Workplace health and wellbeing in construction and retail: sector specific issues and barriers to resolving them

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1. Introduction

Health and wellbeing in the work place is of paramount importance to individuals, businesses and society at large. The workplace is where people in employment spend most of their waking hours, and the workplace community is one to which most adults belong. A healthy and happier working population is not only an ethical priority for business, but can also benefit business materially through increased productivity and reduced costs associated with injuries and illness including costs relating to presenteeism and sickness absence (Hosie and Sevastos, 2015; Goetzel and Ozminkowski, 2006; Shain and Kramer, 2004). There are also wider costs to society of ill-health reflected in the priority given to health policy, and the workplace has been identified as an important setting in which to implement interventions to reduce the health care risk associated with inactivity and being overweight (World Health Organization (WHO), 2011).

The focus of this study on the construction and retail sectors reflects previous research which suggests that both sectors, but the former in particular, have significant workplace and industry level stresses. For example, in reviews of previous research high levels of stress have been reported in construction particularly for project managers (Fenton *et al*., 2015; Love and Edwards, 2005). Love *et al.* (2010) claim that "construction professionals are subjected to a plethora of occupational demands that can have a negative effect on their psychological wellbeing" noting that "such demands can have an adverse influence on individual and organisational performance" (Love et al., 2010: 650). Du Plessis *et al.* (2013: 716) link poor health outcomes including musculoskeletal degradation, high rates of disability, chronic disease and mortality for male blue-collar construction workers in Australia to the physical nature of their work. Du Plessis *et al*. (2013) also point to the high proportion of short-term projects in construction and consequent loss of continuity as another causal factor underlying stressful environments in the sector. In the UK the Health and Safety Executive (2014) report higher than average rates of Musculoskeletal Disorders (MSDs) in four sectors that include specialised construction the other three being agriculture, postal and courier and health care. In a comparison of occupations the UK Health and Safety Executive (2014) also identifies the building trades along with nursing, personal care and skilled agriculture trades as having higher rates of total cases of MSDs. This body of evidence also highlights some policy and practice implications. For example, the work of Groeneveld *et al.* (2011) on construction workers in the Netherlands and to a less extent that of Sorensen *et al*. (2007) in the USA and Canada, highlight a role for sustained intervention programs to encourage smoking cessation. Love *et al*. (2010:657) also note that while self and social stress were contributors to poor mental health of construction managers, "the presence of work supports may be an important factor in preventing stress" and "social and work supports may have a preventative role in stress conditions arising from the workplace by actively promoting good mental health".

However, the construction sector is not alone in being associated with particular mental and physical health risks. For example, Wilson *et al.* (2004:582) found that in the retail sector "work characteristics influence psychological work adjustment factors that ultimately affect employee health and well-being". In a Canadian study, Marchand (2007) found that that the retail trade was one of four industries where higher risks of poorer mental health were concentrated (the others were manufacturing; wholesale; transportation and warehousing). An earlier study (Vézina and Gingras, 1996) also found higher risks for mental health problems in seven sectors that included shoe, clothing, and textile retail stores, department stores and restaurant services. Braun and Morton (2008:6)

additionally found that the sales and services (including retail) as well as trade (including construction) sectors were among the four Canadian sectors reporting the highest smoking rates (the other two were transport or equipment operators and processing, manufacturing or utilities occupations). In another Canadian study, Macdonald *et al.* (2006) found that Employee Assistance Programmes (EAPs) were under-represented in both the retail trade and the construction industries. They attributed this to the types of employment contracts within these two sectors specifically lower wages and benefits for retail and trade workers and the high percentage of contract workers in construction (Macdonald et al., 2006: 124). This body of evidence confirms that the construction sector is associated with a high incidence of health and wellbeing risks. However, other sectors, including the retail sector also show a high prevalence of mental health problems and poor health choices associated with negative health outcomes amongst the workforce.

In response to this evidence we conducted in-depth, semi-structured interviews with a sample of experts in the construction sector with the aim of exploring health and wellbeing issues, the factors underlying these issues and the obstacles to improving the health and wellbeing of the workforce. We also conducted interviews with a small sample of experts in the retail sector in order to provide a point of comparison. The retail sector was chosen as a comparator because it is another sector that previous research indicates has particular health and wellbeing issues. However, in comparison with construction, specific evidence is limited: the US study by Wilson *et al.* (2004) is one of the few to have specifically explored workplace wellbeing in the retail industry. The workplace environments in retail and construction are also very different and the intention in including these two contrasting work settings in the research design was to facilitate identification of workplace specific factors. These included a stronger focus on safety concerns linked to industry practices and more masculine culture in construction with a more holistic approach to workplace wellbeing in retail.

The paper is structured as follows. Section 2 describes the sample and methodology. Sections 3-7 discuss the main themes that arose from the interviews. Section 8 concludes by briefly summarising the main findings and highlighting some issues for further research, policy and practice.

2. Sample and methodology

This qualitative study conducted in-depth, semi-structured interviews with a purposively sampled group of ten experts, seven from firms in the construction sector and three from retail businesses. The interviewees were either directors, chief executives, senior managers, owner-managers, and/or had oversight or a particular interest or experience in workplace health and wellbeing. The participants and their businesses were purposively sampled and independently approached. The recruitment utilised business links associated with the wider portfolio of work in occupational health and workplace wellbeing in which this study was situated. The interviews were conducted with either company directors or owners or with managers or employees nominated because they had a particular remit, interest or specialist knowledge of workplace health and wellbeing. The broad features of the organisations participating in the study are summarised in Table 1 where all individual and company names, locations and any identifying details have been changed. The interviewees role within the company have also been omitted to preserve anonymity. Throughout the paper, names and locations and details relating to identifying activities have been either omitted or changed.

