Risk factors in the hospitality sector

LITERATURE REVIEW

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CONTENTS

1.0 **Introduction** **5**

2.0 **Method** **7**

3.0 **Strategic context** **9**

3.1 Accommodation and food and beverage services subsectors 10

3.2 Employment in the sector 10

3.3 Businesses in the sector 12

4.0 **Harm profile** **13**

4.1 An overview 14

4.2 Work-related injuries and diseases 14

4.3 Psychosocial health 16

5.0 **Risk factors** **18**

5.1 An overview 19

5.2 Hazardous working conditions 20

5.3 Workplace culture and management 24

5.4 Vulnerable labour market 27

5.5 The nature of work 28

5.6 Stress 29

6.0 **Conclusion** **32**

appendix

Appendix 1: References 36

figures

1 Employee count in the accommodation and food and beverage services subsectors (Source: Stats NZ, n.d.) 11
2 Number of enterprises in the accommodation and food and beverage services subsectors (Source: Stats NZ, n.d.) 12
3 An integrated view of risk factors in the hospitality sector 19

EXECUTIVE SUMMARY

This document provides an overview of the literature on the harm profile and occupational health and safety (OHS) risk factors in the hospitality sector, with a particular focus on the accommodation and food and beverage services subsectors. Business demographic data from Statistics New Zealand (Stats NZ) shows that the hospitality sector is growing rapidly, so it is important to manage health and safety within the sector adequately. This literature review is conducted to provide insights that serve such a purpose.

In addition to reviewing the literature related to the identification of risk factors in the hospitality sector in both New Zealand and international contexts, analyses of secondary data are also used to obtain an overview of the harm profile in the sector. Together, these analyses help establish a robust understanding of the current health and safety issues and management in the hospitality sector.

The review indicates that hospitality workers are experiencing various work-related injuries and diseases. In particular, while cuts/burns/falls are frequently reported injuries in the food and beverage services subsector, pain and musculoskeletal disorders (MSDs) appear to be more predominant in the accommodation subsector. Some work-related diseases commonly reported include noise-induced hearing loss, dermatitis, hypertension and cardiovascular diseases. An issue that has increasingly been noted is the risk of psychological harm, including stress, depression, anxiety and emotional exhaustion. These poor psychological health outcomes are exacerbated by several distinctive characteristics of the hospitality sector such as unsocial work hours, being emotionally demanding and the long-established perception of the sector being a 'sexualised industry'.

The harm profile of the sector mentioned above can be explained by a number of risk factors. This review has specifically emphasised the modifiable, underlying risk factors around hazardous working conditions, workplace culture and management, the vulnerable labour market, the nature of hospitality work, and stress.

- Hazardous working conditions in the hospitality sector are often related to dangerous physical work environments (eg hot kitchens, excessive noise levels at bars/pubs, contact with dangerous substances for cleaning duties) and poor job design (eg long hours, shift work, night shifts, low pay, low job control, repetitive tasks).
- Workplace culture and management in the sector has been known to contribute to unhealthy workplace behaviour with the existence of bullying, discrimination, harassment and abuse from both co-workers and customers. More specifically relevant to the kitchen environment is the cheffing culture with the 'harden up or get out' mind-set that accepts hostile and abusive behaviour. In addition, negligence from management in terms of training provision and reward-effort imbalance contributes to the risks of hospitality workers experiencing poor occupational health and safety.
- The vulnerability of the hospitality labour market is attributed to the predominance of young, female and migrant workers, agency work companies and small businesses as well as the seasonality of the job market. A high level of drug and alcohol consumption commonly seen in the sector by both workers and customers is another risk to be aware of.
- The nature of work that involves unsocial hours,[1] emotional demands and precarious employment adds to the likelihood of hospitality workers experiencing poor health and safety outcomes, especially in relation to work-life balance, emotional exhaustion and stress.

[1] Unsocial working hours often refer to those that are outside normal business hours (8am-5pm, Monday – Friday). They may include late nights, early mornings, weekends, and public holidays.

- Stress is associated with the four categories of risk mentioned above. It is both a disease and a risk factor for physical injury and ill health. Some stressors commonly reported by hospitality workers include working overtime, shift work, bullying, sexual harassment, job insecurity, low job control, and customer abusive behaviour.

These risk factors are interrelated. As an example, hazardous working conditions could be the result of poor workplace management practices, which then cause stress for workers. An understanding of how these risk factors are interconnected would enable a fuller consideration of their impacts on workers' health and safety outcomes. Accordingly, the findings in this review suggest that intervention programmes for hospitality workers should aim to influence both physical and psychological hazards. Moreover, by applying the identified risk factors into the safety system context, it is clear that a focus on organisational, leadership and employment practices would likely result in a wider impact.

