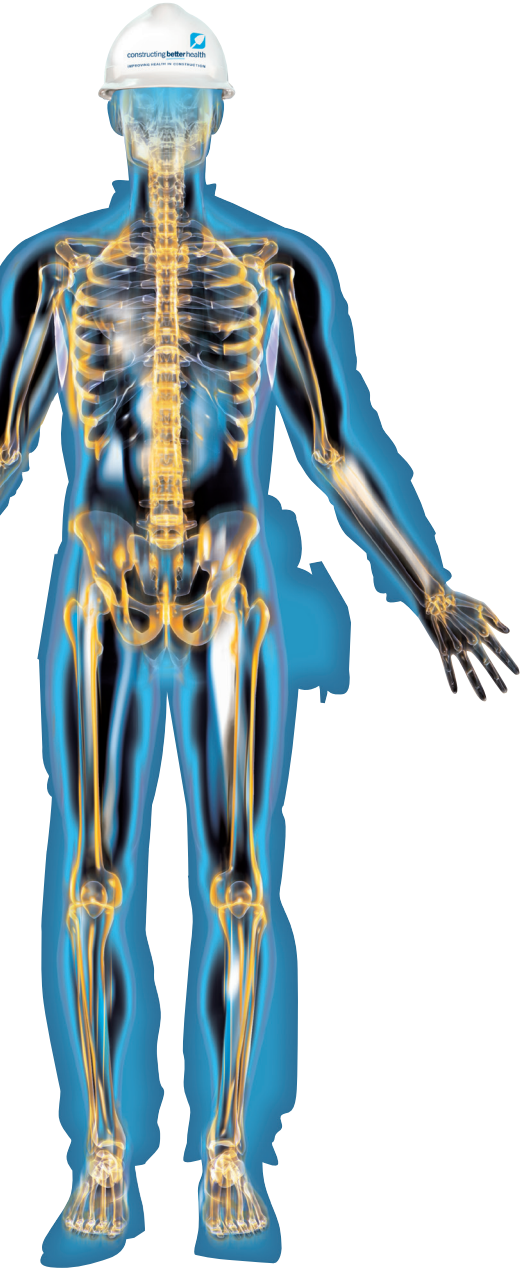
constructing better health

IMPROVING HEALTH IN CONSTRUCTION

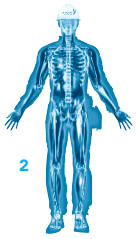


NEW HEALTH HORIZONS

STRATEGIES FOR OCCUPATIONAL HEALTH MANAGEMENT IN CONSTRUCTION

WHITE PAPER

September 2009



Executive summary

This white paper includes a new strategic framework designed to put the health back into construction health and safety and to improve the health profile of the UK's construction workforce.

The last decade has seen an intense policy agenda focus on health and wellbeing in the workplace. Traditional models of fitness for work have been challenged and the positive power of employment has been trumpeted as a pathway to returning to work.

As the UK economy cycles through another recession, with the inevitable decimation of the construction workforce, desperately needed construction skills are leaving the sector. Entry-level recruitment is not enough to fill the gap and the spectre of ill-health promises to heap more woes on a troubled industry.

Whilst the safety element of Health & Safety has received much deserved attention in the past decade, health has been the poor relation. Pilot occupational health monitoring schemes have identified clear gaps in the management skills of construction's current and future leaders. Constructing Better Health believes this should be tackled now, because:

- We need to keep key skills in the construction sector
- Healthy companies perform much better
- We need to reduce the cost of health liabilities and the risk of future litigation
- We think it is the right thing to do within the Corporate Social Responsibility agenda.

But we have identified that the current occupational health framework is not up to the task. Workers are turning up on site and doing jobs that may affect their health, and potentially the safety of those around them. So, what is the solution?

Constructing Better Health proposes that a new strategic framework for occupational health risk assessment, monitoring and action be introduced, providing contractors with the tools to assess health risks, and to plan and implement health surveillance programmes:

- Educating workers that a healthy workplace is just as desirable as a safe one, that promoting occupational health is not a threat to their livelihoods, and that doing nothing is a threat to their lives
- Introducing a card for each worker, which is linked to a central occupational health database. Operating in a similar way to the Construction Skills Certification Scheme (CSCS), this would cut to the heart of the problem, providing contractors with audit trails and workers with occupational health profiles. It would save lives, time and money.