Table 1

ID PSEUDO NAME	SECTOR	MAIN ACTIVITIES OF COMPANY
1. **COLLECTIVEORG1**	Construction	Consultancy, representation, policy influence, advice and information, promoting best practice
2. **SPECENG**	Construction	Specialist engineering, maintenance, installation, modernisation, repair
3. **STEELBUILD**	Construction	Structural steel construction, manufacture and build
4. **COLLECTIVEORG2**	Construction	Training, advice and information, management support, data collation/management, evaluation
5. **BUILDTECH&TEST**	Construction	Building and civil engineering, testing services, geotechnical services
6. **BUILD&SUPPORT**	Construction	Infrastructure design, construction, maintenance, integrated support services
7. **INTERNATORG**	Construction (and related)	Specialist training/education, policy influence, guidance/information worldwide, campaigning,
8. **SUPERMARKET**	Retail	Supermarket
9. **HOMESTORE**	Retail	High street store (Home furnishing, carpets etc.)
10. **FASHIONSHOP**	Retail	High street store (men's and women's fashion)

The interviews were conducted by four of the research team in the participant's place of work or by telephone/skype using a pre-constructed interview schedule. The average duration of the interviews was 45 minutes. In the interviews we asked open questions adopting a narrative approach focussed on the participants' experience of work. The interview schedule incorporated some flexibility in order to respond to answers and the different sectors, work roles and experiences of the participants.

All interviews were transcribed verbatim and any identifiable data relating directly to the interviewees was anonymised. The interviews transcripts were analysed thematically in order to explore the significance of the individual experiences. We used a staged process based on grounded theory (Glaser & Strauss, 1967) that involved systematically coding transcripts and identifying themes and patterns across the data (Burnard *et al.,* 2008; Burnard, 1991). Initially the transcripts were read by the lead researcher and open codes allocated to individual concepts. In the next stage, similar codes were collated together into a smaller number of conceptual categories. In the final stage, themes were identified in relation to the coded extracts and the entire data set. To establish trustworthiness of the analysis, all transcripts and the thematic structure were subsequently reviewed by the co-researchers and cross checked to ensure congruence. Although the sample size was small, very few new codes were identified in the final transcripts. This perhaps suggests a shared knowledge of workplace wellbeing issues.

In the interviews, we asked the participants to talk about issues they had experienced in their own workplace or their sector more widely, any initiatives that were being undertaken to support the health and wellbeing of their workforces and any barriers to the implementation of such initiatives and workplace health and wellbeing more generally. However, the starting point of each interview was a question about the participants' own conception of workplace wellbeing and its importance in the context of their business. We thought it was important to begin the interviews in this way since the concept of wellbeing in general and ideas about workplace wellbeing are not always clearly defined and this has implications for the design and evaluation of workplace initiatives. Workplace wellbeing is a broad social concept reflecting quality of working life and incorporates the somewhat narrower concepts of physical and mental health (physical fitness, absence of illness or infirmity and mental stability) and, by implication, safety from health risks (Chartered Institute of Personnel and Development (CIPD), 2007:4). For example, mental wellbeing as defined by NICE (2009:6) citing the

Foresight Mental Capital and Wellbeing Project (Foresight, 2008) is: "a dynamic state in which the individual is able to develop their potential, work productively and creatively, build strong and positive relationships with others and contribute to their community. It is enhanced when an individual is able to fulfil their personal and social goals and achieve a sense of purpose in society". This definition captures the eudemonic approach to wellbeing, encompassing purpose and meaning and implies a strong link between wellbeing and physical and mental health as a personal resources (Foresight, 2008). In contrast, hedonic approaches to wellbeing, encompassing evaluation and affect, focus more on "the type of affective feelings that a person experiences (e.g. anxiety or contentment) and also on the adequacy of those feelings (e.g. whether the person is satisfied with certain aspect of their life)" (Bryson et al, 2014:12).

In line with the eudemonic definition, interventions focussed on wellbeing are often synonymous with maintaining and enhancing physical and mental health. Examples include: counselling for issues such as alcohol; diet and physical fitness programmes; health information and assistance; and, educational and behavioural interventions directed to stress management. Interventions reflecting the hedonic approach tend to focus on wider aspects of job satisfaction or contentment "which allows an employee to flourish and achieve their full potential for the benefit of themselves and their organisation" (CIPD), 2007:5). There are though points of convergence between the eudemonic and hedonic approaches as evidenced by Faragher et al. (2005: 105) who finds that "job satisfaction level is an important factor influencing the health of workers". A further complication is related to causality and effect as highlighted by Shain and Kramer (2004) and Hymel *et al.* (2011). The former emphasise how "the physical and psychosocial aspects of the working environment (organisation or work) can influence the abilities of individuals to care for their own wellbeing and to maintain their own 'personal resources'". Figure 1 develops their approach by highlighting how both external and individual factors may be important drivers for the success of workplace health and wellbeing interventions. This multidimensionality suggests that workplace wellbeing programmes may need to be constructed holistically in order to allow for the interconnections between different wellbeing outcomes as well as work-related and non-work-related, "social contextual" factors (Quintiliani *et al.,* 2010).

In the interviews we did not impose any prior definitions of workplace wellbeing or give clues as to causality as we were interested in how the participants, as industry experts, conceived these issues, their causes and how they could be resolved. In the following sections, the findings are discussed in detail as aggregates of the individual narratives. The main themes centred on the conceptualisation and value of workplace wellbeing; different health and wellbeing issues; barriers to workplace wellbeing; and, future trends and issues.

