SHINY HAPPY PEOPLE? UK CONSTRUCTION INDUSTRY HEALTH: PRIORITIES, PRACTICE AND PUBLIC RELATIONS

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The UK construction industry is arguably in poor health, rates of occupational illness are statistically significantly higher than for workers in any other industry. Despite growing awareness that the 'slow burn' of occupational health requires alternative management approaches than those made to secure safety, health remains neglected. Recently, the scope of health management on large sites has actually increased; public health now included within the organisational health management remit, as promoted by the UK Government's Public Health Responsibility Deal. Yet concerns have been raised that prioritisation of public health management will distract from the more challenging problems of occupational health in practice. A critical discourse analysis of UK 'construction industry health' has been carried out, using the industry's own representations of its health; the organisational websites of the top ten UK contractors by yearly work won. Findings show that whilst safety remains the dominant partner in the H&S amalgam, 'public' has overtaken 'occupational' within the discourse of 'construction industry health'; the latter restricted to legal compliance presented as corporate citizenship, the former championed as evidence of benevolent organisational values. Yet public health concerns are limited to those of individual responsibility, whilst more complex issues around the social determinants of health as associated with work, are missing from the discourse, separating organisations from the impacts of their work on their workers. Instead health has become associated with events, prizes and awards, which are subsequently commodified to provide grist to the Corporate Social Responsibility mill.

Keywords: Corporate Social Responsibility, occupational health, public health.

INTRODUCTION

Despite their seemingly unbreakable amalgam, health and safety are theoretically and practically very different things. The immediacy and impact of an accident has led to a prioritisation of safety in both practice and research, whilst health has been more neglected (Skan 2015) due to its 'slow-burn', and indeed the fact that it can be much more problematic to manage in practice. In recent years this inequality has become more apparent, and to redress the balance occupational health has been gaining priority within the UK construction industry, as demonstrated by its high profile on the London 2012 Olympic Park construction project (Tyers and Hicks 2012).

However, occupational health in UK construction has also been impacted by a recent paradigm shift in public health management. The UK government launched its Public

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Health Responsibility Deal (PHRD) in spring 2011, aiming to improve public health through '… a more collaborative approach to tackling the challenges caused by our lifestyle choices.' (Department of Health (DoH) 2015), and in late 2013, they launched a specific Pledge (H10) for Construction and Civil Engineering Industries. Aspects of this H10 Pledge, and its potential impact on the UK construction industry health management agenda, have already been explored elsewhere (Sherratt 2015a; Sherratt 2015b), through analyses that also revealed the growing influence of Corporate Social Responsibility (CSR) on construction health. The emergence of CSR activity within the construction industry has previously led to suggestions that organisations have become more focused on the packaging and presentation of construction site health management, rather than the fundamental methods and processes of its implementation (Rawlinson and Farrell 2010).

Although empirical findings have suggested moderation of theoretical challenges, there is still the potential for construction industry 'health' to be cause for concern; the difficult and complex management of occupational health obfuscated by much more simplistic and photogenic 'public health initiatives', the management of health on sites delivered in the way most suitable for its subsequent commodification and publication as CSR. This paper seeks to present the next steps in this ongoing project and empirically explores a specific discourse of health within the UK construction industry; the way large UK construction organisations position health within their organisational identities, the subsequent relationships between public and occupational health, and the role of CSR within this context. This will provide a better understanding of contemporary 'construction industry health', and therefore a clearer context for research, and the development of improvements in practice.

CONTEXT

The health of the UK construction industry

The UK's Health and Safety Executive (HSE 2015a) have reported that annually around 69,000 construction workers suffer from an illness they believe was caused or made worse by their work, a rate of illness statistically significantly higher than for workers in any other industry. Specific health issues can also be associated with construction work, for example incidents of work-related musculoskeletal disorders and lung problems are again statistically significantly higher than in other industries. Whilst the HSE (2015a:9) also note that the current burden of occupational cancers are highest within workers from the construction sector, they emphasise that these cases are from past exposures to asbestos and silica. Yet this fails to acknowledge that the industry is now regularly working with newly-developed materials, such as Nano-technologies, where associated health risks for lung disorders and even cancers could potentially be significant, but as yet remain unknown (Jones et al 2015).

In terms of its practical management on sites, occupational health should be subjected to the same approach as safety; through robust management systems and the risk assessment process as required by the Management of Health and Safety at Work Regulations 1999. Industry is also supported by various initiatives, most prominently Constructing Better Health (2015a), which provides guidance, training and links to accredited occupational health providers who work within the industry.