Constructing Better Health has already developed the standards of occupational health management that can be applied now. It uses a strategic framework that designs out health risks in the same way that current regulations design out safety risks.

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First published in September 2009 by Constructing Better Health

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1.0 Introduction

The UK's construction sector is a major powerhouse of the economy, even in times of economic downturn. In the region of 250,000 construction firms employed 2.1 million workers in 2007 (Department of Business, Innovation and Skills 2009). Even with the huge decline in economic activity of some construction areas during the present recession, the industry remains a significant employer.

Yet work-related illness in the UK cost society an estimated £10 billion per year. The musculoskeletal conditions common to workers in construction account for £5.5 billion of this total (Health and Safety Executive 2000 p.3) and are thought to be responsible for a quarter of working days lost through absence (Black 2008a p. 41).

> ***" Construction is more than just an industry. It is about the built environment and how we live in it. "***
>
> (Donaghy 2009 p.15)

So, is work good for workers or bad for them? And is tackling health issues good or bad for businesses? Well, this appears to depend on the workplace. Research evidence shows that health and wellbeing programmes do produce economic benefits, and that these can be enjoyed by firms of all shapes and sizes, inferring that 'good health is good business' (Black 2008a p. 10).

However, the construction industry's record on occupational health clearly deserves attention, according to Rita Donaghy's recent report on fatal accidents in construction. Thousands of workers die every year of occupational health-related conditions and fewer than a hundred, albeit still far too many, are killed at work as a result of failures in safety (Donaghy 2009 p.45; p.19).

Why does construction have such a poor record when it comes to occupational health management? The sheer scale of the numbers given in the first couple of paragraphs of this section go some way to explaining why occupational health management is such a challenging task. And the challenge grows exponentially when you consider the complexity of the construction supply chain.

So, who is involved and who should take action? Primary contractors on a given site have clear roles and responsibilities, plus, being generally larger and longer-lived businesses, they also tend to have a more stable workforce. As the supply chain shakes out, subcontractors and sub-subcontractors tend to be small to medium sized enterprises (SMEs) and self-employed workers – many have neither the infrastructure nor any incentive to factor occupational health monitoring and management into their operations.

National importance has been placed on the creation and maintenance of a health and wellbeing management strategy, particularly following the publication of Dame Carol Black's review of the health of the UK's working population and supporting data (Black 2008a, Black 2008b). As such a prominent employer, construction must make changes as a result of the Government's response (Health, Work and Wellbeing Steering Board 2008).

What is encouraging is the acceptance that a 'bottom-up' safety culture is not likely to succeed (Donaghy 2009 p. 11), so the responsibility for driving change in the sector lies with larger players, such as primary contractors. These organisations should be able to see the business benefits of encouraging occupational health in their workforce, both from a financial point of view and a corporate social responsibility perspective. Those imperatives should persuade primary contractors to insist that their supply chains follow suit – right down to giving support and guidance to self-employed workers.

There is a clear process for firms to follow – understanding occupational health as clearly distinct from safety, and then creating a workable and economically justifiable occupational health management programme. Then the challenge is to engage with the long 'tail' of the supply chain and insist that a condition of sub-contractors winning contracts is that they adopt their own, fit-for-purpose occupational health processes.

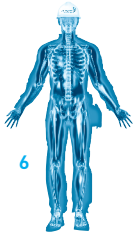
The precedents are there, as evidenced by the imposition of corporate social responsibility practices, including audits, on large and highly complex global supply chains (PricewaterhouseCoopers 2008).

The framework advocated by Constructing Better Health takes monitoring down to the level of the individual, by the implementation of a national card scheme – either a stand-alone Constructing Better Health (CBH) card or a simple extension of the Construction Skills Certification Scheme (CSCS) card. The CSCS card is increasingly a mandatory on-site requirement for individual workers to be able to demonstrate their competence in safety. Following Constructing Better Health's recommendations would ensure that workers are similarly certified to be fit for the task they undertake on-site.

Individual monitoring via a central national database is the only viable option for a workforce that is so necessarily transient – construction workers typically work over large geographies and for many employers. The complexities of record keeping on the part of an employer would rapidly render locally administered schemes ineffective. But, as the CSCS scheme shows, a national system can be highly effective.

Each worker's card would provide a route for employers to check their personal occupational health management strategy, based on the specific risks they will be facing in the workplace. This provision could ultimately reduce the chances of construction firms facing costly litigation and compensation claims in the future.