This review places a strong emphasis on psychological harm, which appears to be under-reported. The under-reporting issue is likely to be attributed to several reasons. First, it may be the high proportion of migrant workers in the sector who are less likely to report due to language barriers, fear of losing jobs, or lack of understanding of New Zealand regulations and standards. Another potential reason is the commonly accepted perception of the sector being a 'tough' one that discourages workers from raising health and safety issues as this can be considered as 'weak'. Psychosocial health[2] being a fairly new concept with limited developed measurable indicators can also be an explanation. Nevertheless, the combination of a low fatality rate and the under-reporting issue result in limited understanding of psychosocial harm in the sector. More research is needed to explore this type of harm further.

The review also calls for more robust data collection related to the psychological wellbeing of hospitality workers. This will enable a better understanding of the current situation regarding hospitality workers' psychological health in New Zealand as well as the link between their psychological health and the identified risk factors. Such understanding is crucial to help develop intervention programmes that are better targeted at addressing workplace-related harm.

[2] In this literature review, psychosocial health refers to mental health and wellbeing.

1.0 Introduction

The hospitality sector has become one of the most important economic activities in New Zealand.

According to the tourism satellite account 2018 report, tourism contributes significantly to the overall economic contribution of New Zealand, with a direct contribution of $15.9 billion (6.1% of GPD) and an additional of $11.1 billion indirect value added (4.3% of GDP) (Stats NZ, 2018). The industry workforce has continually expanded over the past decade, of which the majority are migrant workers and often employed through agency work companies (MBIE, 2013; Stats NZ, 2018). With such growing importance to GDP, it is important to ensure that occupational health and safety is well managed within the sector.

The hospitality sector is often mentioned in conjunction with the tourism sector, and both tourism and hospitality are sometimes referred to as one industry. The tourism and hospitality industry covers a wide range of subsectors such as accommodation, food and beverage services, transport (road, rail, water, air and space) and arts and recreation services (Stats NZ, 2018). Within the scope of this literature review, the primary focus has been on the hospitality sector, and it specifically looks at the accommodation and food and beverage services subsectors.

This literature review examines relevant literature in both international and New Zealand contexts. It aims to address the following questions:

- What are the harm profiles in the hospitality sector, especially the accommodation and food and beverage services subsectors?
- What are the risk factors that contribute to the common harms identified in the literature?

In order to confirm the presence of evidence for particular risk factors among different occupational groups, this review provides separate evidence by subsector where possible.

The interrelated nature of some risk factors means that the focus should be on addressing the shared underlying causes and contributors to a range of poor OHS outcomes rather than on individual mechanisms of harm. This literature review first looks at the harm profile in the sector and then investigates the risks that may lead to such harms. Relevant findings can help inform the development of appropriate interventions that aim to improve health and safety outcomes in the hospitality sector.

2.0 Method

This literature review followed a robust process adopted from Xiao and Watson (2017), which includes three key stages: formulating the problem, conducting the review and reporting the review.

In the first stage, the problem this literature review aims to address is the identification of risk factors that contribute to workplace harm and poor health outcomes in the hospitality sector generally, and in the accommodation and food and beverage services subsectors specifically.

In the second stage, the review was conducted following some key steps. First, a number of electronic databases were used to search for relevant literature: Google Scholar, EBSCO and the internet. Backward search was also employed to identify relevant work. The keywords used for the search comprise **hospitality industry, tourism industry, accommodation, hotels, restaurants, harm, injury** (or injuries), **risk, health, safety, workplace, workers** and various combinations of these words. The result of the search for academic materials was then refined by the following criterion: they must be either in a peer-reviewed journal or published by a reputable organisation, especially those with a similar remit to WorkSafe (eg Health and Safety Executive (UK) or Safe Work Australia).

Key sources of the literature used are:

- government reports and statistics
- non-government organisations (eg Hospitality New Zealand, Restaurant Association of New Zealand)
- academic materials (eg journal articles, book chapters, research notes)
- news media.

As the literature review developed, some articles and reports were excluded in the final report, often on the basis of their having little relevance to the research questions and their dated time of publication (before the year 1990).

In addition to reviewing the relevant literature, secondary data on employment, businesses and injury claims in the hospitality sector was also analysed. The purpose was to obtain some understanding of the strategic context and the harm profile of the sector.

