSR is beyond rules, subject to voluntary rules or mandatory rules, and whether universal standards of CSR are evolving. According to Adeyeye, two schools of thought dominate the first issue: *traditional* and *multi-stakeholder*. Friedman is the primus motor of the traditional school of thought in which company responsibilities are directed at shareholders via the maximisation of profits while engaging in open, free and fraud-free competition. A company's social responsibilities are philanthropic with cost and labour cuts all the while ensuring that it did not adversely affect the workings of a free market economy. Adeyeye continues that the context upon which Friedman based his assertions in the 1960s has changed. The world is more interlinked and the actions of companies have direct effect on the environment and communities in which they act, therefore, moral legitimacy is important. Scherer & Palazzo state that it refers to moral judgements about output, procedures, structures, and leaders – it is constructed by means of considering reasons to justify certain actions, practices, or institutions[7]. They continue that it requires the "explicit consideration of the legitimacy of capitalist mechanisms and corporate activities by giving credit to the interests and arguments of a wide range of constituencies that are affected by…corporations…[it]is a result of a communicative process"[8]. Moreover, global, local and media savvy NGOs have surfaced threatening legal actions and bad reputation placing further onus on companies to act and do well. The other school of thought is "multi-stakeholders"[9]. Recognising that while shareholders still are important a firm affects and is affected by a multitude of interest groups including employees, suppliers, customers and host communities. The second issue is the rules governing CSR. Many are convinced that CSR should be entirely voluntary; however, Adeyeye states there are already rules and laws in place governing parts of CSR such as anti-corruption laws[b]. Furthermore, advocates of regulation question the ability of the free market as a mechanism to support CSR – market failure and the business environment do not reward firms engaging in CSR. Of course opponents argue that the free market promotes the interest of individuals and in turn society[10]. Adeyeye pointed out that "CSR cannot be beyond rules, but should include clearly mapped out rules to which corporations should adhere" [11]. She continues[12] that many standards do create awareness but their effectiveness remains to be seen. If CSR is to have an impact and be able to contribute to the company bottom line these weaknesses must be addressed and regulated. This again assumes that people will the majority of the time act unselfishly and within the parameters of the law. Although it will be described in detail in chapter three the *implicit-explicit* CSR framework has merit here[13]: in DK much CSR is *implicit* being regulated by the government whereas in the US CSR is much more *explicit* –not as regulated by the federal government and more up to the company discretion. This fits in into Adeyeye's third issue: whether universal standards are evolving. She quotes the

[b] The Alien Torts Claims Act holds American companies directly liable for tort injuries caused by actions in violation of the laws of nations or treaties of the USA

World Business Council for Sustainable Development (WBDSC) that universal standards will not develop because of the political, religious and governmental structures that exist and the fact that CSR is perceived differently in different parts of the world. Despite this she argues that universal standards are evolving in the areas of human rights, contributions to sustainable development, the environment and anti-corruption. The UN work with CSR through the Ten Principles in its Global Compact[c] encompassing meta-concepts of human rights, labour, environment, and anti-corruption. So instead of working with a CSR definition it works with a set of core values[14]. However, in the Innovation Brief from February 2007[15] the UN states that CSR "aims both to examine the role of business in society, and to maximise the positive societal outcomes of business activity". Therefore, CSR can be viewed in a very broad sense as an "overall contribution of business to sustainable development", with a *minimum* standard where business fulfil legal requirements and work at not doing harm. Then there is the *middle* "which goes beyond compliance, calling for business to do their best, and where a 'business case' can be made, to contribute positively to sustainable development by addressing their social and environmental impact, and potentially also through social and community investments". The brief goes on to mentioning a *maximum* standard pointing towards the "active *alignment* of internal business goals with externally set societal goals (supporting sustainable development)". "Do no harm" seems short-sighted and unambitious, especially where "do good" is more proactive and forward thinking and deserves more than a mention as a potential maximum standard. One needs to supersede the "one-size-fits-all" definition of CSR as it is a custom-made process depending on the development, ambitions, scale, scope and orientation of firms.

Professor Charles Handy wrote[16] that profit-making is a means not an end and that every company needs to discover a purpose beyond itself; a purpose that embodies a vision that is not just ambitious but accessible to everybody in the corporate community. In other words, increasing the accessibility of CSR will ensure that more businesses will consider, plan and implement it in their daily operations. This is all well and good but Matten & Moon elaborate on why defining CSR is difficult and hard to use [17]: first, it is a contested issue as it is so complex and open to interpretation. Second, it is an umbrella term overlapping with some and being synonymous with other conceptions and business-society relations, and third, it is a dynamic phenomenon. But at its core it reflects the imperatives of society and the consequences of business success. Scherer & Palazzo agree "The literature on CSR is very diverse and there is no consensus on the precise definition of CSR"[18]. This makes for a difficult and easily exploited concept for businesses worldwide. The notion of what constitutes CSR is not just coloured by culture, political systems & governance and micro- & macroeconomic factors, but also directionality – internal and external CSR. It allows the firm to manage its total impact while generating stakeholder and shareholder value. But while

[c] See Appendix 1

some believe that this constant change and vagueness in definition is a weakness, it can also be construed as the opposite and a reflection of society where a rigid definition might actually hinder progress and render it redundant.

For the purpose of the thesis various aspects of CSR will be discussed to clarify it in the thesis context with scholars, organisations and businesses having developed different definitions depending on the school of thought:

Economic View

Milton Friedman famously declared in the 1960s, that "*the social responsibility of business is to increase its profits*", adhering strongly to a classical economic view. Friedman is often quoted as pro-capitalism and seeing CSR as folly. It also posits that there is a clear separation of business and politics - social responsibility is only assumed if it advances the value of the firm[19].

Inclusive View

According to Carroll *et al.* CSR is[20]: "*the social responsibility of business to encompass the economic, legal, ethical, and discretionary expectations that society has of organisations at a given point in time*", stating this definition is useful because of its "enduring application in CSR research" and because it specifies economic responsibility as key[21], making the business case. They elaborate that legal and economic responsibilities are required, the ethical responsibilities are expected and the discretionary/philanthropic responsibilities are desired.

Stakeholder View

Freeman formulated the stakeholder theory in 1984, and defined it as *any group or individual that can affect or is affected by the achievement of a corporation's purposes*[22]. Freeman highlights that it is not about trade-offs between stakeholder groups, but rather "the jointness of stakeholder interests"[23], this is further emphasised by "Business is about how customers, suppliers, employees, financiers…, communities, and managers interact and create value"[24].

As demonstrated, literature on CSR is diverse but to create focus and direction the WBCSD definition[25] is used as it mirrors the stakeholder *and* business-focus: "*Corporate Social Responsibility is the commitment of Business to contribute to sustainable economic development working with employees, their families, the local community and society at large to improve their quality of life*". Exactly the commitment to work *with* stakeholders is vital; since CSR is stakeholder-dependent firms need to connect the ambitions and expectations of itself and its stakeholders as in the UN's *maximum* standard. Furthermore, improving quality of life fits perfectly with the focus on O&O. It may seem a herculean task to align the expectations and goals of a firm and employees, and do they even care? A wide array of stakeholders cares, according to

Carroll[26]: boards, CEOs, CFOs and business executives care as they are responsible for the company bottom-line. Shareholders care because financial performance and management priorities directly affect them. Social activists care because if their initiatives are supported it serves their long-term self-interest. Governments care because companies can usually deliver more cost effective benefits to society and the environment than they can through regulation. Last but not least, the average consumer cares because she wishes to live in and pass on a better world. The Danish government agrees with this: "The advantage of CSR work at strategic level is that it can help ensure cohesion between the commercial activities of the company and its social and environmental activities"[27].

Much CSR has been implemented or reviewed in response to external stakeholder demands. This meant, *inter alia* to enhance corporate reputation, respond to NGO actions, pre-empt legal sanctions, generate customer loyalty and manage risk[28]. This also means that much CSR has been divorced from company strategy; however, for it to be successful it must be integrated with a firm's internal strategy, structure and processes. On the basis of the previous discussion on CSR certain clarifications are needed especially within the scope of this thesis. There is a general agreement that CSR encompasses the TBL: to do good, to protect the environment, and that businesses can earn money while doing it - a full sustainability circle. Yet for a company to succeed then the primary producers of the goods and services – the employees – need to be in focus, therefore an internal perspective is applied with importance on CSR strategies being coherent and consistent. But where does weight tie in with CSR? For the past years the CSR concept has expanded to encompass more issues than first thought possible or needed. Many more "social ills" are found worthy of CSR attention – among these is O&O. In this thesis focus is solely on the internal stakeholder group: employees.

Having clarified CSR and choosing a definition, the next part looks at O&O, its causes, development, and consequences.

Overweight & Obesity – Causes, Definitions & Consequences

The following clarifies the O&O grading system Body Mass Index (BMI), its inherent issues, and other alternatives. Second, because O&O is not a singular issue co-morbidity factors and sequelae are also highlighted.

The BMI

Table 1: The International Classification of adult underweight, overweight and obesity according to BMI

Classification	BMI(kg/m²)	
	Principal cut-off points	Additional cut-off points
Underweight	<18.50	<18.50
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	18.50 - 24.99	18.50 - 22.99
		23.00 - 24.99
Overweight	≥25.00	≥25.00
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	≥30.00	≥30.00
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Source: Adapted from WHO, 1995, WHO, 2000 and WHO 2004.

BMI calculates one's weight-for-height and is used to estimate whether one is under-, over- or normal-weighted: the weight in kilogrammes is divided by height in metres squared (kg/m2)[29]. The table below[d30] shows the different weight gradings - as can be seen, one is considered overweight with a BMI of 25-29.99 and obese at ≥ 30. The BMI values come with certain issues. The World Health Organisation (WHO) states that "BMI may not correspond to the same degree of fatness in different populations due, in part, to different proportions". It has been debated whether to develop different BMI gradings and cut-off points for different ethnic groups.

Problems Using BMI & other Measurements

According to the 2006 report "Risikofaktorer og folkesundhed i Danmark"[e], there are methodological issues using BMI as an O&O measure - three are emphasised[31]: lack of control regarding smoking, insufficient control of the effects of obesity on blood pressure & cholesterol, and lack of control of weight loss due to subclinical illness. Moreover, BMI is not a good measure of the body composition, as it does not distinguish between muscles and fat, and may thus overestimate the amount of fat on people with high muscle mass. Actually, a LA Times article [32] states that using BMI as a measuring tool may misclassify roughly half of women and over 20% of men.

A more accurate measure would be the *BVI* – Body Volume Index. It measures the hip-waist ratio – in other words the abdominal fat, the dangerous fat. Abdominal fat increases the risk of cardiovascular disease, as written in an article from December 3rd, 2008[33], women are 50/50 pear/apple shaped while men are

[d] and Appendix 2
[e] Translated: The Report on National Health, Denmark 2007

primarily apple-shaped –explaining why it is predominantly men that are afflicted by heart problems. The study was published in the American Journal of Physiology, Endocrinology and Metabolism. The BVI, unlike BMI, takes into account the fat distribution on the body as well as age, weight, height, shape, sex and medical history[34]. The Danish article *Forskerne siger farvel til BMI - maven skal med i målingen af din vægt*[f,35], states that BMI was never intended to be used as a tool to measure obesity and that BVI can be used as an early warning system to identify people with a risk of heart disease, stroke, and diabetes. However, the central weakness of the BVI is it must be done by a doctor using a 3D scanning. So while it seems that BVI is on the right track by taking into account body composition, the effect it will have on public health is limited, as also commented by Professor Klarlund[36]. That very weakness is also why BMI continues to be such a widespread measure of weight – there simply is not another measurement as easily accessible, calculated or understood. The aforementioned LA Times article states[37] that other "Simple measures such as waist circumference, hip circumference and waist-to-hip circumference have gained new adherents as criticism of BMI has mounted", this is supported by the authors of "Risikofaktorer og folkesundhed i Danmark "[38].The WHO defines obesity using WC for women as having an increased WC if it is ≥80 cm and substantially increased with a WC ≥88cm. For men the respective cut-off points were 94 and 102 cm[39].
A 2008 article from the Danish newspaper Politiken[40] commented on the cost of abdominal fat: per *extra* cm around the waist it costs the Danish Health care system 100 DKK. A woman of normal weight costs the health care system 9,100 DKK per annum, for every extra cm of abdominal fat the expense to the health care system increases by 1,25%. On average a man of normal weight costs 8,700 DKK per annum, and with every extra cm the expenses increase by 2.08 %. These calculations are based on a study of 31,840 Danes and it was published in the European magazine "Obesity Facts"[41]. The most viable measurement is the waist-hip ratio and it has been proven to be a better indicator of heart disease[42]. Professor Klarlund also referenced[43] a new measuring system that accounted for gender, body type and height to measure one's ideal weight[g]. It must be mentioned that studies have shown that there seems to be a "protective" effect with a BMI slightly above "normal"[h,44]. Knowledge about the link between WC and health care costs lacks but still it seems a more accurate indicator of future health care costs.
Although there are problems using the BMI, it will be used as much literature use it.

[f] Translated: Scientists say goodbye to BMI – the belly must be accounted for when measuring your weight
[g] The author of this thesis ought to weigh 60.9 kg
[h] BMI of 25-30

The Global Epidemic – Development, Causes & Sequelae

Obesity is not a single issue. According to "Folkesundhedsrapporten, Danmark 2007"[i] the O&O sequelae are: metabolic syndromes (insulin resistance, high blood pressure, cholesterol abnormalities[45]), cardio-vascular illnesses, cancer, arthritis, lunge problems & sleep apnoea, quality of life (such as psycho-social problems) as well as death[46]. A 2008 study by Højgaard[47] seconds these. Many of the illnesses are often intrinsically related to obesity though not always present, making obesity costs hard to accurately calculate. The paper "Health and economic burden of the projected obesity trends in the USA and the UK"[48] states that the obesity health burden largely comes from type 2 diabetes, cardio-vascular diseases and cancers - illustrated by the fact that "every additional 5 kg/m2 in BMI increases a man's risk of oesophageal cancer by 52% and for colon cancer by 24%, and in women, endometrial cancer by 59%, and postmenopausal breast cancer by 12%". The severity and array of sequelae also depends on contributing factors such as smoking, alcohol, and physical activity. The effect of O&O on absenteeism is slightly lessened if smoking, alcohol and physical inactivity are taken into account[49].

According to a WHO fact sheet[50] obesity has doubled worldwide from 1980 to 2008 with >1.4 billion adults 20 years or older being overweight. Of these >20 million men and nearly 300 million women were obese: more than 1 in 10 of the world's adult population was obese. Making it is the fifth leading risk for global deaths, with at least 2.8 million adults dying of O&O annually. This means that 65% of the world's population live in countries where O&O kill more people than underweight; this also translates into an increase in preventable diseases. Globally[51], 44% of diabetes, 23% of ischaemic heart disease, and 7-41% of certain cancers are attributed to O&O. Previously, O&O was associated with high-income countries but has now become prevalent in low- and middle-income countries. Exacerbating this is the fact that obese children have a high propensity to become obese adults and develop diabetes and cardiovascular diseases at a younger age leading to premature death, disability, and increased costs.

There are many causes of O&O making it hard to address, but Centers for Disease Control and Prevention (CDC)[j] speak of the *caloric balance equation*[52]: consumption of energy dense food & lack of physical activity, body weight as the result of genes, metabolism, behaviour, environment, culture and socioeconomic status, and third behavioural and environmental factors. Energy dense food is high in fat, salt, and sugars and low in vitamins, minerals, and other micronutrients[53]. Behaviour and environment play a large role as decisions are based community, home, child care, school, *and* work. The CDC stress that it is important to create environments that make it easier to engage in physical activity and eat a healthy diet[54].

[i] Translated: The Report on National Health, Denmark 2007 published by The National Institute of Public Health
[j] The CDC is part of the US Department of Health and Human Services and monitors, analyses and works to prevent disease in the US

Furthermore, it seems as if the social and economic development, transport, urban planning, environment, education, food processing, and marketing influence dietary habits and physical activities. Increasingly, these promote unhealthy weight gain and lead to a rise in the prevalence of childhood obesity, according to the WHO[55]. The WHO also mentions that genetics play a role in the development of O&O as well as seen in disorders such as Prader-Willi syndrome.

In sum, contributing factors include eating habits, lifestyle habits, how and where people live, work, attitudes, emotions, income and genetics[56].

This leads to a shot description of the thesis problem statement and research question.

Problem Statement & Research Question

The WHO state that "curbing the global obesity epidemic requires a population-based multisectoral, multi-disciplinary, and culturally relevant approach"[57], meaning that "Governments, international partners, civil society, non governmental organizations and the private sector all have vital roles to play in contributing to obesity prevention"[58]. O&O has reached such levels that not a single actor can alleviate the epidemic but collaboration is needed and firms have a part to play. The global rise in O&O[k] and the costs increases strongly affect firms via *inter alia* absenteeism and presenteeism.

Therefore, based on the above, the following research question is formulated:

With overweight & obesity on the rise should firms engage in CSR programmes targeting the stakeholder-employee?

The research question is comprehensive so the following sub-questions are used to guide the discussion and analysis.

1.1) Considering CSR, its inherent vagueness, the role of internationalisation and personal lifestyle choices do firms have a right to implement CSR initiatives targeting O&O among stakeholder-employees?

1.2) According to theory, how can CSR initiatives targeting O&O be integrated and which approaches have the case companies adopted?

Thesis Relevance & Purpose

For many years CSR focus has been the environment and pro-poor development. While this is a worthwhile endeavour with positive outcomes the fact that CSR is a dynamic concept means that more social ills become relevant; and as firms and stakeholders discuss societal development reality is constructed and the expanding role of business is central. This is in line with social constructionist thinking where reality is

[k] See chapter 4

constructed through interactions and the more people confirm each other in the fact that more must be done then new avenues must be considered. This thesis has its relevance in looking at the role of O&O in DK and the US and the costs incurred whether firms can help alleviate the epidemic by combating the obesogenic culture that exists. The thesis looks at the costs to firms in terms of increased absenteeism and presenteeism due to O&O and what can be done by them to keep costs down and employee wellbeing and loyalty up.

Via CSR efforts targeting the health and wellbeing of employees by focusing on O&O the thesis looks at what the two case companies have done – as a best case. It is fully expected that this area within CSR research will garner more attention in the coming years and more firms will implement initiatives focusing on O&O or develop those already in place. The focus on O&O in the work place and the positive influence firms can exert is new but highly relevant with organisations such as the WHO labelling obesity as an "epidemic". Being a new and not yet fully researched topic it is also sensitive fostering questions about the right of firms to intervene and the right of the employee to pursue her desired lifestyle. Employees are, as will be demonstrated in the theory chapter[I], one of the most salient stakeholders a firm has and a one whose needs and demands warrants much attention being a valuable resource to the firm, and if not satisfied can have a very negative effect on the firm bottom line and reputation.

With Novo and SJM in mind the objective is to understand whether and if yes, why contributing in this area will benefit firms and create a win-win situation for the firms, the stakeholder-employee and countries. The ambition is to add to the existing literature and supplement the debate on CSR.

Methodology

This chapter highlights the philosophical approach, the methodological considerations and concludes with a critique and delimitation.

Philosophical Approach

The philosophical approach in this thesis is *social constructionism*; as will be demonstrated in the Analysis and Discussion chapter it is highly relevant because a key point in this is that *reality is constructed through interaction*. With construction occurring through interaction a firm can via its CSR efforts emphasise

[I] See pp. 24-26

dissemination of information, so that discussions and interactions are enlightened, a beneficial reality can be built and thereby perception of overweight and obese individuals will not be tarnished by prejudice. This interaction can verbalise issues and highlight that the obese are not "lazy" or "unintelligent"[59] - lessen the social stigma that often leaves the obese feeling ostracised by highlighting consequences for the firm and the fact that "together" the situation can alleviated.

Social constructionism is based on four assumptions[60]. First, it demands a critical stance toward taken-for granted knowledge; one is cautioned to be suspicious of assumptions about how the world appears to be. Therefore, one must also be careful with preconceived ideas of how to address firm issues and prejudice regarding overweight and obese people. A Reuters article[61] stated that the hatred of fat in the USA is actually hurting the efforts fighting it, because of the stigmatisation beginning in preschool, where children speak of the overweight as mean, stupid, ugly, and having few friends - a misconception not ameliorated in adulthood, where overweight people are seen as "self-indulgent, lazy and unable to control their appetites". This translates into poorer job prospects for the obese compared with their slim peers[62,63]. Second, the concepts used are historically and culturally specific; therefore, the thesis includes a comparison between the Danish Novo and the US SJM and their CSR efforts with a point of departure in the implicit-explicit framework[m] and how those efforts are focused on encouraging healthy living among employees. Third, knowledge is sustained by social processes: people construct the way of understanding the world between them via interactions, "social interaction of all kinds, and particularly language, is of great interest"[64]. Theoretical articles on stakeholders and CSR are used to highlight this area. Fourth, knowledge and social action go together, meaning that how we understand the world is 'negotiated'. Therefore, it takes many forms and there are many possible social constructions of the world. As an example Burr states[65] that before the Temperance movement drunks were seen as responsible for their actions and sent to prison. As knowledge and social action developed drunkenness was seen as an illness and treatment was offered instead of imprisonment. Now with many perceiving obese people as lazy and responsible for their own consumption, it would be interesting to see if this perception too will change over time to also be accepted as an illness/addiction to be helped in communion.

This approach is chosen because it looks at constructs in and created by society, constructs such as CSR. As previously written, it is a fluid concept changing with geography, context, interactions, and culture. Interestingly, social constructionism also looks at language as key and because language changes our concepts then our perception of right and wrong also changes – a reason why CSR has encompassed more foci. Through daily interactions knowledge and understanding of the world is constructed and identity is created. But at the heart of this is *power*. Burr makes an interesting point that we "behave, think and feel

[m] See pp. 23-24

differently depending on who we are with, what we are doing and why"[66] - people tend to emulate powerful and dominant figures and thoughts such as top leaders, where one rarely sees overweight. Therefore, people generally also wants to work for powerful corporation such as Novo or SJM and with their health focus people will emulate this. Looking at language and power Matten & Moon offer the implicit-explicit framework describing the development of CSR over time and coloured by the culture in which it is used. This will be described extensively in chapter three and used in the analysis to support the comparative set-up and explain *why* DK and the US have used CSR differently and *how* the case companies have chosen to frame their CSR strategies.

But DK has not had much explicit CSR language whereas the US has excelled in this area; lately DK has begun to emulate that trend for many reasons: one of these could be that the US is one of the most dominant players in world business and striving to improve business relations with the US forces imitation - also why a comparison between DK and the US is interesting. Language as the 'crucible of change' both personally and socially constructs, maintains and challenges identity and for people who may feel trapped or repressed by their identity (whether in themselves or in the eyes of the world) such as the obese it can also be a way to change explaining why O&O should be targeted via more explicit CSR[67]. Of course one is bound by the existing social practices but work places and the view of the employee have changed over time from one of mere task performer to asset and firms formulating health programmes and using positive language to motivate and support is a step on the way.

Research Strategy & Design

The thesis is a comparative study juxtaposing two national contexts with Novo and SJM functioning as cases. Case studies serve to illuminate decisions highlighting *why, how* and *what*. Furthermore, this contrasts the decisions of Novo and SJM as to *what* the respective health programmes entail, *who* is included – and for Novo *why* and *how* it was rolled out. In other words, case study designs underscore the topic validity and making it more easily understood by generalising the two contexts and how they influence the strategic choices made by Novo and SJM. The two firms will be analysed and compared firm-to-firm and on a more meta-level where their respective national contexts are brought into the equation. Using a multiple case study design gives access to more data and the ensuing analysis becomes more solid. Using more cases would give access to more data and perhaps shed light on issues not accounted for in this thesis; but using the two cases serve the scope and scale well. A goal is to see if having a CSR initiative focusing on improving the health and well-being of employees in the work place will have a positive impact on productivity and employee satisfaction – something which one case could not account for.

The research design is three-fold: *descriptive*, *explanatory*, and seeks to be *problem solving* within the area of O&O in firms. These purposes build upon each other with the problem description at the centre, explanation of its effects and a clarification of how the situation can be improved or avoided in the future.

The explanatory focus is used to emphasise the need for intervention at a more direct level due to the many economic and social implications there are. Although O&O is far from a new problem in the US the development and consequences of it need to be brought into the discussion as DK is also influenced. With the case study design a description and an explanation of their programmes, the underlying reasons and the national contexts are also needed. The descriptive and explanatory levels are highly interlaced as explanations are used to underscore the situation description. In support of this quantitative data on O&O and health is primarily attained via the *Institut for Folkesundhed*[n] in Denmark and its report on national health from 2007. There is not much quantitative data on O&O in DK as *Danmarks Statistik*[o] does not gather information nor tables, graphs etc. on O&O in DK but links to the reports already used. Much of the US information is attained from the CDC. Additionally, through the analysis and the methodological approach potential solutions are offered to show what action can be taken – inspiration is from the initiatives put in place by Novo and SJM as well as other sources. On this basis the thesis topic becomes highly relevant for researchers and firms alike for a few simple reasons: as a new issue in society it has the potential to influence the daily running of business and elaborate CSR theory, and if implemented properly it has the potential to increase public and internal goodwill as well as firm bottom-line.

A large part of the thesis compares the Danish firm context to the American one. The two national backgrounds differ in their perception of business in society as well as the extent to which the national government can interfere – therefore, the implicit-explicit framework by Matten & Moon serves a frame and the discussion on what the businesses can do improve the situation of their employees and by extension themselves furthers the understanding of O&O. It is expected that the implicit-explicit framework will show why CSR has developed so differently in seemingly similar countries such as DK and the US. Moreover, expectations are that considering the increased international trade that although national political systems colour CSR choices of firms that explicit CSR will spread because it can be used to brand and market firms.

[n] Translated: Danish National Institute of Public Health, a part of the University of Southern Denmark - formerly housed by the Danish Ministry of the Interior and Health: http://www.si-folkesundhed.dk/Om%20instituttet.aspx
[o] Translated: Statistics Denmark

Case Companies

The reasons for selecting Novo and SJM were simple: both operate in the medical industry, both have health programmes for employees indirectly targeting O&O, and both are large global firms. Although they do not cover completely the same areas perhaps impeding a full comparison, they were chosen because they are best practice firms when focusing on CSR-driven health care programmes directed at employees and targeting O&O. Furthermore, for Novo diabetes care is the primary business area not O&O, but O&O is one of the major contributors to the development of type 2 diabetes. SJM works with, *inter alia*, cardiac rhythm management, arterial fibrillation, and cardiovascular modulation all areas that is affected by obesity. With O&O being such a new focal area best practice firms were chosen to show what and how it is being done and if something is not done well – how it can be improved.
Since both are large international firms access to online reports such as annual reports is made easy. Moreover, the medical industry was chosen as focus because as a highly exposed industry it has had to adopt CSR strategies early to counteract negative externalities. Having had an early CSR presence generally means that CSR strategies have become more developed over time.

