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Health of Entrepreneurs

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Stating the Existence of a Blind Spot

The French economy has very few statistics regarding occupational health in SMEs, particularly with regard to the employer. This fact, however, is not specific to France. At the current time, it seems that there is very little work and very few statistics from abroad either on this theme. There is thus an almost universal lack of information. Occupational health appears to have been pushed away from the entrepreneurial realm.

Nevertheless, one of the founding works on occupational medicine, written by Ramazzini in the 1700s, is entitled the “*Traité de la maladie des artisans*” (Treaty on the illnesses of craftsmen) (*De Morbis Artificum Diatriba*). Its aim, wrote Ramazzini, was to understand through observation why certain trade associations seemed preserved from certain dangers, such as the plague, for example, when others presented on the contrary much stronger prevalence. As man spent more time working than doing anything else, the conditions in which he did it, as well as the fact of handling certain harmful or healthy substances inherent to his business, were able to explain his health. Occupational medicine was born.

The most notable and most decisive progress with regard to occupational health came undoubtedly from Louis René Villermé who, in the nineteenth century, was interested in the work conditions of the working class in a context of increasing industrialization. His major work, the *Tableau de l'état physique et moral des ouvriers employés dans les manufactures de coton, de laine et de soie* (Table of the physical and moral state of the workers employed in cotton, wool and silk factories), which was first published in 1840, was the origin of a law limiting child labor in factories. The role played by Villermé and the rise of industrial hygienism explain why occupational medicine focused on the effects of mass industrialization on health at work.

Occupational medicine probably has a more social mission than other medical disciplines: its genesis in the nineteenth century and its extensions in the twentieth century have, over time, defined an implicit social purpose, to defend the weakest (the work of women and children) and especially the underprivileged classes. In such a context, the working class becomes central, and “workerism” still remains strongly anchored in the writings of contemporary occupational doctors. René Barthe, who was the inspiration for the law of July 28, 1942 in the Vichy regime which established occupational medicine as an obligation and was the author of the first “*Que Sais-Je*,” on occupational medicine, in 1944, declared “Let us be the good ‘housekeepers’ of our factories, as our farmers are the good

“housekeepers” of our land. This essay aims to present this new culture, which is a permanent effort for a better life for our working class world” (Barthe 1944, p. 9). The question of workers’ health remained for a long time and is, even today, a profound identity marker for occupational medicine. It is moreover in the bastions of industry that developed the first initiatives for a chair of occupational medicine, such as in Lyon in 1930 or in Lille in 1935, in the heart of the mining cottages of the mining industry in the North. Today, there is still a strong tradition for occupational medicine in Lille.

In France, occupational medicine has been highly structured since the law of 1946 (Desoille 1958). It focuses almost exclusively on the occupational health of employees. Barthe considered that a “definition of Occupational Medicine is easy to find if we restrict ourselves to its general principle: it is a Social science directed toward the protection of employees in their very place of work” (Barthe 1944, p. 6). This focus on employees only has had two consequences.

On one hand, occupational medicine has allowed numerous forms of social progress to develop and analysis of employees has been perfected with subtle subcategorizations: workers are divided into qualified and unqualified. Similarly, statistics make a distinction, with good reason, between executives and senior executives. On the other hand, the disadvantage is that the self-employed are totally excluded from the tables and any data calculated on such matters. Only directors with employee status are covered by occupational medicine, although only 170,000 companies have such directors and are a tiny minority with regard to the 2,411 million nonwage earners counted by INSEE (National Institute for Statistics and Economic Studies) in France in 2008.

For this reason, as soon as it is a question of nonwage earning independent workers, there are less statistics, and those that are there are more vague because they are very heterogeneous. Sometimes storekeepers and craftsmen are included. Sometimes there are the liberal professions, as if master bakers or stonemasons can be

compared with professionals such as attorneys and lawyers! Where are the business managers, who are neither craftsmen, nor storekeepers, and even less liberal professions? How do we make a distinction between the leaders of very small firms, small firms, and medium-sized companies?

Do the statistics for occupational health take into account managerial contingencies, in particular those related to the size of workforce? Experts were skeptical at first, but no longer have such doubts today. The concept of SME, taken in its full complexity, is not a relevant category for the medical sciences. Nevertheless, independents work in conditions with many particularities.