The results of the literature review were synthesised into key themes that help explain the research questions in a more structural way. Within each theme, relevance to the two focused subsectors (accommodation and food and beverage services) has been made.

3.0 Strategic context

IN THIS SECTION:

3.1 Accommodation and food and beverage services subsectors

3.2 Employment in the sector

3.3 Businesses in the sector

3.1 Accommodation and food and beverage services subsectors

This review focuses on two subsectors of the hospitality sector – accommodation and food and beverage services – for the following reasons:

- the high number of reported accidents and incidents in these subsectors
- to be consistent with the ANZSIC06 industry classification
- the significant economic contribution of these sectors to the tourism and hospitality industry (Stats NZ, 2018).

The accommodation subsector includes short-term accommodation services such as hotels, motels and camping grounds. It also includes student hostels, holiday houses and flat rentals. The food and beverage services subsector includes cafés, restaurants, takeaway venues, catering services, pubs, taverns and bars and clubs (Stats NZ, 2006).

For clarity of terms used, it should be noted that sometimes the food and beverage services subsector is referred to as food services or the restaurant industry in a number of publications. While many risk factors and health outcomes are similar between these two subsectors, the way these risk factors are manifested in each can be different from one another. In this document, for the purpose of consistency, it is referred to as the food and beverage services subsector. Throughout the document, particular subsectors and types of businesses are mentioned in accordance with the cited references to ensure originality of information.

The strategic context of the hospitality sector in New Zealand is described in two main aspects: employment and businesses in the sector. The employment aspect provides an overview of the growth and characteristics of the labour market in the sector. The businesses aspect indicates the growth and characteristics of enterprises operating within the sector. This information enables a better understanding of the context by which occupational health and safety can be affected.

3.2 Employment in the sector

Information presented in this section describes the growth and characteristics of the labour market in the hospitality sector. Relevant data shows that the sector is made up of a diverse workforce that has been steadily increasing over the past five years. Characteristics such as low wages, commonality of seasonal and temporary employment types, as well as being over-represented by migrant workers and younger workers, are of particular note for their potential association with several risk factors discussed in later sections.

Growing labour market

According to Stats NZ's business demography statistics by industry (Stats NZ, n.d.), the accommodation and food and beverage services subsectors employed approximately 168,800 workers as of February 2018. This makes up approximately 8% of the total labour market. In terms of employment distribution, the number of people employed in the food and beverage services subsector is about four times higher than in the accommodation subsector (Figure 1). In the last five years, the employee count in the food and beverage services subsector increased at a higher rate than in the accommodation subsector (22% compared to 15% between 2014 and 2018).

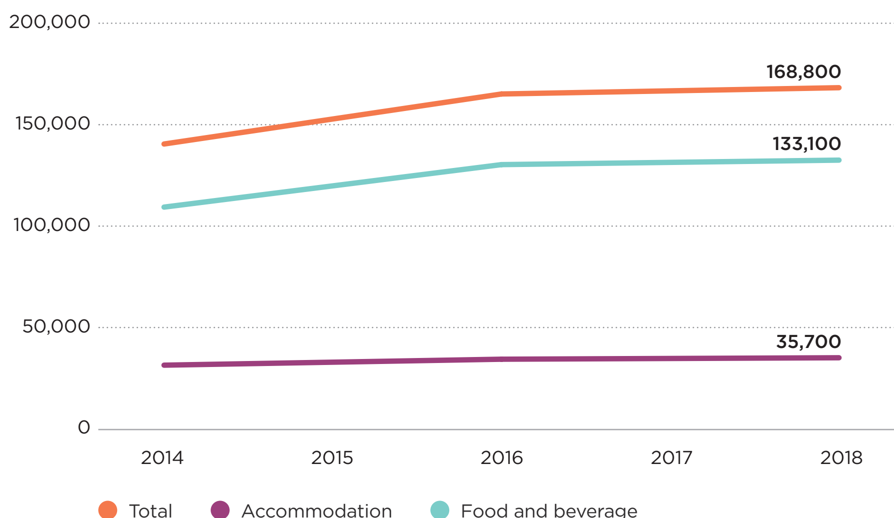


FIGURE 1:
Employee count in the accommodation and food and beverage services subsectors (Source: Stats NZ, n.d.)

Moreover, the number of jobs filled in the accommodation and food and beverage services subsectors in New Zealand has increased steadily, with an increase of 11% between Q2/2016 and Q2/2017, although the number dropped by 6% in Q4/2018 (Figure.NZ, n.d.-c).