Novo Nordisk[68]

Novo is a global health care company headquartered in DK with 89 years of innovation and leadership in diabetes care. It holds leading positions within haemophilia care, growth hormone therapy and hormone replacement therapy. As a global firm it employs some 33,900 people in 75 countries and markets its products in 190 countries. In 2011 Novo had total sales of 66,346 million DKK and a gross profit of 53,757 million DKK[69]. Furthermore, President and CEO L.R. Sørensen commented[70], that combined with a focus on operational efficiency Novo had an operating profit growth of 18%. Cementing Novo's status as a dominant global player within its field. Novo attributes its business philosophy to the TBL[p] of being financially, environmentally, and socially responsible stating that they "believe that [the TBL] is fundamental to long-term business success". It is applied when pursuing business solutions that maximises value to its stakeholders and shareholders. Furthermore, Novo developed the Novo Nordisk Way (the Way) listing ambitions and aspirations within diabetes leadership, growing the business and delivering competitive results while not compromising on ethics or quality and offering opportunities to employees.

[p] See Appendix 3

Novo published its first environmental report in 1995 and the first social report in 1998. Since then the reporting has become more integrated. Novo is a signatory to the UN Global Compact, a part of the ISO 26000[q] and follows the Global Reporting Initiative.
Mr Martin Kristiansen, Head of the NH programme at Novo has been in e-mail correspondence answering the semi-structured questions posed.

St Jude Medical[71]

SJM is a US firm producing medical technology and services within the areas of cardiac rhythm management, arterial fibrillation, cardiovascular and neuromodulation. It is headquartered in the US and employs 16,000 employees worldwide, is present in some 90 countries and sells its products in some 100 countries.
SJM is ranked no. 1 on FORTUNE Magazine's list of Most Admired Companies and no. 436 on FORTUNE 500 list of companies in 2011[72]. In terms of revenue, net sales in 2011 totalled $5,612 billion of which gross profit totalled (in 1000) $4,079,485, an increase from 2010[73] - it has increased its gross profits since 2007, although the operating profit was slightly down from 2010[74]. Chairman, President and CEO D.J. Starks states that growth is expected to accelerate[75]. The website state that SJM "believe good corporate citizenship contributes to our combined ability to deliver value to our shareholders in a meaningfully and socially responsible manner"[76]; tying financial and socially responsible goals together.
The SJM Code of Ethics follows the AdvaMed Code of Ethics because as stated by SJM CEO "We cannot be successful as a company unless we conduct ourselves with the highest degree of professional ethics and integrity". Furthermore, all employees are required to sign a responsibility statement stating that they have understood and will comply with the Code of Business Conduct.

Data Collection

Due to the social constructionist base a primarily deductive approach is chosen because point of departure is a concrete problem in society negatively affecting firms. Furthermore, the intention is to bridge the identified gap[r] through the use of existing theories and in doing so attain a deeper understanding of the stakeholder-employee and the institutional contexts that influence firms. O&O as a CSR concept needs, due to its recent emergence, to be brought to the attention of managers. Part of the thesis is inductive in nature as there is relatively little information on the effects of O&O on society and firms and some generalisations need to be made on the basis of the accessed macro level data.

[q] Corporate Sustainability Guidance
[r] See p. 21

Qualitative Method & Comparative Case Study

As described on page two CSR is a concept of "soft" topics making it hard to measure. Therefore, a qualitative approach with two cases is used to "see precisely which events led to which consequences, and derive fruitful explanations"[77]. Eisenhardt state that case study research focuses on understanding the dynamics present within single settings, and can moreover have multiple levels of analysis[78]. Being a comparative case study focusing on a novel area forces the analysis to look at multiple levels of data, national and firm, to construct meaningful data as specific ones do not exist making a quantitative approach impossible. Although qualitative in approach it is supplemented with country level data on O&O that draws a somewhat tenuous link to firm level. The use of quantitative data generated by other researchers is necessary to strengthen the analysis and keep the "researcher from being carried away by vivid, but false, impressions in qualitative data…bolster[ing] findings"[79].

Although a qualitative approach was chosen because of the lack of quantitative data, the differences in approach merit a quick look. Bryman *et al.* explore and list 11 differences[80], *inter alia*: numbers vs. words, theory & concepts tested in research vs. theory & concepts emergent from data, structured vs. unstructured, generalisation vs. contextual understanding, and macro vs. micro.

Quantitative research uses numbers to get measurable data whereas qualitative research uses words to describe. As it has been impossible to collect own quantitative data and Novo has chosen to not measure the impact of NH micro-level data does not exist. But national reports such as *Risikofaktorer og folkesundhed i Danmark* and information from sources such as the CDC are used to get the costs of O&O to society and links to firms; important to highlight the severity. The CDC's tables on the development of O&O in the US illustrate this. Theory tested or emergent sees quantitative research as set up on the basis of certain theories and the tools used correspond to this predetermined set-up, in qualitative research concepts and theory emerge out of the data collection. This thesis is more deductive in nature with an observed issue as topic and using theory to frame the data. The predetermined theory and the test thereof leads to a very structured set-up in quantitative research compared to an unstructured set-up in qualitative research. The unstructured set-up ensures the possibility of extracting meanings in line with the social constructionist approach. Social constructionism states that interaction constructs our understanding of the world and therefore interviews with managers in charge of the respective health programmes and the employees benefiting from them would have been ideal to observe body language and vocabulary. But access to people has been near impossible and data on the programmes and their use is primarily gathered from the firm websites and annual reports. But these and the language used is a good way to convey meaning. With the lack of contact the programme descriptions are the only means of finding the values and image they wish to convey. But this grants a contextual understanding of the data where the quantitative

method is more concerned with generalisations. Such an understanding is vital as O&O is new on the social agenda. Eisenhardt[81] state that qualitative data is useful for understanding the rationale or underlying relationships revealed in quantitative data. Furthermore, quantitative research is often concerned with macro level societal trends and connections between variables whereas qualitative research is more micro-level and small-scale aspects of society such as interaction. Qualitative research is needed because CSR is such an elusive non-measurable variable. Especially the focus on O&O is highly dependent on social interaction and understanding. Qualitative data excels at going in-depth with the material and presenting meaning - the *why* that is crucial to internal validity[82], but because there is the chance of researcher bias "the reliability and validity of qualitatively derived findings can be seriously doubted"[83]. Using the mentioned sources and the juxtaposition of seemingly similar cases can lead to more sophisticated understanding[84] – and the iterative moving back and forth between the firms and their home contexts have led to redefinitions of the RQ[85].

Although only the *middle approach*[s], making the business case is a goal and to do this facts garnered from different reports and public and private institutions are used. Therefore, the material is primarily from peer-reviewed journals to get the most current writings on CSR and O&O. These include scientific and academic journals such as The Lancet, Obesity Facts, The Journal of Business Ethic, and Academy of Management Review. Additionally, organisations such as the UN and the WBCSD provide both meta-level information and a micro-level view. The juxtaposition of multiple level data and constant comparison from meta to micro level and country to country enhances the probability of reliable data[86]. Corporate home pages have been used to get their own information on how and why initiatives were implemented but these are biased and need to be used carefully. This process and ensuing understanding will diminish said doubt and the, at times, contradictory data and difference in CSR approach depending on country context create insights through a "process of reconciling these contradictions forces individuals to reframing perceptions into a new gestalt"[87].

Critique & Delimitation

A number of issues need to be addressed in order to narrow the scope. CSR covers everything from environment to health - but focus is O&O among employees. This is placed into a context of the development of O&O in DK and the USA and what firms can do. Unfortunately, the O&O focus does not lend itself easily to a box and concessions are made. As the angle is internal to the firm the figures supporting the discussion ought to be micro-level but such figures have not been found. Therefore, the figures used are macro-level information garnered from public websites and reports. The report

[s] See p. 4

Risikofaktorer og folkesundhed i Danmark makes assumptions based on macro-level figures drawing a connection to the potential impact on firms. Therefore, the thesis cannot conclusively answer all questions as neither theory nor fact fully cover the topic. It is unsure whether using more case companies could have strengthened the positive link, but macro-level data does suggest that action must be taken at all levels of society including firms. Furthermore, an important part of the thesis is the comparison between DK and the USA and the *implicit-explicit* nature of CSR. However, due to the amount of data collected only two case companies are used. There is a shortage of consistent, high-quality data on the consequences of production loss, especially as part of absenteeism and presenteeism levels. Some of the data make predictions, this type of data always carries with it uncertainties and is biased depending on the figures used and the researchers' personal agenda.

Having surveyed Novo and SJM would have strengthened the analysis, as the extra information would have clarified firm intentions and employee perceptions as well as supported the comparative set-up. In the same manner interviews with NH and LiveWell participants and managers would have clarified issues and benefits with the programmes as well as strengthened reflections on the use, implementation, and need of the programmes. Unfortunately, it has been impossible to establish any connection with SJM despite many attempts; therefore, information regarding LiveWell is collected solely from the homepage. This means that the information is biased reflecting the image that SJM wishes to impart. While Novo has been willing to collaborate and Mr Kristiansen freely answered e-mails he has frequently been away on business trips or in meetings so an interview has been impossible to attain.

Generally speaking, many scholars point out that for O&O initiatives to be effective focus should also be on childhood obesity - bad habits and knowledge of healthy living is cemented in the early years. This too is outside the scope of the thesis. The data needed to incorporate this factor is enormous and connecting it with the employee focus is difficult and can only be looked at as philanthropic action – a different focus than the strategic CSR highlighted.

It must be noted that while having a well-planned and integrated strategic CSR portfolio can lead to competitive advantage; it is not necessarily a panacea for solving social responsibility issues, retention, productivity, or absenteeism. CSR is a broad and fluid topic and there is not a 'one size fits all' solution. However, integrating a strong employee focus by improving health can lead to a decrease in presenteeism and set a firm on the positive path of employee retention. The lack of access to the selected firms has led to assumptions being made in the analysis on absenteeism and employees inclusion - assumptions that may be erroneous but nonetheless necessary. As Novo was the only firm responding there may also be some bias towards a "Danish-international" model. So while businesses are important actors in the alleviation of O&O they are not the sole driver of change within this context, a wide array of actors form a foundation

these actors include, but is not limited to governments, NGOs, and civil society.
As mentioned, focus is only on the medical industry, so while other companies have very interesting CSR health programmes focused on their employees this is only used as inspiration for potential solutions. The medical industry was chosen because it is highly exposed, constantly in the media due to issues with pricing strategies, developed vs. developing world, ethical concerns, and "scandals". Therefore, the industry uses CSR to ameliorate this and seem to have some of the more developed strategies in place, making them very interesting.

Firm, Corporation, Business

These are used interchangeably.

Tables, boxes & Graphs

All used are also in appendices

Summary

The overarching purpose of the thesis is to add to the existing literature on both CSR by focusing on the fairly new and controversial area of O&O but also by contributing to the understanding of the role of the firm in society as more than a work place, more than a tax payer and money generator, but an integral interdependent part of society as a whole.
The qualitative approach is used to garner the most relevant in-depth information with quantitative support from reports on health and costs at country level. Social constructionism is used because the focus is on *creating reality* in the work place between employer and employee and between employees via interaction and dissemination of information and thus creating a perception of jointness and making a difference together instead of excluding the overweight and obese. Literature-wise focus has been on articles and reports published in academic and scientific journals to get the most updated information available from acknowledged scholars.

With this in mind the theoretical framework will now be described and discussed.

Theoretical Framework

Friedman's argument[t] is outdated considering the interconnectedness of today's world, especially as noted by Scherer and Palazzo[88] that it was made "in a bipolar world, divided into Western capitalist countries and Eastern communist countries". First, the chapter will emphasise an identified gap in literature. Focusing on this gap is a means to elaborate and expand on what CSR is and how it can help firms cement their role and gain a competitive advantage. Second, through the theories this gap will be bridged and from this discussion the RQs emerge. Third, the chosen theories are critiqued, and a short summary concludes the chapter.

The objective is through theory to understand the background for the thesis and elaborate on the importance of a strong stakeholder focus.

Gap in Literature

In this interconnected world firms involve many stakeholders and need to be aware of potential conflicts and how they look at firm involvement in the stakeholder-employee and through that how it can benefit itself in the long-run.

CSR has gained momentum and support among business leaders with organisations such as the WBCSD backing it. More firms are incorporating it in their vision & mission statements as well as their annual reports as part of business strategy. CSR has had different foci but it seemed to lack introspection. The thesis idea developed as it became clear that society is facing grave health concerns with O&O on the rise and as part of society firms and employees are affected by this. Porter *et al.* said that "successful corporations need a healthy society"[89]. Admittedly, the quote had nothing to do O&O but it can be expanded to encompass that notion too as they mentioned that health care is "essential to a productive workforce".

CSR has been lauded as a concept that can grant firms a competitive advantage and solve a multitude of firm, social and environmental ills. Much is also written on O&O in health journals and at country level due to its increasing negative influence on health care budgets. The combination of the two, how businesses are negatively influenced by and how they can positively influence it is however a neglected area. No research has completed in-depth analysis on the impact of O&O on business nor the role firms play. Some

[t] See p.5

reports focus on the country-level exposure to O&O as part of a larger body of work on negative health influences drawing cautious links to firms but do not delve into the subject. The aim of this thesis is to bridge the gap by linking them through an analysis of the O&O development in the US and DK, bringing the topic to the firms and their increasing social responsibilities by showing *how* they are affected by it and *what* can be done.

Internet search on *CSR* and *obesity* finds blogs, texts on childhood obesity and what the food and drink industry (F&D) is or is not doing. Searching on EBSCO Host via CBS library one is told that the initial search did not yield any results but a few academic journals feature it with a focus on F&D. Through a series of reformulating search words it became apparent that no text or theory would cover the topic in its entirety. From then on focus was on finding information, journals and reports that covered the area from different angles such as the changing role of business in a globalised world, how to gain a competitive edge using strategic CSR, how to distinguish stakeholder salience, national health risks in DK and the US, influencers on national health care budgets etc. Gradually, by connecting the texts of scholars and business leaders a more coherent picture of the situation and the role of business became clear.

It was found that a combination of CSR, stakeholder, and institutional theory covered the most salient parts of the research area. The three theories are discussed in the following.

Discussion of Main Theories

This section focuses on the three theories used to bridge the identified gap. First, institutional theory (IT) with a focus on Matten & Moon's *implicit-explicit* framework is used to describe the contextual setting that firms operate in as well as the pressures that force them to develop CSR. Being a comparative case study looking at DK and the US, what the CSR initiatives of the case companies entail this is an important base. The chapter then moves to stakeholder theory (ST). It explains the stakeholder-employee and her salience to the firm further sharpening the focus. Third, CSR theory is used to cement the role of business and the different avenues available to them when formulating and implementing CSR programmes.

Institutions

IT often describes how organisations within a given context act and look similar. DiMaggio *et al.*[90] contend that structural change and homogeneity in organisations occur as "powerful forces emerge that lead them to become more similar"[91]. They continue the forces best describing the homogenisation is *isomorphism* – a "constraining process that force one unit in a population to resemble other units that face the same set of environmental conditions"[92]. They state that there are two isomorphic pressures: competitive and institutional. The first assumes a rationality focusing on market competition, and the second where

organisations not just compete for resources and customers but also political power and institutional legitimacy, for "social as well as economic fitness"[93]. In line with the social constructionist approach Scherer & Palazzo say that "institutional theory consider legitimacy as the result of a *social construction*"[94] being subjectively perceived and ascribed to action taken by firms. There are three mechanisms through which institutional isomorphism occur: *coercive*, *mimetic*, and *normative*[95]. *Coercive* isomorphism can take the form of government legislation[u], the expansion of the state and the centralisation of capital[96]. *Mimetic* isomorphism is when uncertainty or modelling encourages imitation. Generally speaking, "the wider the population of personnel employed by, or customers served by, an organization, the stronger the pressure felt by the organization to provide the programs and services offered by other organizations…a skilled labor force or a broad customer base may encourage mimetic isomorphism"[97], DK beginning explicit CSR is also an expression of this. *Normative* isomorphism is professionalisation, which the authors define as "the collective struggle of members of an occupation to define the conditions and methods of their work, to control 'the production of producers', and to establish a cognitive base and legitimation for their occupational autonomy"[98]. Matten & Moon[99] use these isomorphisms to point out that IT is useful in the comparison of CSR activities across nations for three reasons: understanding cross-national differences in corporate governance, understanding the actions of managers, stakeholders etc. within their national, cultural, and institutional contexts, and third it brings the interdependencies between and the interactions among stakeholders into the analysis – vital for understanding CSR, given its societal orientation. They expand on the theory[100] that *New Institutionalism* (NIT) allows for the fact that institutional frameworks change and new opportunities arise as well as why *explicit* CSR is expanding globally. NIT concerns itself with the homogenisation of institutional environments across borders with increasing standardisation and practices in organisations; an argument focuses on legitimacy and how it is attained via the three isomorphic processes. Matten & Moon use these three processes to describe the rise of explicit CSR in Europe[101]. In NIT externally codified rules, norms, or laws assign legitimacy to new management practices; such as the advent of Europeans governments' strategies and initiatives regarding CSR or other codes such as issued by the UN. Other forms of mimetic processes are the many CSR reports and memberships of CSR organisations – something that both Novo and SJM do, as described on page 14 to 16. They argue that shifts in the balance of implicit & explicit CSR reflect the changing nature of firms' historical and national institutional settings[102]. So firms act and are dependent upon the home institutional context and bring with them that mind-set in their international endeavours. This leads to a description of Matten & Moon's "implicit-explicit" framework as part of IT.

[u] Example: mandatory reporting on CSR in DK

The Implicit-Explicit Framework

Matten & Moon[103] address the issue of why CSR differ among countries. They based on two observations[104]: 1) While many US firms have been attributed and claim social responsibilities, this has not been done elsewhere, and 2) firms elsewhere in the world have recently begun to adopt the language and practice of CSR, particularly in Europe. This does not mean that CSR is new in Europe nor does it mean that US firms are the only ones who have practiced it. The authors argue that the answer lies in the national institutional context; based on the political, financial, education and labour, and cultural system[105]. A key distinguishing feature between the US and the European political system is the power of the state; which historically has been greater in Europe. So European governments have been more involved with social and economic activity – and the US has had greater scope for corporate discretion with US firms having greater opportunity to decide who and what to include, such as SJM whose LiveWell programme is only for *benefit-eligible* employees. Looking at the financial system the stock market has been central to US economy leading to a high degree of accountability and transparency. The European model has been based on networks of mutually interlocking owners with a focus on long-term preservation of power and influence so stakeholders play an important role "equivalent to or above that of shareholders"[106]. With respect to the educational and labour systems then Europe has had publicly led training and active labour market policies; in the US corporations themselves have developed strategies in this area. Furthermore, there has been higher union participation in Europe and issues have been negotiated as firms have been more inclined to seek collective interests. The fourth feature is cultural systems[107]. Broadly speaking there is in the US a stronger ethic of "giving back" whereas in Europe there is a reliance on representative organisations. The US has thus been more reliant on market-based forms of contract-based ownership and Europe has had much direct or alliance ownership with many embedded relationships and a wide set of stakeholders. Based on this Matten & Moon have developed their *implicit-explicit* framework to understand the use and spread of CSR arguing that US CSR is rooted in a system with more opportunity for firms to take on more explicit CSR and European CSR is set in a context of wider organisational responsibility leaving firms with narrower opportunities[108].

The term *explicit* CSR refers to the corporate policies that assume and articulate responsibility for some societal interests that combine business value and issues. Because it is explicit it is also responsive to stakeholder pressure resting on corporate discretion [109]. *Implicit* CSR is the role of firms within a wider institutional setting of interests and concerns consisting of values and rules resulting in requirements for firms to address stakeholder issues on more collective terms[110]. Employment related CSR activities have been virtually absent on the corporate agenda in Europe because it is covered at a national level. This is

gradually changing with explicit CSR on the rise in Europe because, argues Matten & Moon, the political systems are changing as is the capacity of the welfare state due to issues of mass unemployment and fiscal stress making governments encourage CSR as part of a restoration process[111]. Although CSR is becoming more explicit in Europe there are still differences[112]: the European version is still, comparatively speaking, government driven with regulation urging the change on, as reflected by Danish legislation. Second, CSR initiatives are largely driven by industry associations via initiatives. Third, these initiatives are primarily concerned with environment and sustainability, and fourth, it is still mostly an issue for large companies in Europe as reflected in the Danish Financial Statements Act from 2008[v,113].

Stakeholders

Freeman revolutionised management thinking with stakeholder theory, positing that any group or individual that affects or is affected by business is a stakeholder and must therefore be taken into account when designing business strategies. Mitchell *et al*. state that a narrow definition look at stakeholders as having *direct relevance to the firm's core economic interests*[114] and "on which the organization is dependent for its continued survival"[115] – something which employees have in abundance. Freeman revisited his approach and emphasised that ST is a managerial approach rooted in practical concerns on how to become better at identifying, analysing and negotiating with key stakeholder groups[116]. Freeman & Buchholtz wrote that considerable attention is now being given to the stakeholder-employee– her status, rights, and satisfaction, because most adults spend the bulk of their daytime hours at work[117]. They continue that internal stakeholder issues include but are not limited to: sexual harassment, gender, age, smoking, religion, race, and pay. With the increase in O&O in the US and DK it is a logical next step in this plethora of issues.

Freeman states that "corporate survival depends in part on there being some 'fit' between the values of the corporation and its managers, the expectations of stakeholders and the societal issues[118]- The "central insight" is the "jointness of stakeholder interests"[119]. He stated[120] that the "stakeholder approach allows management to infuse traditional strategic analysis with the values and direction that are unique to that organization"[121]. Mitchell *et al*. elaborated on ST positing that identifying and determining the salience of stakeholders[w] is very important[122], a typology Carroll also used in his 2009 book. They hold that stakeholders can be identified by the following[123]:

1) *Power* to influence the firm

[v] Danish businesses can chose to have CSR or not but they *must* take a position on CSR. The businesses covered by the act have 1) total assets/liabilities of DKK 143 million, 2) Net revenue of DKK 286 million, and 3) and average of 250 full-time employees (see www.csrgov.dk)

[w] the degree to which managers give priority to competing stakeholder claims

2) *Legitimacy* of the relationship with the firm
3) *Urgency* of the stakeholder's claim on the firm

One or all can be present in a stakeholder, it is important to recognise that although a stakeholder may not hold much power over the firm, the legitimacy of her claim can make her very salient[124]. Mitchell *et al.* defines power as either *coercive*, *utilitarian*, *normative*[125]. Coercive power is physical resources of force or violence, utilitarian is material or financial resources, and normative is symbolic resources. The second attribute, legitimacy, is a "generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed systems of norms, values, beliefs, and definitions"[126]. Mitchell *et al.* continue that if the dynamics of a stakeholder-manager relationship must be captured, then urgency must be added. Urgency is defined as "the degree to which stakeholder claims call for immediate attention"[127]. In sum, "Power gains authority through legitimacy, and it gains exercise through urgency…Legitimacy gains rights through power and voice through urgency…with legitimacy, urgency promotes access to decision-making channels, and in combination with power it encourages one-sided stakeholder action. In combination with both, urgency triggers reciprocal acknowledgement and action between stakeholders and managers"[128]. These attributes are dynamic as stakeholders may acquire or lose one or more.

Determining the salience of stakeholders depends on the combination of attributes[x] and manager *perception*. Low salience or "latent" stakeholder possess by only one attribute, moderate salience or "expectant" stakeholders possess two attributes, and highly salient or "definitive" stakeholders possess all three[129]. Highly relevant is the expectant stakeholders sub-group, *dominant* stakeholders (possessing power and legitimacy) because it includes the *firm-employee relationship*[130] - any expectant stakeholder can become definitive by acquiring urgency through a powerful ally, i.e. the government, unions etc. Mitchell *et al*. continue that the most common occurrence is likely to be the movement of a dominant stakeholder into the definitive category. Employees are dominant stakeholders, they have legitimate claims on the firm whether they act on them or not. Dominant stakeholders have some formal mechanisms in place acknowledging them – such as a HR function that recognises the importance of the firm-employee relationship[131]. Employees can become definitive stakeholders by acquiring the last attribute: urgency. If that happens "managers have a clear and immediate mandate to attend to and give priority to that stakeholder's claim"[132].

In support of this, Freeman wrote that "Business can be understood as a set of relationships among groups which have a stake in the activities that make up the business… customers, …employees…and managers

[x] See Appendix 4

interact to create value" he continues "…if you take away the support of any stakeholder you simply do not have a viable business"[133]. Freeman *et al.*[134]argue that "the main goal of CSR is to create value for key stakeholders and fulfil our responsibilities to them". In the words of Mitchell *et al.* then ST holds the key to more effective management[135] and Freeman *et al*. posit that the concept of CSR needs to become more inclusive where business, ethics, and society are more integrated. This, he argues, can be obtained with greater stakeholder involvement. ST is important being so embedded in management practices: a firm has to know who its most salient stakeholders are, especially when engaging in CSR efforts that affects and is directed at the stakeholder so that they do not become a hindrance. Therefore, it is exceedingly important for the formulation of company strategy to include employees if the strategy is to have an effect.

CSR

Finding the right CSR theory was difficult as many are relevant but none covered the topic fully. But to bridge the gap a practical CSR theory was used showing the different ways to integrate CSR. Yuan *et al*. [136] highlight it looks at the *internal* "bundling of CSR initiatives and prevailing business practices", the middle section on figure 1 to the right[y] –important with the proposed focus in this thesis.

Figure 1: Integrating CSR Initiatives in Business

Using the core-periphery lens Yuan *et al.* look at the seven patterns of CSR adoption, they seek to bridge the gap between core routines and CSR strategy by ensuring a *fit*[137]:

1) *Born CSR oriented*: CSR is incorporated from the onset and CSR routines are established as "core" reducing internal fight for resources
2) *Patching (adding new CSR core routines)*: CSR elements interact with most of the current routines by changing some organisational practices, such as drafting ethics codes, training and encouraging employees to consider CSR in the decision-making process
3) *Thickening (creating new CSR routines as peripheral, core-extending practices)*: adding core-extending CSR activities to support/reinforce existing business or CSR routines
4) *Positioning (creating new CSR routines as independent peripheral practices)*: adding independent, peripheral CSR routines not central to firm strategy or operations; they do not exert much

[y] and Appendix 5

influence. Many CSR routines are intentionally independent, peripheral elements separated from core business routines

5) *Relabeling (recognising current routines as being CSR oriented)*: some existing routines already are CSR quickly "adding" to the portfolio
6) *Trimming (eliminating routines detrimental to CSR)*: reduce core and peripheral routines that have a negative effect on CSR, as a precursor to adding new CSR practices
7) *Cooperating (creating CSR routines through alliances)*: engaging in alliances with external partners such as NGOs and other stakeholder groups –lending credibility to the CSR efforts. These have grown in multitude, magnitude and importance

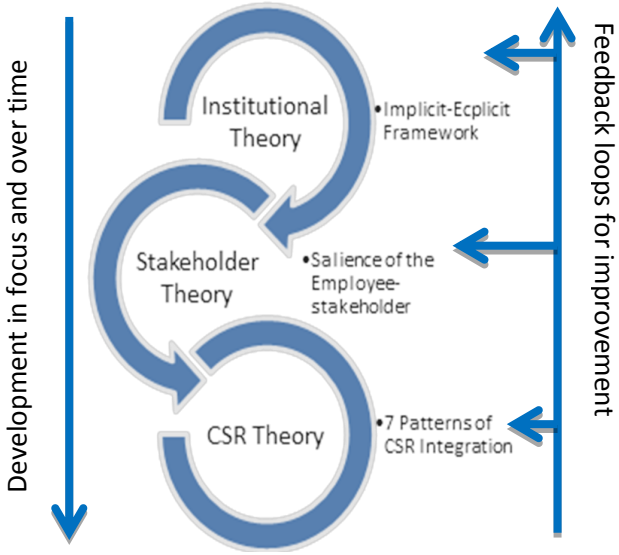
These patterns lead to different types of fit between CSR routines and core business and hopefully create better CSR implementation. Therefore, depending on the firm, its level of CSR integration and its ambitions it choses its CSR configuration. Yuan *et al*. posit[138] first, that not all organisational routines interact with each other. The practices not linked to core routines are independent practices and serve neither coherence nor internal consistency. Second, some practices reinforce each other leading to a high degree of coherence and internal consistency. Third, some practices interact with each other are clearly incoherent and inconsistent. These types of interactions may all exist in the same firm at the same time. This theory is used to identify the patterns Novo and SJM have used to integrate their health programmes. The above framework complements Porter & Kramer's perspective on strategic CSR as it also focuses on the internal fit rather than societal stakeholder demands. A strength is that it advocates looking at the complex interactions among existing routines where Porter & Kramer recommend the full integration of CSR initiatives without offering solutions on the *how*[139]. Furthermore, the internal consistency focus of this theory and the advocacy of connecting CSR initiatives with core elements complement the focus of medical firms on improving the health and wellbeing of employees.