Although health is an essential topic, the health of business managers is an unrecognized aspect. Nevertheless, the health-capital of the director, whether he is a craftsman or a storekeeper, is probably the first immaterial asset in the company because dependence on the director is all the greater if the company is small, and this is precisely the main feature of small shops and the craft industry (Mouzaoui and Horthy 2007). Henri Fayol, in his *Administration Industrielle et Générale* makes health and physical strength the first cardinal value of the business manager. “The qualities and desirable knowledge for all CEO are as follows:

1. Health and physical strength
2. Intelligence and intellectual strength
3. Moral qualities: well-thought out, firm desires, and perseverance; activity, energy and, if necessary, audacity; the courage of responsibilities; a feeling of duty; and a concern for general interests
4. Good general knowledge
5. Administrative capacities
6. General notions of all the main functions
7. The widest possible range of skills in the particular profession that is characteristic of the company”

The director’s health is often synonymous with the good health of the company, whereas on the contrary, a health problem can bring down the whole company (Chao et al. 2007; Massey et al. 2004).

Fayol adds that “the absence of health can cancel out all other qualities together”

(Fayol 2005, p. 84). It is enough to think of the devastating effects which a health problem can have on small-sized companies, as Chao et al. (2007) do with AIDS to show the value of cross-referencing medical sciences and entrepreneurship sciences. All these considerations plead in favor of a study of the health-capital of directors, in the style of what Bournois and Roussillon (2007) did in the context of the directors of large groups, but instead adapting it to the specificities of SMEs (small- and medium-sized enterprises).

The objective of this contribution is to draw up a corpus of hypotheses on the occupational health of entrepreneurs. Then, it presents the fundamental equation for entrepreneurial health. What researchers know about the working environment of entrepreneurs pushes them to believe that their working system is pathogenic (work overload, stress, uncertainty, loneliness. . .). But, in reference to the works on “salutogenesis” (Bruchon-Schweitzer 2002) which can be traced back to the middle of the 1990s in the field of health psychology, this entry will show that these negative effects are probably compensated for (in whole or in part?) by a system of beliefs which can be beneficial for health. The key question is to know in which direction the scales are tipped.

Given what is at stake, studying the beliefs, attitudes, and behaviors of entrepreneurs with regard to physical and mental health is a surprisingly virgin field of research (Kaneko et al. 2011). The results of such research could be very interesting. The initiative behind the AMAROK observatory, the first observatory for entrepreneurial health, is part of this perspective. Certain aspects of this observatory are presented in the conclusion.

The Failings of Health Statistics for Entrepreneurs

“Self-employed” is a banner label for all independent workers with no employer, employers themselves, and home helps. In 2008, they represented 9 % of the active population in France. The lowest percentage (5 %) is found in the Paris area, while Languedoc-Roussillon has the highest, with 13.5 %. To answer the question of the health of this population, the observer is

obliged to notice that the existing statistics are profoundly insufficient, both at the quantitative and qualitative levels. The first notable fact is the almost total absence of data on the health of SME directors. It is true that SMEs are not regarded as a relevant dimension for studies on health.

Among the most commonly selected variables, there is a high frequency of age; gender; average revenue; socioprofessional categories; level of study; and, to a lesser extent, place of residence and marital status. It is thus very difficult to obtain statistics which are dedicated exclusively to SMEs.

It is, however, possible to obtain some statistics which get closer to the world of SMEs, even if they do not exhaust the subject: it is the statistics which are interested in the social and occupational group of craftsmen and storekeepers. Even if these statistics are invaluable when it comes to tackling the problem of the health of directors of SME, they are nevertheless presented under a common category of extremely heterogeneous situations. These statistics often group together the category of storekeepers with that of craftsmen. However, the trade and craft industries have notable differences with regard to the relationship to work and know-how and trade union representativeness (Medef/CGPME for the trade vs. UPA (Professional Union of Craftsmen) for craftsmen).