3. Conceptions and value of workplace wellbeing

In construction there was a tendency to adopt a eudemonic approach in a focus on health and safety. For example defining wellbeing in terms of general health (SteelBuild) or focusing on the quality of the working environment (SpecEng). Diet, hygiene and workplace relations were also mentioned in this context. Representatives from retail tended to adopt a more holistic perspective encompassing work satisfaction. For example, the manager of FashionShop thought that workplace wellbeing was about "*taking care of the people who use us and the people who we employ"* and talking about staff that "*it's very important that they are happy at work"*. Similarly the manager of Supermarket thought it was important to create "*an environment where people are happy to be in work".*

For the construction representatives, safety was naturally of major importance and other issues such as mental wellbeing were secondary or conditional on safety. A central aim was that "*everyone should go home at the end of the day in the same condition they came in the beginning of the day"* (SteelBuild). While safety was also given priority in retail, construction representatives highlighted that the concerns of site and office working environments were very different: "*what's important is you go*

*home from work with the same amount of arms, fingers, limbs, that you went to work with and you haven't hurt yourself in the meantime" (*SpecEng).

In construction, the importance of management in supporting a healthy workplace was articulated in relation to both setting priorities, strategic directions and buy-in by senior management (CollectiveOrg2), particularly in relation to occupational health (InternatOrg). This emphasis on the role of leadership is consistent with evidence from previous research especially in relation to safety (e.g. Dodge, 2012). In contrast, there was a view in both sectors that employers have a supporting role but individuals should assume personal responsibility for their own health and wellbeing (CollectiveOrg1, Supermarket). This is consistent with a more holistic view of wellbeing that recognises multiple causes of ill health, including stress, that people bring stresses into the workplace that impact their performance (Build&Support). However, employers may still support measures to prevent stress Love *et al*., 2010:657; Wilson *et al.,* 2004:582).

Some potential links between workplace wellbeing, the success of a business, and the business case for workplace wellbeing initiatives, were recognised by most of the participants. This was particularly true for the retail representatives. For example, the owner-manager of FashionShop felt that by looking after her staff she was creating loyalty and thus a reduction in staff turnover. The manager of Supermarket also thought that looking after his employees when they were unwell was cost effective. He explicitly referred to the link between ill-health and reduced productivity, noting the value of investing in a return to work policy for employees who had been off work because of ill health. The links between health and productivity were also recognised in construction. The BuildTech&Tst representative thought that "*a healthy work force is a more effective work force"* and linked an *"unhealthy work force"* to a higher accident rate. There was also some discussion about the ageing workforce in construction providing additional rationale for investing in health so that people could work for longer and "*have a more fulfilled life*" (CollectiveOrg1).

The costs of failing to comply with the health and safety framework was recognised as important incentive for workplace health and wellbeing initiatives. For example, one company used evidence from medical auditing to present a business case for introducing healthier eating options in the canteen on the basis of a health need (BuildTech&Tst). However, it was also argued that the business case for workplace wellbeing initiatives should not just be made in terms of short-term financial returns, that reputation and resilience were also important (InternatOrg). In this context the CollectiveOrg1 representative referred directly to the business and legacy case made for the occupational health service linked to the London 2012 Olympic Park construction. This report concluded that "the provision of treatment services and health surveillance on site can have substantial economic benefits" (Tyers and Hicks, 2012:7). In line with these findings, the SteelBuild manager believed that people will work harder if they believe that they are genuinely being looked after.

4. Workplace health issues

This section highlights the workplace physical and mental health issues identified as priorities for interventions.

4.1 Physical health

A wide range of work-related health and wellbeing issues were mentioned particularly in relation to the construction sector. For the interviewees based in retail, physical health issues were restricted to problems linked to lifting, use of machinery and equipment, sedentary office work and time spent standing. For example, the HomeStore representative said that although there was "*a lot of lifting"* any accidents tended to be minor "*something might drop on your toe, or you trap your fingers in between a door*". He also thought there were positives to heavy lifting as a form of physical exercise, presumably in contrast to other, more sedentary aspects of the job. In contrast, the work in

construction is in general very physical and often performed in difficult and harsh conditions (building sites, tunnels, railways) and the interviewees talked about musculoskeletal health problems and about wearing people out (CollectiveOrg1, CollectiveOrg2). Specific problems related to the use of machinery and particular equipment were also highlighted. Some of the interviewees also talked about how these issues had been addressed. For example by ensuring that the equipment purchased was of the highest quality achieving "*the lowest vibrations"* (BuildTech&Tst), or limiting *"the amount of time that a guy can use the tools"* (SteelBuild).

Exposing workers to harmful substances is another significant problem for construction. The risks are high and the consequences potentially serious. One very concerned participant highlighted the high number of deaths in the construction sector due to "*work place related ill health"* including cancers. (CollectiveOrg2). One interviewee blamed traditional ways of working for health problems related to asbestos, dust, silicone and exhaust fumes and highlighted how the consequences of using different materials and processes were not initially known (CollectiveOrg1). While some of these health risks have been addressed, the Build&Support manager said that risks were still being taken with other substances: "*we'll then willingly go and cut curbs of concrete and not worry about the silica"*. However, his firm does include a major cancer element in their current health strategy. While not linked to harmful substances as such, skin cancer is another health issue for construction since most on-site work is performed outside (CollectiveOrg2).

4.2. Danger, risk and safety in construction

A key theme among the representatives from construction was the sheer physical danger in their work (SteelBuild). The danger means a real risk of death in construction as noted by the CollectiveOrg2 representative, talking about the sector over: "*we kill around about 40 people every year through safety related accidents".* Because of the danger, concerns with safety trumped concerns with mental wellbeing and health as highlighted by the SpecEng director who said *"much as I want you to not be stressed at work, I'd probably be more concerned if you were decapitated*". In this context health and safety rules and regulations tended to be viewed positively (SteelBuild). The concerns of office workers tended to be trivialised in relation to these kinds of risks: *"Well you know people don't die in an office normally and I've had four people die working for me over the last 10 years"* (SpecEng).