However, research suggests that occupational health within construction can be misunderstood and its management rendered relatively ineffective. For example, Thompson and Ellis (2011) found that health is often managed alongside safety as one

coherent unit, rather than as separate aspects which require different approaches in their mitigation and minimisation. This has the potential to limit effectiveness should controls be applied from the perspectives of immediacy, as necessary for safety, rather than the long-term view required for health, as manifested on the 2012 Olympic Park; whilst researchers found that the level of personal protective equipment (PPE) on site was good, '…access to equipment or procedures designed specifically to control [occupational health] risks (e.g. checks on noise levels … well-maintained dust extraction equipment and use of anti-vibration handles) was less common' (Tyers and Hicks 2012:8). Whilst PPE is the most immediate, readily available and cheapest response to the identification of health risks within a construction process, it should only be considered the last resort from both a risk assessment and a long-term health management perspective (HSE 2015b).

Although efforts are certainly being made to improve the health of the UK construction industry, and recent statistics do show improvements, health management is arguably still in its infancy when considered alongside the myriad of systems, controls, work processes and practices that are now in place to manage safety on sites.

Public health in the construction context

The construction industry is perhaps more closely aligned with public health than some others; it needs 'healthy' workers for production - to walk and climb, to lift and move, to balance and level, to force and fit. There remains a heavy reliance on manual labour and skills within traditional work processes, and therefore health becomes an inherent and necessary characteristic of the construction worker, the big, strong 'beefy builder' stereotype. Yet, the UK construction industry loses on average 1.2 million working days through work-related ill health each year (HSE 2015c), to the detriment of productivity and output and, much more importantly, to the detriment of the workers themselves.

Economically public health can be seen as a corporate concern, employers interested in mitigating economic losses suffered as a result of illness, and the idea to manage public health alongside occupational health is often seen as an eminently practical and sensible approach (Healey and Walker 2009). Yet public health is also grounded in what are termed wider health inequalities, themselves described as 'wicked problems' (Dhesi 2014:30), where the complex interplay of factors such as status, social class, power, earnings, education and living standards all contribute to poorer or better health (Marmot 2004). It has been suggested that many of the high risk health behaviours that foster chronic disease, such as smoking, drinking, eating to obesity and drug taking, are connected with the workplace (Healey and Walker 2009:47), a relationship which contributes to the 'social determinants of health' (Wilkinson and Marmot 2003), the reasons why people smoke, drink or take drugs. (Dhesi 2014), and therefore one area in which occupational and public health can become closely intertwined. Indeed, one of the policy objectives put forward by Marmot et al (2010:9) in 'Fair Society Healthy Lives' for the UK Government was to 'create fair employment and good work for all'.

However, the ways in which work influences these social determinants of health can themselves be complex. Research carried out by Papadopoulos et al (2010) exploring the 'changing work environment' found that increased work intensity, long working hours, weekend work, increased percentage of employment under subcontractors and job insecurity and temporary contracts all negatively impact on worker heath. Indeed, higher levels of alcohol consumption, smoking, drug use and obesity are found among

temporary workers than permanent employees (Papadopoulos et al 2010). But for the UK construction industry, this is not a 'changing work environment' – this simply is our work environment; fundamentally our work is structured to the inevitable detriment of worker health. Hours on UK construction sites can be excessively long, the process of competitive tendering for winning work creates an unstable work environment reliant on subcontracting, long supply chains, and a transient and fragmented workforce, all managed through bonus and payment schemes that encourage intensive work practices to support the constant demand for progress.

But these are issues and concerns that cannot be resolved with the simple application of PPE; they relate to much more fundamental aspects of the way the construction industry 'works', and as a result are much more difficult to change. It is perhaps therefore unsurprising that health within the occupational context is often limited to the superficial; indeed 'work-site wellness' programmes rarely include changes or improvements to fundamental working conditions, and efforts are instead directed to what can be more easily controlled; behavioural factors and individual 'lifestyle' issues used to deflect '… attention away from serious examining the effects of corporate cultures or the work environment' (Conrad 2005:546). And in the UK, the PHRD itself arguably supports and even facilitates such deflection. It provides a clear distraction from the more complex problems of occupational health ingrained in construction industry operations by shifting attention from the workplace to the worker, from the underlying occupationally-triggered social determinants of health to the more simplistic 'public health' concerns of their consequences, all the while allowing the relationship between the two to remain obscured.