Finally, a core strategy for the understanding, monitoring and management of occupational health in construction would be the provision of much-improved education. This would cover the negative impact already being experienced as a result of work-related health risks, plus the positive economic effects of a healthier workforce.



2.0 Health in construction – a definition

Health and safety has assumed a vastly increased role over the last two decades, and in particular since the introduction of the first set of Construction (Design and Management) Regulations in 1994. However, emphasis and understanding has been on safety and not health, with a general lack of awareness at all levels, including management, of occupational health issues (Tyers et al 2007 p. vii).

According to the British Medical Association (Constructing Better Health 2008b), an occupational health service should:

- *Promote, protect and maintain the health, safety and welfare of people at work*
- *Advise on the rehabilitation and placement in suitable work of those temporarily or permanently incapacitated by illness or injury*
- *Advise on the provision of safe and healthy conditions by informed assessment of the physical and psychological aspects of the working environment*
- *Carry out or promote research into the causes of occupational diseases and injury and into the means of their prevention.*

Despite the fact that construction workers as an occupational group have one of the highest rates of occupational poor health, awareness of the topics is mainly restricted to the larger contractors (Constructing Better Health 2008b). This lack of knowledge is compounded by the fact that construction industry employers are not sure where to go for expert help.

2.1 Key construction work-related health risks

Most occupational health disorders suffered by UK construction workers fall into one of the following six groups:

1. Musculoskeletal Disorders; the most common occupational illness in the UK, affecting muscles, tendons, ligaments, nerves and other soft tissues and joints
2. Hand-Arm Vibration Syndrome (HAVS); typically caused by hand-held power tools that cause HAVS and carpel tunnel syndrome (CTS), includes vibration white finger
3. Noise-Induced Hearing loss; continual or sudden exposure to noise results in irreversible hearing loss
4. Skin disorders; mostly work-related irritant dermatitis, or eczema, caused by cement and sand and other substances, and can develop into an allergy
5. Respiratory disease; includes asthma and chronic obstructive pulmonary disease (COPD), plus asbestosis
6. Work Related Stress; the Health & Safety Executive (HSE) definition is "the adverse reaction people have to excessive pressure or other types of demand placed on them" (Constructing Better Health 2008a p.29)

One key feature that connects all of these conditions is that symptoms can sometimes take years to manifest, usually well after the worker has left the job in which they were exposed to the health risk.

2.2 Health is not safety

Focus in the construction sector, and in the wider policy context, has been on safety, where construction site fatalities have an impact and immediacy that occupational health lacks. Yet an examination of the statistics show that occupational health is a far more serious problem than safety – several orders of magnitude so. Although the focus of Donaghy's report is on construction fatalities at work, the author acknowledges that:

> ***" Occupational health remains a serious problem in the construction industry. Thousands of workers die every year from mesothelioma and other occupational cancers and lung diseases. Twenty skilled workers (electricians, plumbers, etc) die every week from asbestos related disease and 12 more construction workers die every week from silica related lung cancer. While this was outside the scope of this Inquiry, it is vital that renewed efforts should be made to tackle this issue. The dangers are known and the preventative work needs to be done. "***
>
> (Donaghy 2009 p. 13)

The 72 workers killed at work in the construction sector in 2007-2008 suffered tragic, untimely and largely avoidable deaths. But, as table 2.1 highlights, their deaths are a fraction of the construction industry's 'body count' as a whole.

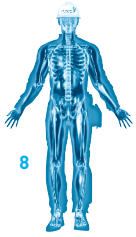
	Due to ill health	Due to accidents
Deaths	2056 died of mesothelioma (a cancer related to asbestos exposure), plus thousands more from other occupational diseases	72 workers killed at work
Working days lost (2007-2008)	1.7m days lost due to work-related ill-health	1m days lost due to workplace injury

Table 2.1 Worker deaths in construction in 2007-2008 (adapted from Donaghy 2009 p. 45)

Although significant progress has been made on safety, the reasons for and management of ill health have largely been neglected. Some larger contractors have addressed the issues, but SMEs lack the infrastructure and the motivation to tackle the issue, largely adopting a 'make do' approach and simply getting the job at hand done (adapted from Donaghy 2009 p. 46).