Similarly, craftsmen develop the use of manual work much more than in trade, and manual work often involves a more intense use of the body, which can result in specific pathologies. Shopkeepers and craftsmen are thus two similar fields of activity as they are often keen to preserve their independence but which nevertheless have differences. These differences, in terms of health, deserve greater differentiation.

But the worst is that sometimes studies are based on figures which mix craftsmen, tradesmen, and liberal professions. Although the liberal professions are also concerned by independence, as evidenced by the professional orders which govern them, they have very considerable differences with craftsmen and tradesmen. For example, the “level of study” variable is generally high in liberal professions and much lower among craftsmen and

tradesmen. Yet, it has been proven that this variable has an impact on health (Bruchon-Schweitzer 2002). Another variable that has an incidence on health is the capacity for organization of liberal professions when in work collectives.

Lawyers, chartered accountants, medical specialists, solicitors, land surveyors, and receivers work much less on their own than previously. Increasingly, they group together as partners, which greatly facilitates the pooling of means (secretarial department, office) and resources (clientele, network), as well as making possible a better management of absences, particularly in case of illness or vacation time. In addition, the feeling of loneliness is reduced, and certain works have shown that loneliness has a pathogenic impact on health (Bruchon-Schweitzer 2002). Storekeepers and craftsmen, on the other hand, are often very much alone in their jobs, and this can be an almost insoluble problem when they fall ill or wish to take time off.

Another point which deserves to be underlined is the total ignorance of the size of the staff for which storekeepers and craftsmen are responsible. Although most storekeepers or craftsmen work alone, sometimes with the assistance of their spouses or children (what statistics refer to as family help), many businesses have employees, sometimes several dozen. This gives these storekeepers/craftsmen the role of an employer business manager. But the statistics never provide information regarding the size of the company of which the storekeeper or craftsman is the director. In other words, the size of the staff is never indicated, and it is a shame, as it is a situation which strengthens the impression that the statistics for health in the work place are not interested in SMEs.

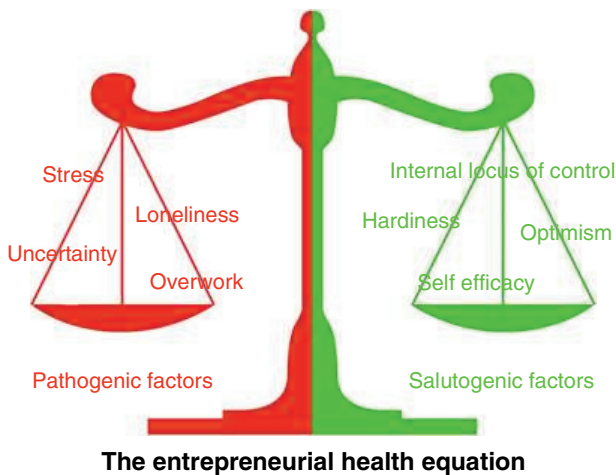
In spite of all these limitations associated with the heterogeneity of the craftsmen and storekeepers socioprofessional category and the even greater heterogeneity of the craftsmen, storekeepers, and liberal professions category, we can, by cross-referencing the few statistics available, nevertheless obtain a body of evidence which converges on the same observation: craftsmen and storekeepers sometimes have a state of health more like that of workers than that of senior executives.

The Entrepreneurial Health Equation: Pathogenic Factors Versus Salutogenic Factors

The health of entrepreneurs is subject to permanent conflict between pathogenic factors, which have a negative impact on health, and salutogenic factors, which are beneficial. The equation for entrepreneurial health is thus:

On the one hand, although occupational doctors have long been aware that overwork, stress, uncertainty, and solitude are long-term pathogens for employees (Leclerc et al. 2008; Niewiadomski and Aïach 2008), they have never wondered what effect these factors have on employers. But how is it not possible to see just how much entrepreneurs often accumulate these four factors? Many works have been published on overwork and the resulting increase in stress (Buttner 1992; Akande 1994; Mcdowell-Larsen 2007; Ahmad and Salim 2009) among company owners, who often work more than 60 h a week (Boyd and Gumpert 1983; Rousillon and Duval-Hamel 2006). Uncertainty is also one of the fundamental elements of the entrepreneur, one of whose characteristics is that he has variable income, unlike the regular monthly salary paid to employees. In certain sectors, the order book does not go further than a few months in advance, sometimes just a few weeks in times of crisis. The director must deal with this uncertainty on a permanent basis. Finally, Gumpert and Boyd (1984) have insisted heavily on the isolation, or even solitude, of directors, to the extent that the use of entrepreneurial networks, or associations of peers, is often salutary. Such isolation makes the director fragile, and when difficult decisions – such as redundancy – have to be made, directors are often filled with doubt and remorse (Torrès 2009).