4.3. Mental health and stress

The representatives from retail and construction interestingly both shared the view that mental health was important and the workplace could be stressful. However, the views expressed about the causes of stress differed between the two sectors.

In retail relationships, participants reported that customers could be a cause of stress for example if a customer is awkward or abrupt (Supermarket). At the same time, interactions with customers were sometimes seen as a positive feature of the workplace (HomeStore). The manager of Supermarket felt that his work environment was less stressful than some others (in retail) because of the co-owned financial structure of their business, meaning that competitive expectations were less and managers did not drive their teams as hard. In a similar vein, the owner-manager of FashionShop felt that because they were an independent enterprise there were fewer pressures for staff, in part because there were no sales targets as such. In the UK's 'performance' orientated business culture, reflecting the dominant *laissez faire* rationale, particularly evident in retail, it is interesting that subverting competitive pressures was seen as a marker of success in relation to the health and wellbeing of staff.

A repeated concern among the representatives in construction was that issues linked to workplace stress were important but hidden or not given sufficient attention (SteelBuild). This was attributed in part to the masculine character of the industry and because men did not like to admit to suffering from stress or ask for help (CollectiveOrg2). There was felt to be a lack of collective understanding of the causes and effects of stress, and a stigma around mental health (InternatOrg). Even talking about

stress could be considered "*wimpish"* (CollectiveOrg1). The lack of discussion about mental health issues was reflected in fewer initiatives, compared with those designed to address safety or physical health issues (SpecEng). While, as already noted, it was a common theme that the causes of stress were not necessarily work related, it was also acknowledged that more could be done at work to help people to deal with stress (Build&Support). Nevertheless, there appeared limited understanding of what could be done to support employees with mental ill health conditions or to facilitate mental wellbeing. There was a desire for more evidence and also some appetite for initiatives to be developed beyond traditional suicide helplines or occasional counselling services. However, mental health remains poorly understood and integrated into overall wellbeing strategies in the construction sector, which remains primarily focused on physical health. This is significant as work patterns and structures such as long hours and travel times and tight deadlines, were identified as common causes of stress in construction (CollectiveOrg1). The "*litigious contractual nature of the way we contract and construct"* (SpecEng) was also cited as contributory factor as were the pressures of managing wider risks for the public in some major constructions such as roofs, rail and tunnels. It was acknowledged that workers could also become stressed because of the attitudes or behaviour of a line manager and concerns about bullying in the workplace (BuildTech&Tst).

5. Barriers to improving health and wellbeing

While a number of barriers to improving health and wellbeing in construction were discussed, very few were highlighted by the retail representatives.

5.1 Traditional work practices, older workers and unwillingness to change

In construction traditional ways of working, the way things had always been done, were identified as barrier to improving the health and wellbeing of workers (SteelBuild). Relatedly, older workers, "*people with 20 years service"* were thought to be more likely to have accidents because "*they just get complacent, get a bit lazy" (*SpecEng) or they were more fatigued (BuildTech&Tst). One interviewee with expertise in workplace health and wellbeing felt that it could sometimes be demoralising trying *to "change hearts and minds of an industry...that doesn't want to change its heart or mind*"(CollectiveOrg2).

5.2. Contracting and the structure of employment in construction

The workplace in construction "often consists of large numbers of subcontractors that each have their own policies, procedures, and company cultures" (Du Plessis *et al.*, 2013: 719). On any given building site, the principal contractor may only employ ten of their direct employees and everyone else could be either self-employed or contracted by agencies (SpecEng). This complexity makes it is difficult to implement, manage, monitor and evaluate health and wellbeing policies. As recognised by the CollevtiveOrg2 representative, subcontracting can therefore act as a barrier to implementing health and wellbeing initiatives. Du Plessis *et al.* (2013: 719) note that subcontracting "makes it particularly challenging to keep track of individuals in the workforce, to achieve consistency with group-based initiatives and sustain longer term interventions". However, on larger sites run by major construction clients this could be less of a problem when they "*provide facilities and put fairly robust plans on large projects together to actually address wellbeing"* (CollectiveOrg1). Nevertheless, the duty for health checks would normally be passed down the supply chain by the principle contractor to the direct employer, which makes compliance difficult to monitor (CollectiveOrg2).

5.3. Working away from home, transient and temporary employment

In construction the workforce is transient, often working away from home and on relatively short term contracts (CollectiveOrg1). This can diminish the effectiveness of wellbeing initiatives as "*it's more difficult in terms of a health surveillance programme, wellbeing initiative, to engage with people on longer term*" (InternatOrg). The transient nature of the workforce means that the impact of an initiative could be limited making such initiatives costly relative to impact (CollectiveOrg1). One

participant felt that these trends had been fuelled by employment legislation that encouraged major contractors, and sub-contractors to take on temporary and part-time staff or self-employed people who had weaker links to the company (CollectiveOrg1).

The fact that many employees are working away from home, and living in temporary accommodation such as caravans on site, leads to health and wellbeing problems. Not only because of poor living conditions but also because of the absence of social support networks, family and home comforts including home cooking as well as lack of easy access to primary care support, dentists and doctors (BuildTech&Tst). The latter is particularly problematic when people are being paid by the hour, since it is costly to take time off (CollectiveOrg2).

Short term contracts and temporary work also create financial insecurity and stress for workers, which motivates some construction workers to travel abroad to secure long-term contracts (BuildTech&Tst). However, working in another country is associated with its own pressures and problems. Some large companies make a big commitment to their skilled employees abroad to alleviate some of these problems for example by paying to relocate contracted employee's family (BuildTech&Tst). Many construction workers in the UK are also ex-patriots themselves. The sizeable migrant workforce in the UK construction industry was perceived to present its own problems, not only for the workers themselves but also in the workplace due, for example, to language differences and associated breakdowns in communication between employees (CollectiveOrg2).