Data from the Health and Safety Executive (Health and Safety Executive 2009) confirms the magnitude of the occupational health issues facing construction – 88,000 workers currently working or recently employed in the sector are suffering from an illness caused or made worse by their job.

An additional factor is the latent nature of many construction-related occupational health issues. Conditions that may take decades to develop cannot be effectively monitored by employers. Construction workers frequently move employer and spend periods as self-employed, so it becomes very difficult, if not impossible, for contactors to monitor their workers' health over the long term.



2.3 The business case for health in construction

Few organisations have the luxury of being able to adopt strategies that do not, in some way, contribute to financial wellbeing. Construction firms operate in a sector where margins can be slim and where, in a tough economic climate, break-even can be viewed as an admirable achievement. At the top end of the supply chain, contractors are mostly publicly owned and must maintain healthy profits to appease investors, whereas on-site, many sub-contractors live hand-to-mouth with all cash invested in maintaining operations.

Neither of these scenarios would suit a corporate social responsibility attitude that did not pay for itself, and long-term worker-health management strategies would seem to be a non-starter. However, the evidence suggests that investing in worker health and wellbeing does give a return on investment.

The Black review (Black 2008a pp. 53-54) clearly identifies non-financial reasons for investing in health and wellbeing initiatives:

- 'Pure' corporate social responsibility to improve the quality of life of the workers and their families
- Differentiation of conditions of employment to attract and retain the best staff in a competitive labour market
- Halting the rising cost of sickness in the workforce, which could threaten the very survival of individual businesses.

Clearly, the second and third reasons will also ultimately impact positively on the financial performance of a business.

A greater incentive for the larger contractors to invest in occupational health management programmes can be found in research by PricewaterhouseCoopers (PwC), as reported in Black (2008a p.54). PwC conducted a literature review and compiled over 50 UK case studies that showed a positive impact as a result of introducing health and wellbeing programmes.

Benefits included:

- Reduced absence due to sickness
- Lower turnover of personnel
- Higher levels of employee satisfaction
- Lower levels of accidents and injuries
- Higher productivity
- Improved company profile.

Each of these by themselves could be a compelling argument to introduce a new initiative. But taken together, they make a highly compelling case for occupational health monitoring as being at the least cash neutral, and at the best having a positive impact on the bottom line.

3.0 Occupational health management in action

The evidence suggests that organisations which invest in occupational health management programmes clearly receive tangible benefits as a result. Such benefits vary according to the organisation and the health and wellbeing programme implemented, as do the causal links.

Equally, at the other end of the scale, it is clear that certain characteristics of the construction sector – such as the high level of self-employment – are linked to issues such as low levels of training; poor job security; high workforce mobility; increased chances of accidents; and the lack of team working (Donaghy 2009 p. 36).

Yet larger organisations that have invested in the wellbeing and health of their workers have clearly enjoyed enhanced performance, as the following case studies demonstrate.

3.1 The Post Office

In the UK, the Royal Mail Group employs 180,000 workers over thousands of sites in hundreds of different roles. It believes that work is a positive part of its workers' lives, and that managing health and wellbeing is a part of its remit.

As part of its employee health and wellbeing programme, the Royal Mail Group:

- Conducts comprehensive occupational health screening
- Provides a 24/7 telephone health advice service
- Has health clinics at more than 90 of its sites
- Offers fitness centres with instructors at 38 sites
- Provides workers returning to work after injury or illness with occupational therapy and physiotherapy
- Offers a confidential advice and counselling service
- Plus other benefits.

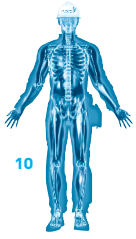
Royal Mail Group also has a defined occupational health services and occupational health and safety function, which tries to proactively risk assess and manage out causes of ill health.

According to Royal Mail Group, this significant investment into its occupational health management programme and a much more holistic approach to health, has resulted in marked improvements in performance. These include:

- A 7% fall in absenteeism
- A more flexible response to change
- Reduced costs, improved productivity and enhanced morale.

Clearly, the strategies employed by Royal Mail Group have had a significant, and quantifiable, impact.

SOURCE: Health, Work and Well-being (2009)



3.2 South West Water

South West Water has been cited by the Health and Safety Executive as an organisation that works to improve the health of its workers and has a strong health and safety culture. By implementing a strategy to address upper-limb disorders, South West Water anticipates saving £1m over ten years.