Low income

On average, accommodation and food and beverage services workers earned $20.48 per hour in Q4/2018, making it the lowest-paid industry in New Zealand (Figure.NZ, n.d.-a). Differences in average hourly earnings also exist between male and female workers ($22.12 and $19.29 respectively) in the accommodation and food and beverage services subsectors in the Q4/2018 (Figure.NZ, n.d.-b).

Diverse workforce and working arrangements

Data from the 2013 Census provided some background information on the workforce in the accommodation and food and beverage services subsectors. It suggests that these subsectors have a large, insecure workforce with younger workers, women and migrants being over represented. It also highlights a different ethnic composition in the sector than the overall New Zealand workforce, with a large number of workers identifying as being of one or more Asian ethnic groups. Key relevant statistics are presented as follows:

- 35% of accommodation workers and 42% of food and beverage services workers were employed part-time, which is higher than the overall population (23%). Recent labour force statistics suggest that the proportion of part-time employees in the sector may have increased since 2013.
- The majority of the workforce in these sectors were in the 15–24 age group (35%) compared to 13% of the New Zealand workforce overall. Moreover, over half of all workers in accommodation and food and beverage services aged 15–24 were employed part-time in 2013 (54%) – far higher than those aged 25–44 (24%) or 45–46 (18%).
- Women were also more likely to be employed part-time than men in both accommodation (44% compared to 20%) and food and beverage services (48% compared to 32%).
- Most employees were European and Asian (64% and 25% respectively) compared to the New Zealand workforce overall (77% and 11% respectively). The difference in ethnic composition was particularly pronounced among male employees, with 58% and 32% of male accommodation and food and beverage services workers identifying as European and Asian respectively.

3.3 Businesses in the sector

Information presented in this section provides an overview of the characteristics of businesses in the sector. Such information is helpful to understand potential challenges to health and safety management. Characteristics of particular note are the sector being made up of a large number of small and medium enterprises (SMEs) and having high turnover rate. These are associated with resource constraint, which is known as a barrier to health and safety compliance.

Mirroring the growing trend of the industry labour market, data presented in this section also reveals a steady increase in the numbers of businesses in the accommodation and food and beverage services subsectors over the last five years (Figure 2). There are significantly more businesses in the food and beverage services subsector than in the accommodation subsector (approximately three times higher).

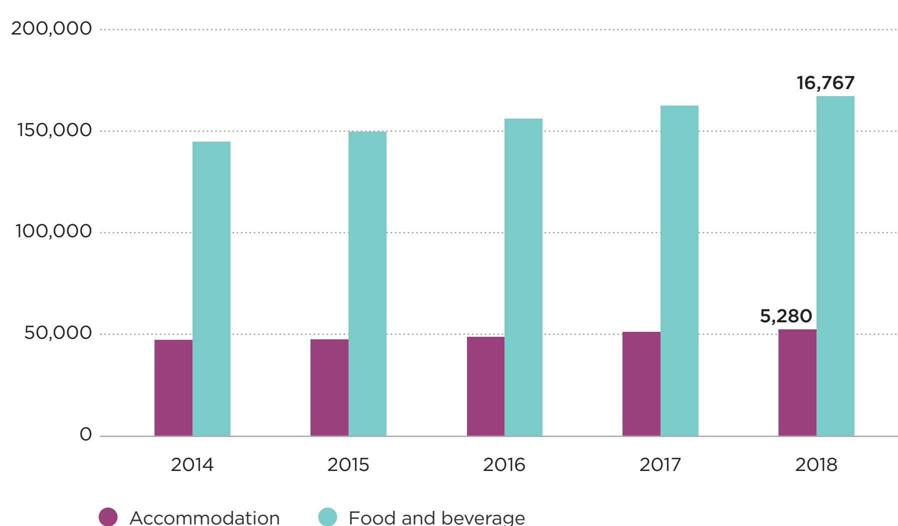


FIGURE 2: Number of enterprises in the accommodation and food and beverage services subsectors (Source: Stats NZ, n.d.)

According to business demography statistics in February 2018, businesses in the accommodation and food and beverage services subsectors had more employees on average (6.5 and 7.8 per enterprise respectively) than businesses overall (4.2 per enterprise) (Stats NZ, n.d.). As of February 2019, 54% of enterprises in these two subsectors were small firms (1–19 employees).