5.4. Long working hours and long travel-to-work distances

The negative impact on the wellbeing of construction workers of extended working days due to long hours and time spent travelling in combination with tight deadlines linked to financial penalties was widely recognised. It was felt that project managers were *"driven to the absolute end"* (CollectiveOrg2). Long days and working weekends were not atypical and would leave people "*absolutely exhausted"* (CollectiveOrg1). The CollectiveOrg2 representative gave the example of a senior manager who, some weeks, drove over 1,000 miles leaving home at 4 am in the morning and not returning till 10 pm, and was on call seven days a week. Such long working days can obviously lead to fatigue and this this would have knock on effects on performance at work and accident rates (BuildTech&Tst).

Long hours and long travel-to-work distances can also impact on health through poor diet and lack of physical exercise (Build&Support). This interviewee thought it was really important to ensure that: "*outside of those times, guys have got access to good food or good exercise"* (Build&Support). He thought that long working hours also deterred people from being physically active in their leisure time: "*you say when was the last time that you got out on your bike or got out for a run and they'll sort of say, well, I'm working away all week, and when I get home at the weekend, I want to spend time with the family, so I haven't been on my bike for six months"* (Build&Support). And so his company were looking at ways to address this by for example, including gym membership in their employee benefits scheme. Long working hours and performance related and time monitored pay schemes also mean that when health and wellbeing schemes are introduced people need to be allowed time *"out of their working day"* to take advantage of these (InternatOrg).

But of course, long hours of work and long travel-to-work times are not unique to construction and also featured in the interviews with representatives from retail for example, when talking about buying in stock: *"it's tiring, it's long days, it's at sort of 20 past five in the morning train and back home at sort of 8 o'clock at night, so it's a long old day"* (FashionShop).

5.5. Tight deadlines, low profit margins and the macroeconomic climate

The considerable stress imposed by contract deadlines in construction was referred to repeatedly: "*there's a lot of deadlines to meet, very demanding clients and yes, I wake up in the middle of the night thinking have I done this, have I done that, and it's … it is very stressful"* (SteelBuild). The deadlines are

so stressful in part because of the associated financial penalties which can go into hundreds of thousands of pounds. The SpecEng representative gave an example: "*we've just finished a job …we have a contract for £480,000 …. but our damages were £100,000 a week if we were late … So you can imagine the stress"*.

The sector is also believed to an industry with low profit margins *"on single digit profit figures"* (SpecEng, CollectiveOrg2). Low margins coupled with large penalties for missing deadlines inevitably lead to scrutiny of costs and a focus on efficiency. This can put pressure on health and wellbeing initiatives that are seen as less important and expensive (CollectiveOrg2). The Build&Support representative gave illustrative costs for on-site medical provision: *"£1500 on site refits, paying for 1200 people to have £100 medicals and paying for a nurse, with a van to be on site at £600 a day"*. For SteelBuild, who nearly went out of business a couple of years ago, improving the menu in the canteen to offer more healthy options was not a priority. This may represent a lost opportunity as the workplace can play an important part in improving dietary patterns (Quintiliani, *et al.,* 2010) generating competitive advantages (Houghton *et al.,* 2009).

The stress caused by tight deadlines in combination with low profit margins is an issue for management (SteelBuild) but costing practices mean these pressures permeate down through all levels to the "*guy on the site, with a spanner"* (SpecEng). One interviewee thought that this sometimes manifested in what he referred to as bullying: "*I want that piece of work done, I don't care how you get it done, just do it"* (CollectiveOrg2). The SpecEng representative thought that the stress due to performance expectations and monitoring could be mitigated by good management, but doubted the calibre of management in construction to do this (SpecEng).

Financial pressures are not unique to construction, they are a feature of business in general and small and medium enterprises in particular. This was highlighted by the owner of Fashionshop who thought owning and managing a business was "*incredibly stressful".* This was in part due to cash flow problems associated with the need to bulk-buy stock upfront. However, the fortunes of the construction industry are especially vulnerable to the economic cycle and the UK economy is only just emerging from recession following the recent financial crisis (Build&Support). The volatility of the construction industry in response to exogenous macroeconomic forces can also weaken incentives for long term investment in wellbeing programmes unless a strong business case can be made.

5.6. Predominantly male workforce and macho culture

In contrast to the retail sector the workforce in construction is predominantly male. Most of the interviewees thought that the industry's macho culture was a potential barrier to improving health and wellbeing (InternatOrg). This perspective was summed up by one interviewee who when asked about future challenges for workplace wellbeing said: "*the biggest challenge, honestly is…is culture. Yes. Attitude, behaviour, and culture….it's a very macho culture, you know, you can't stand the heat get out of the kitchen"* (CollectiveOrg2).

The macho culture appears to present particular issues for mental health because men do not want to talk about mental health issues "*because it is a very bloke-y environment"* (SteelBuild). In contrast, in the more female retail environment people perhaps feel freer to discuss problems: *"if there's something…they'll usually just take me on one side and say can I have a chat with you, I've got a problem, this is happening, or that's happening, and I say to them, how can we help, how can we support you?"* (FashionShop).

In construction, wellbeing initiatives need to adopt strategies that take the male character of the workforce on board. For example, BuildTech&Tst have been "*putting together a manual of an A-to-Z of what to look out for, something that's very self-explanatory, that they can refer to themselves, we found better buy-in from that".* Similarly the SteelBuild representative said that: "*we find that a lot of the men, I'm as bad as well, we don't like going to the doctors, so we do give health checks at work"*

(SteelBuild). Resistance to seeing a medical professional meant that education and communication were important: *"they keep away from the GP until it's the last resort, so it's all about educating and communicating" (*BuildTech&Tst).