This may not appear to be a huge saving, but an enormous human cost has been saved, too, and this is only one initiative aimed at one specific work-related occupational illness. The total savings could be considerably more.

SOURCE: Health and Safety Executive (2000 p.4)

3.3 'Best companies to work for'

PricewaterhouseCoopers has conducted a number of studies that the Black review cites as further evidence of the financial benefits of investing in worker occupational health programmes (Black 2008a p.59).

Those US corporations in the 'Best companies to work for in America' outperformed their industry peers to earn 14% per year from 1998-2005.

Similar evidence from the Sunday Times 'Best Companies to Work For in the UK' demonstrates that businesses with higher levels of 'staff engagement', which includes employee well-being, enjoy:

- 13% lower staff turnover
- Below half the UK average staff absence for sickness
- Consistently outperforming the FTSE100.

The causal links are more tenuous than the Royal Mail Group and South West Water case studies, but still demonstrate that adopting the right kind of philosophy can have startling results, including on business and financial performance.

SOURCE: Black (2008a p.59)

3.4 'Working well together'

The Working Well Together campaign was launched in 1999, with an objective to cut accidents and ill health in the construction sector. A Health and Safety Executive-backed organisation, the campaign brings together all stakeholders in the construction sector and has a particular focus on small and micro-businesses and workers – those parts of the industry that are judged to be hard to access.

The success of the initiative is difficult to judge, as the Health and Safety Executive has not published performance indicators. However, Working Well Together has been in existence for ten years and appears to have a thriving events programme, which suggests its members value what it is doing.

SOURCE: Health and Safety Executive (2000 p.21), Working Well Together (2009)

3.5 Constructing Better Health pilot

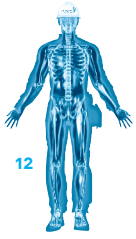
The most compelling evidence of an occupational health management programme in action is the pilot conducted between October 2004 and June 2006 by Constructing Better Health. The pilot was created and implemented to test various models of occupational health management in the field. Its aim was also to determine which elements of the programme would be of most value and readily accepted at a national level.

The pilot ran for 21 months and, in that time, Constructing Better Health provided services to 367 different employers at every level of the sector. As part of the delivery, 1,724 voluntary health checks were completed. The results were startling, revealing that a third of all workers had potentially harmful underlying occupational health issues.

In addition, the pilot debunked a number of assumptions about the views of the construction sector, and identified that managers' actual activities and skills fell well short of what is required to effectively manage occupational health within their businesses

The pilot was considered a success because it achieved one of its primary objectives, which was to raise the profile of occupational health at a national level. Lessons learned have been adopted into a national framework.

SOURCE: Tyers et al (2007).



4.0 Creating a health management strategy

The pilot occupational health programme run by Constructing Better Health between 2004 and 2006 highlighted that there is a general lack of awareness and knowledge at management level throughout the construction supply chain. It also clearly identified that any solution must be workable to gain acceptance from the industry (Tyers et al 2007).

In theory, employers already have a duty to inform employees, and workers from other organisations, about health risks. But the existing requirements are not sufficiently rigorous, nor widely undertaken.

Based on the results of the pilot (Tyers et al 2007) and subsequent work (Constructing Better Health 2008a, 2008b), Constructing Better Health has created a strategic framework designed around risk management, prevention and control.

With a 'prevention is better than cure' approach, early involvement of clients, designers and planners is essential. The approach is similar in methodology to the Construction (Design and Management) Regulations (CDM), in which health and safety is 'designed in' to the construction process. Similarly, occupational health risks are 'designed out' of the process by limiting the opportunities for workers to be exposed to health risks.

4.1 What the law says

Employers have a legal duty to assess and reduce, so far as reasonably practicable, the risks to the health and safety of employees and others who may be affected by work activity.

The **Health and Safety at Work Act (HSAWA)** sets out the general duties that employers have towards employees and members of the public, and that employees have to themselves and also to each other.

The Management of Health and Safety at Work Regulations 1999 requires employers to carry out risk assessments. It also requires them to make arrangements to implement any necessary measures resulting from the risk assessments to protect the health and safety of workers. In addition, employers are required to appoint competent people and arrange for appropriate information and training.