Linking the theories

The chapter started with a short introduction on the connection between the theories, but further elaboration is needed. As can be seen in figure 2[z] below the three theories feed into each other to create a more coherent theoretical picture of the theory as applied to the thesis.

[z] and Appendix 6

Figure 2: Linking the Theories



The starting point is IT as all firms are part of an institutional context with rules and cultural backgrounds dictating behaviour, such as the difference in culture in DK and the US and the level of firm discretion regarding CSR. This pressure from external stakeholders forces firms to evaluate strategy, *how* and *whose* demands are catered to. In this thesis the *who* is the stakeholder-employee, which is why IT feeds into ST. ST determined the salience of the stakeholder-employee: as employees are *dominant* stakeholder with possibility of becoming *definitive* firms need to implement processes and structures to foresee and encompass their needs – even if it they are not yet articulated. This can be done via CSR and Yuan *et al*. determined the seven patterns of CSR integration. Having chosen the appropriate CSR integration type management can formulate strategies that match firm and stakeholder values and goals and adapt programmes. Formulating such strategies is a time consuming endeavour as many facets must be accounted for to ensure successful implementation and use. Furthermore, the feedback loop is important feeding into three places: 1) institutional and cultural contexts may change depending on where a firm does business. Therefore, what is needed or accepted may differ from country to country and thus needs to be country-specific, 2) salience levels of the stakeholder-employee is not stagnant and has to be revised, and 3) CSR integration forms may change over time along with ambitions and new types may be needed. Management must have their end-goal in mind throughout the entire process: improving O&O and welfare among employees to benefit the bottom line through improvements in presenteeism and absenteeism.

Critique

Focus is on the internal fit between the core business and CSR routines but achieving this can be difficult. Yuan *et al*. state that the fit is three-fold[æ] but such completely integrated approaches are rarely seen and having stakeholder buy-in is vital for the success of the initiatives. Yuan *et al.* state that organisational changes have ramifications throughout a firm and new CSR practices need to be analysed by taking into account the *entire* core routine system - a massive undertaking and understandable why so many leaders view CSR as too difficult to handle. So complex multi-layered firms such as Novo and SJM may have issues

[æ] See appendix 5

integrating CSR completely. Furthermore, a sole focus on CSR with an internal fit can come at the expense of an external fit. A key question is how to do it without upsetting the status quo. Few managers have neither got time nor the breadth of view to see the multitude of stakeholders and their salience levels. Even internal to a firm, employees may have different salience levels from the cleaning crew, shop worker to desk personnel and management.
One could even ask if a different approach and other theories would present a different picture: Organisational theory could have highlighted how the different parts of the firm strategy, finance, marketing, operations, human resources etc. could have collaborated to create CSR programmes. Porter said that involving stakeholders is not favourable, so excluding stakeholder theory could have yielded entirely different solutions. Had a political view of CSR been chosen just like Scherer & Palazzo then focus would not have been on internalising the demands and interests of stakeholders but on a move into the political sphere in order to respond to external challenges and focus would be on public discourse and stronger engagement in transnational processes in policy making[140].

Being new to CSR also means little information is found on the issue of O&O in the workplace, and its implications for firms. This could mean that sweeping assumptions might have been made forcing the topic in my own perhaps biased direction. However, to better potential false assumptions the next chapter looks that the data existing on O&O – first at country level drawing links to firms.

Summary

The identified gap in literature is bridged using three theories: IT, ST and CSR. These three theories feed into each other in such a manner that the gap is sought bridged from different angles. IT and the implicit-explicit framework describe how firms from different home contexts approach CSR, while ST proves the high salience of the stakeholder-employee and the need for firms to have a strong focus on her, CSR theory show the different ways a firm can integrate CSR initiatives.
While focus is on the internal bundling CSR initiatives as focus is the stakeholder-employee there is a chance that there will be a lack of fit with other firm initiatives, especially external ones – something that firms have to be careful with.

The following looks at O&O in DK and the US and how the case companies have approached this in their CSR initiatives.

Overweight & Obesity –Danish & US Contexts

Table 2: Days of Yearly Absence (thousands) Related to Overweight for ALL Employed Men and Women, Distributed on Age

Age	Men	Women	Total
16-24	63	56	119
25-34	191	155	347
35-44	252	224	476
45-54	284	229	513
55-66	238	163	401
Total	1,028	827	1,855

Source: Risikofaktorer og folkesundhed i Danmark

NB: The authors of the report have made a typo. In the total column for 25-34 year olds it should be 346.

Table 3: Extra Yearly Days of Absence (thousands) Related to Overweight for ALL Employed

	Men	Women	Total
Moderate overweight	629	632	1,261
Obese	399	195	595
Total	1,028	827	1,855

Source: Risikofaktorer og folkesundhed

NB: The authors of the report made a typo. In total number of obese, the figure is 594

The development of O&O in DK and the US respectively will be examined. For many years DK has heard about obesity in the US and the seemingly futile fight against it. Unfortunately, Denmark seems to partake as of late. The development of O&O is looked at in a temporal setting to see the "progress" over time and the estimated costs of O&O. First the Danish and then the American situation will be described. The chapter concludes by commenting on the observations.

Overweight & Obesity in Denmark

O&O has not been much of an issue in Denmark or one that has received much attention. But that changed a few decades ago with the rise of easily accessible fast food, longer working hours, and perhaps also the advent of reality TV. Juel *et al.* published *Risikofaktorer og folkesundhed i Danmark*[ø] in 2006 outlining 19 risk factors with consequences for national health and the socioeconomic situation; *inter alia* O&O. It states the reasons for and the consequences of being overweight or obese. The consequences are calculated in financial terms but also in terms of morbidity, mortality and quality adjusted life years (QALY). Although, the report state that much of the data is based on self-reported figures and may thus not be accurate - possibly underestimated - the interrelatedness of O&O and financial cost is interesting. It is one of the few works DK has on national health and risk factors making it very relevant. Between 1997 and 2001 the average amount of obesity related deaths was 1,348 per annum, with women accounting for approximately 2/3. It shows that the amount of these deaths increase drastically in the age group 45-54

[ø] Translated: Risk Factors and National Health in Denmark

years and even more so from 55-64 years, meaning that obesity-related deaths occur some 25 years too soon for men and 24 for women[141]. It is estimated that approximately 14,600 men and 61,500 women suffer from long-term morbidity as a consequence of O&O. Appendix 7 shows the hospitalisation over-propensity among overweight people compared with normal weight people distributed on men and women –the overweight have many more hospitalisations than the normal-weighted and nationally these figures translate into some 55,000 extra hospitalisations a year and that of all hospitalisations in DK[å], some 6% of them for women are attributed to overweight and for men the figure is almost 7%[142]. O&O also incur more contacts with the general practitioner (GP): on a national level, overweight-related contacts with the GP amount to an extra 1,2 million – approximately 3% of all contacts, most of which are in the age group of 35-64 years, as seen in the Appendix 9.

Hospitalisations, contacts with the GP and increased morbidity translate into increased absenteeism and presenteeism for firms. Juel *et al.* state[143] that the relationship between absenteeism and being moderately overweight and being obese is very significant for both men and women. Both table 2[aa] and table 3[bb] show absenteeism related to overweight – table 2 show the general absenteeism levels in DK for all overweight people in the working population and table 3 show the *extra* absenteeism days related to overweight. Nationally this means that in the Danish working population the overweight and obese have 1,8 million *extra* days of absence[144] and in the obese group one can see that men have twice as many days away from work than women. Another issue tshat arises is early retirement: page 178 of the report state that almost 5% of all health related early retirements for men, and 9% for women, are related to O&O, a high figure with financial repercussions for individual businesses and society as a whole[cc].

A study by Labriola & Lund[145] shows that if a firm wishes to reduce absenteeism caused by illness three areas must be targeted: smoking, obesity, and physical & psychosocial work environment exposure. They pointed out that absenteeism has great consequences for society, individuals, and employers – especially long-term absenteeism, as it may lead to permanent exclusion from the work force. Furthermore, the overweight and obese tend to suffer from psychosocial problems feeling ostracised from colleagues and society. Labriola & Lund noted that approx. 20% of employees accounted for 80% absenteeism, a figure based on the 3.792 employees that participated in the study and the 23.792 days of illness reported with 60% of the participants having ≥1 day of illness[146]. While a low statistical significance between absenteeism and influence & development possibilities was found, it was left in because its correlation with other

[å] See Appendix 8
[aa] See Appendix 10
[bb] See Appendix 11
[cc] See Appendix 12

factors was strong. Considering stakeholder theory the Labriola & Lund study found that this point in and of itself is not significant, employers still have to take it into account in CSR efforts as it *in conjunction* with other factors is very significant. Furthermore, the study showed that if the self-reported sense of health was low it often was a strong predictor of absenteeism; a view supported in the *Helbred, trivsel og overvægt blandt danskere*[dd] report from 2010. Therefore, when designing a CSR strategy it needs to encompass features that may not seem relevant but in fact influence the overall success, examples like Novo and the food in the canteen. It is concluded that, *inter alia*, absenteeism can be reduced through a variety of preventative efforts directed at smoking, obesity and physical & psychosocial work place exposures. Adipositasforeningen[ee] was interviewed for an article[147] stating that operations or consultations with a dietician do not help because they do not attack the underlying issues – therefore, long term treatments with a psychologist is recommended, much like that that alcoholics and other addicts receive. An obese person's need for food resembles an alcoholic's need for alcohol which is why cognitive behavioural therapy is recommended especially in the light of budget cuts and operation had totalled a quarter of a billion annually. A Politiken article [148] points out that Ninna Thomsen, Mayor of Health and Care in Copenhagen, wishes to start a project where nursing and cleaning staff at nursing homes in the municipality of Copenhagen will three times a week for 20 minutes at a time exercise *during* their workday. The initiative was created in dialogue with the union FOA[ff], and was conceived because absenteeism and illness levels among sosu[gg] employees in 2011 averaged 19.8 days, much higher than the average. Exacerbating this is the fact that half of all female FOA-members are overweight or obese and more than one in four report that they suffer from one or more long-term illnesses. Related to this, a pilot project was carried out in Valby, Copenhagen: scepticism among employees was high from the onset; however, as the training began participants became enthusiastic[149]. A preliminary review of the project deemed it a success but with a caveat: the training had to be *during* the workday, as many of the employees were single with children and did not have the necessary surplus energy or time to train later. This project proved that an increased focus on the health and wellbeing of employees carries with it many rewards. A Berlingske Tidende article[150] stated that the obesity epidemic in DK seems to surprisingly have plateaued[hh], much like the US. Although the figure is high there are regional differences: Aalborg has seen an increase in overweight people and Copenhagen has seen a fall.

[dd] Translated: Health, Well-being and Overweight among Danes
[ee] Translated: The Danish Association for Obesity
[ff] FOA: The Union for Public Employees
[gg] Sosu: social and healthcare employee
[hh] Based on an analysis of data collected from 8,000 people published in the Danish "Ugeskrift for Læger" (Weekly Journal for Doctors)

The Financial Costs of Obesity in Denmark

Table 4: Socio-economic productions costs calculated by the *friction* method (calculated as yearly current value using a 5% discount rate, million, 2005-DKK

Production loss by the friction method				
	Absence due to illness	Early retirement	Death	Total
Men				
16-24	28.2	0.5	0.1	28.8
25-44	577.1	7.5	3.5	588.2
45-64	683.0	18.3	23.7	725.1
≥64	2.4	0.1	0.0	2.5
Total	*1,290.8*	*26.5*	*27.3*	*1344.6*
Women				
16-24	18.1	0.2	0.0	18.3
25-44	343.2	9.2	3.1	355.5
45-64	350.3	25.6	19.2	395.1
≥64	0.3	0.1	0.7	1.1
Sum	*712.0*	*35.0*	*23.1*	*770.1*
Total	**2,002.7**	**61.5**	**50.4**	**2,114.6**

Source: Risikofaktorer og folkesundhed i Danmark

Table 5: Socio-economic productions costs calculated by the *human capital* method (calculated as yearly current value using a 5% discount rate, million, 2005-DKK

Production loss by the human capital method				
	Absence due to illness	Early retirement	Death	Total
Men				
16-24	28.2	152.3	17.0	197.6
25-44	577.1	556.1	250.3	1,383.6
45-64	683.0	584.8	630.5	1,898.3
≥64	2.4	0.0	0.0	2.4
Total	*1,290.8*	*1,293.2*	*897.9*	*3,481.9*
Women				
16-24	18.1	53.4	7.6	79.1
25-44	343.2	600.9	206.6	1.150,7
45-64	350.3	753.6	474.3	1,578.3
≥64	0.3	0.0	0.0	0.3
Sum	*712.0*	*1,408.0*	*688.5*	*2,808.4*
Total	**2,002.7**	**2,701.2**	**1,586.4**	**6,290.3**

Source: Risikofaktorer og folkesundhed i Danmark

Juel *et al.* estimated the annual cost of obesity to be 1,625 million DKK[151]. It was based on hospitalisations and payments of health care benefits. However, it was impossible to calculate outpatient contacts or hospital emergency contacts, underestimating the actual total cost to the health care system. It was noted that people with normal weight more often volunteer for surveys and that the data potentially underestimated the actual number of overweight and obese people[152]. That said the report is still very relevant giving a good picture of the Danish situation.

Premature death due to obesity increases the health care system costs with circa 87 million DKK. However, said premature death also translates into future savings as the deceased no longer uses its services, amounting to 239 million DKK. However, the net cost totals 1,473 million DKK[153]. Two distinct methods were used to calculate costs: friction & human capital methods. The friction method calculates the production loss three months after the exit and the human capital method calculates the cost of production loss as a consequence of people exiting the

working market placing people on par with other production factors.[154]. Many 25-64 year olds leave the job market due to obesity related illnesses. Furthermore, 43% of the production loss is caused by early retirement, 25 % by death and 32% by absenteeism due to illness – men causing the majority of the loss[155]. Using the friction method then overweight causes a socio-economic production loss totalling 2,115 million DKK, see table 4[ii], with *95% of the production loss is caused by absenteeism due to illness*; early retirement accounts for 3% and death the remaining 2%[156].

As can be seen in table 4, the 25-64 year olds and men account for the greatest percentage in terms of total production loss. But the loss is matched by annual savings in future consumption as a consequence of early death – calculations are 2,540 million DKK. Using human capital method, production loss totals 6,290.3 million DKK[jj]. A large part of the loss is caused by overweight 25-64 year olds who have to terminate their connection to the working market due to illness - 43% is caused by early retirement, 25% by death, and 32% by illness[157]. All in all O&O accounts for about 2% of all deaths, a loss of approx. 30.000 life years. The WHO estimated that in 2000 around 10% of male deaths and 12% of all female death in developed countries could be attributed to obesity[158]. Juel *et al.*quote an obesity study in the EU estimating that approx. 6.9% of all deaths in DK are related to obesity - the EU average is 7.7%[159]. They found that in DK circa 2% of all deaths are due to overweight – a discrepancy that only serves to emphasise calculation difficulties. Furthermore, the study found that the correlation between BMI and mortality is U-shaped with increased mortality for under- and overweight individuals compared to a person within the normal weight range[kk]. Table 6[ll] to the left shows the development of moderate overweight and obesity from 1987 to 2009. The obesity development especially was striking with the number of obese having more than doubled since 1987. The moderately overweight rose until approx. every fourth woman and second man were overweight[160]. Juel *et al.* note that several foreign

Table 6: Development in the Share of 25-44 Year Olds and 45-64 Year Olds Moderate Overweight and Obese Danes (BMI≥25). 1987-2009. In Percentages

	Men		Women	
	25-44 years	45-64 years	25-44 years	45-64 years
	Moderate Overweight			
1987	31.7	46.1	10.8	24.3
1994	33.4	49.5	17.1	26.2
2000	37.7	48.5	20.5	29.8
2005	37.9	47.2	23.9	27.5
2009	40.8	48.4	24.4	31.3
	Obese			
1987	4.8	8.1	3.3	8.7
1994	7.6	12.0	4.0	10.7
2000	7.8	13.8	9.1	10.6
2005	10.6	13.9	11.3	12.2
2009	11.8	16.7	12.9	14.3

Source: Helbred, Trivsel og overvægt blandt danskere, p. 64

[ii] And Appendix 13
[jj] And Appendix 14
[kk] BMI: 18.5-24.99
[ll] And Appendix 15

studies have found that slight overweight had a somewhat "protective" effect[161], as also commented in the Economist[162].

The following examines Novo's CSR efforts regarding employees. It is based on information from Novo's web site and information given by Martin Kristiansen, Global NovoHealth Manager.

NovoHealth Efforts

Novo measures its social performance on three dimensions: improving care for people whose health care needs are served, developing employees and ensuring healthy and safe work environment, and third making a positive contribution to the communities in which it operates[163]. This is where *the Way* enters the picture. It is the firm's values-based management system framing ten essentials and how they are put into action. The essentials[mm] comply with the principles for responsible business conduct in the UN Global Compact[164]. It covers 13 key areas[165], *inter alia*, business ethics, finance, and people. According to the 2011 Annual Report business is run following the TBL. It states that "Recognising that long-term business success relies on a healthy economy, environment and society, we manage our business in a way that addresses multiple dimensions of performance: financial, social and environmental"[166]. The report continues that the "corporate priorities reflect initiatives in support of business objectives as well as broader sustainability goals….offering an inclusive, healthy and engaging working environment…helps attract, motivate and retain employees and that is critical to sustaining our company's growth…"[167]. This is underlined in the video *The Novo Nordisk Way*[168] where the CEO stated that "The main foundation for Novo Nordisk is the Triple Bottom Line, because that is what's protecting our license to operate, our license to innovate, our license to be a business. And that begs and obliges everybody working in the company not only to see to that we become a good business - that's the financial bottom line – but that we do so in a way which is socially and environmentally responsible. So all these three dimensions are important and all employees in the company can one way or another find something they can do in their everyday life to ensure that the company moves in that direction." He continues "can you create one, global culture which builds on the same values in so different national and cultural contexts. And it seems like we have been able to do it over the last ten years, and this gives us of course great hope that we will be able unite people around a set of values, an ambition and a direction, which will engage them for the next ten, fifteen, twenty years". Therefore, linking the TBL with the creation of a global culture by focusing on employee wellbeing is a constructive way to enhance employee loyalty and productivity while improving the bottom-line by controlling costs such as absenteeism and presenteeism. Furthermore, it is stated in "Additional

[mm] See Appendix 16

Information" that Novo's aspiration is to become the best company to work for[169], placing onus on Novo to be innovative when focusing on employee satisfaction.

There are many ways to do it; one is through health. NH is meant to prevent type 2 diabetes and other lifestyle-driven diseases and it started as a Danish undertaking in 2004, when in 2006 it was decided that a global strategy should be formulated. January 2008 NH was implemented globally at a large event for Novo's 300 top managers. Novo has now announced that NH is available to 80% of all employees[170]. Part of the decision to go global was, according to Mr Kristiansen[171] that as an organisation Novo wishes to combat type-2 diabetes through prevention. Mr Kristiansen also emphasised that prevention and health are issues often articulated internally and externally and as a company Novo feels the importance of being a front-runner.

On the web[172] NH is introduced with[nn] "NovoHealth – healthy employees equal a healthy company" and has four key health areas 1) providing healthy food and beverages in the workplace and encouraging a healthy diet, 2) providing access to and encouraging employees to do physical activity, 3) providing smoke-free work environment and highlighting the benefits of non-smoking, and 4) providing access to and encouraging a health check with individual advice every second year. NH is implemented in major affiliates[oo,173] and is combined with campaigns such as *Count your steps* and *Know your numbers*[174]. The first was completed in 60 countries and served to increase awareness of physical activity – together employees walked the earth 6.5 times; the latter was an awareness campaign focusing on knowledge and the importance of health checks. Moreover, NH will "help drive a very high engagement amongst employees"[175], but ensuring participation in NH is a difficult topic and only encouragement can be provided. Mr Kristiansen does not have the figures on how many uses the initiative globally as management decided to *not measure* any impact making it a pure lifestyle programme and a service to employees. Mr Kristiansen pointed out that indirectly everyone who eats in Novo canteens participate due to their nutrition guidelines[176]. Novo's efforts targeted at employees have paid off: in 2009 Novo took first place and became *Denmark's Healthiest Company*. The panel of judges stated that "Novo Nordisk has developed and refined a solid concept around health, which brings Novo Nordisk to the forefront amongst the most visionary and thorough"[177], continuing that NH is about attracting and retaining talented people…offering a work place that supports a healthy lifestyle.

Although Novo decided to not measure the impact a glance at the Annual Report could clarify the issue. The overall absenteeism figures in 2009, 2010, and 2011 were 2.4%, 2.5%, and 2.3%, respectively[178]. Without context this does not mean much, but pre-NH absence rates were 3.2% (2005), 3.0% (2006), 2.7%

[nn] See Appendix 17

[oo] Incl. Japan, India, China, Germany, the USA, France, Brazil, Turkey, Poland, Italy, the Gulf region, and DK

(2007) and 2.2% (2008)[179]. This shows a steady decline from before the implementation of NH indicating that NH may have worked – a sweeping assumption to make but nevertheless *something* changed. In terms of employee turnover the figures were 10% (2006), 11.6% (2007), 12.1% (2008), 8.3% (2009), 9.1% (2010), and 9.8% (2011). A difference in the Engaging culture (employee engagement - scale 1-5) can be seen with increases every year from 4 (2006) to 4.3 in 2009 where it remained to 2011. Any connection with the implementation and expansion of NH remains speculation, but it may have played a role in the positive figures.

Although O&O is not a focal area Novo wishes to establish a presence there[pp,180] as it is a major contributor in developing type-2 diabetes. Novo's medicinal focus concentrates therefore on gaining regulatory approval for antiobesity medications and is exploring the use of the anti-diabetic drug liraglutide, and Victoza[181]. It stands to increase sales potential to 22 billion DKK – very telling about the magnitude of O&O.

Overweight & Obesity in the USA

Information on O&O in the USA is gathered both at country- and state-level highlighting geographical issues and indicating where efforts should be focused. In the following the state-level figures is used to see where the problem is greatest followed by the country-level figures used for the comparison with DK.

According to Nayga Jr., Americans lead the world in body mass with only 19% within the recommend weight range and 18% underweight[182]. A Businessweek article writes that soon obesity will overtake smoking as the greatest health challenge[183], bringing in its wake a "tsunami of preventable diseases" increasing the financial burden. The obesity figures are taken from CDC[184] and the O&O evolution has been terrible; see table 7 below[185]: no state had an obesity percentage above 14% in 1985,[186] but already by 1995 27 states had a percentage between 15-19% and 23 states had between 10-14%. By 2000, 22 states had an obesity percentage between 20-24% and already in 2001 the first state had an obesity percentage of 25-29% - this was also the last year a single state had an obesity percentage of "just"10-14%. By 2005 three states had a percentage ≥ 30%. This figure had risen to 12 states in 2010 – and no state had an obesity percentage < 20%. An alarming development and Appendix 19 shows the development at selected years to show how quickly the US gained weight. While the figures tell a sad story of the individuals– O&O is a problem for society at all levels: federal, state, community and the business. In 2010 more than 1/3 of the American population was obese. According to an article by Hellmich it seems that the extreme growth in obesity has tapered off, as there has been no significant change in recent years[187]. The article continues that in 2010 35.7% of U.S. adults (around 78 million people) were obese – up from 27.5% in 2000 but not

[pp] See Appendix 18

Table 7: Obesity Trends Among US Adults 1985 and 2010

Obesity Trends* Among U.S. Adults; BRFSS, 1985
(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
Alabama	Arizona	Georgia		
Alaska	California	Indiana		
Arkansas	Connecticut	Kentucky		
Colorado	Florida	North Dakota		
Delaware	Idaho	Ohio		
Hawaii	Illinois	South Carolina		
Iowa	Minnesota	West Virginia		
Kansas	Montana	Wisconsin		
Louisiana	New York			
Maine	North Carolina			
Maryland	Rhode Island			
Massachusetts	Tennessee			
Michigan	Utah			
Mississippi				
Missouri				
Nebraska				
Nevada				
New Hampshire				
New Jersey				
New Mexico				
Oklahoma				
Oregon				
Pennsylvania				
South Dakota				
Texas				
Vermont				
Virginia				
Washington				
Wyoming				

Source: BRFSS, CDC.

Obesity Trends* Among U.S. Adults; BRFSS, 2010
(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

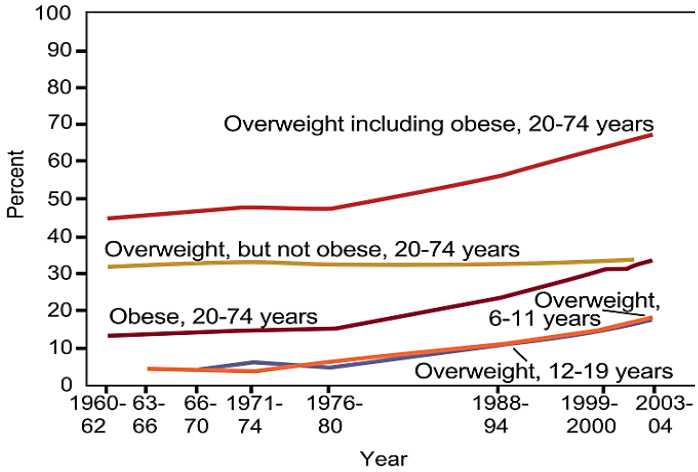
No Data	Less than 10%	10%-14%	15%-19%	20%-24%	25%-29%	Greater than or equal to 30%
				Alaska	Delaware	Alabama
				Arizona	Florida	Arkansas
				California	Georgia	Kentucky
				Colorado	Idaho	Louisiana
				Connecticut	Illinois	Michigan
				Hawaii	Indiana	Mississippi
				Massachusetts	Iowa	Missouri
				Minnesota	Kansas	Oklahoma
				Montana	Maine	South Carolina
				Nevada	Maryland	Tennessee
				New Jersey	Nebraska	Texas
				New York	New Hampshire	West Virginia
				Utah	New Mexico	
				Vermont	North Carolina	
				Washington D.C.	North Dakota	
					Ohio	
					Oregon	
					Pennsylvania	
					Rhode Island	
					South Dakota	
					Virginia	
					Washington	
					Wisconsin	
					Wyoming	

Source: BRFSS, CDC.