On the other hand, health psychologists (Bruchon-Schweitzer 2002; Fischer and Dodeler 2009) are aware that the internality of the locus of control, endurance (hardiness), self-efficacy, and optimism are all salutogenic... even though they have never noticed that they are simply entrepreneurial attitudes and beliefs! Once again, how is it possible to not notice that these are characteristics that are often associated with entrepreneurs? Although empirical studies hoping to validate the



Health of Entrepreneurs, Fig. 1 The entrepreneurial health equation (Source: Torrès 2012)

locus of control theory have never been able to establish even a modest correlation between this psychological characteristic and entrepreneurs, it nevertheless remains positive (Janssen and Surlémont 2009, p. 41). Verstraete (1999, p. 165) also evokes the importance of the internality of the locus of control in entrepreneurial behavior. Finally, Filion (1997), by identifying the works from what is known as the “school of characteristics,” showed that optimism and perseverance are psychological traits common to entrepreneurs. The same can be said for self-efficacy (Bradley and Roberts 2004). Entrepreneurship, is it good for health (Volery and Pullich 2010)? (Fig. 1)

Hence, this fundamental equation for entrepreneurial health: on the one hand, we accept the work of occupational medicine is interesting; there is a system of constraints to which a large number of directors are subject and which seems to be pathogenic. And, on the other, recent works from the field of health psychology, which show that the entrepreneurial attitude and belief system is in fact salutogenic. The question this raises is thus how do we know when the scales are going to tip one way or another?

Conclusion and Future Directions

It was in the aim of resolving this entrepreneurial health equation that the initiative of creating the

AMAROK observatory is appeared, the first such structure for the health of SME owners. AMAROK is an Inuit name that means wolf. It refers to a legend, the moral of which is that a society must protect those who support it.

AMAROK is an observatory with a scientific and experimental vocation, the aim of which is to study the beliefs, attitudes, and behaviors of SME owners, craftsmen, and tradesmen with regard to their physical and mental health. Based on the theories governing the specificity of SMEs, this observatory also aims to devise and propose practical actions in the field both in terms of prevention and cure. The priority population is that of SME owners and craftsmen.

The objective of this observatory is to combine medical and entrepreneurship sciences. The AMAROK project is complex and requires a multidisciplinary approach. The scientific skills mobilized involve occupational medicine and public health, entrepreneurship and management, health and workplace psychology, as well as the economy and geography of health. However, this observatory remains anchored primarily in management science because the ultimate purpose is to improve SME management.

By combining the two sides of the employers’ health equation (i.e., the pathogenic and salutogenic aspects), AMAROK hopes to attain an ambitious goal: ideally, AMAROK would like to produce the first medium-term statistics on the health of employers. The issues at stake are perfectly matched to this ambition.

- Either AMAROK discovers that the owners of SMEs, craftsmen, and tradesmen put their health in danger without their knowledge and brings to light a public health scandal
- Or, on the contrary, AMAROK will discover that entrepreneurship is beneficial for health. In the latter case, AMAROK will have one of the best arguments for promoting human-sized enterprises and craft industries: SMEs are good for your health!

In the medium term, the aim of AMAROK is to create one of the first epidemiological records of a cohort of SME managers. The stakes are high because the sums involved are substantial and the commitment must be long term (one to several

decades) (Bousquet; Dreyfus Daures, Demoly, 2004). It is important to know that there is no such register anywhere in the world.

Cross-References

- ▶ [Entrepreneur](#)
- ▶ [Entrepreneurial Capability and Leadership](#)
- ▶ [Entrepreneurship and Social Inclusion](#)
- ▶ [Individual determinants of Entrepreneurship](#)

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Healthcare and Innovation

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Synonyms

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