Linked Employer-Employee Data (LEED) suggests that the turnover rate in the accommodation and food and beverage services subsectors is higher than the average for all industries (26% in the December 2017 quarter compared to 14% for all industries). Worker turnover was higher in small firms with 1–9 employees and medium firms with 10–49 employees (approximately 26%) compared to large firms with 50+ employees (21%). Turnover was also higher among younger workers (32% for the 15–24 years age group). This is higher than the average (26%) for workers aged 15–24 but mirrors overall employment trends where worker turnover declines by age.

4.0 Harm profile

IN THIS SECTION:

4.1 An overview

4.2 Work-related injuries and diseases

4.3 Psychosocial health

4.1 An overview

This section discusses the harm profile of the hospitality sector, specifically in the accommodation and food and beverage services subsectors. The purpose is to provide an overview of the health and safety outcomes currently experienced by workers in the sector. It summarises the analysis results of secondary data from numerous sources such as ACC claims, government/sector reports, news media and academic articles. Understanding the harm profile within the sector is helpful for the identification of the risk factors that may cause these harms and the prioritisation of areas to focus.

Whilst there is adequate data on acute harm such as injuries caused by falls/trips/slips/body stressing, there is a lack of information in relation to psychosocial and chronic harms. However, anecdotal evidence from news media suggests that psychosocial harm is a significant form of harm faced by hospitality workers. Data about certain types of harm proven to be dominant in the sector are limited in the New Zealand context. In these cases, relevant data from other international contexts is used to support the arguments made.

Overall, hospitality workers are at risk of experiencing work-related injury and diseases as well as poor psychosocial health. Types of common injuries are different across various subsectors in the broader sector. While cuts/burns/falls are frequently reported injuries in the food and beverage services subsector, pain and MSDs appear to be more predominant in the accommodation subsector. Besides recorded acute injuries, it is also important to recognise the risk of work-related diseases that are often under-represented in reported data. Some work-related diseases commonly reported include noise-induced hearing loss, dermatitis, hypertension and cardiovascular diseases.

Moreover, it appears that young, female and migrant workers are more likely to be at-risk of occupational harm compared to other groups in the sector. Issues of under-reported harm also apply to data on the psychosocial health of hospitality workers. News media have increasingly raised awareness of problems of stress, depression and anxiety being experienced by the sector workforce. The interrelation among the outlined types of harm should be taken into account to provide a comprehensive picture of the harm profile in the hospitality sector.

4.2 Work-related injuries and diseases

Research shows that workers in the accommodation and food and beverage services subsectors experience work-related acute injuries and diseases such as MSDs, noise-induced hearing loss, cardiovascular diseases and dermatitis.

According to work-related claims provisional data from Stats NZ, there were 10,365 claims in the accommodation and food and beverage service subsectors in 2018, which accounted for 4% of all work-related injury claims. This represents a rate of 84 claims per 1,000 FTE workers. Young workers in the 15–24 age group accounted for approximately 30% of these claims. In addition, about 1,200 claims (12%) involved entitlement payments.

Provisional Stats NZ data of ACC claims in 2018 suggests that the most common injuries in the accommodation and food and beverage services subsectors are soft tissue injuries (61% of all injuries), laceration/puncture/sting (22% of all injuries) and burn/scald/corrosive injury (9% of all injuries). Soft tissue injuries constitute a larger proportion of injuries among younger workers (53% of claims by those aged 15–24 or 25–34), whereas the proportion of injuries classified as laceration/puncture/sting or burn/scald/corrosive injury declines with age. This indicates the higher likelihood of younger workers experiencing injuries. The most common injuries requiring a week away from work were soft tissue injuries (63%), fracture/dislocation (12%), laceration/puncture/sting (14%) and burn/scald/corrosive injury (6%).

[3] Based on data collected between July 2017 and June 2018.

Data from the System for Work-related Injury Forecasting and Targeting (SWIFT) at WorkSafe New Zealand indicates a similar pattern. With injury claims that result in no time or less than one week away from work, body stressing and hitting objects with a part of the body (35.3% and 18.3 respectively) appeared to be the most common types of injury in the accommodation and food and beverage services subsectors in 2017/18.[3] More serious injuries that resulted in time away from work reveal body stressing (33%) as being the most common type, followed by falls/trips/slips (26%) in 2017/18.

Internationally, the food and beverage services subsector has long been recognised as having a high incidence of injury and illness. Gleeson (2001) conducted a study of catering students in Ireland and found that 12% suffered at least one injury or health condition requiring treatment during their course, 41% of these injuries were lacerations, cuts or amputations, 27% were burns or scalds, 10% were contact dermatitis and 10% were MSDs. While Gleeson (2001) noted that these types of injuries were rarely severe, several students were advised to change career due to the resulting health conditions.