Grist to the mill? Health and Corporate Social Responsibility

The growing emphasis on CSR within construction organisations also has the potential to enhance the superficiality of health management in practice, as the need to provide 'content' and other evidence of the manifestation of CSR in practice, through organisational reports, media presence and other PR, becomes more pressing. CSR has become a cornerstone of construction industry identity and marketing, with health (and somewhat inevitably safety) drawn under this wider 'Responsibility' umbrella and given a thick coat of PR gloss to become part of a demonstrable corporate citizenship (Rawlinson and Farrell 2010).

Yet whilst the inclusion of health within the CSR remit may seem harmonious, CSR can be defined as ' … a business approach for addressing the social … impact of company activities' (Frynas 2009) and so arguably does concern workforce health, it must also be kept in mind that it is fundamentally a tool for marketing and work winning. Indeed, the suggested drivers behind the growth of CSR, including moral obligations, have long been challenged by those with a much more pragmatic view of the ultimate organisation goal - to make profit and pay shareholders (Henderson 2001) - a perspective from which work winning is much more of a concern than addressing the nuanced complexities of workforce health.

Indeed, it is arguable that the growth of CSR has furthered misdirection in health management within the UK construction industry. CSR has created a temptation to focus on the superficial consequences of poor worker public health instead of any underlying social determinants relating to industry work structure and organisation, to address something with ready metrics and photogenic output that can be easily measured and commodified, and to focus on the management of public health issues

rather than the more complicated, fundamental and mundane occupational health risks that can be so readily identified within construction work practices.

METHODOLOGY

In order to begin to explore the way large UK construction organisations position health within their organisational identities, the relationships between public and occupational health, and the role of CSR within this context, a critical discourse analysis (Fairclough and Wodak, 1997) was carried out. This is a methodological approach which explores the discourses that make up our social worlds from acknowledged and explicitly critical perspectives. It seeks to unpack the way we position and create shared understandings of phenomena, examining the processes and functions of the discourses (Gergen, 2009) within their situated contexts, which here have the potential to reveal the complexities around construction industry 'health'.

The sample for this study was partly one of convenience, comprising Building's top ten largest UK contractors in terms of 'yearly work won including civils September 2014 – 31 August 2015', yet also purposive; their size and success suggestive of pro-active organisational health (and safety) practices. The sample contractors were explored through their public faces - their organisational websites. The use of web sites as documentary sources can prove useful (Rawlinson and Farrell 2010), as they can be considered 'public documents of private origin' developed through the collective authorship of the organisation itself, and are therefore authentic, credible and representative data (Scott, 1990).

A systematic approach to the websites was made, to ensure capture of all relevant pages, through direct links and a search for the keyword 'health'. It must of course be acknowledged that this is presented data (Webb *et al.* 1966) designed to portray a positive image, yet this is of course highly relevant here. It is precisely the way health is positioned by these organisational identities and through organisational policies that is sought, as this necessarily contributes to the development of discourses that will have 'social consequences … such as influencing the social beliefs and actions of the recipients' (Van Dijk 2008:5). This 'version' of industry health will therefore affect, and indeed be affected by, the manoeuvring between public and occupational health, the potential for the attention paid to the former to be detrimental to the latter, and also better illuminate the complex role CSR plays within this relationship. Although naturally limited in generalisability by the underlying research philosophy, this approach is still able to explore and illuminate health for this stratum of the UK construction industry.

FINDINGS AND DISCUSSION

The positioning of health (and its seemingly inevitable partner, safety - subsequently noted as 'H&S' where they occurred in this format) from the organisations' homepages could be traced through two distinct paths. The first travelled via 'sustainability', 'responsibility', or, more explicitly, 'corporate responsibility', to a page in which H&S was a link alongside those leading to environment, governance and community. The second positioned H&S within some form of corporate identity; 'about us', 'who we are', and 'how we do it', the H&S link here sitting alongside those leading to values, culture, strategy and history. These two different approaches were split equally between the ten organisations, five adopting a 'sustainability' approach, and five an 'identity' approach. Interestingly this reflects one of the wider debates around CSR; is it something the company does, or something the company is? From this perspective,

health, occupational or public, becomes either a practice or a 'value', and therefore its management and consideration can become very different things. However, further analysis did not reveal any coherence within the subsequent discourses of health as located beyond these two pathways, rather several nuanced facets became identifiable within the wider discourse of health that emerged from within the data as a whole.