Source: Centers for Disease Control and Prevention

significantly different from the 33.7% in 2008. In another article[188], Donna Ryan, president of the Obesity Society, states that obesity levels in the USA may have plateaued for now, but "to level off at 34% obesity is no great achievement. It is still very, very alarming". The article also states that generally speaking obesity has levelled off; but obesity among males is increasing. Furthermore, based on predictions from the American Journal of Preventive Medicine, Melissa Healy wrote[189] that by 2030 42% of Americans will be obese, see Appendix 20 and that the cost will add up to $550 billion over the next two decades. Wang *et al.* add that with the shift in age structure (baby boomers growing older) projections suggest that in the USA there will be as many as 65 million *more* obese adults compared to 2010[190]. This is an enormous financial burden and one that will also narrow the employee field. Health Economist Eric Finkelstein is quoted: *Even small improvements in obesity prevalence…could result in substantial savings*. This is where businesses enter with, i.e. workplace promotion of health. A LA Times article[191] states that combating the "obesogenic" culture in the USA requires "sweeping changes across all aspects of daily life", continuing that "Workplaces…should 'increase the support structure' for obesity prevention, diagnosis and treatment and for encouraging healthful behaviors such as regular exercise, healthful eating…", making O&O a business concern. Moreover, obesity costs are projected to double every decade until it accounts for 16-18% of total US health care expenditure. Not unreasonable considering that in 2003 the annual *extra* medical costs of obesity were estimated at $75 billion and accounted for 4-7% of total health care spending[192]. A Finkelstein

Graph 1: Overweight and Obesity – Development from 1960-2006 and in Different Age Groups



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*, Figure 13. Data from National Health and Nutrition Examination Survey

study found that US employees annually missed work ranging from 0.5 more days in men who were overweight to 5.9 more days in men who were classified grade III obese[qq] as compared with men of a healthy weight[193]. This emphasises a need for business intervention. Calculating production loss due to presenteeism is very difficult but as an estimation the annual cost of presenteeism in men who were obese in the USA equalled a month of lost productivity and cost employers $3,792 annually[194].

With obesity projected to increase so will sequelae. Based on historic trends projections are that there will be in excess of 8 million cases of diabetes, 6.8 million coronary heart disease and stroke and more than 0.5 million cancer. The historical data also project an increase in annual medical costs from treating O&O and obesity-related disorders of $28 billion per year by 2020 and by $66 billion per year by 2030 - $22-66 billion increase in health-care spending representing a 0.8-2.6% increase from the 2.5 trillion spent on US health-care in 2009. Top contributors are arthritis, coronary heart disease, and diabetes incurred predominantly by the ageing population[195]. However, more recent data suggest there will "only" be excess of 6 million cases of diabetes, 5 million coronary heart disease and stroke and more than 400.000 cancer[196]. Wang *et al.* continue that this obesity trend may translate into a loss of 24.5-48.2 million QALYs in the USA from 2010 to 2030. They set up three future scenarios[rr]: scenario 1 where past trends continue unabated and two each addressing the question: what would be the health and economic effect of ameliorating the obesity trend?[197] Scenario 2 has its point of departure in a 1% reduction in BMI across the entire population roughly equalling a 1 kg weight loss for an adult of average weight. Compared with scenario 1 a 1% reduction would avoid 2.1-2.4 million cases of diabetes, 1.4-1.7 million cases of cardiovascular diseases, and 73.000-127.000 cases of cancer and an approximate gain of 16 million QALYs. The 1% translates into a net caloric reduction of 20kcal per day sustained for 3 years. Scenario 2 is more aggressive and harder to achieve: a return to 1990 levels. Wang *et al.* state that the UK Foresight Programme has valuable lessons to teach the USA

[qq] See p. 7
[rr] See Appendix 21

because defining the size of the problem can raise awareness and political will to address it[198]. As seen on graph 1[ss] the scenarios need to be taken seriously as the development in all age groups has been astounding and the projections 2010 to 2030 staggering[tt].

In the following, SJM and its efforts is gone through. Unfortunately, it is based solely on information garnered from SJM website.

LiveWell Efforts

SJM identifies is stakeholders as people around the world "who impact or are impacted by our business"[199], using Freeman's broad definition. A key stakeholder is employees. They are important because "The success of our business depends on the contributions and engagement of our employees" [200] it continues that the primary area of focus regarding employees are: personal development, inclusion, health and safety, competitive compensation and benefits.

As part of the stakeholder-employee view SJM offers benefit packages that vary by country, with benefits designed to provide resources to help protect and support employees and their families[201]. Part of the benefits is the LiveWell programme[uu,202]. It provides health screenings, assessments and coaching with rewards for employees who participate incl. a reduction in annual health insurance premiums. It offers employees the ability to participate in various health programmes including physical activity, online health programmes, smoking cessation, group weight management programmes, and access to comprehensive information on wellness. The programme itself is, however, *only available for benefit-eligible US employee* [vv] - in line with explicit CSR where firm discretion is at the centre. Employee participation in the programme has increased from 2010 to 2011 with a percentage of the total eligible population from 28% to 34%[203]

Graph 2: SJM Employee Composition

[ss] And Appendix 22
[tt] See Appendix 23
[uu] See Appendix 24
[vv] US. Employees: 65.1% of all

maybe due to the rewards. Varying from location and division SJM also pays a part of one's health club membership or has on-site fitness facilities[204]. Apart from having its own programme SJM is part of American Heart Association's (AHA) *Fit Friendly* companies where they support walking as a driver of health[205].

The CSR report lists on page 21 graphs showing the employee composition: *Employees by Age*, *Employees by Job Category*, and *Total Employees by Gender* are interesting in the thesis. The graphs above show that the vast majority are between the ages of 30 and 49, approx. 1/3 of the work force is in production and it is almost 50-50 in terms of the gender composition[ww]. Wang *et al*. note that shifts in age structures are a potential problem for the US. The mentioned Hellmich article state that obesity levels in men and boys is increasing, and seeing as 54% of the SJM work force is male and the fact that more unskilled labourers have a tendency to being overweight or obese - SJM has to consider activation. Furthermore, Juel *et al*. stated that the majority of the production loss comes from 24-64 year old and men in DK[xx] – perhaps a parallel can be drawn to the US situation as well.

Observations & Comments on the Danish & American Situation

Both countries show big increases in O&O over time with the US starting early. Although the US still has higher obesity prevalence, DK unfortunately is seeing a negative development in this area. While O&O in DK has not reached the same levels as the US nor is it as highly a discussed topic – the government calls for firms participate more.

Granted O&O is not the most discussed when talking of CSR, it should be though - especially considering a study that concluded that the economic burden of obesity worldwide accounts for 0.7%-2.8% of a country's total health care costs, and the obese had medical costs 30% higher than those of normal weight[206]. Wang *et al*. mention a study by Withrow that says that obesity is conservatively estimated to account for up to 2.8% of health-care expenditure but that the actual costs are likely to be higher[207]. O&O is not merely a US problem nor one of generalisations; the EU estimated that the combined direct and indirect costs in 2002 were roughly €33 billion a year[208]. Productivity suffers too. The Economist writes that obesity "lowers workers' productivity and in the longer term raises the risk of myriad ailments"[209].

Geography also plays a role in O&O: one sees that Southern USA (≈29%) suffers most, followed by the Midwest (≈28%), the Northeast (≈25%) and the West (≈24%)[yy] – and in DK the west suffers more than the

[ww] And Appendix 25
[xx] See pp. 34-35
[yy] See APPENDIX 26

east[zz]. The Economist quote a Tulane University study that projected that in 2030 the global number of obese people may double to 3.3 billion, having vast implications for individuals, governments, and employers. It states that in 2008 about 1.5 billion adults worldwide were overweight or obese and in rich countries the share of the population that gets insufficient exercise is more than twice as high as in poor ones[210]. The article continues that "Mothers spend more time at work. Food companies push their products harder…heavily processed foods may have helped increase obesity rates. Softer foods take less energy to break down and finely milled grains can be digested more completely, so the body absorbs more calories". The article continues that obesity is the illness that since 1990 has grown faster than any other and in women a high BMI is the third largest driver of illness.

Nayga also pointed out that socio-demographic factors play a part in the distribution of weight across the nation[211]. The figures are from the 1990s but the observations are interesting: among the more exposed are women who have given birth due to hormonal changes and changes in lifestyle and blacks are more likely to be obese than whites. According to the US Department of Health and Human Services, about 10% of non-Hispanic black men and 20% of non-Hispanic black women are severely overweight compared with just 7-.7% and 9.9% for non-Hispanic white people[212]. Men are less likely to be overweight and people with lower education are more likely to be overweight than higher educated individuals. Furthermore, the Danish Business Authority published a simple equation for calculating the direct costs of illness absence: *Number of employees*7 days of sickness absence*pay per day = annual cost of illness absence*[213]. Although merely a calculation of direct costs and not the indirect ones, then knowing the direct costs involved one may also reduce indirect ones: costs of employing substitutes, delivery problems, decreased productivity & quality, re-organisation of work, augmented workload for colleagues increasing the risk of stress, and difficulties in recruiting and retaining employees.

O&O and sequelae incur many direct and indirect costs. Direct costs are medical costs related to managing obesity-related disorders, hospitalisation, excess use of ambulatory care, and long term care[214]. Indirect costs include, *inter alia*, decreased years of disability-free life, increased mortality, early retirement, disability pensions, absenteeism, and presenteeism[215]. Albeit individual estimates vary, many suggest that that the monetary value of lost productivity is several times larger than medical costs. But calculating costs, even direct ones, is quite an exercise. But compared with normal weight people, the obese incur 46% increased inpatient costs, 27% more physician's visits and outpatient costs, and 80% increased spending on prescription drugs[216]. Combining this with the 2011 study that Wang *et al.* quoted, a gloomy picture emerges: In 2008 approximately 1,46 billion adults were estimated to be overweight and of these 502 million were obese[217]. While it seems it has stabilised in some populations the consequences are still grave.

[zz] See p.33

Societies are burdened by increasing costs brought on by premature mortality, increased morbidity, and lost productivity. In 2003, the annual extra medical cost of obesity in the US were estimated at $75 billion and accounted for 4-7% of total health-care expenditure. On the same note the European Union estimated that in 2002 the combined direct and indirect costs of obesity amounted to roughly €33 billion a year[218]. The Economist[219] stated that governments of course can do something to promote healthier living, but not much. Obesity is in many ways the result of personal choices but considering it is a *global* epidemic, then as commented by the Economist "Millions of people, of all cultures, did not become lazy gluttons at the same time, en masse". Trying to be proactive the Danish government imposed "sin" taxes on fatty and sugary foods in 2011, to no avail and it was abandoned one year later – it might have had more success if an equivalent reduction on fruit and vegetables had been implemented. What can then be done? Again the Economist comments[220]: governments should ensure that parents do not overfeed babies, teach children to eat healthy and give them time to run around, urban planners should make streets and pavements friendlier to cyclists and pedestrians, taxing sugary, fizzy drinks and limiting the size of their containers, like Philadelphia and New York have done. But does this reach in to the heart of the matter? No. What can firms do then? Both Novo and SJM have chosen to focus on health checks, physical activity and smoking cessation in their programmes. Easing the access for employees seems a good way to promote healthier living.

The following chapter takes the above issues into an analysis of what can be done and thus answer the RQs.

Discussion & Analysis

"Under the conditions of globalization, the strict division of labour between private business and nation-state governance does not hold anymore"[221] posits Scherer & Palazzo. They hold that there is a widespread understanding of CSR as compliance with societal expectations that business has begun to assume a state-like role and by default have become important players in the global industry[222]. According to them the main causes behind the expansion of CSR is the division of power between business and government coupled with the growing pressure of civil society actors[223]. Which is where CSR and O&O is found.

On the basis of IT the role of firms is seen to now encompass issues previously having pertained to the realm of governments. As Scherer *et al.* stated then the strict division between firms and governments does not hold anymore especially when looking at the development of O&O in both DK and the US and the rise of costs - CSR is thus an appeal to enlightened self-interest: the TBL of economic, social, and environmental performance. Porter *et al.* describe it, as "companies should operate in ways that secure long-term economic performance by avoiding short-term behaviour that is socially detrimental"[224]. They posit that successful corporations need healthy societies and vice versa; therefore many issues are addressed in CSR policies but the challenge is finding those that match competencies and contribute to the bottom-line.

Although a reiteration, the analysis would have benefitted from interviews and surveys at Novo and SJM, but without sufficient access to either firm their websites, annual reports and other documents are used to grant a picture of their health oriented CSR.

This chapter is divided into three parts, each addressing a RQ using theory and examples from the case companies. Closing each part is a sub-conclusion contributing to the thesis conclusion later on.

RQ1: With overweight & obesity on the rise should firms engage in CSR programmes targeting the stakeholder-employee?

Having demonstrated that strategic CSR is beneficial, then to answer the main RQ stakeholder theory is used as base with questions on how to ensure healthy and happy employees, why O&O should be targeted and who the at-risk employees are to guide the discussion.

Porter *et al.* are hesitant involving stakeholders, as firms then cede too much control. They admit that stakeholder views are important, but they can never fully understand the corporation's abilities, competitive positioning, or its trade-offs[225]. However, it seems that they overlook the employees. They carry out firm activities and are intrinsically involved with firm success. They do, to a large extent, know the limits and strengths and they do need to be satisfied to ensure retention, loyalty and hard work. Because today's work force is more mobile and less loyal with trust in employers having eroded over the past 20 years a new *social contract* between employers and employees exists[226]. They seek competitive pay, benefits, and employers who recognise them, so to avoid retention issues the stakeholder-employee must be taken into account. In line with this Dawkins *et al.* highlight that employees are "one of the most important spokespeople for a company in the eyes of other stakeholders"[227] and continue that for CSR programmes to have any impact they must be aligned with their expectations[228]. Therefore, Freeman poses the question *how can we be sure our employees are healthy and happy and are able to work creatively so that we can capture the benefits*…?[229] - very relevant considering the stakeholder-employee salience level.

WBCSD[230] has a "fundamental belief that a coherent CSR strategy, based on sound ethics and core values, offers clear business benefits" –it has a bottom-line pay-off because business and society are interdependent. In its stakeholder dialogues WBCSD selected quotes mirroring the stakeholder-employee focus[231]: "The employees are the company's most valuable resource – they must take care of them to maintain a healthy business" and "It's about business contributions to better living conditions for its employees and the community that it operates in". These underline the importance of caring for employees – even if it is only in self-interest. Thus emphasising the importance of keeping the stakeholder-employee happy. The thesis CSR definition[ææ] also emphasises this by working *with* stakeholders in the pursuit of sustainable economic development. Freeman writes that if you take away the support of any stakeholder you simply do not have a viable business[232] - he comments that from a managerial perspective if trade-offs are sought then the "sweet spot" will not be found[233], so it is in the firm's best interest to have an integrated strategic approach to CSR working with stakeholders to minimise conflict and maximise quality. Freeman continues that "Stakeholders that are difficult to please, critics, employees who push back, even conflicts of values, all can be sources of value creation, when approached with the 'no trade-offs' mind set of managing for stakeholders"[234]. He quotes the CEO of Medtronic[235] that "Serving all your stakeholders is the best way to produce long term results and create a growing and prosperous company…there is no conflict between serving all your stakeholders and providing excellent returns for shareholders. In the long term it is impossible to have one without the other. However, serving all these stakeholder groups requires, discipline, vision, and committed leadership", because no stakeholder "stands alone in the process of value creation"; he continues that the "primary responsibility of the executive is to create as much value as possible for stakeholders". This thesis holds that attention to employee health and wellbeing through O&O focused CSR initiatives will help pave the way towards this goal, and keeping them happy requires continuous improvement. Exactly what should be done vary from firm to firm.

But a more in-depth discussion on firm engagement in CSR is needed to explain the business case to business leaders (with responsibilities to shareholders to increase profits) why CSR is good for business. David Grayson[øø] identified nine ways a firm benefits from CSR[236], *inter alia*, *employees & future workforce*, *operational effectiveness, risk management, direct financial impact, organisational leadership,* and *macro-level sustainable impact*. The first covers productivity, recruitment, satisfaction, and loyalty; i.e. responsible business practices that positively affect employees' working life. Operational effectiveness covers improvements and innovation in the practices and processes of an organisation, creating more effective operations and higher levels of efficiency. Risk management is improvements to an organisation's ability to

[ææ] See p.5

[øø] He is the director of the Doughty Centre for CSR at Cranfield School of Management

identify and reduce exposure to risk, as well as preparing for and managing it better. Direct financial impact is benefits in access to capital, reducing costs, and improved shareholder value. Organisational leadership covers being a leader by helping society resulting from a change in internal corporate values and external market rebuilding. Macro-level sustainable development is defined as the impact and responsibilities a firm has to further economic, social and environmental issues. These are all areas that managers are used to dealing with on a daily basis to augment efficiency and earnings, therefore, the way it is done is perhaps the "only" difference as an integrated CSR approach is useful.

Another who weighed in on why CSR is good for business is Carroll. He listed both the pros and cons of CSR[237]; the *con* list shows:

1) Firms hold one responsibility: maximising owner/shareholder profits
2) Firms are not equipped to handle social problems and managers do not possess the expertise
3) CSR dilutes a business' primary objective
4) Businesses already wield too much power
5) Loss of global competitiveness
6) Many consumers do not have the means to support companies with a CSR focus, so CSR initiatives are not rewarded and the business case falls[238]

The *pro* list shows:

1) Ward off government regulation
2) Let business try
3) Business has the resources with a reservoir of management talent, functional expertise and capital
4) Proactive is better than reactive
5) The public supports CSR, making it a smart investment
6) Enlightened long-term self-interest

While the arguments against CSR have merit they are short-sighted. The Friedmanite argument was presented at a time when the world was simply different. The world is now very linked with easily digested and circulated information. Firms have direct effect on the environment and the communities in which they act and any wrong-doing is easily discovered. As stated by Scherer *et al.* this model of business and society integration may work in a world where state institutions are actually "able to predict problems and conflicts in society, to formulate regulations *ex ante*, and to enforce legal rules and contracts through the legal and administrative system"[239]. Moreover, Friedman's assertion fails to recognise the potential long-term negative effects of the maximisation principle and many governments simply do not have the

legitimacy, money or power to act socially, so why not fill that void if you are a business for added power, goodwill or market share? The DAP seconds this by stating that firms' "voluntary effort may represent a useful – and oft needed – supplement to legislation. Because legislation alone may not be enough to solve the complex challenges in our society"[240], recognising that governments alone cannot lift the full burden of social responsibility, that a more inclusive approach is needed, and as part of daily activities firms can *help alleviate* social ills. Scherer *et al*. argue that the role of business is already becoming politicised. They suggest that in the globalised world the known division of labour is redundant[241] and in the course of this development some firms have taken on a state-like role: making CSR politicised and the decline in state governance is partly compensated for by new forms of governance such as firms, international organisations and NGOs[242]. The issue that companies and managers are not equipped to handle social concerns is short sighted as they are used to handle employees and manage their concerns. The third argument states that CSR dilutes the primary objective, which could be correct with ill-conceived non-strategic CSR. However, in this world of conscientious consumers CSR efforts can be a positive competitive factor, as many stock exchanges worldwide have discovered[åå]. The fourth argument of power also has merit; but governments can and do control business via legislation and incentives and in the complex world of global politics and the pressure put on by NGOs then the concept of CSR has expanded and with it the role of the involved parties[243]. The fifth argument "lost competitiveness" is only true if firms do not, as stated previously, have a coherent, consistent CSR policy that fits with the firm's internal and external strategies and stakeholders.

But then why target O&O? For one, O&O is a current and important area. A group of Danish researchers completed a study[aaa] on focusing on the costs of abdominal fat[244] basing their calculations on the size of the adipose tissue depots that are connected to serious health problems. In the study four models are developed, of which the "simple model" (SM) and the "simple model, no confounders" (SMNC)[245] are used. It found that subjects with increased or substantially increased WC were more likely to have co-morbidities than subjects with normal WC. The SM showed a highly significant association between health care costs and people with above normal WC range. The SMNC showed that women with increased WC incur additional costs of 1.25% for every added cm above 80 cm, annually. For men the impact is even greater with an added cost of 2.8% per cm above 94 cm WC[246]. In USD the average annual cost of a woman *without* co-morbidities and a "normal" waist line is circa $1,814, but *with* co-morbidities the *future* annual cost increases to $2,242. The average annual future health care costs for a woman without co-morbidities and a

[åå] Stock exchanges such as FTSE4Good and Dow Jones Sustainability Index are "green"

[aaa] Based on: 31,840 pax aged 50-64. They had baseline health status, lifestyles & socio-economic assessed at entry. Individual data on health care consumption and associated costs were extracted from registers for the subsequent 7 years (1996/1997-2003/2004). 15,344: men & 16,506: women

WC of 85 cm or 95 cm are $1,938 or $2,211, respectively[247]. This means that a woman with a WC of 95cm, compared with a woman of a normal WC, will incur added future costs of $397 per annum – 22% higher. For women with co-morbidities the cost would be approximately $491 per annum. For a man without co-morbidities an increase in WC to 109 cm corresponds to an increase in health care costs of 39%. The study came to the conclusion that the incurred health care costs associated with increased WC were substantial. In DK in 2005 the total health care expenditure constituted 9,1% of GDP and in the US 15,3%[248]. The study found that the correlation between WC and health care costs is stronger for obese men and the rise in costs with increasing WC is higher for people with co-morbidities. It is also noted on page 151 that the calculations *only* relate to health care costs, but more costs are incurred, leaving the figures *underrepresented*: "…obesity is associated with absenteeism, unemployment, social stigmatization, and discrimination"[249] suggesting that preventative measures targeted at those with a risk of increased WC will likely result in cost savings to society business. Furthermore, the WHO has published maps showing the global prevalence of obesity in 2002, 2005, and 2010 in males[bbb] and females[ccc] showing that more populations are moving in to the area of O&O.

In table 2 one sees that the yearly days of absenteeism related to overweight for the 25-66 year olds in DK totals 1,737,000 days – a monumental cost to firms. With the US cost adding up to $550 billion over the next two decades[ddd] the business community needs to act preventatively to control risks and costs – underscoring the need for further research into this and the role of business.

There is a degree of uncertainty regarding figures with discussions revolving around on whether there will be net cost savings with a reduction in obesity levels. Wang *et al.* bring forth various points on the subject[250]: some point out that a reduction in obesity levels will lengthen an individual's life-span and thus incur increased costs over the entire lifetime and especially in age-related treatments (dementia etc.). Other researchers have pointed out that a 20-years old obese individual might incur lower costs over her lifetime than a normal weight adult of the same age because of her roughly 5 year shorter life expectancy. Yet another analysis has shown that lifetime medical costs in the USA are much higher in obese adults. Wang *et al.* point out that there is a key distinction between the projected lower lifetime health-care costs for an obese individual compared with a person of healthy weight and the higher costs for an obese population at a specific time or during a particular period: an obese population will incur greater health-care costs at a particular time than a lean population of the same age distribution –a preventable cost. It is emphasised that, although prevention may not be a cure for increasing expenditures, it may be a cost-

[bbb] See Appendix 27
[ccc] See Appendix 28
[ddd] See p. 39

effective cure for much mortality and morbidity[251] - having a positive effect on national expenditures and business costs.

One issue is definitely cost, but a Berlingske Business article quoting the Wall Street Journal state weight can be a hindrance in promotions due to prejudice[252]: 750 leaders were interviewed and the thought was that if one is disciplined and structured enough to exercise and eat healthy it extends into the work realm and vice versa. Professor Posner of Santa Clara University supports the findings due to stereotypes[eee]. Considering the obesity prevalence in the US there is interestingly enough a hatred of fat as mentioned on page 12. These opinions are detrimental to the obesity fight, as many think that the obese can "just" change their habits. Reuters/Ipsos[253] conducted an online poll of 1.143 people where 61% of the respondents said that O&O was caused by "personal choices about eating and exercising". Because many think that it is due to poor choices they also think that insurance companies have a right to charge obese more for health insurance, explaining why SJM offers reductions in premiums for LiveWell participants. But this stigma can also explain some of the psychosocial problems many obese suffer from. In the USA *only* Michigan and a few cities have outlawed the practice of denying obese people jobs or refusing to rent them an apartment[254], this in a population where 2/3 is overweight or obese.

Lately though, the perception of what is a "normal" weight has changed. Gallup conducted a poll in the US asking "what is your ideal weight"" and "How much do you weigh" in 1990 and 2012[255]: In 1990 men answered that they ought to weigh 78 kg but in 2012 it was 84 kg – the average weight among the men was 89 kg. Women have also increased their ideal weight by 5 kg. Professor Arne Astrup[fff] is not surprised by this as the ideal weight increases with the average weight of the population and when 80% of the US population is overweight and 34% of them obese then the remaining 20% look skinny[256]. Combining this with the 1.625 million DKK annual costs of obesity and the 1.8 *extra* days of absence from work in DK[ggg] and the US face similar problems with the annual *extra* medical costs of obesity amounting to $75 billion and a month of lost productivity[hhh] then not targeting O&O could have severe detrimental effects on productivity and the bottom line. It is a difficult area but creating a conducive setting for weight loss is the most effective way to combat obesity as changing the environment has the greatest effect, according to the Institute of Medicine. The business community can be a very powerful player.

To Claire Herrick of King's College London the connection between CSR and obesity is long overdue. Though her article focuses on the F&D industry, her observations are still valid in a broader context. She states that CSR is connected to obesity via three claims: health and wellbeing may be used as a way of securing brand

[eee] See p. 12
[fff] Head of Department at the Department of Nutrition, Exercise and Sports at Copenhagen University
[ggg] See pp.33-35
[hhh] See p. 39

value and consumer goodwill, that CSR has been used to promote and reinforce existing epidemiological renditions of obesity, shifting blame from food to diet to sedentarism with consequences for the individuals and population groups that make "inappropriate" choices, and third as a defensive and innovative response to avoid government regulation and has thus taken a health and sports promotion role[257]. Herrick's first claim is an area all firms wish to excel in – as increased brand value and consumer goodwill translate into more sales. The second fits with the Reuters/Ipsos poll and the perceptions that exist with regard to O&O. She states[258] that the promotion of health is oft based on the assumption that "most respondents know what constitutes a healthy diet [but] lack awareness of what such general information means in practice". People need to challenge preconceived notions and through interaction and disseminating information help others. Firms can also step in by spreading information, serving healthy food, letting employees purchase it as "take-away", or encouraging fitness activities. The third claim has been discussed on page 47. However, lack of knowledge is not the only reason for obesity; socio-demographic factors play a role too. Therefore, when designing and implementing a CSR strategy focused on O&O it must be targeted at the at-risk stakeholder-employees[259]. This is supported by the authors of *Den Nationale Sundhedsprofil 2010*[iii] in DK[260] placing pressure on firms to work out a strategic and well-functioning programme targeting appropriate employees without alienating them or others. Although generalising, Nayga completed a study to assess the impact of socio-demographic traits and the possibility of obesity: results indicated that those with children have an increased likelihood of being obese because pregnancy and child rearing changes lifestyles with regards to physical fitness activities[261]. Nayga writes that lower levels of physical activity has a profound effect on the body because cravings are nature's way of counteracting a lack of energy output[262] - making employees with a long commute and children at risk. Furthermore, as written on page 43 then some ethnic groups are more disposed to O&O as well as manual labourers. While this is controversial and there may be more at risk employees, it is important knowledge when designing CSR focusing on reducing O&O in the work place.