Other key legislation and regulations applicable to the construction industry includes:

- The **Noise at Work Regulations 1989,** which require employers to take action to protect employees from hearing damage
- The **Control of Substances Hazardous to Health Regulations 2002 (COSHH),** which requires employers to assess the risks from hazardous substances and take appropriate precautions. COSHH covers chemicals, products containing chemicals, fumes, dusts, vapours, mists, gases and biological agents, including bacteria such as Leptospira, which can lead to Leptospirosis (Weil's disease) and Legionella pneumophila, the cause of Legionnaires disease
- The **Control of Vibration at Work Regulations 2005** (the Vibration Regulations), which aim to protect workers from health risks associated with vibration, for example when using power tools or certain machinery. The regulations set limits on hand-arm and whole-body actions and vibration
- The **Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR),** which requires employers to notify cases of certain occupational injuries, diseases and dangerous events
- A range of more specific regulations covering particular hazards, such as the health risks posed by asbestos and lead.

Created so that health and safety is 'designed in' to construction projects over a certain size and duration, **The Construction (Design and Management) Regulations 2007 (CDM 2007)** aim to:

- Integrate health and safety into the management of the projects
- Encourage everyone involved to work together to improve the planning and management of projects
- Identify risks to health and safety early on
- Target effort where it can do the most good in terms of health and safety
- Discourage unnecessary bureaucracy.

According to standards published by Constructing Better Health (Constructing Better Health 2008a), health surveillance should be considered wherever there is a significant residual health risk to employees, and, of course, where such surveillance may be a legal requirement.

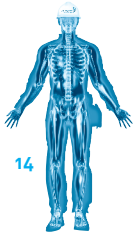
Employee attendance for health surveillance activities is mandatory where a risk assessment has established that a genuine need for health surveillance exists. Although employees do not have to undertake any tests or answer medical questions, any lack of cooperation is likely to result in the occupational health provider undertaking the health surveillance programme to inform the employer. This would mean that a fitness for work statement could not be made for any workers failing to cooperate. Whether to take further action, such as preventing the health surveillance 'refusers' from working, becomes a management decision under the relevant employment legislation.

Section 2 of the Health and Safety at Work Act 1974 states that employers have a general duty of care to ensure, so far as is reasonably practicable, the health, safety and welfare of all their employees. This involves health surveillance, which means having procedures in place to detect work-related ill health at an early stage and a process for acting on the results. Health surveillance should not be viewed as an end in itself, but as a mechanism to demonstrate whether control measures to reduce and avoid workplace health hazards are actually working.

To put this into context, very loud noise is known to damage hearing. Hearing tests, a form of health surveillance, can detect the effect of workplace noise on the hearing of people who work in noisy conditions. Ultimately, employees should benefit, as health surveillance, in the form of the hearing tests, will identify those workers most at risk, so that measures can be taken to protect them, improve working conditions and review the existing control measures.

Currently, employers can adopt a 'tick-box' and reactive approach. This satisfies the minimum legal requirements, but does not actually address the underlying occupational health issues of the workers.

So, in theory, employers already have a duty to inform employees about occupational health risks. But, in practice, although the existing regulations are clearly sufficiently prescriptive to require ongoing monitoring and occupational health management, the evidence suggests that industry is falling short of the mark when it comes to compliance.



4.2 Constructing Better Health strategic framework

Constructing Better Health proposes an occupational health framework that addresses the issue at two levels:

> Having a manageable scheme for employers, which enables them to quickly assess new workers whilst minimising their record-keeping and administrative burdens

> Having a tailored and personalised record for each worker, which assesses the risks specific to the worker and informs the resulting occupational health strategy.

This two-pronged solution would enable a site manager to instantly assess a worker's fitness for a given task. It would also satisfy the audit requirements for subcontractors providing workers, in addition to the main contractor's personnel.

When it was first introduced, the Construction Skills Certification Scheme (CSCS) met with resistance and has taken many years to gain the level of acceptance it now enjoys. When many public sector clients started to insist that bidders for contracts must have a 'carded' workforce, take-up increased rapidly. The ease of large-scale training and assessment, facilitated by organisations like Train to Gain, has also accelerated the CSCS card's take-up.

Constructing Better Health has introduced a parallel card scheme to satisfy the occupational health management programme requirements of employers and individual workers. As a centrally managed scheme, the Constructing Better Health card is also appropriate for the small and micro-businesses that would normally be unwilling to carry the cost burden of additional health-related regulation.

Training and education, targeting both workers and employers, are a key component of the scheme. Rapid and widespread take-up will only happen if workers are satisfied that their occupational health records were working in their favour and not preventing them from working.