The macho male environment in construction also appears to create stresses because of the way people interact: "*I go to lots of meetings where I'm shouted at and screamed at and phoned up on the Sunday at home by the boss of some company and shouted at a bit more and it is … that's the nature of the beast, that's the industry we work in" (*SpecEng). The long hours in construction were also linked by one interviewee to a competitive male culture where men prided themselves on the hours they worked (SteelBuild). The CollectiveOrg2 representative was particularly concerned about the effects of this high pressure, macho culture on younger employees but also thought that younger cohorts could instigate change.

5.7. Company attitudes and wider social norms

The InternatOrg participant felt that company level culture was the key to tackling health and safety but there had to be a will to address these issues. However, the representative from CollectiveOrg2 felt that that the issues were sectorial. This representative contrasted construction with other sectors including the oil and gas sectors which he thought were comparable but had made more advances in health and wellbeing (CollectiveOrg2).

The SpecEng participant had worked extensively outside the UK and felt that the construction industry in some other countries had a more responsible attitude to health and safety. He drew particularly unfavourable comparisons with Nordic countries and Switzerland who he reported operated more safely but within a looser bureaucratic and legislative framework. His experiences suggested that in the UK there was an ingrained resistance to taking responsibility for health and wellbeing in the workplace, that this is part of a wider national culture and needed to change: *"the magic bullet is to change the culture and by, only by changing the culture will you then be able to implement campaigns that, or interventions that work"* (CollectiveOrg2).

5.8. Targets and competitions

While competitive pressures linked to the male culture in construction have already been mentioned, there was a more general view that targets and competition could have adverse consequences on health and wellbeing, not only because of the pressures imposed but also because of under-reporting or falsification of information. One example was the potential for accidents at work to be under-reported due to participation in a target driven competition to complete "*a million man hours without an accident*" (SteelBuild). Unintended consequences of targets, such as the under-reporting of accidents, are due to targets conflicting with one another. As a sector, the construction industry needs to think carefully about such targets as there is a risk of losing sight of what is actually important, in this case, safety. In a similar vein, when talking about whether it could be useful to make cross company comparisons, the Build&Support representative pointed to the potential risks of competition. He thought there was a need for independent benchmarks and accreditation to generate a more collectively responsible culture (Build&Support).

5.9. Lack of support from leaders and middle management

The CollectiveOrg2 representative talked about conflict with middle management due to insecurities and lack of understanding with respect to the complexities of workplace health and the related legislation. He also felt that because of their focus on safety, health and safety professionals could be "*quite a big obstacle with regards to health as well, work place health"* (CollectiveOrg2). This view was reiterated by the BuildTech&Tst representative who felt that there was a need for health auditing in the sector in addition to a safety focus.

As already noted, the role of leadership in general and leadership buy-in for health and wellbeing initiatives was considered very important: *"I think it very much helps that the senior leadership are visible in getting involved in the activities and that there's management support"* (InternatOrg). But this was not always in place: "*a lot of the time, the leadership is very financially driven and it's all about figures and costings"* (BuildTech&Tst).

6. Future trends and ongoing issues

In the face of these issues there was a general view among the participants that there has been increased recognition of the importance of promoting health and wellbeing in the workplace (CollectiveOrg1). Positive trends were identified in the reflections of some of the interviewees who had many years of experience in the construction sector. They compared current health and safety practices very positively with the working environment they had encountered on their first forays onto a construction site *(*SteelBuild). Programmes had been put in place and new initiatives were being developed. In these developments, improved access to professional support (e.g. hygienists and occupational health service providers) was considered to have been particularly important (Build&Support). However, the CollectiveOrg1 representative expressed the view that there was a lack of professional health and wellbeing expertise to support the industry. Furthermore, in relation to mental health, views such as those of the InteratOrg representative who said "*we've still got a very long way to go"* were typical.

There was recognition and support for the leading role that some larger employers had taken in (CollectiveOrg2). There also appears to be acceptance by industry leaders that they have a responsibility to take on this leadership role (Build&Support). This proactive approach towards health and wellbeing in some larger companies appears to be underpinned by a moral rather than an economic rationale: "*we feel it's the right thing to do so we've done that"* (Build&Support). Willingness to take a leading role also appears to be indicative of a recognition that smaller companies face particular difficulties in implementing health and wellbeing initiatives (internatOrg).

One feature of the workplace that appears to have changed materially and is perhaps evidence of the growing recognition of the importance of health and wellbeing, is an acceptance of people's right to refuse to work in unsafe conditions or with those working in unsafe way and an acceptance of whistleblowers more generally (SteelBuild). However, this view was contrasted with the fear of blacklisting in the industry as uncovered in the 2009 investigation by the Information Commisioner's Office (ICO, 2009) and discussed in the Union of Construction, Allied Trades and Technicians report (UCATT, 2009) (BuildTech&Tst).

One interviewee, while of the view that "y*ou can never be too safe"* and had never found any health and safety regulation "*to be bad",* suggested that changes in legislation only reflected what good companies would consider good practice and had been doing for many years: "*it's got a lot more formal over the past 10 to 15 years say, but I think informally we've been doing it for about 20"* (SteelBuild). An alternative view that there needed to be more regulation and legislation was also expressed: *"the HSE needs to kind of really push out a standard there to push the other employers … more legislative requirement because I think a lot of companies will try and get away from it because they know that they can"* (BuildTech&Tst). Along the same lines, the InternatOrg representative felt that it would be helpful to have a formal, industry wide, information and resource structure in place to deal with the transient workforce. However, the representative from SteelBuild felt that the existing legislation had reached a kind of "*plateau",* and that a new more "*behavioural*", less prescriptive direction would be more effective in changing the way people thought about health and safety and encouraging them to question traditional practices. This approach seems to be supported by the Build&Support representative who advocated a "*covert*" approach towards interventions on diet.