Sub-Conclusion

In the discussion it became clear that CSR can have positive effects on a firm and the bottom line. A strategic CSR programme can get a firm buy-in from many stakeholders – from the employee to the government. It can be used in a strategic positioning and differentiation strategy with focus on *internal* CSR – it is useful when it comes to not only attracting and retaining the best employees but also one of branding compared to competitors.

[iii] Translated: The National Health profile 2010. It was written by the National Health Service of Denmark

As demonstrated in the discussion above and in chapter four the rise in O&O levels have severe financial consequences for firms – the percentage of people becoming overweight or obese has, although perhaps momentarily plateaued, reached high levels and with this more sequelae have come along which translate into more illness and absenteeism from work and lower productivity levels. Moreover, as shown on pages 25-26 the stakeholder-employee salience is dominant with potential to become definitive[jjj] – a stakeholder group that holds both power and legitimacy in its claims. The stakeholder-employee may not necessarily act on this but if she becomes too dissatisfied she can ally with i.e. a union and acquire urgency and become definitive, in which case that firm *must* react. But a firm can do much *preventatively* through CSR to attain and maintain employee loyalty and ward of regulation among these is a focus on O&O.
In sum, to protect itself and its stakeholder-employees firms should look at expanding their CSR portfolio to buffer its bottom line from problems and its employees - if done with a win-win approach seeking synergistic value creation while serving the stakeholder-employee and itself success occurs. This thesis finds that yes, firms should target O&O via health oriented CSR initiatives targeting O&O. A perhaps easy start is, like Novo and WDC, looking at the food served and encouraging fitness by paying part of memberships like SJM.

Having demonstrated that targeting O&O among employees should be done from a firm perspective the next section looks at whether a firm has a right to do so.

RQ 1.1: Considering CSR, its inherent vagueness, the role of internationalisation and personal lifestyle choices do firms have a right to implement CSR initiatives targeting O&O among stakeholder-employees?

The implicit-explicit framework is used to see the context firms operate in and the level of discretion firms have had when designing CSR programmes to determine "right". This is looked at on a base of an increasing international orientation and trade. Second, ST is used to further cement to need for an employee focus followed by a short discussion on the right of the firm to engage.

Having concluded that firms should engage in initiatives targeting the stakeholder-employee, there are still issues. Porter *et al.* [263] comment that many companies have done much to improve the social consequences of their activities but that they have not been productive for two reasons: they pit society and business against each other when they are interdependent, and second, they pressure companies to think of CSR *generically* instead of what is most appropriate for firm strategy – leaving a "hodgepodge of uncoordinated CSR…disconnected from the company's strategy that neither make any meaningful social impact nor strengthen the firm's long-term competitiveness"[264]. It may also become a *hodgepodge* if done half-

[jjj] See p.26

heartedly because of insecurities with rights or needs. Porter *et al.* talk of shared value between business and society; and in turn shared value between business and employee – the choices must benefit both sides. Therefore, integrating a social perspective into its core framework is a must to understand competition and guide business strategy[265]. Novo has, for example, made systematic use of stakeholder dialogue as a part of its TBL [kkk] to "address key areas of our business and building and maintaining good relations"[266]. Long-standing engagements are used to build trust & understanding on different issues, monitoring trends and reconciling dilemmas - with solutions being more successful. Being in an exposed industry medical firms need to maintain good relationships with stakeholders. When building its NH programme Novo engaged an advisory panel wherein doctors helped define the most important areas along with top management - an expert panel, but considering the fact that NH is targeted at employees, no representatives took part. So while Porter *et al.* do have a point that stakeholders do not know the business fully, one could posit that the targeted stakeholder should be consulted just as SJM did when they collaborated with the Page family[267].

While targeting O&O is perhaps a logical next step in the US where they, as posited by the *implicit-explicit* framework, have had more discretionary power than European firms and high levels of O&O; then lately Danish firms have begun to adopt a more explicit CSR version, why is that? An expectation from the onset was that Danish firms would be less involved with CSR than US firms simply because Danish law has encompassed many facets covered in the CSR programmes of their US counterparts. Matten & Moon posit that the answer to the CSR *type* lies in the respective national business systems moulded by political systems, financial markets, education and labour systems, and culture[III,268]. On the basis of this, US firms have developed a much more *explicit* version of CSR and CSR language; whereas in Denmark and Europe in general a more *implicit* version has been used and the language of CSR only recently adopted. Regardless of this, *explicit* CSR is spreading because firms use it to position and brand themselves. Therefore, Danish firms need to learn to use CSR, its language, and formulate strategic CSR policies of their own. Furthermore, privatisations in services have also pushed the spread of explicit CSR by placing greater societal pressure on firms. Matten & Moon point out that European explicit CSR is comparatively speaking government driven[269], as evidenced by Danish legislation, and with *explicit* CSR being new in DK, it is expected that Danish firms are hesitant and somewhat unaware of how to "do" it. A point of view also reflected in the DAP where a Capacent Epinion from 2007 showed that 39% of Danish businesses find it hard to put the idea into practice lacking the knowledge and tools to do so[270]. Moreover, perhaps it is also *where* to focus

[kkk] Novo stakeholders: patients, customers (healthcare providers & payers), employees, investors, suppliers and other business partners, neighbours and other key publics
[III] See pp. 23-24

the attention – after all, it has to be done well and in a way that differentiates a firm from competitors and benefits itself. The DAP[271] states that DK has focused on businesses' social commitment in the context of a socially inclusive labour market; something of keen interest when it comes to O&O and the stereotypic perceptions that exist.

Varieties of Capitalism propose two types of capitalist production regimes[272]: coordinated market economies (CME) and liberal market economies (LME) – with CMEs denoted by patient capital supporting long-term employment relations, such as DK; and LMEs denoted by a lack of patient capital leading to short-term employment relation, such as the US. This is seen in Novo and SJM as Novo offers NH for all employees and SJM LiveWell for the American benefit-eligible employees only, which also ties in with the implicit-explicit framework. But Brown & Knudsen posit, quite differently, that firms' CSR strategy do not necessarily have much to do with the national political context in which a firm originates, suggesting that CSR type has more to do with the firm's international orientation, the sector it operates in and its size[273]. Usually, internationally oriented firms are more focused on securing international competitiveness rather than managing domestic initiatives and use CSR to do this. They also found that large firms are more likely to seek out internationally oriented CSR for competitive advantage. The industry plays a part too, especially *exposed* industries such as pharmaceuticals. They also found that pharmaceutical firms are generally very internationally oriented. This is demonstrated by the fact that a mere 1% of Novo turn-over originates in DK[274] and SJM US sales represented 47% of its worldwide net sales in 2011[275]. Danish firms have adopted CSR programmes for a variety of reasons *inter alia* government pressure and the need to compete in an international market characterised by increased competition and where a well-thought out CSR strategy can be the defining trait. A third reason is trade with the US. *Danmarks Statistik* shows that Danish export to the US has increased until it in 2010 placed fourth behind Germany, Sweden, and the UK[276]. Furthermore, Novo has focused its efforts on the US, and the Danish Ministry of Foreign Affairs adjusted its expectation of Danish exports to the US because of the success of pharmaceutical exports[277] - an increase of 44% equivalent of 6.4 billion DKK. Danish export to the US totalled 20 billion. With Danish exports to the US in mind and the fact that the US has been at the forefront of explicit CSR this may have prompted Danish interest – and in the case of Novo and SJM being in an exposed industry it functions as risk management. It seems that CSR truly is enlightened self-interest making the terms of business favourable regarding branding and the goodwill of the market, governments, NGOs, consumers and employees. In other words, strategic and recurring CSR can and must lead to an improvement in long-term competitiveness, profitability and growth[278]. Again much CSR is, as seen above, outward focused but having a strong external CSR strategy can strengthen the internal strategy, and underline the validity and of having CSR initiatives and employee acceptance of such as status quo.

Interestingly, Scherer *et al.* propose to analyse corporate responsibility from a world order where the labour division is not stable and the economic globalisation creates challenges that exceed the capabilities of any single state[279], further highlighting the expanding role of business as well. As stated in the introduction, Yuan *et al.*[280] wrote that to integrate CSR initiatives and to maximise outcome, the new CSR set should have a three-fold fit[mmm]: coherent, internally and externally consistent, and in the end contribute positively to business and social performance[281]. Although CSR initiatives need to fit the organisation, many still see it as divorced from business operations and do not attempt to *routinise* it[282]. Since the success of any new undertaking depends on linking it with existing practices and routines the challenges to implementing CSR may lead to inadequate cross-functional coordination and ultimately weak performance if not failure to achieve societal and corporate goals[283]. Moreover, if the business case is held as minimum then the success must at least outweigh the costs of implementation. Yuan *et al*. posit that successful implementation of CSR routines may require clear performance measures and related incentives to enhance employee commitment that go beyond simply institutionalising CSR as core values[284]. This presents problems because how does one measure and draw the link between employee weight loss, increase in well-being and increases in efficiency levels? As mentioned, Novo chose to *not* measure links between NH and employee efficiency or decreased absenteeism: it is meant to prevent diabetes and other lifestyle-related illnesses[285] - risk management. Whether SJM measures linkages is unknown, but does offer various incentives to participate[nnn].

Box 1: Key Benefits of CSR – found by Ethical Corporation

Ethical Corporation, September Magazine Issue, p.40

1. Brand value and reputation improvement of the value of the brand and/or the reputation of the brand or organisation
2. Employees and future workforce affecting the working life of employees, and the ability to attract and hold on to talent: employee motivation, productivity, recruitment, satisfaction, retention, engagement, and loyalty.
3. Operational effectiveness: improvements and innovation in an organisation's practices and processes as a direct result of being more responsible and sustainable, creating more effective operations and higher levels of efficiency.
4. Risk management improving the organisation's ability to identify & reduce exposure to risk, and prepare for and manage risks better.
5. Direct financial impact direct benefit to the financial performance of an organisation. i.e. improving access to capital, reducing costs, and improving shareholder value.
6. Organisational growth an opportunity for overall organisational growth derived from being a responsible business, whether through new markets, new product development, lateral expansion, new customers, or new partnerships/alliances.
7. Business opportunity new opportunities or innovation generation created for all stakeholders specifically because of their efforts in being a responsible business. This can result in new business development, but critically it is about win-win opportunities for a variety of stakeholders.

To be continued.

[mmm] See Appendix 5
[nnn] See p. 41

Key Benefits of CSR – found by Ethical Corporation

Contd.

In addition, there were two new categories of benefit that emerged in the most recent years covered by the review.

- **Organisational leadership** – defined as "leadership achieved through helping society" which results from a radical change in the internal corporate values and external market reconstitution.
- **Macro-level sustainable development** – defined as "the impact and responsibilities an organisation has to higher level economic, social and environmental issues".

Using explicit CSR can benefit firms internationally but certainly also *internally* as employees become more aware of the efforts put in by their work and augment buy-in because a reality is *created* around being a "good firm". When said efforts are directed at themselves they may feel more valued and perform better wanting to keep benefits. As shown, the stakeholder-employee is very salient being *dominant* having both *power* and *legitimacy* in her claims on the firm[ooo]. By aligning with external partners she can acquire *urgency*, if she feels her rights or needs are not met. The pharmaceutical industry depends to a high degree on employees with a higher education. These are often aware of their rights and ensure that receive their due. Furthermore, being highly salient consulting them could be a determining success factor in CSR initiatives, so that they are properly targeted and received in order to be beneficial to firm and employee alike. Carroll *et al.* organise firm benefits into the four categories[286]: cost & risk reduction, gaining competitive advantage, developing reputation & legitimacy, and seeking win-win outcomes through synergistic value creation. The first argument state that certain CSR activities will reduce costs and risks i.e. CSR activities and policies directed at reducing negative environmental impact or investing in employee training and well-being, can cause lower turnover and absenteeism, and increased loyalty. So why should a firm not carefully construct CSR policies targeting O&O among employees? In terms of gaining a competitive advantage it is to be understood in the context of differentiation[287]. Carroll *et al.* see stakeholder demands as opportunities rather than constraints, where Porter *et al.* prefer to control and limit stakeholder influence[288]. *Ceteris paribus*, if stakeholder demands are not met it translates into lost customers, suppliers, opportunities and employees.

As can be seen in Box 1 the key benefits are highlighted among which also is a focus on employees, risk management, direct financial impact and business opportunities. These tie in with the different frameworks offered by scholars through which improvements to the daily running of the business, firm bottom line and the employee welfare and loyalty can be improved. As Carroll *et al.* see it if companies strategically manage their resources to meet stakeholder demands then they are also able to use the opportunities associated with them to benefit the firm, such as increased loyalty[289]. With competitive advantage as differentiation, then the CSR strategy should be unique and enhance relationships with stakeholders. The developing reputation & legitimacy argument is used when promoting CSR as a licence to operate. Firms focus on

[ooo] See pp. 25-26

creating value by leveraging reputation & legitimacy and gains by aligning them with stakeholder interests. Using opportunities by bringing together the different stakeholder demands can lead to synergistic value creation and win-win situations. Starting, implementing, and maintaining interactive and constructive relationships with stakeholders are about creating these win-win situations – where stakeholder demands are satisfied and business pursues its operations while profiting from them. Effective CSR is directed at improving stakeholder relations and welfare[290]. Carroll *et al.* write that "it will not be too long before we can begin to assert that the business of business is the creation of *sustainable value* –economic, social and ecological"[291]. In support of this, the Economic Intelligence Unit completed a major survey which results suggest that the vast majority of US business leaders concede that there is a clear correlation between CSR performance and financial performance[292]. Concluding that it is unavoidable and using it strategically will have a positive effect on the bottom-line in the short-, medium-, and long-run.

Previously, people of higher education have been "exempt" from being overweight or obese as their knowledge of what constituted a healthy lifestyle was high, again here findings are contradictory: a report say that the inequality health wise between people of lower education and a higher education has increased the past 23 years[293], but another article quote Statens Institut for Folkesundhed[ppp] stating that people of higher education are becoming more overweight[294]. A Berlingske Tidende article[295] says that the obesity epidemic in DK is halted but that it, much like the US, is still at a high level. Regardless, O&O is a problem for people of all social and income levels. Of course targeting O&O is a sensitive area as people have a right to lead the life they desire, even though it negatively affects them. In that sense the efforts by both Novo and SJM are well thought out *offering* participation in their health programmes and by giving incentives. The voluntary nature of the programmes is at this point in time vital; the O&O aspect is still too new to be embedded in peoples' perception. Looking at the previously sensitive topic *smoking* then the "market" for prohibiting smoking at work took close to a decade until it was accepted as natural - underlining that change in perception takes time and hard work.

Sub-Conclusion

The vague nature of CSR can actually be construed as a firm strength, as firms can mould it to fit goals and initiatives as well as using it to gain acceptance of why O&O is targeted via health oriented CSR initiatives – as part of a broad range of internal and external initiatives. Of course as emphasised many times, CSR must be thought of strategically to reap the benefits and because otherwise it may be perceived as "green washing" whereby stakeholders at all levels and salience lose confidence it the firm.

[ppp] National Institute of Public Health

Implementing O&O targeted CSR initiatives may have slow beginnings but it will help change the culture and environment at work and over time more can join helping to create a sense of belonging and a positive self-enforcing reality. It can also create a proactive reality where more employees participate to make themselves and their colleagues healthier. This is an important factor considering the psycho-social issues the obese often suffer from.

Apart from the time factor and investments then as also discussed having a CSR strategy focussed on the stakeholder-employee and O&O can be good business by preventatively decreasing costs related to absenteeism and presenteeism. Based on the costs, the expanding responsibilities of firms, and the many benefits of CSR listed they do have a right to implement CSR initiatives targeting O&O among employees insofar as it is done without coercion or having employees feeling ostracised if they do not participate. This should be prevented via a verbalisation of being part of a healthy firm. Luckily such incentives also benefit employees. Regarding lifestyle choices, people do indeed have a right to live, eat and exercise as it pleases them. However, firms can become a facilitator for good choices by making it easy and accessible and thus gather more followers to programmes.

Furthermore, branding and international trade also mould business actions and with CSR being increasingly used to do so it can help firms gain a competitive advantage by differentiating them.

With this in mind the thesis moves on to look at why and how integration occurs and how Novo and SJM did.

RQ 1.2: According to theory how can CSR initiatives targeting O&O be integrated and which approaches have the two case companies adopted?

Answering this requires a look at Yuan *et al.*'s framework as well a looking at other initiatives. The CSR integration choices of Novo and SJM are found using the mentioned framework.

CSR must be strategic for a company to reap the benefits - it is going beyond best practices, doing it differently from competitors by lowering costs and serving stakeholder needs best, and by unlocking shared value by investing in social aspects to strengthen competitiveness[296]. Porter *et al*. make an interesting point, that creating shared value should be viewed as R&D: long-term investment in the future competitiveness[297]. Thus investing in employees' physical and mental well-being, by focusing on O&O to reduce absenteeism, presenteeism and augment employee efficiency, loyalty and general wellbeing is key. But to ensure success a structure for the implementation process and execution must be in place before it begins, constant monitoring to ensure issues are solved before they become a problem, and a feedback loop to ensure that it does not become stagnant in the long-run is needed – there are many ways of doing it. Much of the foundation for this should already be present the form of "soft laws" such as codes and

standards, like SJM's Code of Business Conduct and Novo's *The Way*[298]. Being voluntary and company-initiated they are advantageous: non-threatening to a firm and have the potential to create substantial significance in the CSR agenda, flexible and easily adaptable, and a necessary tool to improve corporate behaviour. Of course the effectiveness depends on, *inter alia*, the influence of stakeholders, achievability, fit to company activity, and the mechanisms in place for implementation, monitoring and compliance[299].

Many firms have taken a stance on obesity, health and prevention recognising the increasing problems with O&O worldwide. The Walt Disney Company (WDC) has taken drastic steps regarding childhood obesity with the *Magic of Healthy Living* initiative (MOHL)[qqq,300]. While childhood obesity is outside the scope of the thesis, it is interesting: not allowing food or drink ads with unhealthy amounts of sugars and fats on programming targeting children and families and reducing sodium in meals[301]. Interestingly, Disney chairman and CEO Roger A. Iger said that the initiative "…is not altruistic. This is about smart business" and that health food for children had already become "a very, very solid business"[302]. In a press release the WDC stated that it had decided to reduce sodium levels even more from its 2006 initiative and starting the *Mickey Check* tool on licensed food products, recipes, and menus[303] - branding and differentiating itself from competitors. MOHL came in the wake of the New York City proposed ban on drinks larger than 16 oz.[rrr] to reduce Americans' caloric intake, eliciting a veritable storm of opinions, from the beverage industry labelling it "misguided", to people wanting to decide for themselves[304]. New York City Mayor Bloomberg is behind the initiative as a part of a broader campaign against obesity. The proposal stated that in New York City 58% of adults and 40% of city public school kids are obese or overweight[305], and that simple things such as controlling sodium and sugar content served in food at work can have an effect. Novo has implemented food guidelines as part of its NH programme and via this it covers all employees who eat in the canteen also with healthier less energy dense food[sss]. One in many ways of implementing initiatives targeting O&O via meals.

Yuan *et al*.'s framework uses the core-periphery approach to see how CSR integration occurs with the type of adoption depending on ambitions and the level of integration needed/desired[ttt]. It is vital, however, to ensure that the *fit* exists. As described Novo and SJM have approached CSR from two different angles targeting the same area – a difference probably due to home context[uuu].

[qqq] See Appendix 29
[rrr] 16 oz. = ½ litre
[sss] See p. 9
[ttt] See pp. 27-28
[uuu] See pp. 22-24

Novo has for many years had an integrated annual report and via its policies it encourages the employees to *walk the talk*. Part of making employees aware of the initiatives and the direction management wishes Novo to take is through the verbalisation of the codes and initiatives to engage employees. Through this verbalisation of being a healthy firm and of being healthy employees a reality will slowly be constructed whereby more will join. Without having interviewed employees it is difficult to ascertain how empowered they feel, how aware they are of The Way and the 10 essentials, or how/if they manage to incorporate this into their daily work life and if they make use of the NH programme's facilities. The annual reports and the e-mail correspondence with Mr Kristiansen have given insights into the workings of Novo.
It seems as if Novo uses two strategies: patching and thickening. *Patching* is adding new CSR core routines making them interact with most current routines, these are part of organisational practices such as drafting codes this places NH in line with the TBL, the 10 essentials, and The Way. *Patching* is a good first as achieving full integration from day one requires extensive planning and training of employees and management – if not a "revolution" of company culture. Novo started NH in DK in 2004 and in 2006 it was decided to define a global strategy; this was rolled out in 2008. This makes the second pattern *thickening*. This is when one adds core-extending CSR practices to support or reinforce existing business or CSR routines. Mr Kristiansen stated in an e-mail from October 26, 2012[vvv] that the reason for implementing NH is to prevent the spread of diabetes and other lifestyle illnesses; he continues that Novo as a firm wishes to fight diabetes on all fronts and one of the most important roles in the control of diabetes 2 is prevention. Therefore, as a company Novo wishes to lead by example via the NH programme – tying this CSR routine closely with the core competency of Novo. Even though the programme is voluntary the majority participates in the programme if they eat in the canteen.

Unfortunately, less is known about SJM making a similar analysis difficult. But one could argue that it being a US firm it has probably engaged in CSR activities for a while; however, it seems they published their first CSR report in 2010. So finding out exactly when and how SJM began its CSR journey is difficult to see but it has had ISO 14001[www] for a while. SJM's framework for sustainability focuses on performance, product, planet and people. From an observational standpoint SJM seemingly also has two modes of CSR integration: patching and positioning. *Patching* is, much like Novo, because the health focus via LiveWell fits the health focus of SJM as a medical firm. Furthermore, part of patching is the formulation of ethics codes etc. and encouraging the stakeholder-employee to consider CSR in her decision making process. SJM gives each new employee a copy of the code and she is expected to know it. The code is always available on the intranet and electronic versions are distributed annually to ensure that it is adhered to and considered in

[vvv] See Appendix 30
[www] Environmental management systems.

decisions[306]. *Positioning* is using peripheral CSR routines not central to operations or strategy, they are not very influential. SJM, unlike Novo, has separate reporting on CSR indicating that CSR is not as integrated as one could have expected from an American firm. It must be mentioned that if they are they intentionally independent from core routines it may have been done to augment the flexibility of the CSR initiatives and to be able to change them as external or internal demands vary - a strategic position in and of itself.

Sub-Conclusion

A purely external focus on CSR reduces the potential of the initiatives to contribute to performance although there has been a tendency to do so. An internal focus also helps tie initiatives to core competencies, strengthen the validity of the initiatives and the CSR bundle. Both Novo and SJM have acknowledged the need for inward looking initiatives to strengthen the bundling and focused on the stakeholder-employee. They have chosen each their approach depending on the integration level desired and the context they originate in – with Novo seeking a more encompassing version incorporating nearly 80% of employees and SJM for the eligible US employees only. As seen several forms of integration can be in place in a firm at the same time – some initiatives may be newer than others and not as integrated and other initiatives may deliberately kept separate from the core to augment flexibility. Novo and SJM have approached the integration of CSR differently focusing on those that fit with the firm structure and the national context. The seven different fits depend on the focus, context and ambitions firms have and choosing the right one(s) depends entirely on the firm with success determined by the level of integration, buy-in and in the thesis case, participation. This is a success factor because if it is done well interest is created, involvement ensues, and the concept is strengthened.
Interestingly, SJM claim a strong focus on CSR yet it has chosen a version less connected with the rest of firm strategy and more loosely coupled perhaps to allow for greater flexibility to change but mentions it AHA participation[xxx]. Novo is much more through pushing the TBL, The Way, the essentials, and the Global Compact membership so as to thicken the bundling of initiatives and create a more coherent strategy. Furthermore, finding the fit is vital to target the right stakeholder-employees while offering the initiatives to all. Attracting, maintaining and retaining the "happy employee" important for firms to drive up efficiency and driven absenteeism down – of course it must be done in conjunction with the stakeholder-employee to ensure cooperation and not place pressure on the employee by letting them feel stigmatised if the "right" results are not achieved.

Having discussed, analysed, and answered the RQs the thesis closes with the conclusion and future perspectives.

[xxx] See p. 41

Conclusion

Without having had access to SJM or much access to Novo to interview employees or managers a full understanding of the motives behind the implementation of CSR programmes targeting health and O&O, which factors have been discussed or even why employees have not participated in the process may have hampered the discussion and analysis forcing assumptions to be made. Determining success as well is a problem. Still, annual and CSR reports as well as the e-mail correspondence with Mr Kristiansen have illuminated the topic to a satisfactory degree so the analysis and conclusions drawn are not based solely on assumption.

Having reviewed the data available it can be concluded that while CSR is said to be an important part of the business process it may not be the full truth. Novo does seem to have been able to integrate CSR more into it processes than SJM has had but the reach of both programmes is undetermined. Both have shown "genuine interest in creating new CSR core practices...by corporate efforts to institutionalize the core values driving CSR activities...through drafting ethics codes, ...[and]guidelines"[307] through their *patching* strategies and in doing so encourage the stakeholder-employee to consider this in decision-making. The second strategy observed at Novo was *thickening*, used to reinforce existing core routines. SMS's second strategy was *positioning* means that the initiative is not central to firm strategy and that it does not exert much influence. Whether or not employees participate, it does not make a difference and they have to have worked at SJM for a while before even being allowed to participate. Complexity is heightened in multilayered firms such as Novo and SJM therefore, focusing on few highly influential choices at a time can be thought of as strategic – so Novo and SJM being in the health industry are playing to their strengths with the NH and LiveWell programmes.[308]. Full integration of CSR initiatives is a time-consuming task and for it to not have any detrimental effect of business it is important to *routinise* it into core operations and the decision making process. Once routinisation has happened it is easier to see contributions to business performance. For it to happen managers need to *walk the talk* as Novo says, for employees to accept, adopt and use the CSR initiatives. In O&O terms this means that managers should verbalise and use the facilities, bike to work, use the stairs not the lift. Of course firms may decide to have loosely coupled initiatives to have a higher degree of flexibility and so be able to change the initiatives as needed. Such initiatives can also be in place due to the national context that the firms originate in. In the US for example

it is not uncommon that employees have to work for a number of years at a firm before becoming *benefit-eligible*, such as SJM have chosen to do.

In the introduction the question was posed of how a firm uses CSR and make it benefit not just the environment, the stakeholders but also the aforementioned financial bottom-line? At this point there still is not *a* clear answer with the vagueness of the CSR concept and the different types, sizes and industries that firms are in, inhibit this. The seven patterns of CSR integration are avenues firms can use to choose the best fit for them and their individual situation and through this make the CSR bundle benefit the firm, its stakeholders and the environment best. Both case companies have responded to the stakeholder presence and needs by implementing health initiatives.