In a study about commercial kitchen workers in Japan by Tomita, Muto, Matsuzuki, Haruyama and Ito (2013), respondents reported a high level of low back pain, cuts and burns (reported by 37%, 24% and 16% of respondents respectively). Of concern in the international literature is the excessive noise level experienced by restaurant and bar workers that is associated with both induced hearing loss and several non-auditory effects such as elevated blood pressure, loss of sleep, increased heart rate, cardiovascular restriction and difficulty in breathing (Green & Anthony, 2015; Welch, Ma, & Reddy, 2019).

Hotel staff and cleaning/house staff also have high levels of MSDs and multi-site pain (Burgel, White, Gillen, & Krause, 2010; Chyuan, Du, Yeh, & Li, 2004; Scherzer, Rugulies, & Krause, 2005). For example, approximately 75% of hotel cleaners in San Francisco (Lee & Krause, 2002) and in Las Vegas (Scherzer et al., 2005) reported work related pain. Hotel room cleaners in a study by Krause, Scherzer and Rugulies (2005) reported experiencing severe and very severe neck pain, upper back pain and low back pain and that these types of pain were greatly influenced by workers' physical workload and ergonomic problems. Rosemberg et al. (2019) found a number of common chronic conditions experienced by hotel cleaners, including chronic back pain, migraine headache, arthritis and hypertension, reported by over 30% of the respondents. Hypertension is known to be a major risk factor for cardiovascular diseases (Feaster & Krause, 2018), and women and immigrants are at higher risks of poorer hypertension management leading to poor health outcomes (Sanon, 2013).

It also appears that work-related injury rates in the hospitality sector vary by sociodemographic characteristics such as gender, age and ethnicity. For example, a study by Buchanan et al. (2010) found that female housekeepers reported higher injury rates than did men. Results in gender-specific exposure to painful/tiring postures among workers in hotels and restaurants in Korea also revealed differences between male and female workers (Park, Han, & Kim, 2017). Regarding the age factor, Balanay et al. (2014) found restaurants were the most frequently reported work setting among young college students in Greenville (North Carolina), and that one in every five students experienced an injury while at work. In their intervention study, Ward et al. (2010) showed that injuries among young workers in the hospitality sector accounted for 37% of total occupational injuries in Washington State from 2000 to 2008.

With regard to ethnicity, in the US, research indicates that immigrant employees (especially Hispanic immigrants) are at higher risk for allostatic load (AL)[4] compared to non-immigrants (Sönmez, Apostolopoulos, Lemke, Hsieh, &

[4] The concept of AL is defined as the accumulative physiological dysregulations across multiple body systems in response to chronic or severe stressors (Read & Grundy, 2012). It refers to the long-term effects of continued exposure to repeated or chronic stress.

Karwowski, 2017). It is known to contribute to high levels of poor health outcomes such as obesity, hypertension and cardiovascular diseases (Sönmez et al., 2017). While the literature demonstrates that immigrant workers in the hospitality industry are likely to be at higher risk of experiencing poor health outcomes, in some cases, however, it was found that Hispanic immigrant workers reported fewer injuries than did US-born workers partly due to language barriers (Madera & Chang, 2011). This is also associated with the under-representation of injury data from migrant workers in the hospitality sector in some cases.

4.3 Psychosocial health

Despite a strong recognition of mental health issues among hospitality workers in the literature, the number of ACC claims made for mental stress is almost non-existent. This reflects the complex nature of identifying psychosocial harm and the limited coverage of the compensation system for this type of harm under ACC. In New Zealand, a few sources that have a limited amount of related data are the Survey of Working Life[5] and the Health and Safety Attitudes Survey.[6] Relevant data for the hospitality sector specifically remains limited.[7] As a result, information in this section relies on academic literature and news media. Some of the commonly recognised psychosocial harms experienced by workers include stress, anxiety and depression.

Mental health issues in the hospitality sector in New Zealand have been increasingly noted by news media. Neville (2017) reported that the restaurant sector in New Zealand is experiencing a mental health crisis, and this is seen in part to be due to the harsh working conditions and a workplace culture that is often described as 'harden up or get out'. Her article shared several cases where chefs struggled to work in such a highly stressful environment, battled with depression on their own and, in some extreme cases, committed suicide.