Employers will also need to become educated clients of occupational health service providers, who can provide the expertise currently lacking at management level. It was highlighted in the results of the pilot (Tyers et al 2007) that employers' managers lacked not only occupational health expertise, but also the knowledge about where to find help and how best to apply the expertise available.

Figure 4.1 provides a simple representation of how the process could work. It starts with the contractor completing an occupational health risk analysis, based on Constructing Better Health's tools and industry standards.

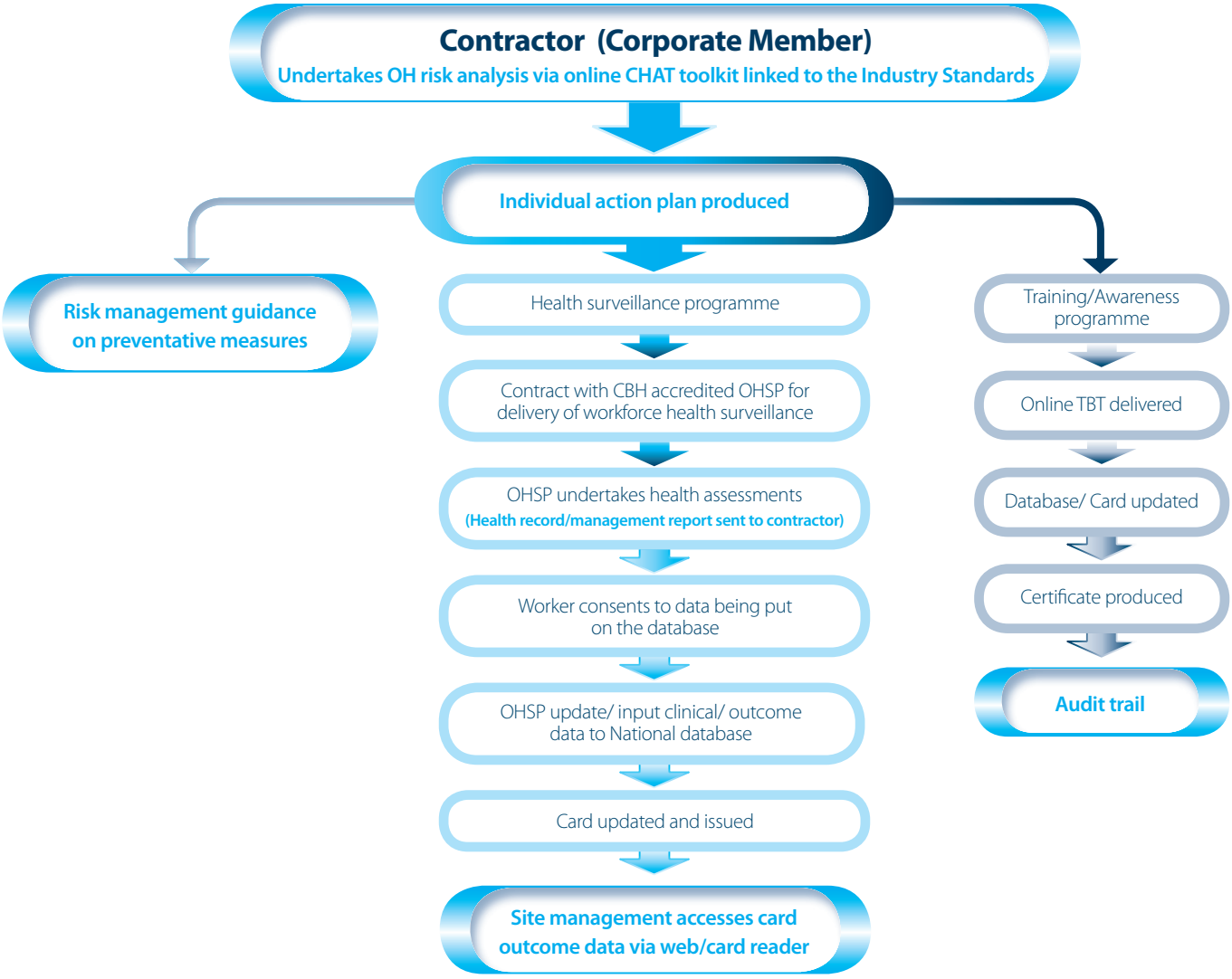
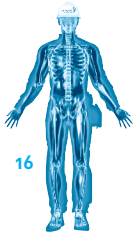


Figure 4.1 Constructing Better Health framework for contractor occupational health programme

On completion of the occupational health risk analysis, a contractor would have an individual action plan produced that reflects the actual occupational health risks faced by workers as a result of the contractor's specific activities on site. The action plan will clearly highlight guidance on preventative measures that should be taken.