Targeting O&O via health oriented CSR programmes focused on the stakeholder-employee is an interesting way of expanding the CSR portfolio and something not done by many yet. Moreover, considering the meteoric rise in O&O levels in DK and the US the past decades and the very high plateau it has reached currently makes it an issue with direct impact on firms in terms of increased morbidity, absenteeism and presenteeism. One may even be so bold as to state that it is close to a must to invest in such initiatives because of the stakeholder-employee salience level, the effect it has on efficiency and the bottom line at work. This also means that firms do have a right to implement such initiatives to buffer itself from these externalities – of course with the caveat that it is not forced upon the employee, and that along the line having facilitated the means to participation and firm reality can be constructed around being a healthy firm and a firm that cares for its employees. The issue of the happy employee was brought up in the discussion. She is one who likes and takes pride her work and the work place and she is a friendly and helpful colleague. It is difficult to be a happy employee if one suffers from increased morbidity or psychosocial problems as a consequence of O&O and if one is not happy one does not work constructively or well. The unity between colleagues can be nurtured through shared activities such as participating in fitness classes, group sessions, etc. and tying the stakeholder-employee closer to work as more of her spare time will be spent with her colleagues engaging in activities beyond work.

Future Perspectives

Being a new topic to the CSR debate there are many avenues for future research and there is a need to explore the connection between combating O&O and the role of business especially with the meteoric rise in O&O levels in DK and the US. One could look at the development of work place policies regarding health and O&O. For example, looking at the previously divisive topic smoking then much has changed: from it being normal to smoke inside in the offices, to having to smoke in designated areas to it not being allowed on the premises some places. Perceptions on smoking and smokers have changed in a more negative direction to the degree that Aarhus municipality is now smoke free, stating the smoking is a private matter much like alcohol and will not be allowed during work hours[309]. This may seem extreme but the Danish Cancer Society welcomes the initiative and the change in attitude and perception. Looking at O&O can one then predict or expect a change in attitudes – even to such a degree that two decades later that being healthy is mandatory? Must employees become healthier by training more, eating healthier and participating in group events to cement closer bonds with colleagues? And if so how big a role must the firm play: provide fitness facilities and onsite psychology help, or pay memberships? Should training during work hours be compulsory?

As stated, for initiatives to have an impact focus should be on childhood obesity. TrygFonden[yyy] started an initiative when the former CEO Stine Bosse hiked El Camino with delinquents offering them a future with Tryg, done to highlight their plight[310]. Could such initiatives be viable for firms like Novo, SJM and even SMEs by supporting sports associations, schools, taking children on hikes etc.? In that way teach the importance of being physically active, although more philanthropic in nature, it could help also brand the firm and attract employees.

Another issue is how to and if impact should be measured. Novo deliberately chose to not measure it, but in a justification of budgets, especially in times of crisis, as well as showing employees, shareholders and other stakeholders that a difference can be made measuring impact could be a strong selling point as well as a justification for elaboration.

[yyy] Translated: The Tryg Foundation

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Appendix 1: UN Global Compact

The UN Global Compact asks companies to embrace, support and enact, within their sphere of influence, a set of core values in the areas of human rights, labour standards, the environment and anti-corruption:

Human Rights

- Principle 1: Businesses should support and respect the protection of internationally proclaimed human rights; and
- Principle 2: make sure that they are not complicit in human rights abuses.

Labour

- Principle 3: Businesses should uphold the freedom of association and the effective recognition of the right to collective bargaining;
- Principle 4: the elimination of all forms of forced and compulsory labour;
- Principle 5: the effective abolition of child labour; and
- Principle 6: the elimination of discrimination in respect of employment and occupation.

Environment

- Principle 7: Businesses should support a precautionary approach to environmental challenges;
- Principle 8: undertake initiatives to promote greater environmental responsibility; and
- Principle 9: encourage the development and diffusion of environmentally friendly technologies.

Anti-Corruption

- Principle 10: Businesses should work against corruption in all its forms, including extortion and bribery.

Source: United Nations Global Compact: http://www.unglobalcompact.org/AboutTheGC/TheTenPrinciples/index.html

Appendix 2: The International Classification of Adult underweight, Overweight, and Obesity According to BMI

Classification	BMI(kg/m^2)	
	Principal cut-off points	Additional cut-off points
Underweight	<18.50	<18.50
Severe thinness	<16.00	<16.00
Moderate thinness	16.00 - 16.99	16.00 - 16.99
Mild thinness	17.00 - 18.49	17.00 - 18.49
Normal range	18.50 - 24.99	18.50 - 22.99
		23.00 - 24.99
Overweight	≥25.00	≥25.00
Pre-obese	25.00 - 29.99	25.00 - 27.49
		27.50 - 29.99
Obese	≥30.00	≥30.00
Obese class I	30.00 - 34.99	30.00 - 32.49
		32.50 - 34.99
Obese class II	35.00 - 39.99	35.00 - 37.49
		37.50 - 39.99
Obese class III	≥40.00	≥40.00

Source: Adapted from WHO, 1995, WHO, 2000 and WHO 2004.

Source: World Health Organization: http://apps.who.int/bmi/index.jsp?introPage=intro_3.html

Appendix 3: Novo Nordisk – The Triple Bottom Line

The Triple Bottom Line - our way of doing business

We believe that a healthy economy, environment and society are fundamental to long-term business success. This is why we manage our business in accordance with the Triple Bottom Line (TBL) business principle and pursue business solutions that maximise value to our stakeholders as well as our shareholders.

In practice, this means that any decision should always seek to combine three considerations: is it financially, socially and environmentally responsible? This way, we continuously optimise our business performance and enhance our contribution to the societies we operate in.
The Triple Bottom Line business principle is anchored in the **Novo Nordisk Way** and in our Articles of Association (bylaws) that state that Novo Nordisk "strives to conduct its activities in a financially, environmentally and socially responsible way."

The Triple Bottom Line maximises value

Doing business in a responsible and sustainable way, with a focus on improving public health, benefits patients, society and shareholders. By providing better treatment, raising awareness and advocating for earlier diagnosis and improved health outcomes, we enable people with chronic conditions to live healthier, longer and more productive lives. By promoting responsible and ethical business practices throughout our global value chain and continuously reducing the negative environmental impacts generated by our activities, we stimulate economic growth that is socially just and environmentally sustainable. Finally, TBL makes good business. It delivers long-term growth for our business by building trust, protecting and enhancing our licence to operate and attracting and retaining the best people.

Accountability is key

Exercising social and environmental responsibility is a business imperative and must be managed and accounted for in the same way as all other aspects of our operations. We set long-term targets for our social and environmental performance and have built the TBL principle into corporate governance structures, management tools and methods of assessing and rewarding individual performance. Overall responsibility lies with The Board of Directors, but every **single** Novo Nordisk employee is responsible for enhancing our financial, social and environmental performance.
Since 2004, the Novo Nordisk Annual Report has accounted for financial, social and environmental performance in one inclusive report. Read more in **our annual report**

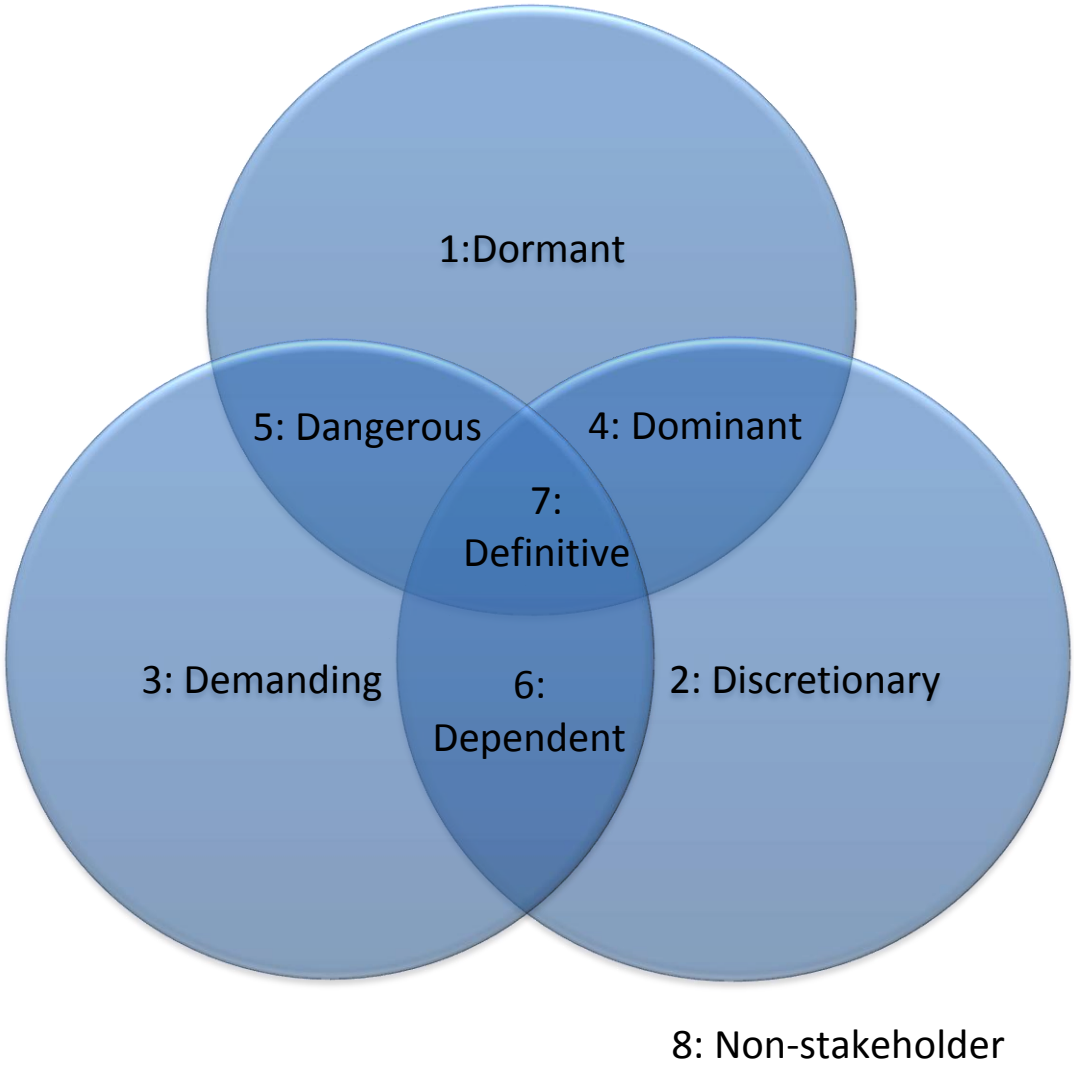
Consistently high sustainability performance

Since the launch of the DOW Jones Sustainability Indexes (DJSI), Novo Nordisk has consistently been awarded scores in the top of the healthcare sector – either as number one or two. The Dow Jones Sustainability Indexes are the first global indexes tracking the financial performance of the leading sustainability-driven companies worldwide.

Following a review of its implications for Novo Nordisk's long-term business, a strategy is framed for those issues that are deemed material and subsequently data, indicators and targets are identified. Once management of the issue has been embedded in the organisation, so that it is fully integrated into business processes, the strategy will be revisited as appropriate. Moreover, issues that are included on the learning curve are monitored as part of the integrated risk management process.

Source: Novo Nordisk home page: http://www.novonordisk.com/sustainability/Sustainability-approach/The-triple-bottom-line.asp

Appendix 4: Stakeholder Typology: One, Two, or Three Attributes Present

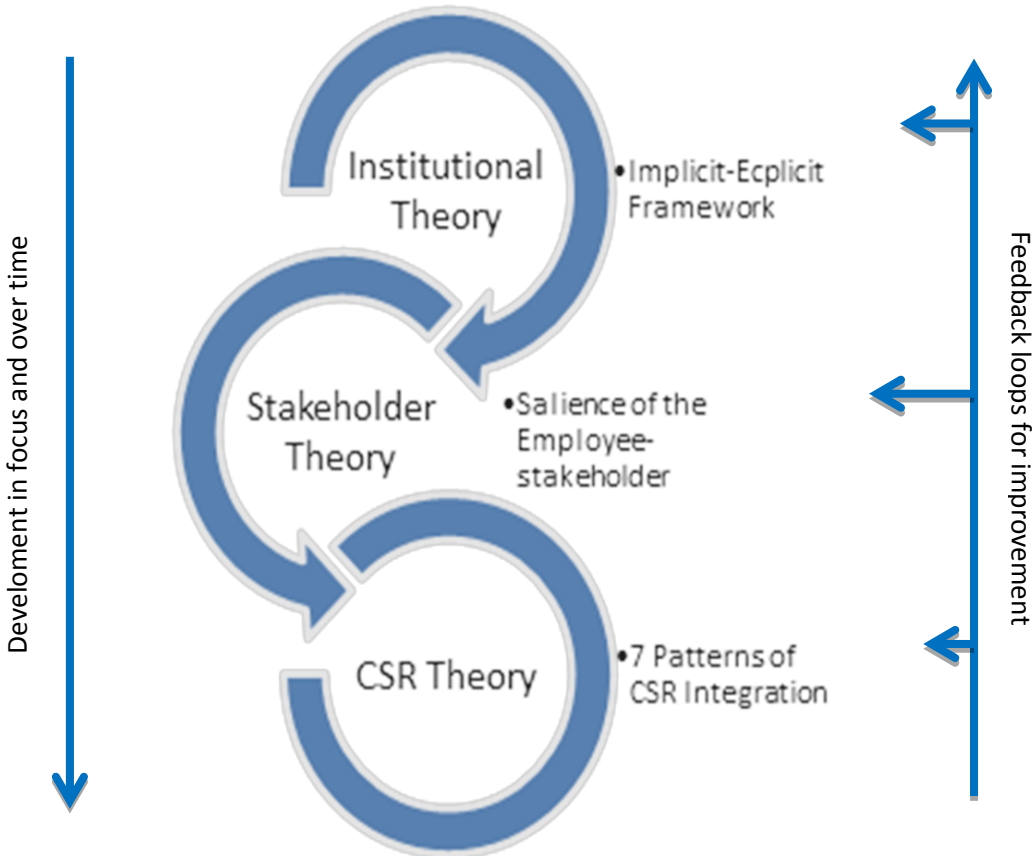


Source: Mitchell, Ronald K., et al.; *Toward a Theory of Stakeholder Identification and Salience: Defining the Principle of Who and What Really Counts*, The Academy of Management Review, vol. 22, no. 4, 1997, p. 854

Appendix 5: Integrating CSR Initiatives in Business

Source: Yuan, Wenlong et al. *Integrating CSR Initiatives in Business: An Organizing Framework,* Journal of Business Ethics, 2011, pp. 80-86

Appendix 6: Linking the Theories



Appendix 7: Hospitalisation Over-propensity among the Overweight Compared to People of Normal Weight

	Moderate Overweight	Obese
Men		
16-34	1.2	1.5
35-64	1.1	1.4
65-74	1.0	1.2
≥ 75	1.1	1.4
Women		
16-34	1.2	1.2
35-64	1.2	1.4
65-74	1.2	1.3
≥ 75	0.9	1.0

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, p. 171, table 9.7.1

Appendix 8: Extra Yearly Hospitalisations Related to Overweight

	Men	Women	Total
Moderate overweight	15,252	15,086	30,338
Obesity	14,184	11,236	25,320
Total	29,435	26,222	55,657

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, p. 176, table 9.7.3

Appendix 9: Yearly Amount of Contacts (in thousands) with the General Practitioner Related to Overweight and Parts of all Contacts, Divided by Gender and Age

Amount of Contacts				Percentage of all Contacts		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
0-14	.	.	.	.	.	.
15-24	12	23	35	1.5	1.3	1.4
25-34	30	59	89	2.4	2.1	2.2
35-44	106	162	267	6.4	5.7	5.9
45-54	127	164	291	7.0	6.0	6.4
55-64	133	183	316	6.0	6.1	6.1
65-74	33	101	134	1.7	4.0	3.0
75-84	1	21	22	0.0	0.9	0.6
≥ 85	0	8	8	0.0	0.6	0.5
Total	441	722	1,162	3.3	3.4	3.4

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, table 9.8.2, p. 177

Appendix 10: Yearly Days of Absence (thousands) Related to Overweight for all Employed Men and Women Divided on Age

Age	Men	Women	Total
16-24	63	56	119
25-34	191	155	347
35-44	252	224	476
45-54	284	229	513
55-66	238	163	401
Total	1,028	827	1,855

NB: The authors of the report have made a typo. In the total column for 25-34 year olds it should be 346.

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, p. 171, table 9.3.2, p. 177

Appendix 11: Extra yearly days of absence (thousands) related to overweight for all employed in Denmark

	Men	Women	Total
Moderate overweight	629	632	1,261
Obese	399	195	595
Total	1,028	827	1,855

NB: The authors of the report made a typo. In total number of obese, the figure is 594

Source: Juel, Knud *et al.*, *Risikofaktorer og folkesundhed*, 2006, p. 177

Appendix 12: Yearly Amount of Early Retirement Related to Overweight, Distributed on Gender and Age

Amount of Early Retirement				Percentage of All Early Retirements		
Age	**Men**	**Women**	**Total**	**Men**	**Women**	**Total**
16-24	26	13	39	5.5	3.8	4.8
25-34	38	25	63	5.5	3.8	4.7
35-44	65	147	212	4.6	9.2	7.1
45-54	130	288	419	5.7	10.3	8.2
55-66	121	260	382	5.7	10.3	8.2
Total	*380*	*735*	*1,115*	*5.4*	*9.3*	*7.5*

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, table 9.10.1, p. 178

Appendix 13: Socio-Economic Productions Loss Costs Calculated by the Friction Method (calculated as yearly current value using a 5% discount rate, million, 2005-DKK)

Production loss by the friction method				
	Absence due to illness	Early retirement	Death	Total
Men				
16-24	28.2	0.5	0.1	28.8
25-44	577.1	7.5	3.5	588.2
45-64	683.0	18.3	23.7	725.1
≥64	2.4	0.1	0.0	2.5
Total	*1,290.8*	*26.5*	*27.3*	*1344.6*
Women				
16-24	18.1	0.2	0.0	18.3
25-44	343.2	9.2	3.1	355.5
45-64	350.3	25.6	19.2	395.1
≥64	0.3	0.1	0.7	1.1
Sum	*712.0*	*35.0*	*23.1*	*770.1*
Total	**2,002.7**	**61.5**	**50.4**	**2,114.6**

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, p. 178

Appendix 14: Socio-Economic Production Loss Costs Calculated by the Human Capital Method (calculated as yearly current value using a 5% discount rate, million 2005-DKK)

Production loss by the human capital method				
	Absence due to illness	Early retirement	Death	Total
Men				
16-24	28.2	152.3	17.0	197.6
25-44	577.1	556.1	250.3	1,383.6
45-64	683.0	584.8	630.5	1,898.3
≥64	2.4	0.0	0.0	2.4
Total	*1,290.8*	*1,293.2*	*897.9*	*3,481.9*
Women				
16-24	18.1	53.4	7.6	79.1
25-44	343.2	600.9	206.6	1.150,7
45-64	350.3	753.6	474.3	1,578.3
≥64	0.3	0.0	0.0	0.3
Sum	*712.0*	*1,408.0*	*688.5*	*2,808.4*
Total	**2,002.7**	**2,701.2**	**1,586.4**	**6,290.3**

Source: Juel, Knud, et al., *Risikofaktorer og folkesundhed i Danmark*, p. 178

Appendix 15: Development in the Share of 25-44 Year Olds and 45-64 Year Olds Moderate Overweight and Obese Danes (BMI≥25). 1987-2009. In Percentages

	Men		Women	
	25-44 years	45-64 years	25-44 years	45-64 years
	Moderate Overweight			
1987	31.7	46.1	10.8	24.3
1994	33.4	49.5	17.1	26.2
2000	37..7	48.5	20.5	29.8
2005	37.9	47.2	23.9	27.5
2009	40.8	48.4	24.4	31.3
	Obese			
1987	4.8	8.1	3.3	8.7
1994	7.6	12.0	4.0	10.7
2000	7.8	13.8	9.1	10.6
2005	10.6	13.9	11.3	12.2
2009	11.8	16.7	12.9	14.3

Source: Bonke, Jens *et al., Helbred, Trivsel og overvægt blandt danskere*, 2010, Tabel 8.1, p. 64

In collaboration with the Rockwool Foundation Research Unit

Appendix 16: Novo Nordisk – The Ten Essentials

NOVO NORDISK **WAY** ESSENTIALS

The Essentials are ten statements describing what the Novo Nordisk Way looks like in practice. They are meant as a help to our managers and employees for evaluating to what extent our organisation acts in accordance with the Novo Nordisk Way.

The Essentials are as such an important means for identifying actions which our organisation may take to further align our way of working with the thinking and values that characterise the Novo Nordisk Way.

1. We create value by having a patient centred business approach.
2. We set ambitious goals and strive for excellence.
3. We are accountable for our financial, environmental and social performance.
4. We provide innovation to the benefit of our stakeholders.
5. We build and maintain good **relations** with our key stakeholders.
6. We treat everyone with respect.
7. We focus on personal performance and development.
8. We have a healthy and engaging working environment.
9. We optimise the way we work and strive for simplicity.
10. We never compromise on quality and business ethics.

Source: Screen Dump Novo Nordisk web page,
http://www.novonordisk.com/about_us/Novo_Nordisk_Way/NNway_essentials.asp

Appendix 17: Novo Nordisk - NovoHealth

NovoHealth

NovoHealth – healthy employees equal a healthy company.

At Novo Nordisk, we strongly believe that change starts from within. We strive to enable people to **live longer**, healthier and more productive lives. It is this determination that drives our NovoHealth global employee programme.

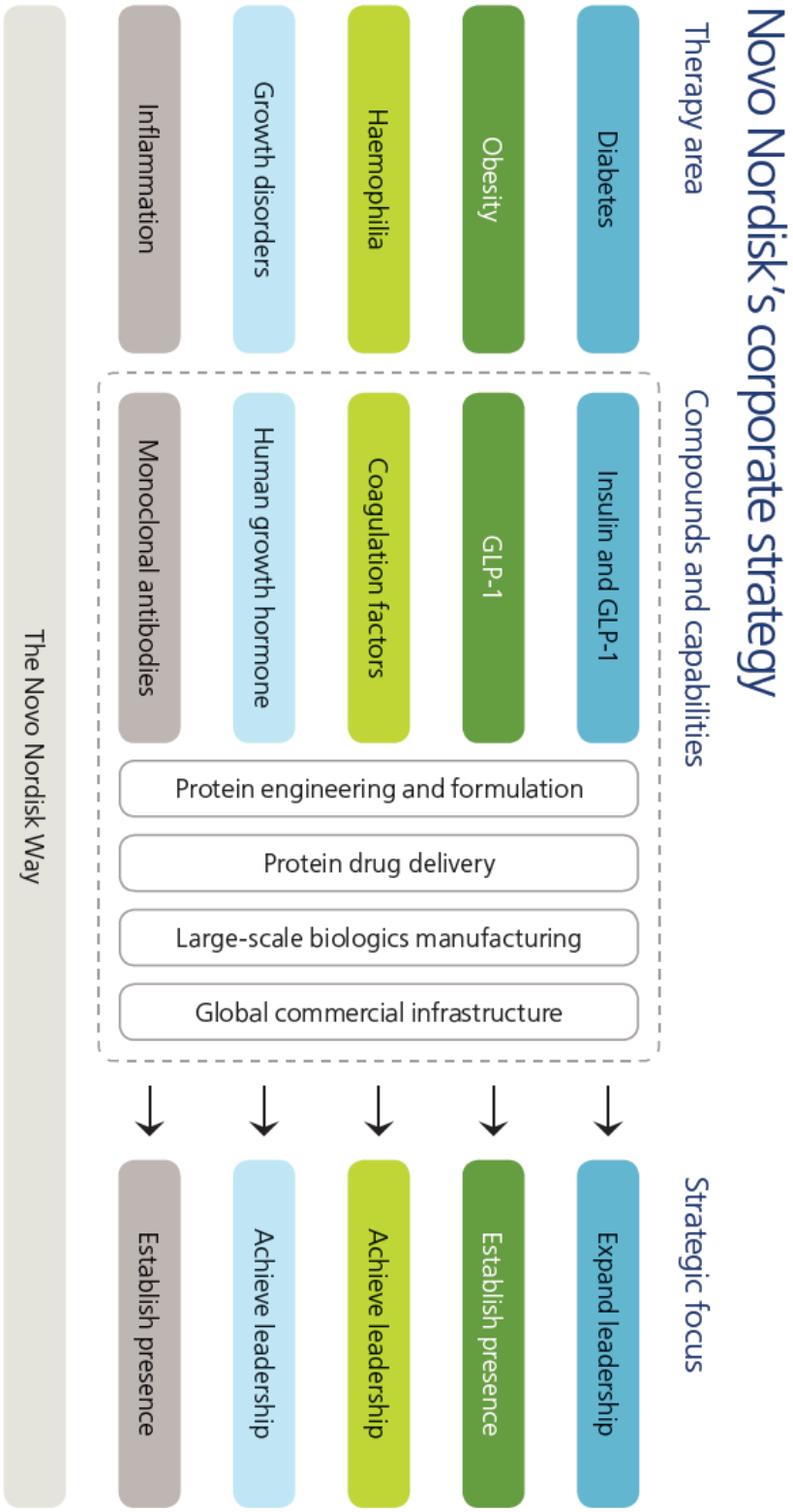
NovoHealth is Novo Nordisk's worldwide employee health programme, seeking to develop a workplace culture that promotes and supports healthy living for all employees – an opportunity for Novo Nordisk to practice what we preach. NovoHealth will inspire healthy living among Novo Nordisk employees as a means to drive people engagement and prevent type 2 diabetes and other lifestyle related diseases.

NovoHealth focuses on four key health areas that are offered to all employees. The four areas are adopted locally by affiliates, in order to support and acknowledge local cultural differences:

- Providing healthy food and beverages in the workplace and encouraging a healthy diet.
- Providing access to and encouraging employees to do physical activity.
- Providing a smoke-free work environment and highlighting the benefits of non-smoking.
- Providing access to and encouraging a health check with individual advice every second year.

Source: Screen Dump Novo Nordisk home page: http://www.novonordisk.com/sustainability/People/NovoHealth.asp

Appendix 18: The Novo Nordisk Strategy



Source: Novo Nordisk Annual Report, 2011, p. 18

Appendix 19: Obesity Trends in the US from 1985, 1991, 1996, 1997, 2000, 2001, 2005, 2010 (8 pages)

Obesity Trends* Among U.S. Adults; BRFSS, 1985
(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
Alabama	Arizona	Georgia		
Alaska	California	Indiana		
Arkansas	Connecticut	Kentucky		
Colorado	Florida	North Dakota		
Delaware	Idaho	Ohio		
Hawaii	Illinois	South Carolina		
Iowa	Minnesota	West Virginia		
Kansas	Montana	Wisconsin		
Louisiana	New York			
Maine	North Carolina			
Maryland	Rhode Island			
Massachusetts	Tennessee			
Michigan	Utah			
Mississippi				
Missouri				
Nebraska				
Nevada				
New Hampshire				
New Jersey				
New Mexico				
Oklahoma				
Oregon				
Pennsylvania				
South Dakota				
Texas				
Vermont				
Virginia				
Washington				
Wyoming				

Source: BRFSS, CDC.

Obesity Trends* Among U.S. Adults; BRFSS, 1991

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
Kansas	Colorado	Alabama	Louisiana	
Nevada	Georgia	Alaska	Michigan	
Wyoming	Massachusetts	Arizona	Mississippi	
	Montana	Arkansas	West Virginia	
	New Jersey	California		
	New Mexico	Connecticut		
	Rhode Island	Delaware		
	Utah	Florida		
	Washington	Hawaii		
		Illinois		
		Indiana		
		Iowa		
		Idaho		
		Kentucky		
		Maryland		
		Maine		
		Missouri		
		Minnesota		
		Nebraska		
		New Hampshire		
		New York		
		North Carolina		
		North Dakota		
		Oklahoma		
		Ohio		
		Oregon		
		Pennsylvania		
		South Carolina		
		South Dakota		
		Tennessee		
		Texas		
		Vermont		
		Virginia		
		Wisconsin		

Source: Mokdad AH, et al. *JAMA* 1999;282:16.