In contrast to these generally positive trends and reflections, there was also scepticism among some of the interviewees. There was a view that some, not all, companies in construction were only doing

the bare minimum in order to comply with government recommendations, legislation or client driven auditing processes: "c*ompanies are only doing it because the client insists there's a KPI auditing process and you must comply"* (BuildTech&Tst). Sometimes actions may be taken only as a tick boxing exercise (CollectiveOrg1, CollectiveOrg2).

Partly because of the financial environment in construction, health and wellbeing programmes also tended to be short, a day or a week when it was felt that a long term investment approach was needed (CollectiveOrg1). This short-termism may reflect the short-term and temporary nature of employment contracts in construction which result in a loss of continuity leading Du Plessis *et al.* (2013:719) to call for "*more sustainable occupational health and safety, and well-being policies within blue-collar industries*". In contrast, larger establishments in retail who have a longer tenured work force can plan for longer term commitments for example by employing an occupational health nurse (Supermarket). A related problem appears to be a lack of specialised knowledge and information in some areas (CollectiveOrg1). Of course, lack of relevant knowledge or simply good sense is not unique to construction (this issue was also highlighted by the manager of Supermarket). One consequence was thought to be that: "*at the moment, we're dealing with the consequences of ill health"* and *"playing catch up"* rather dealing with health problems as they arise (CollectiveOrg1).

7. Summary and implications for further research, policy and practice

The context for this study is the wider social and economic concern with health and wellbeing. This has led to an increased number of workplace interventions and an increase in research on their effectiveness. However, there are still many unknowns. This study focused on the construction and retail sectors as these sectors while different in many respects have both been recorded as having particular acute workplace or industry level stresses. While the study participants recognised that wellbeing is a multi-dimensional concept encompassing quality of life as well as effects of work on health, they also highlighted how sector specific effects can contribute to poor health and wellbeing. In construction, health and safety concerns were perhaps unsurprisingly, more pervasive and causes were strongly tied to industry practice and structures such as short-term and sub-contracting as well as long hours and a masculine culture. However, industry leaders in construction appear to be proactive in trying to address these issues, particularly in regard to safety. In the retail establishments concerns tended to be more holistic, focussing on wellbeing and encompassing work satisfaction although return to work following illness was a particular issue.

This research indicates that in construction there are some persistent workplace wellbeing issues that are obstacles to improving workplace health, safety and wellbeing. Many of the problems and issues discussed were specific to the type of work undertaken, working arrangements and the work culture. Notably, the physical and often dangerous nature of work; short term employment contracts; sub-contracting; long hours; and the masculine character of the workforce. There appears to be general recognition of these workplace health issues and a drive by business leaders in construction to improve the health and wellbeing of their employees. A range of (predominantly physical health) initiatives have been developed but there is still room for significant improvement particularly in relation to mental health. While there were some shared issues, such as long-hours, financial pressures and lack of knowledge, workplace health and wellbeing concerns in retail tend to be less focused on safety and more on wellbeing and general health issues such as return to work.

This research was initiated as a pilot study, as part of a wider project in collaboration with a business partner, and is limited by the sample size. The findings while insightful are not generalizable. More in-depth research with employees as well as industry leaders is recommended in order to improve understanding of work related health needs, the effectiveness of interventions and to inform policy and practice. Further research could also help to address a lack of good quality data and evidence at the industry level: "*we don't have great statistics"* (Build&Support). This is an issue for developing policy and practice including the development of appropriate methodologies for designing and

evaluating the effectiveness of interventions. There is a need to build a long term perspective into evaluation and this can be problematic in relation to health where the effects of an intervention are very difficult to judge in the short term and causality can also be difficult to establish. A common practice in construction is to record whether absence figures fall or staff retention levels improve following an intervention (InternatOrg). However, correlation does not prove causality in the context of multiple unmeasured external influences on health and wellbeing (Figure 1). Other judgements about whether a programme is useful and worth continuing seem to be made mainly on the basis of demand or take-up sometimes coupled with participant evaluation (InternatOrg, Build&Support).

Whilst there is a growing recognition of the importance of wellbeing at work for both employees and employers and an acknowledged need for related programmes, there are many barriers to the implementation of such initiatives. Some barriers are industry specific and therefore difficult to address in the context of existing practices. There is a related need for more high quality, sector specific data to inform future practices and policies. Data that is already collected by employers could also be used more effectively, particularly if employers could collaborate in the provision and evaluation of programmes across a sector, although this may be difficult against the backdrop of competition and commercially sensitive information. Finally, since wellbeing in, and outside work are related, health and wellbeing programmes require a holistic approach which takes into account impact on quality of life rather than just wellbeing while at work.

References

Bryson, A., J Forth, J. and Stokes, L. 2014. Does worker wellbeing affect workplace performance? *Department for Business and innovation and NIESR*, BIS/14/1120, www.gov.uk/bis (accessed 30/08/15)

Braun, S., Morton, S., 2008. *Butting Out to Raise the Bottom Line.* Toronto: Rogers Publishing Ltd.

Burnard, P. 1991. A Method of Analysing Interview Transcripts in Qualitative Research. *Nurse Education Today,* 11:6, 461-6.

Burnard, P., Gill, P., Stewart, K., Treasure, E., & Chadwick B. 2008. Analysing and Presenting Qualitative Data. *British Dental Journal,* 204, 429-432.