An unbreakable amalgam

The fact that 'H&S' naturally became the shorthand within the analytical process was reflective of the fact that safety is still very much the dominant partner within the H&S amalgam. Health was often negated for the maximisation of safety; where H&S formed the link or page title, the content often developed through explication of safety leadership, ways of working safely, safe behaviour, safety incidents and Accident Frequency Rates (AFRs). There was also a 'muddling' of health with safety within the discourse, and its subsequent management in practice. For example, one page stated that 'poor health in the workplace can present significant safety risks', suggesting that health was actually a predetermining factor of safe practice, rather than an occupational consideration in its own right. Another stated that 'employees with safety critical roles for example those at high risk of hearing damage, vibrations etc. are given regular health screenings'. Again, occupational health issues are aligned with safe working and management in practice, and, worryingly, screening after the event is positioned as an acceptable approach carried out for safety reasons alone, rather than any proactive prevention. Where such 'muddling' occurred, health was often the losing party, safety dominating both the organisational discourse and any recourse to practice.

Healthy work and healthy lifestyles

Where health was found alone, it was positioned in one of two ways; either as focused occupational health practice or a broader area of 'concern', which could themselves be aligned with how the two types of health - occupational and public - emerged within the data. Despite its relevance to construction work, and the industry's poor record in this area, occupational health was actually very limited in its recognition. Although there was acknowledgement of 'ill health caused by work', this was not a dominant positioning of health within the wider discourse, and its contribution was limited to associations with management, and most specifically the risk assessment process. For example, one organisation stated that 'all our businesses will conduct health checks and health risk assessments to ensure there is no long-term harm to health from working in our business.' However, this positioning of risk assessments and health surveillance as pro-active efforts, rather than the minimum legal standards they actually are (HSE 2015d), is a highly misleading construct within the wider discourse of health, although one that is commonly employed (Sherratt 2015a). Seeking to create an enhanced positive image around a legally required activity is itself suggestive of PR 'spin' and the need to position organisational efforts as 'above and beyond' minimum standards in the desire to demonstrate corporate citizenship. Within this wider context, it could therefore be considered unsurprising that this dataset did not reveal more details of occupational health management in practice, such mundanity unable to make a strong contribution to what is essentially marketing literature. But this argument can itself be challenged by the fact that this was certainly not the case for health's long term partner, safety. The discourse of safety management within the dataset constantly sought to go beyond mere legal requirements; the development of safety programmes, zero targets, site management

practices and training were all championed as evidence of organisational commitment to safety. Yet occupational health did not receive this same consideration, either proportionally in terms of content, or in the level of detail accorded to its management in practice, and instead was simply reduced to the lowest common denominator of management; that of the minimum legal framework with which all must comply.

Overall, the analysis demonstrated that for large construction organisations whilst some consideration of occupational health is made, it is still not accorded either the attention or consideration paid to safety, and remains a much lesser partner in this relationship. However, the same cannot necessarily be said of public health. The more common manifestation of health identifiable within the data, was as an area of 'concern', frequently linked with wellbeing, as something 'supported' by the organisation but without any corresponding level of detail or operational specificity. This approach, an example being the organisational intention of 'promoting health and wellbeing for everyone who works with us', avoids any description of occupational activity, and instead contributes to the development of a discourse focused more on public health. Although in some instances, both occupational and public health were explicitly considered within a simple, broad reference to 'health', public health issues were themselves much more dominant within the wider health discourse (as extracted from safety or even 'H&S') found within the data. This was evidenced through explicit reference to the PHRD, companies stating their commitment to the Pledge, through the presentation of detailed health and wellbeing programmes seeking to educate and encourage lifestyle changes, or simply through core 'value' statements that 'we support health and wellbeing'. Although safety remains prioritised, public health has arguably superseded occupational health as the dominant 'health' of the UK construction industry.

The role the organisations gave themselves within this discourse was that of a provider of pastoral care, a supporter for the benefit of their workforce. Yet who this workforce actually is remains much more obscure. As noted above, reference was made to 'everyone who works with us', but in just one case the supply chain was specifically highlighted as a partner in the organisational public health improvement strategies. More frequently, the organisations 'workforce' remained obfuscated; 'all our people' providing a lack of specificity in the practical implementation of the health and wellbeing programmes. Indeed the difference in programme goals also adds to the intangibility of the discourse, imagery of offices and computers used to illustrate the need for 'active lifestyles', something perhaps less relevant for those working on site than those based in the head office. This lack of detail in terms of programme implementation is perhaps reflective of the inherent problems in maintaining a transient and fragmented workforce, which also includes large numbers of the self-employed, but, more cynically, also enables organisations to make commitments to education, training and health screening that seem more generous than perhaps they are in practice. Whilst one organisation's aim is for '75% of our employees [to be] using the programme by 2020', this will in fact be far less than the number of workers that will actually contribute to their construction outputs.