The action plan will indicate the health surveillance programme required as a result of the occupational health risks identified. The next stage for the contractor would be to contact an occupational health and safety provider accredited with Constructing Better Health, in order that a workforce health surveillance programme can be finalised and delivered.

On completion of the health assessments of individual workers, the outcomes would be returned to the contractor and, assuming the worker provides consent, the data loaded onto the database. An education campaign is particularly important to ensure that workers understand what data will be supplied to the database and how the results will impact on the improvement of future work-related health issues for the construction industry workforce.



Individual workers will each receive a card that provides the route for site management to confirm their health and fitness to perform particular roles on-site. This ensures that the main contractor running the site knows that all subcontractors and self-employed workers have undergone occupational health assessments, and prevents workers engaging in tasks that they should not perform.

In parallel, the contractor can maintain records on each individual worker. The audit trail will allow subcontractors to demonstrate to primary contractors that they have implemented an occupational health management strategy. In addition, the audit trail can be kept on record, in the event of any future civil claim by the worker.

5.0 Conclusion

The health and wellbeing of the UK workforce has shot up the policy agenda in the last decade. There is now much more emphasis on managing occupational health issues in the workplace and moving away from the traditional model, which typically says that an ill worker cannot work.

Due to its unique operating structure and the nature of the work involved, the UK construction sector suffers from disproportionately high levels of occupational health issues. Workers are highly transient – by employer, geographically and over time – and the sector suffers from deep troughs during economic downturns.

Workers who have spent any time in the sector already typically suffer a range of common occupational health disorders. With the construction sector's current focus on safety and not on health, the existing frameworks for addressing occupational health issues and developing strategies are failing.

Constructing Better Health introduced a new national occupational health management strategy. Contractors would apply a standard methodology that creates bespoke occupational health risk assessments. Risk management plans and health surveillance programmes would be developed accordingly.

The strategy would require individual workers to carry an 'occupational health fitness for task' card, much the same in principle as the CSCS cards workers carry now to demonstrate competence in safety. The Constructing Better Health card would demonstrate to primary contractors managing sites that workers, including subcontractors and the self-employed, are fit for the task they have been assigned.

Accompanying the new card would be a significant communications campaign to educate managers about occupational health, as well as how to manage occupational health issues and practitioners.

Workers would also need to be satisfied that the new card would not threaten their livelihoods and that it would actually have positive results – by helping them avoid the development of new occupational health conditions and ensuring that existing ones are not exacerbated.

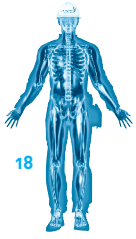
The card would also satisfy the challenge presented to contractors that need to demonstrate that their supply-chains comply with occupational health requirements. In addition, the card would show that employers have completed the health-related steps necessary to reduce or avoid the risk of future litigation.

Constructing Better Health occupies a niche in the construction sector, where it is ideally placed to provide the independent, centralised national role of building and maintaining the occupational health in construction database. The standards required to complete risk assessments and to select appropriate and compliant occupational health practitioners have already been developed by Constructing Better Health.

The industry is ready to take the next step towards improving worker conditions and therefore maintaining a healthy workforce into the future, reducing the risks of future litigation and demonstrating a forward-thinking approach.

The construction industry's current occupational health framework is not up to the task. It is leaving the construction sector open to crippling health liabilities that will drive skills out of the sector and potentially force construction and infrastructure companies into unnecessary recruitment, training and litigation costs.

Constructing Better Health's proposed strategic framework, outlined in this white paper, would ensure the industry avoids this, by taking the next logical step in improving workers' conditions and health. From both a business and a moral perspective, it is the right thing to do.



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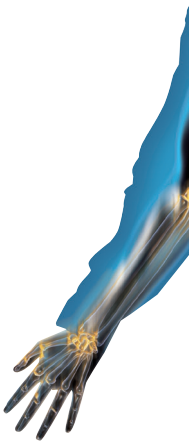

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