CIPD (2007) What's happening with well-being at work? Accessed 18/01/2016 at: http://www.cipd.co.uk/NR/rdonlyres/DCCE94D7-781A-485A-A702-6DAAB5EA7B27/0/whthapwbwrk.pdf

Dodge, B. R. 2012. Patterns of root cause in workplace injury*, International Journal of Workplace Health Management*, 5:1, 31-43

Du Plessis, K., Cronin, D., Corney, T., Green, E., 2013. Australian Blue-Collar Men's Health and Well-Being: Contextual Issues for Workplace Health Promotion Interventions, *Health Promotion & Practice*. 14, 715–720.

Faragher, E. B., Cass, M., Cooper, C.L., 2005. The relationship between job satisfaction and health: a meta-analysis, *Occupational Environmental Medicine,* 62, 105–112.

Fenton, S., Pinilla Roncancio, M., Sing, M., Sadhra, S. & Carmichael, F. 2015 Workplace wellbeing programmes and their impact on employees and their employing organisations: A scoping review of the evidence base, *Birmingham Business School Discussion paper*, *http://epapers.bham.ac.uk/2097/* (accessed 30/08/15)

Foresight Mental Capital and Wellbeing Project. 2008. *Final project report: Executive Summary,* London: The Government Office for Science, www.foresight.gov.uk,

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/292453/mental-capital-wellbeing-summary.pdf (accessed 30/08/15)

Glaser, B. G., & Strauss, A. L. (1967). The discovery of grounded theory: strategies for qualitative research. Chicago, IL: Aldine Publishing

Goetzel, R.Z., Ozminkowski, R.J., 2006. What's holding you back: why should (or shouldn't) employers invest in health promotion programs for their workers? *North Carolina Medical Journal,* 67, 428–430.

Hosie P. J. and Sevastos, O. 2015. Does the Does the "happy-productive worker" thesis apply to managers? *International Journal of Workplace Health Management*, 2:2, 131-160

Houghton, J., Neck, C. and Cooper, K. (2009), Nutritious food intake: a new competitive advantage for organizations?, *International Journal of Workplace Health Management*, 2:2 161-179

Hymel, P.A., Loeppke, R.R., Baase, C.M., Burton, W.N., Hartenbaum, N.P., Hudson, T.W., McLellan, R.K., Mueller, K.L., Roberts, M.A., Yarborough, C.M., Konicki, D.L., Larson, P.W., 2011. Workplace Health Protection and Promotion: A New Pathway for a Healthier—and Safer—Workforce. J. Occup. Environ. Med. 53, 695–702.

Information Commissioner's Office. 2009. Construction blacklist, https://ico.org.uk/for-the-public/construction-blacklist/ (accessed 09/04/2015)

Love, P., Edwards, D., Irani, Z., 2010. Work Stress, Support, and Mental Health in Construction, *Journal of Construction Engineering Management,* 136, 650–658.

Love, P.E.D., Edwards, D.J., 2005. Taking the pulse of UK construction project managers' health: Influence of job demands, job control and social support on psychological wellbeing. *Engineering Construction Architecture Management,* 12, 88–101.

Macdonald, S., Csiernik, R., Durand, P., Rylett, M., Wild, T.C., 2006. Prevalence and Factors Related to Canadian Workplace Health Programs. *Canadian Journal of Public Health Review,* 97, 121–125.

Marchand, A., 2007. Mental health in Canada: Are there any risky occupations and industries? *International Journal of Law Psychiatry*, Special Issue: Work and Mental Health, 30, 272–283.

NICE. 2009. *Promoting mental wellbeing at work: Guide to resources, Implementing NICE guidance*, NICE Public Health Guidance 22, www.nice.org.uk/guidance/PH22 (accessed 17.10.14)

Quintiliani, L., Signe Poulsen, S. and Sorensen, G. 2010. Healthy eating strategies in the workplace, *International Journal of Workplace Health Management*, 3:3 182-196

Shain, M., Kramer, D.M., 2004. Health promotion in the workplace: framing the concept; reviewing the evidence. Occup. Environ. Med. 61, 643–648.

Sorensen, G., Barbeau, E.M., Stoddard, A.M., Hunt, M.K., Goldman, R., Smith, A., Brennan, A.A., Wallace, L., 2007. Tools for health: the efficacy of a tailored intervention targeted for construction laborers. Cancer Causes Control CCC 18, 51–59

Union of Construction, Allied Trades and Technicians, UCATT (2009) *Ruined Lives*, http://www.ucatt.org.uk/ruined-lives-ucatt-report-blacklisting (accessed 09/04/2015)

Shain, M., Kramer, D. M.2004. Health promotion in the workplace: framing the concept; reviewing the evidence. *Occupational Environmental Medicine,* 61, 643–648.

Tyers, C and Hicks, B. 2014 Occupational health provision on the Olympic Park and athletes' village. *HSE and Institute for Employment Studies*, www.hse.gov.uk/research/rrpdf/rr921.pdf (accessed 09/04/2015)

Wilson, M. G., Dejoy, D. M., Vandenberg, R. J., Richardson, H. A., McGrath, A. L. 2004. Work characteristics and employee health and well-being: Test of a model of healthy work organization. *Journal of Occupational & Organizational Psycho*logy, 77, 565–588.

World Health Organization (WHO). 2011. *Healthy workplaces: a WHO global model for action* http://www.who.int/occupational_health/healthy_workplaces/en/ (accessed 7.30.14).

Vézina, M and Gingras, S. 1996. Work and mental health: risk groups, *Canadian journal of public health,* 87:2, 135-40

Health and Safety Executive (2014) *HSE: Information about health and safety at work*, www.hse.gov.uk/ (accessed 11.21.14).

Figure 1: Holistic model of workplace wellbeing