Obesity Trends* Among U.S. Adults; BRFSS, 1996

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
		Arizona	Alabama	
		California	Alaska	
		Colorado	Arkansas	
		Connecticut	Delaware	
		Georgia	Florida	
		Hawaii	Idaho	
		Kansas	Illinois	
		Massachusetts	Indiana	
		Montana	Iowa	
		Minnesota	Kentucky	
		New Mexico	Louisiana	
		New Jersey	Maine	
		New Hampshire	Maryland	
		New York	Michigan	
		Rhode Island	Mississippi	
		South Dakota	Missouri	
		Utah	Nebraska	
		Vermont	Nevada	
		Washington	North Carolina	
		Wyoming	North Dakota	
			Oklahoma	
			Ohio	
			Oregon	
			Pennsylvania	
			South Carolina	
			Texas	
			Tennessee	
			Virginia	
			West Virginia	
			Wisconsin	

Source: BRFSS, CDC.

Obesity Trends* Among U.S. Adults; BRFSS, 1997

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
		Arizona	Alabama	Indiana
		Colorado	Alaska	Kentucky
		Connecticut	Arkansas	Mississippi
		Georgia	California	
		Kansas	Delaware	
		Massachusetts	Florida	
		Montana	Hawaii	
		Nevada	Idaho	
		New Hampshire	Illinois	
		New Mexico	Iowa	
		Oklahoma	Louisiana	
		Rhode Island	Maine	
		Utah	Maryland	
		Washington	Michigan	
		Wyoming	Minnesota	
			Missouri	
			Nebraska	
			New Jersey	
			New York	
			North Carolina	
			North Dakota	
			Ohio	
			Oregon	
			Pennsylvania	
			South Carolina	
			South Dakota	
			Tennessee	
			Texas	
			Vermont	
			Virginia	
			West Virginia	
			Wisconsin	

Source: BRFSS, CDC.

Obesity Trends* Among U.S. Adults; BRFSS, 2000

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	Greater than or equal to 20%
		Colorado	Arizona	Alabama
			California	Alaska
			Connecticut	Arkansas
			Delaware	Georgia
			Florida	Illinois
			Hawaii	Indiana
			Idaho	Iowa
			Maine	Kansas
			Maryland	Kentucky
			Massachusetts	Louisiana
			Minnesota	Michigan
			Montana	Mississippi
			Nevada	Missouri
			New Hampshire	Nebraska
			New Jersey	North Carolina
			New Mexico	Ohio
			New York	Oregon
			North Dakota	Pennsylvania
			Oklahoma	South Carolina
			Rhode Island	Tennessee
			South Dakota	Texas
			Utah	West Virginia
			Vermont	
			Virginia	
			Washington	
			Wisconsin	
			Wyoming	

Source: Mokdad A H, et al. *JAMA* 2001;286:10

Obesity Trends* Among U.S. Adults; BRFSS, 2001

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	20%-24%	Greater than 25%
		Colorado	Arizona	Alabama	Mississippi
			Connecticut	Alaska	
			Florida	Arkansas	
			Hawaii	California	
			Maine	Delaware	
			Maryland	District of Columbia	
			Massachusetts	Georgia	
			Minnesota	Idaho	
			Montana	Illinois	
			Nevada	Indiana	
			New Hampshire	Iowa	
			New Jersey	Kansas	
			New Mexico	Kentucky	
			New York	Louisiana	
			North Dakota	Michigan	
			Rhode Island	Missouri	
			Utah	Nebraska	
			Vermont	North Carolina	
			Washington	Ohio	
			Wyoming	Oklahoma	
				Oregon	
				Pennsylvania	
				South Carolina	
				South Dakota	
				Tennessee	
				Texas	
				Virginia	
				West Virginia	
				Wisconsin	

Source: Mokdad A H, et al. *JAMA* 2001;286:10

Obesity Trends* Among U.S. Adults; BRFSS, 2005

(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	20%-24%	25%-29%	Greater than or equal to 30%
			Colorado	Arizona	Alabama	Louisiana
			Connecticut	California	Alaska	Mississippi
			Hawaii	Delaware	Arkansas	West Virginia
			Vermont	Florida	Georgia	
				Idaho	Indiana	
				Illinois	Kentucky	
				Iowa	Michigan	
				Kansas	Missouri	
				Maine	Nebraska	
				Maryland	North Carolina	
				Massachusetts	Oklahoma	
				Minnesota	South Carolina	
				Montana	Tennessee	
				Nevada	Texas	
				New Hampshire		
				New Jersey		
				New Mexico		
				New York		
				North Dakota		
				Ohio		
				Oregon		
				Pennsylvania		
				Rhode Island		
				South Dakota		
				Utah		
				Virginia		
				Washington		
				Wisconsin		
				Wyoming		

Source: *MMWR* 2006; 55 (36): 985-988.

Obesity Trends* Among U.S. Adults; BRFSS, 2010

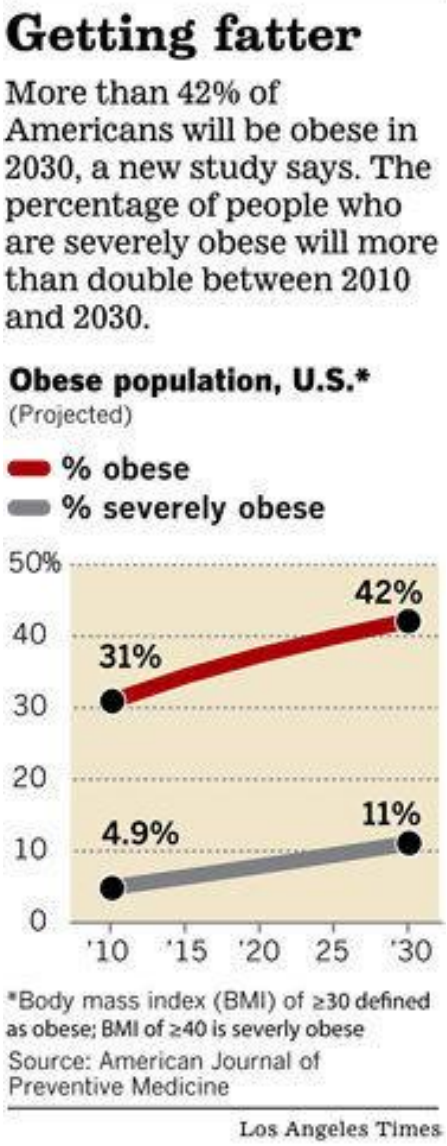
(*BMI greater than or equal to 30, or about 30 lbs overweight for 5'4" person)

No Data	Less than 10%	10%-14%	15%-19%	20%-24%	25%-29%	Greater than or equal to 30%
				Alaska	Delaware	Alabama
				Arizona	Florida	Arkansas
				California	Georgia	Kentucky
				Colorado	Idaho	Louisiana
				Connecticut	Illinois	Michigan
				Hawaii	Indiana	Mississippi
				Massachusetts	Iowa	Missouri
				Minnesota	Kansas	Oklahoma
				Montana	Maine	South Carolina
				Nevada	Maryland	Tennessee
				New Jersey	Nebraska	Texas
				New York	New Hampshire	West Virginia
				Utah	New Mexico	
				Vermont	North Carolina	
				Washington D.C.	North Dakota	
					Ohio	
					Oregon	
					Pennsylvania	
					Rhode Island	
					South Dakota	
					Virginia	
					Washington	
					Wisconsin	
					Wyoming	

Source: BRFSS, CDC.

Source: Centers for Disease Control and Prevention, *Obesity Trends Among U.S. Adults Between 1985 and 2010*

Appendix 20: Getting Fatter



Source: Healy, Melissa, *42% of American adults will be obese by 2030, study says,* Los Angeles Times, May 8, 2012: http://www.latimes.com/health/la-he-obesity-20120508,0,4332050.story

Appendix 21: Projected health and quality-adjusted life-year outcomes, 2010-2030, under three hypothetical scenarios of population-wide change in BMI distribution

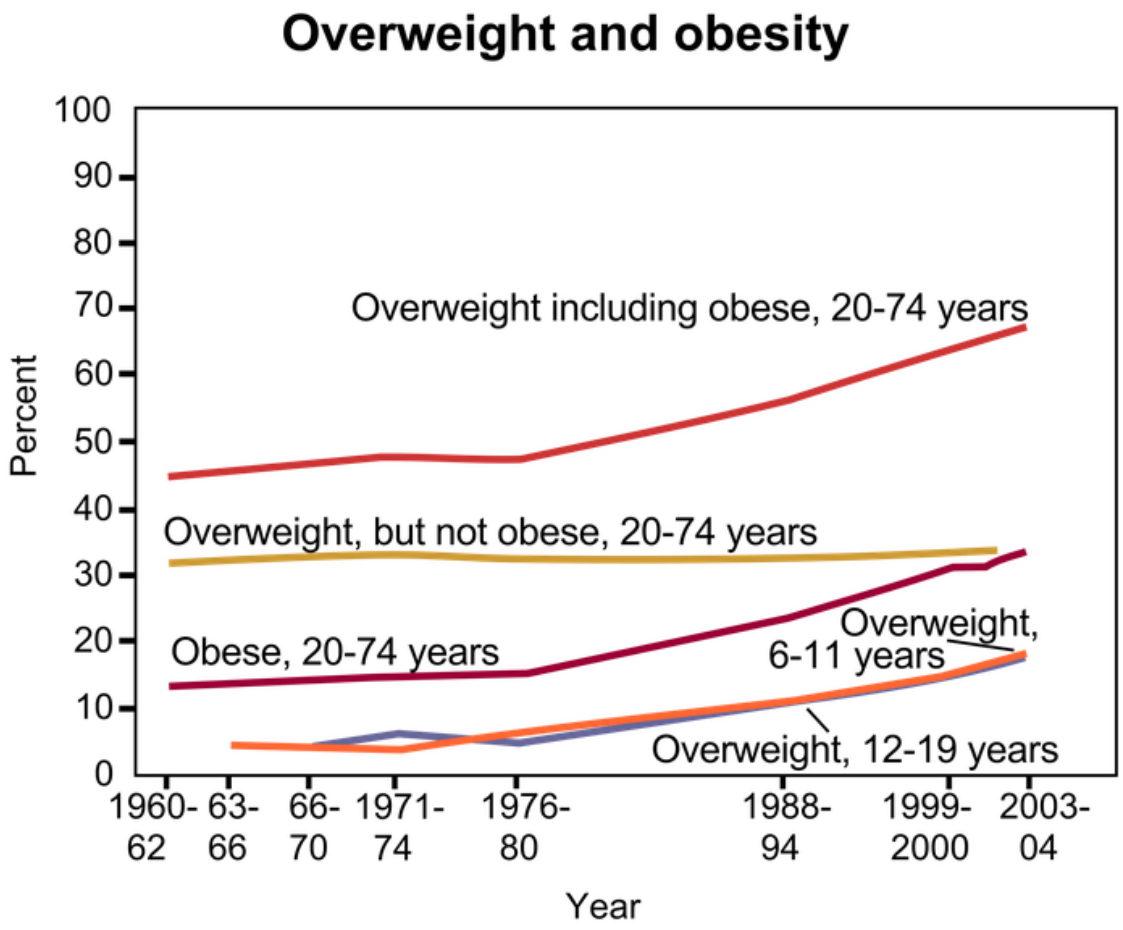
	UK		USA	
	Recent trend	Historic trend	Recent trend	Historic trend
Scenario 1. Past trends continue unabated				
Diabetes (×1000)	+545 (432)	+668 (159)	+5503 (3524)	+7855 (1618)
Coronary heart disease and stroke (×1000)	+331 (407)	+461 (128)	+5365 (3359)	+6836 (1537)
Cancer (×1000)	+87 (108)	+130 (34)	+405 (265)	+539 (123)
Gain or loss in QALYs (×1000)	−2219	−6300	−24 488	−48 259
Scenario 2. 1% reduction in BMI for every adult at baseline				
Diabetes (×1000)	−179 (385)	−202 (139)	−2051 (2922)	−2420 (1461)
Coronary heart disease and stroke (×1000)	−122 (374)	−122 (116)	−1431 (2799)	−1704 (1400)
Cancer (×1000)	−32 (100)	−33 (33)	−73 (219)	−127 (109)
Gain or loss in QALYs (×1000)	+3011 (930)	+3195 (395)	+15 988 (1911)	+16 135 (781)
Scenario 3. If obesity rates had remained at 1990 levels				
Diabetes (×1000)	−897 (216)	−1021 (159)	−8664 (3524)	−11 016 (1618)
Coronary heart disease and stroke (×1000)	−634 (204)	−763 (128)	−7670 (3359)	−9141 (1537)
Cancer (×1000)	−177 (54)	−220 (34)	−534 (265)	−668 (123)
Gain or loss in QALYs (×1000)	+7073	+11 155	+58 177	+81 948

Scenario 1=past trends continue unabated; scenario 2=1% reduction in BMI for every adult at baseline; scenario 3=obesity rates remained at 1990 levels. Recent trend estimates were based on projections with data from 1990, which implied a slower increase in obesity, while historic trend estimates were projected from all available data from 1988, showing a steeper rate of increase in obesity. Data are cases (SE) unless otherwise stated. QALY=quality-adjusted life-years.

Table 2: **Projected health and quality-adjusted life-year outcomes, 2010–30, under three hypothetical scenarios of population-wide change in body-mass index distribution**

Source: Wang, Claire Y *et al.* Health and economic burden of the projected obesity trends in the USA and the UK, The Lancet, 2011. P. 821

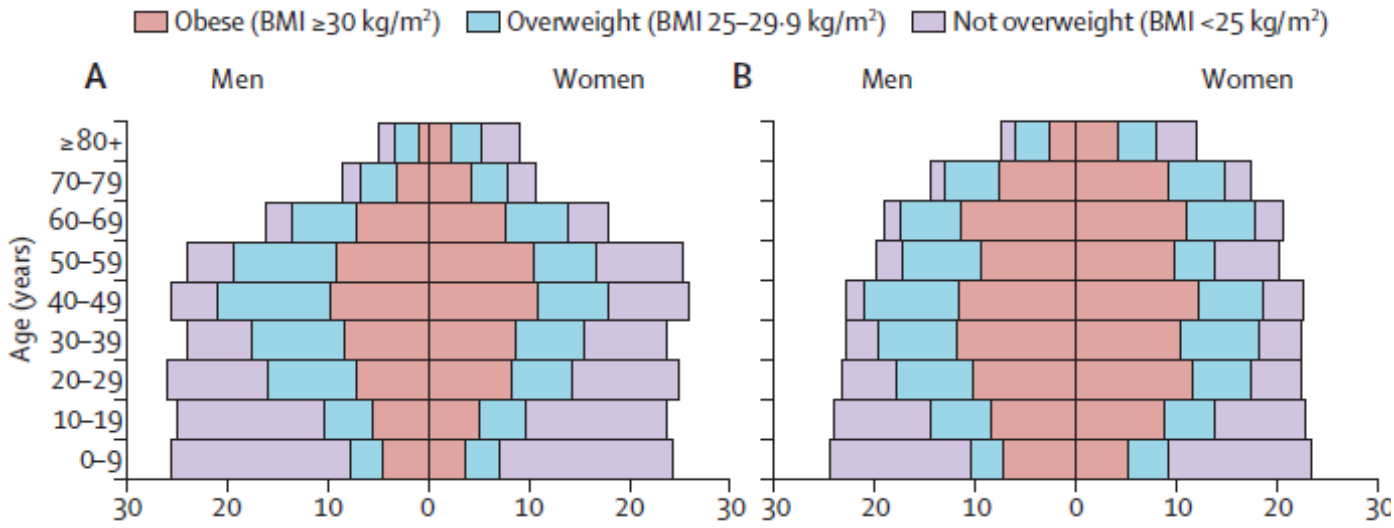
Appendix 22: Overweight and Obesity – Development from 1960-2006 and in Different Age Groups



SOURCES: Centers for Disease Control and Prevention, National Center for Health Statistics, *Health, United States, 2006*, Figure 13. Data from National Health and Nutrition Examination Survey

Source: Centers for Disease Control and Prevention

Appendix 23: US population projection 2010 vs. 2030, by Overweight and Obesity Status Assuming Historic Trend in BMI



A= USA, 2010

B= USA, 2030

Population Pyramid: Size of bars show the size of projected census population (*100,000) by BMI status, sex and age category in the USA

Source: Wang, Claire Y *et al.* Health and economic burden of the projected obesity trends in the USA and the UK, The Lancet, 2011. P. 821

Appendix 24: St. Jude Medical – LiveWell

Fostering Health and Balanced Lifestyles

Our employee benefits are designed to provide resources to help protect and support our employees and their families.

While our benefit packages vary by country, in all cases, St. Jude Medical offers competitive benefits that demonstrate our commitment to our employees. We review our overall benefits package annually to ensure we continue to offer competitive benefits that are affordable and meet the needs of our employees.

Health and Wellness Program

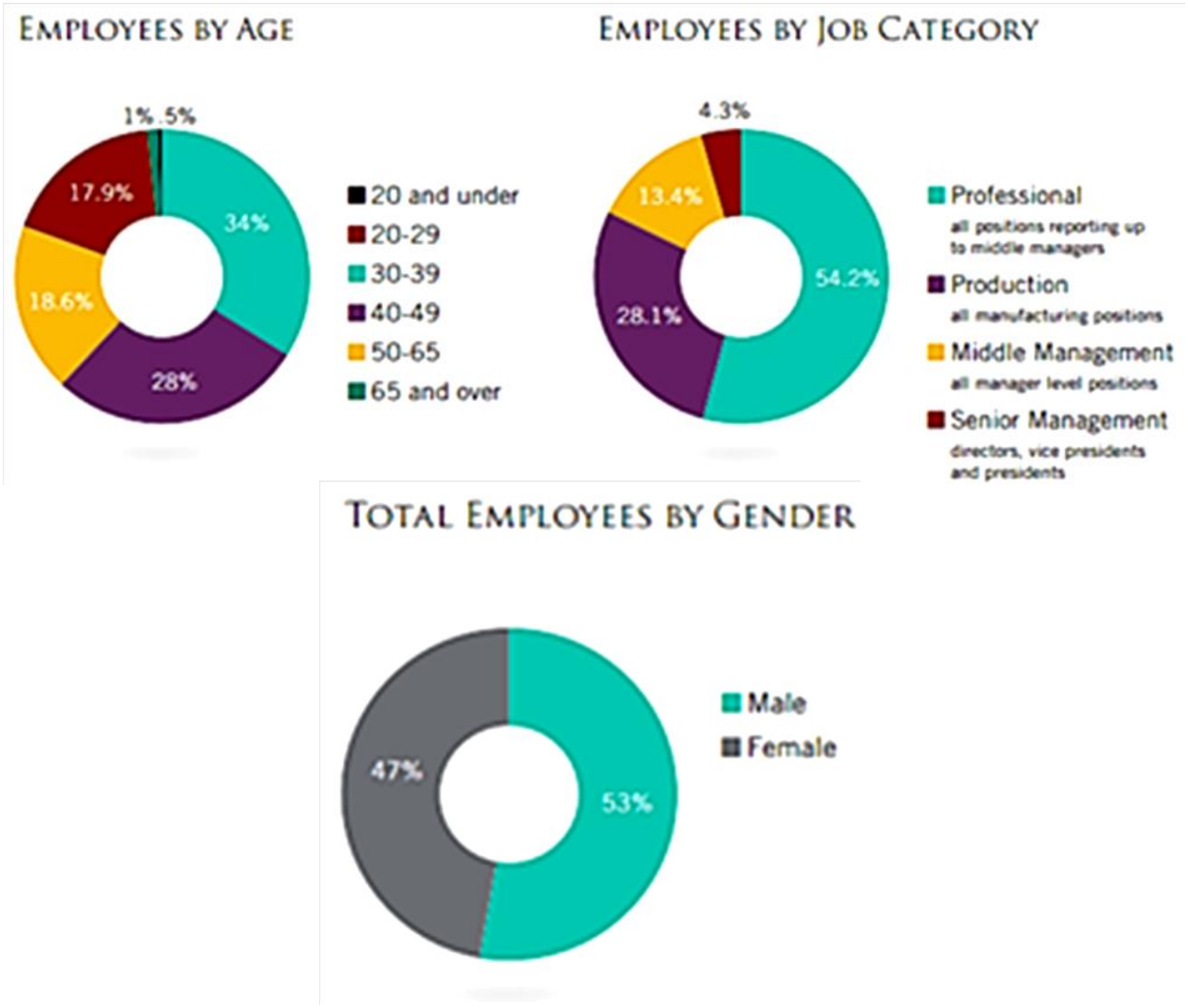
The LiveWell program at St. Jude Medical is a free personalized health improvement program. It is designed to promote prevention and early diagnosis to help our employees take charge of their health. LiveWell eligibility is extended to all U.S. St. Jude Medical benefits-eligible employees. The program provides complimentary on-site health screenings, confidential health assessments, health coaching across a multitude of topics, and rewards for employees who participate, including a reduction in annual health insurance premiums. In addition, our LiveWell Program offers employees the ability to participate in various health and wellness programs including:

- Physical activity programs
- Online health improvement programs
- Smoking Cessation
- Group weight management programs
- Access to comprehensive information on wellness through the LiveWell website

As a percent of the total eligible population, employee participation in one or more elements of the LiveWell program increased from approximately 28 percent in 2010 to 34 percent in 2011.

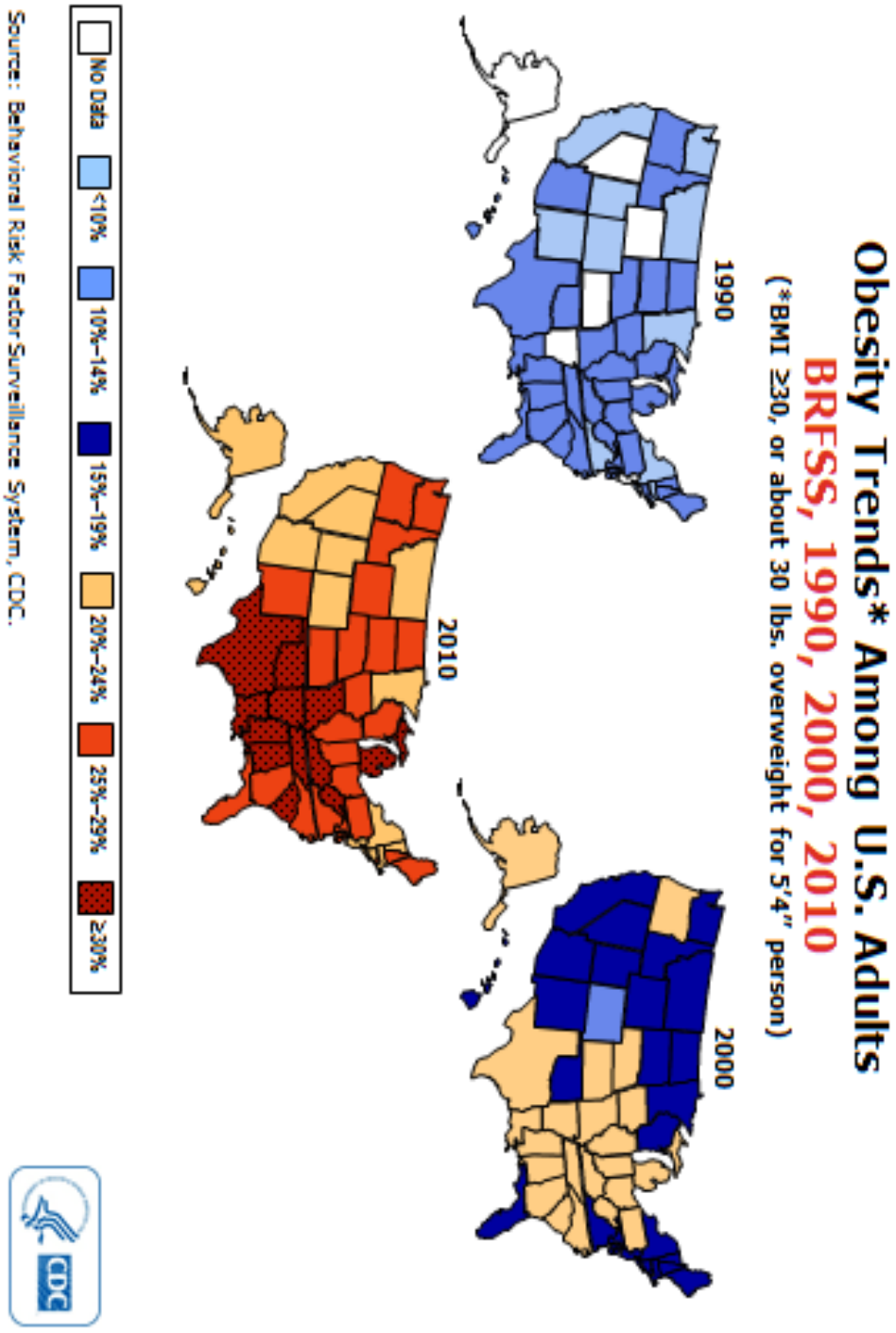
Source: Screen Dump St. Jude Medical web page: http://www.sjm.com/csr/2011/people/balance.aspx