Further concerns can be raised around the public health 'problem issues' found within the data which included diabetes, high blood pressure and stress, whilst those seeking promotion included active lifestyles, smoking cessation and healthy eating. Programmes often include the offer of on-site wellness screening and health-screening clinics, with the overall aim of ‘building a healthier workforce’. Yet many of these issues relate to individual choice and 'lifestyle', areas where notions of positive liberty

and personal freedoms become highly significant (and have already been theoretically explored elsewhere, see Sherratt 2015a), but they are also areas where the organisation is able to distance themselves from their manifestation within the workforce. These are individual issues, not organisational, problems of public not occupational health, and as such the organisation can confidently take on a benevolent position, helping the workforce make the 'right decisions' about their health and lifestyles, whilst the possibility that they may actually have a more significant role to play in the emergence of these health issues as a whole remains unremarked. The dominance of public over occupational within the wider discourse of health further contributes to this misdirection; if organisations are 'committed to promoting healthier lifestyles and helping our people to manage their health', surely they are also doing all they can for occupational health in their workplaces already? Furthermore, this version of public health steadfastly ignores the social determinants of health; the relationships between wider work practices and health decisions. The discourse of public health found within the data does, as Conrad (2005) suggested, focus on individual 'lifestyle' issues, and as such is able to deflect attention or enquiry away from any detrimental work practices.

Image is everything

An interesting aspect of the data collection process was the location of much of the 'health' data beyond H&S webpages. Only three of the ten organisations shared their H&S Policies via their websites, far more chose instead to champion their H&S activities within press releases or news articles; health (and safety) packaged and photographed to create PR content. For example, one organisation had ' agreed to purchase fresh fruit from a local stall holder to provide fruit for our operatives' as part of their healthy eating drive, another had run 'local awareness campaigns around areas such as mental health and well-being, healthy eating and drug and alcohol abuse' which had resulted in a Better Health at Work Award. Indeed, the number of awards that can be won in this area of organisational management is really quite impressive, and although safety still dominates, health remains much more prominent in its public than occupational form.

Again, this is perhaps unsurprising given the dataset explored here, however it does lend support to the argument that such ventures are indeed only attempts to continue to feed this hungry PR machine. The provision of a few bowls of fruit to provide positive content is indeed far more visually stimulating than the provision of face fit dust masks; for one thing the latter inconveniently obscure the smiles of the workforce modelling them. Yet, more seriously, it can be suggested that this 'packaging of health' as revealed by the data has influenced the emphasis on public health over occupational, and shaped the wider discourse of health within construction. The commodification of worker health into PR packages and awards, and by association the organisations ability to position themselves as benevolent champions of the workforce (although which one remains somewhat unclear), also enables industry clients to align themselves with this shiny, happy world. Yet the development of this commercial attractiveness, as dictated by our CSR aware society is arguably a misdirection; of investment, efforts and practices to feed the superficial and photogenic, to the neglect of occupational health within the UK construction industry.

CONCLUSIONS

Although focused on a very specific dataset, this research has been able to illuminate several key aspects of construction industry health. With regard to priorities, health

remains very much in second place to safety, and public health has surpassed occupational health as the dominant discourse within the public faces of the organisations. Although this could be considered unsurprising, due to the mundanity of occupational health management in practice, that safety is so heavily championed, even to the level of site management programmes and activities, suggests that this argument is not necessarily valid. The role of construction health within CSR remains prominent, the positioning of health within press releases and news stories and its association with awards and events, also suggests that efforts around health are indeed aligned to the photogenic and commodifiable, to feed the insatiable PR machine.

But construction workers should be shiny happy people! Arguably construction should be one of the UK's healthiest industries; workers are outside in the fresh air, they are mobile, they are able to use their muscles on a daily basis, to stretch and flex and tense, but they are hampered by their poor occupational health. The social determinants of health that go beyond superficialities of diet and smoking are also critical; the way the industry is organised, the way work and our workforce is structured will hamper the public health of construction much more significantly than a lack of fruit. Further research is therefore proposed to empirically explore occupational and public health management in practice; to establish the extent of the (im)balance as it exists on sites, as well as better illuminate the relationships between the social determinants of heath and construction industry operations. From this broad evidence base it is hoped that effective changes to work practices can be proposed and implemented to improve occupational health, alongside changes to work structuring and organisation to positively impact public health, which can together help create the shiny happy construction workforce of the future.

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