Forrester (2019) also argued that stoicism underpins the hospitality sector. Her article reconfirms the pressure, high demand and antisocial working hours in the hospitality sector that are likely lead to stress, depression and anxiety among its workers. There is a perception that worker health, either mental or physical, appears to be an inevitable compromise for those working in the hospitality sector (Junn, 2018). Interestingly, results from the Survey of Working Life revealed that the majority of employees in the sector reported being either satisfied or very satisfied with their job (82%) and work-life balance (73%) (Stats NZ, 2019). This suggests the need for a more robust and consistent approach to data collection into these aspects of work.

According to Kotera, Adhikari and Gordon (2018), over 70% of hospitality workers in the UK experienced stress and reported feeling overworked. The workers in their sample reported experiencing a severe level of depression, an extremely severe level of anxiety and a moderate to severe level of stress (Kotera et al., 2018). This suggests a concerning reality regarding the level of distress and mental illness among hospitality workers in the UK. More recently, statistics show that there were 3,128 deaths by suicide in Australia in 2017, and the hospitality sector accounted for almost 18% (Afshariyan, 2019).

Another potential psychological harm that workers in the hospitality sector may experience is emotional exhaustion due to the nature of their job. Emotional exhaustion experienced by staff in the hospitality sector is often caused by the presumed expectation of upholding public emotional display at an acceptable

[5] The Survey of Working Life (conducted by Stats NZ) collects information on work arrangements, employment conditions, job satisfaction and work-life balance.

[6] WorkSafe commissioned Nielsen to conduct the Health and Safety Attitudes Survey in 2016 and 2017.

[7] In 2018, WorkSafe New Zealand commissioned Colmar Brunton to conduct the Workforce Segmentation and Insights Programme (WSIP). Recently completed surveys of workers and employers in the hospitality sector as part of this programme of work will help to address this issue.

level, especially for front-of-house staff (Kotera et al., 2018). Research has found that health consequences of emotional exhaustion are serious, including burnout, mental distress and depression (Karatepe & Tizabi, 2011; Mesmer Magnus, DeChurch, & Wax, 2012). It also involves feelings of fatigue, irritability and frustration and is not only experienced by frontline staff but also managers (O'Neill & Xiao, 2010). Moderators for emotional exhaustion are varied, but some of the main factors comprise customer aggression, inadequate job resources, low job autonomy and task variety (Karapete, 2011; Mesmer-Magnus et al., 2012).

Brand, Hermann, Muheim, Beck and Holsboer-Trachsler (2008) found a strong correlation between self-reported insomnia, stress and depression among hospitality workers. Therefore, psychological harms for hospitality workers (stress, anxiety, depression and emotional exhaustion) are likely to be interrelated. Accordingly, interventions that address one issue would also likely have an impact on others.

5.0 Risk factors

IN THIS SECTION:

5.1 An overview

5.2 Hazardous working conditions

5.3 Workplace culture and management

5.4 Vulnerable labour market

5.5 The nature of work

5.6 Stress

5.1 An overview

Exposures to workplace harms can be addressed through well-functioning occupational health and safety management systems. This means that, in most cases, addressing the underlying risk factors for these exposures is likely to be more productive than attempting to address the exposure directly. This part of the literature review discusses the risk factors that are attributed to the occupational harms experienced by hospitality workers mentioned in the previous section. The identified risk factors can be grouped into five categories of:

- hazardous working conditions
- workplace culture and management
- vulnerable labour market
- the nature of work
- stress.

Figure 3 suggests an incorporated view of these risk factors in the context of the safety system that guides most literature review in occupation health and safety at WorkSafe.