Appendix 25: St. Jude Medical Employee Composition



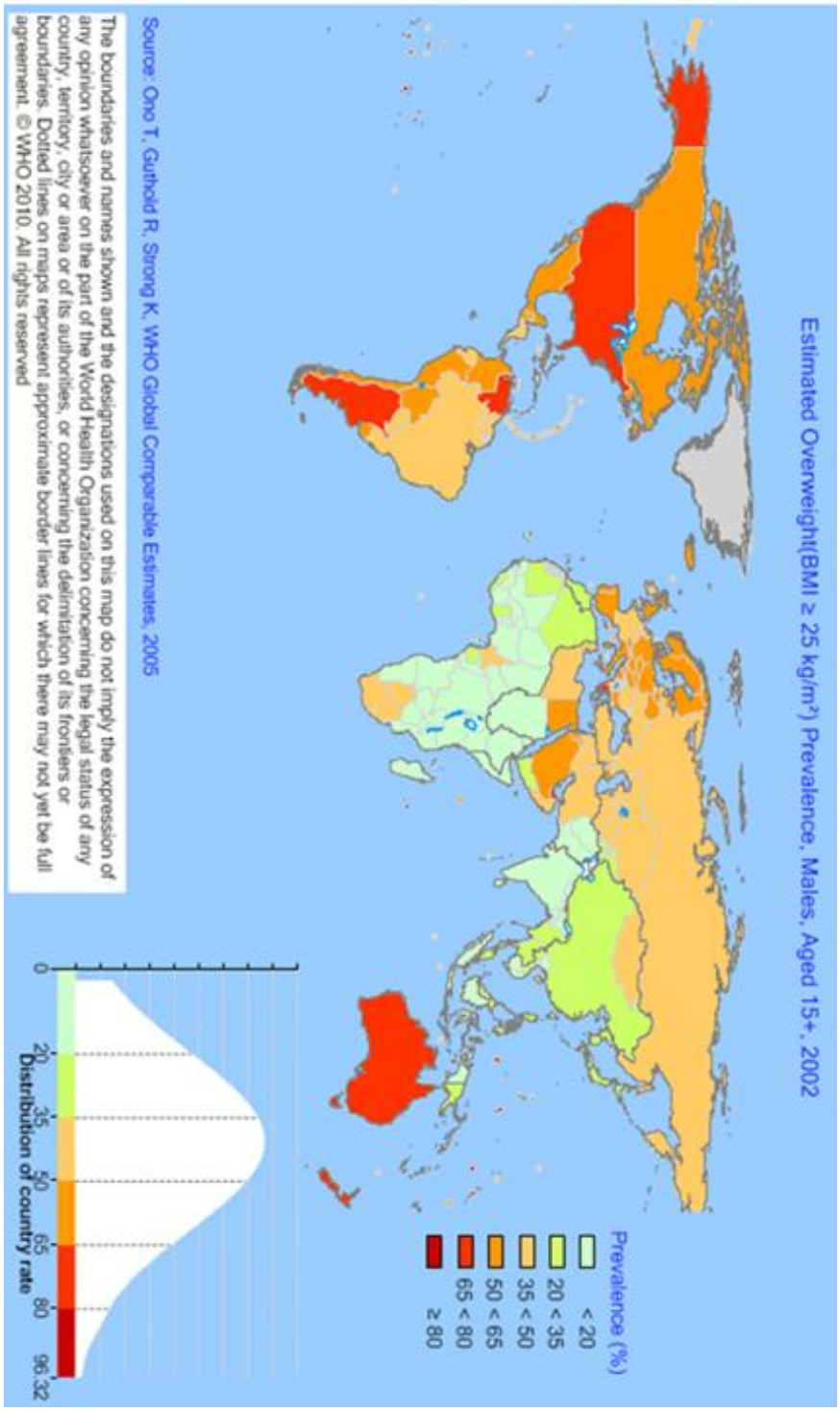
Source: St. Jude Medical, *Corporate Sustainability Report*, 2011, p.21: http://www.sjm.com/csr/2011/~/media/SJM/CSR/2011/Files/2011_CSR%20INTERACTIVE.ashx

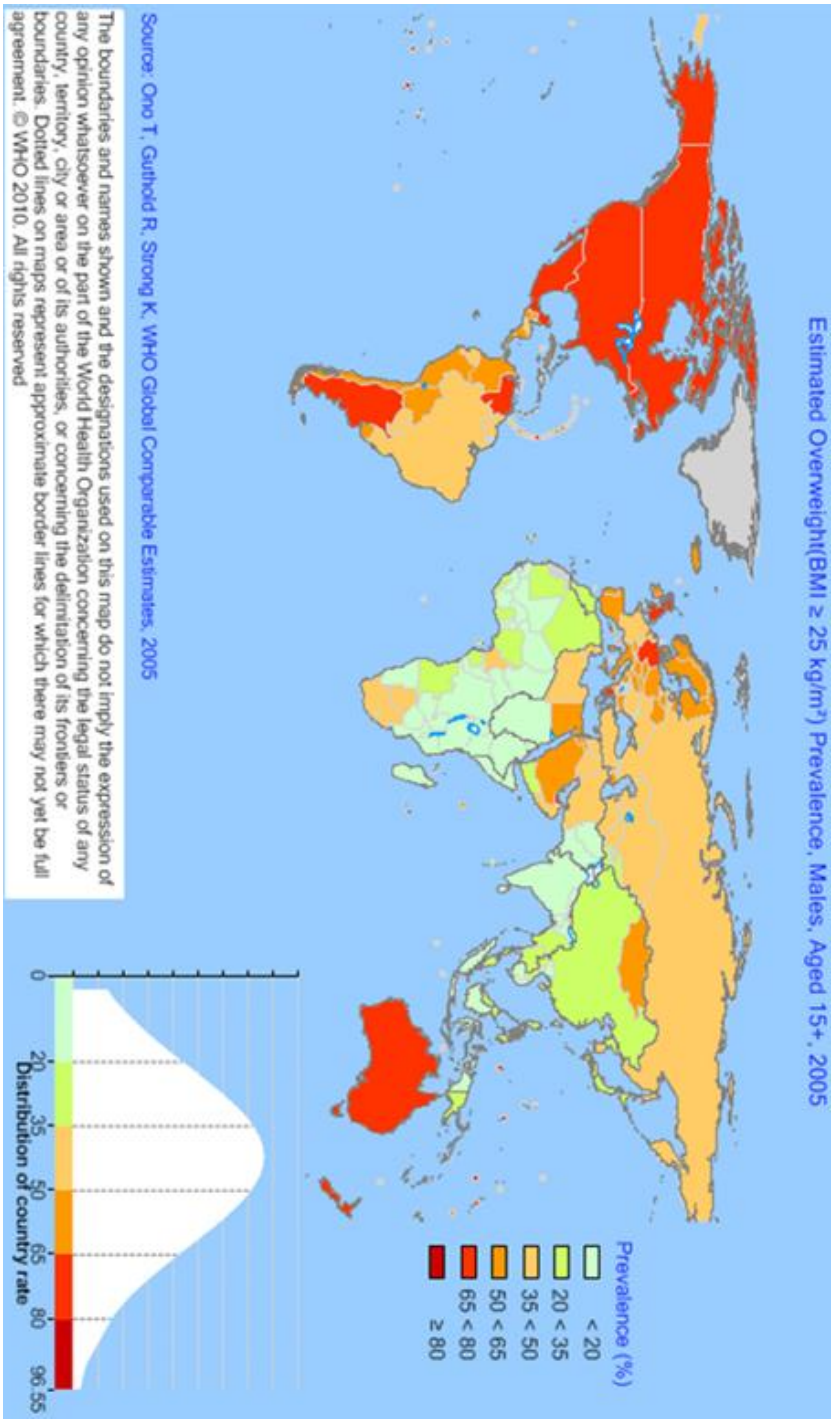
Appendix 26: Obesity Trends Among US Adults 1990, 2000, 2010, State-level

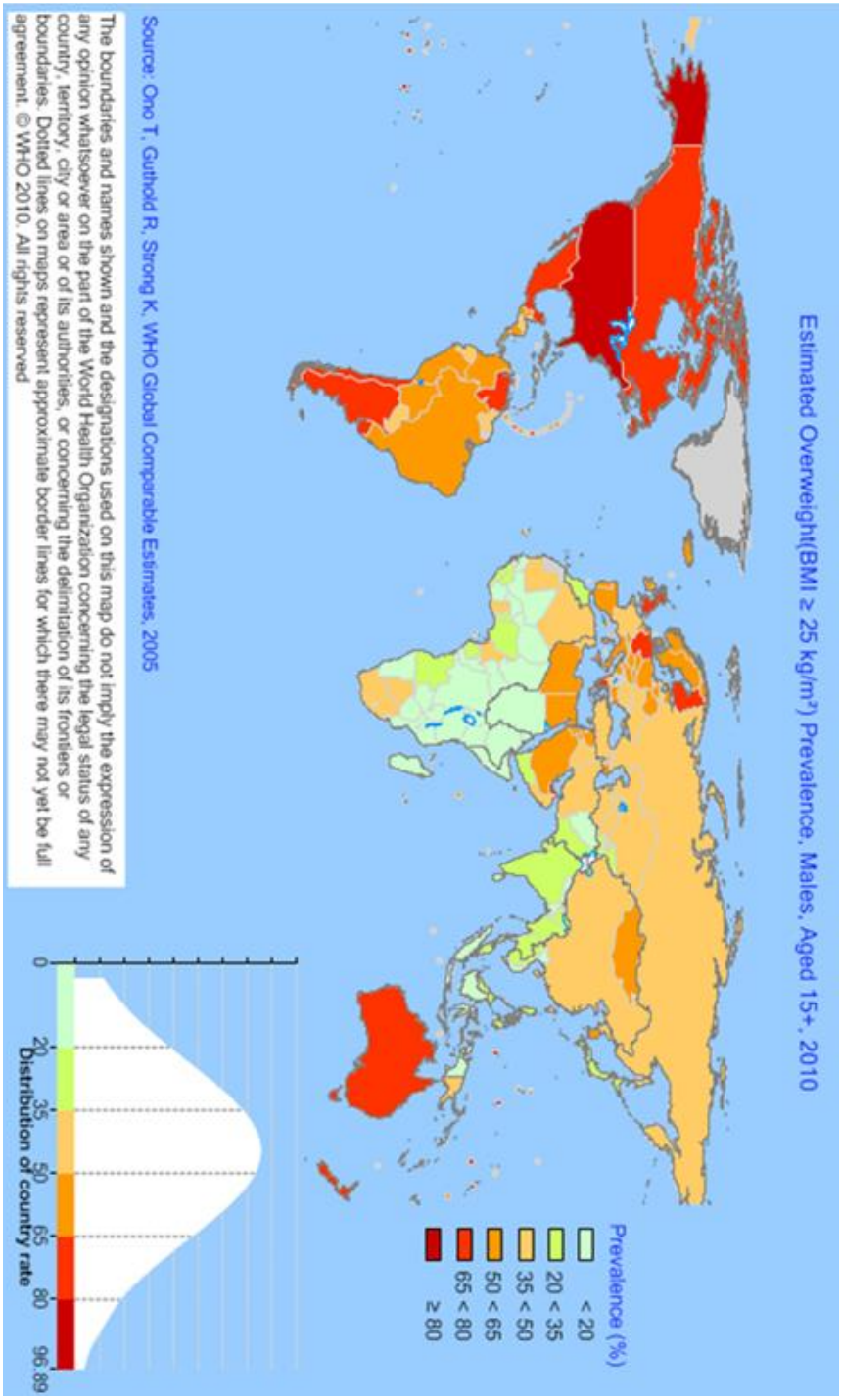


Source: Centers for Disease Control and Prevention:
http://www.cdc.gov/obesity/downloads/DNPAO_State_Obesity_Prevalence_Map_2011_508.pdf

Appendix 27: Estimated Overweight and Obesity (BMI ≥25kg/m^2) prevalence, Males aged 15+, 2002, 2005, 2010 (3 pages)

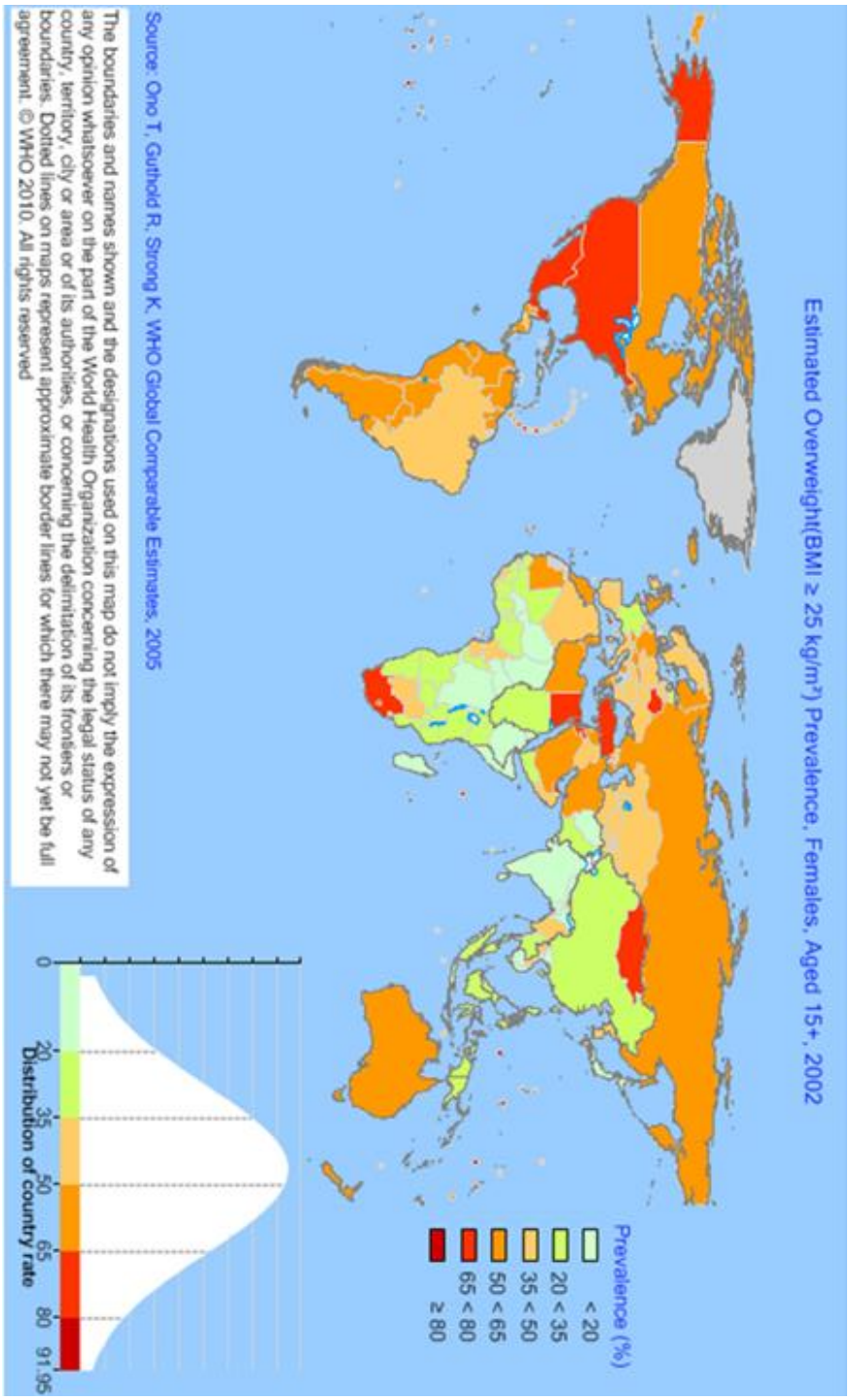


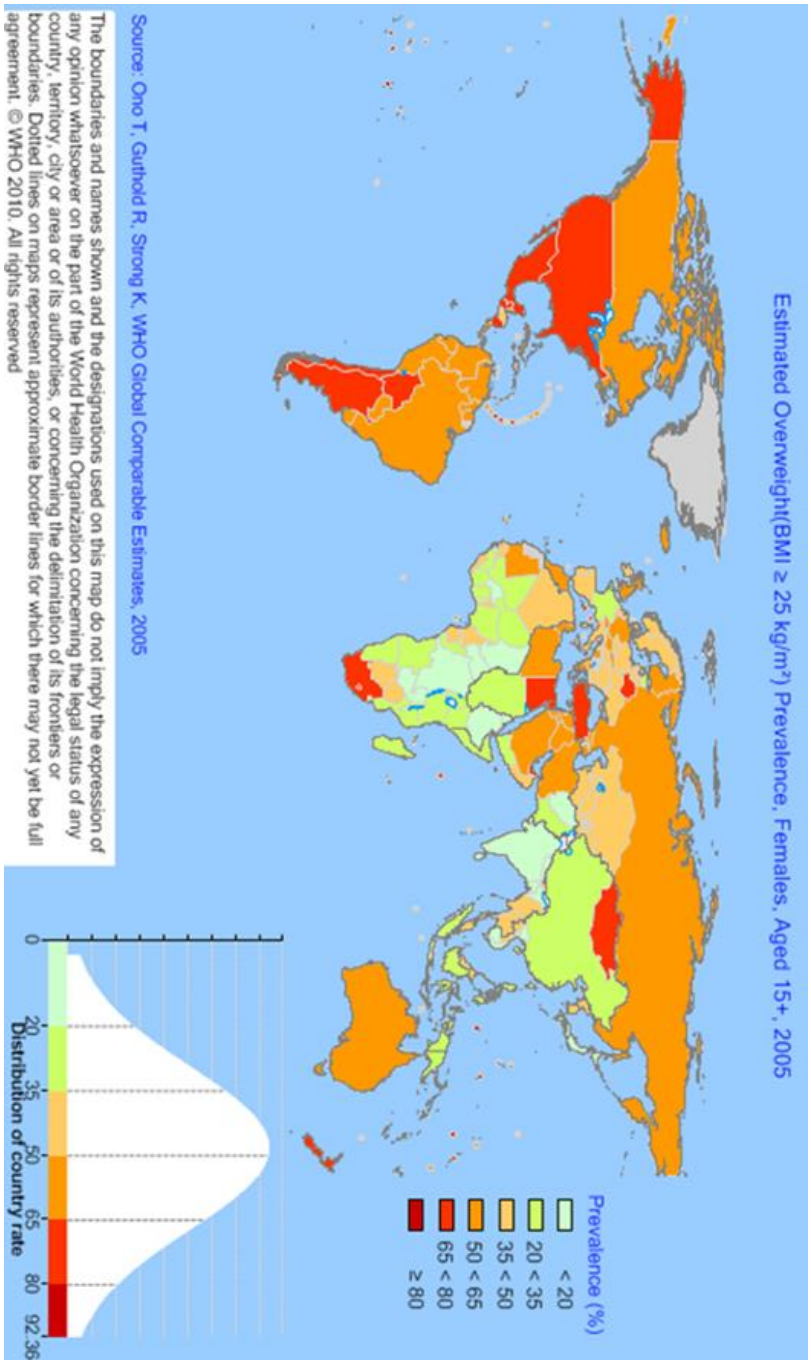

Estimated Overweight(BMI ≥ 25 kg/m²) Prevalence, Males, Aged 15+, 2005
Prevalence (%)
< 20
20 < 35
35 < 50
50 < 65
65 < 80
≥ 80
Distribution of country rate
0
20
35
50
65
80
96.55
Source: Ono T, Guthold R, Strong K, WHO Global Comparable Estimates, 2005
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. © WHO 2010. All rights reserved

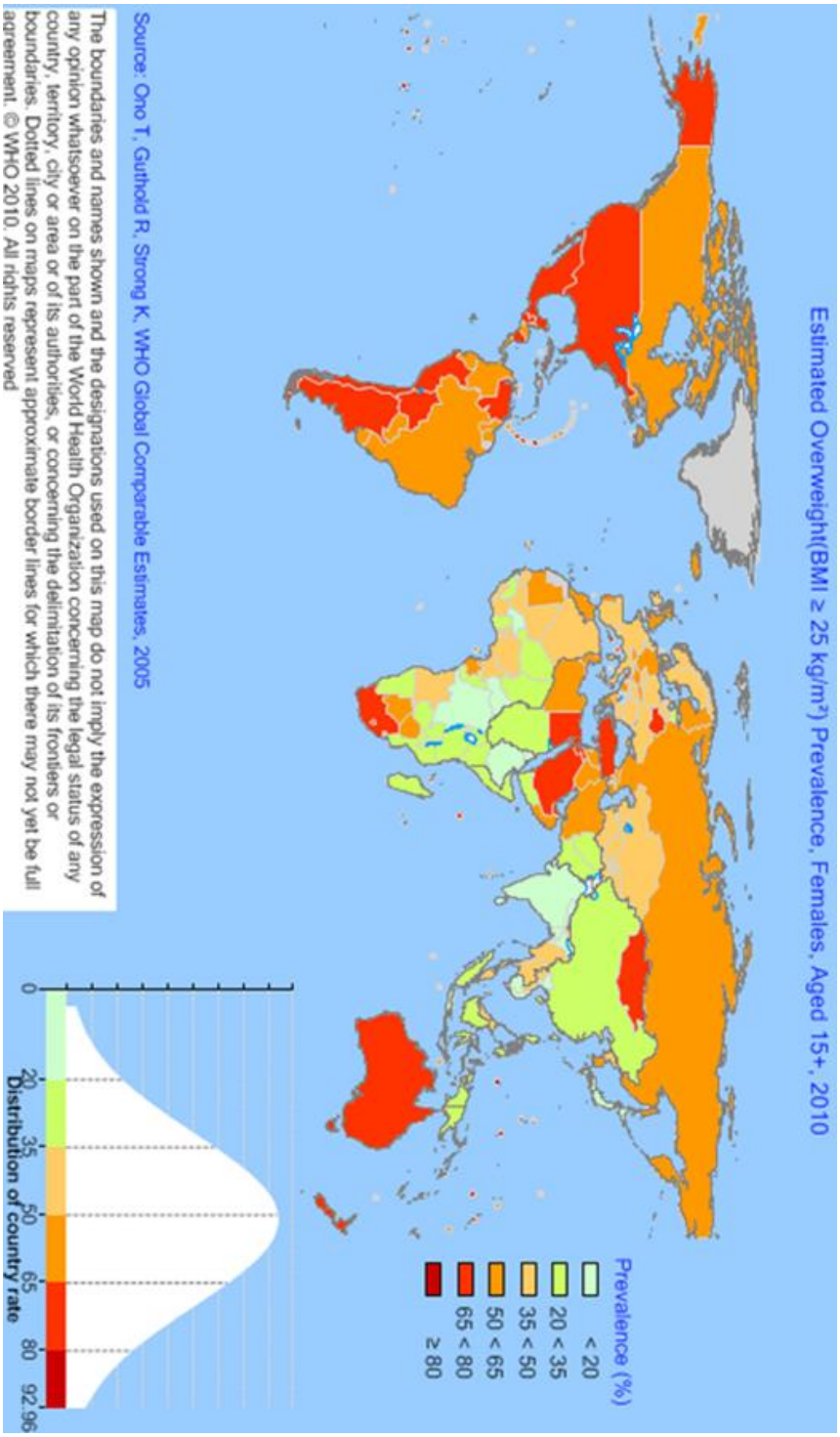


Source: World Health Organization, https://apps.who.int/infobase/?id=1

Appendix 28: Estimated Overweight and Obesity (BMI ≥25kg/m^2) prevalence, females aged 15+, 2002, 2005, 2010 (3 pages)




Estimated Overweight(BMI ≥ 25 kg/m²) Prevalence, Females, Aged 15+, 2005
Prevalence (%)
< 20
20 < 35
35 < 50
50 < 65
65 < 80
≥ 80
Distribution of country rate
0
20
35
50
65
80
92
36
Source: Ono T, Guthold R, Strong K, WHO Global Comparable Estimates, 2005
The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. © WHO 2010. All rights reserved



Source: World Health Organization, https://apps.who.int/infobase/?id=1

Appendix 30: E-mail Correspondence with Mr Martin Kristiansen Global NovoHealth Manager at Novo Nordisk

MKTN (Martin Kristiansen) <mktn@novonordisk.com> 26/10/12

til mig

Hej Mary

Tak for mailen.

Jeg har svaret på dine spørgsmål nedenfor, hpber det giver mening.

Ha en god weekend,
Martin

From: Mary Messerschmidt [mailto:marymesserschmidt@gmail.com]
Sent: 26. oktober 2012 11:52

To: MKTN (Martin Kristiansen)
Subject: Re: Out of Office: CBS specialestuderende søger samarbejde

Hej igen Martin,

Jeg håber, du har haft en god forretningsrejse. Som lovet har jeg nedenunder skrevet nogle spørgsmål, jeg godt kunne tænke mig at høre mere om vedrørende jeres NovoHealth program:

-Hvorfor og hvornår blev NovoHealth startet?
NovoHealth startede som et dansk tiltag i 2004 og i 2006 blev det besluttet at vi skulle definere en global strategi.
Begrundelsen for NovoHealth er, at vi som virksomhed vil bekæmpe diabetes på alle fronter og en af de vigtigste roller i bekæmpelsen af type-2 diabetes er forebyggelse, dette taler vi meget om både eksternt og internt. Det er vigtigt for os som virksomhed, at vi går forrest som det gode eksempel i kampen mod diabetes, det gør vi bla. med vores NovoHealth program.
-Hvem deltog i udformningen af programmet?
Den øverste ledelse, samt et rådgivende panel hvor flere læger var med til at definere de vigtigste indsatsområder
-Hvornår blev det implementeret og hvordan blev det modtaget?
NovoHealth blev rullet ud globalt i januar 2008 på en stor event for de 300 øverste ledere i Novo Nordisk
-Hvor mange ansatte benytter sig af NovoHealth tilbuddet?
Det kan jeg ikke svare på da vi ikke har data for hvor mange der burger locale initiative ude i verdenen. Men alle som spiser i vores kantiner er jo påvirket af NovoHealth, da vi har været med til at definere vores globale kost-guidelines
-Du nævnte, at I traf en beslutning om ikke at måle effekten af programmet, på hvilken baggrund blev denne beslutning truffet?
Vi måler ikke på ROI (return on investment), sygefravær og den slags. Begrundelsen for NovoHealth er som nævnt at forebygge diabetes og andre livsstilssygdomme, vi ser derfor i stedet på nedbringelse af risikofaktorer.

Appendix 29: Disney Nutrition Guidelines (5 pages)

Corporate Social Responsibility – What's Weight Got to Do with It?

Executive Summary

Corporate Social Responsibility (CSR) has gained momentum for the past decades - as a concept it has primarily been focused on what businesses can do to lessen their negative environmental impact and pro-poor development but it has begun to encompass more foci as more social ills has gained prevalence. This thesis looks at what businesses can to for their stakeholder-employees via health-oriented CSR programmes, specifically overweight and obesity (O&O). O&O is a new and somewhat controversial topic on the social agenda but one that has direct influence on the daily running of business as well as the bottom line. In fact, the prevalence of O&O worldwide has reached epidemic proportions as noted by the World Health Organization.

In order to attain usable data a multi level comparative case study approach was chosen. It looks at the development of O&O in Denmark as compared to the United States of American with Novo Nordisk and St. Jude Medical as case companies, representing each their nation. These were chosen as *best case* firms because they already have CSR initiatives indirectly targeting O&O in the work place, as well as being large international companies within the health care industry. Being such a new topic on the international CSR scene a qualitative approach was chosen to garner in-depth information and because the little quantitative data available was at country-level. The topic was chosen as because increased O&O levels bring with them many preventative sequelae in the form of, *inter* alia, diabetes, heart disease, psycho-social problems and sleep apnoea. These sequelae all incur increased morbidity and mortality affecting business operation via increase absenteeism and presenteeism levels.

However, in order to bridge the literature gap on this specific topic means that theoretical approaches were chosen so as to encompass the topic in its entirety: 1) Institutional theory with the implicit-explicit - framework proposed by Matten & Moon to highlight the difference in CSR approaches between the Danish and the American contexts, 2) Stakeholder theory to see the salience level of the stakeholder-employee and why firms must target her via CSR initiatives , and 3) CSR theory and the seven patterns of CSR integration as proposed by Yuan *et al*. to see how firms may chose their best strategic fit.

To highlight the issue the following research question was formulated: With overweight & obesity on the rise should firms engage in CSR programmes targeting the stakeholder-employee? This is comprehensive and two sub-questions were used to guide the discussion and analysis these looked at the right of firms to target O&O, and using the case companies which integration mode was chosen. It was found that O&O in and of itself can be seen on the health care budgets of both Denmark and the USA and in turn affects firms

via increased absenteeism and presenteeism on the basis of the increased costs to firms including the two previously mentioned areas issues such as retention also arise. Moreover, being a highly salient stakeholder ensuring the continued happiness, loyalty and presence of the employees such a focus via health oriented CSR initiatives are a must with the ever expanding role of firms. Furthermore, it was concluded that yes initiatives should be implemented but with the *caveat* that in the beginning offering it was a voluntary programme was necessary in order to not alienate the stakeholder-employee. But gradually a reality of being a healthy and responsible firm would probably ensure increased participation.

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