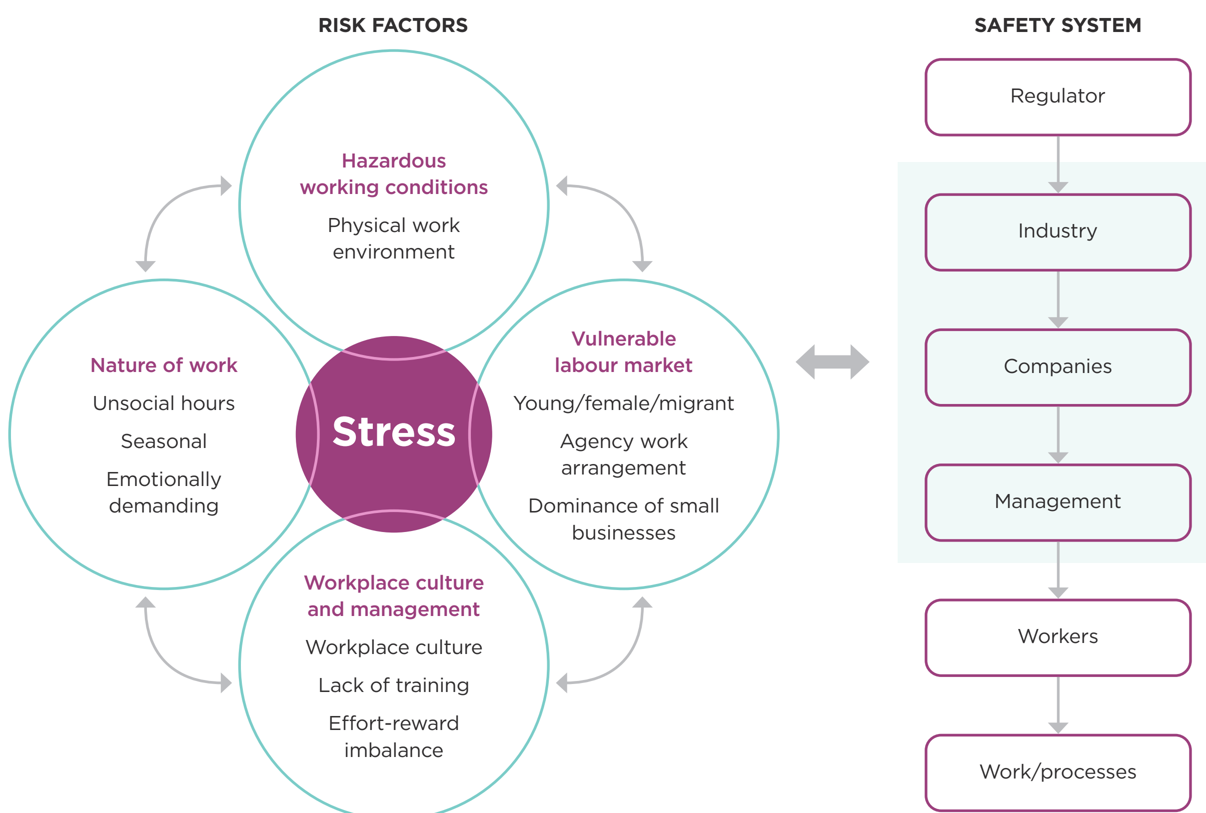


FIGURE 3: An integrated view of risk factors in the hospitality sector

The key categories of risk factors faced by hospitality workers are presented and unpacked in Figure 3. Hazardous working conditions in the hospitality sector are often related to dangerous physical work environments (hot kitchens, excessive noise levels at bars/pubs, contact with dangerous substances for cleaning duties) and poor job organisation (long hours, shift work, night shifts). Moreover, the nature of work where it inevitably involves unsocial hours, emotional demand and seasonality also adds to the likelihood of hospitality workers experiencing poor health and safety outcomes. Workplace culture and management is another

group of OHS risk factors in the sector. Specifically, bullying, discrimination and harassment have been found to be rather common in the hospitality sector. Lack of training and reward-effort imbalance also contribute to the OHS risks for hospitality workers. The vulnerability of the hospitality labour market is attributed to the predominance of young, female and migrant workers, agency work companies and small businesses as well as the seasonality of the job market. Stress, in particular, is placed at the centre to reflect the argument that it is associated with the other four categories of risk.

"The double-ended arrows between the categories of risk factors in Figure 3 indicate their interrelation. It should be noted that stress is not only a risk factor that can lead to poor psychosocial wellbeing of workers such as anxiety and depression but also a poor psychosocial health outcome itself. This literature review places stress in the centre also to draw more attention to the issue (for it being currently an under-reported harm) and emphasise its significant impact on hospitality workers.

Rasmussen (1997) developed a socio-technical system (also called the safety system) involved in risk management in a dynamic society, which is often adopted in research assessing risks. It outlines different levels of a society where risks may exist and be managed. As shown in Figure 3, this literature review argues that most of the risk factors addressed in this document are rooted at the industry, companies and management levels. In particular, a focus on organisational and employment risk factors would likely result in a positive effect on a range of health and safety conditions. It is also aligned with a recommendation by Ariza-Montes, Arjona-Fuentes, Han and Law (2018) that the hospitality sector should focus on labour factors acting as stressors.

Taken together, the risk factors presented in this literature review and their interrelated nature mean multi-faceted interventions are likely required to effectively reduce workplace harm in the hospitality sector. This is consistent with an argument by Lo and Lamm (2005) that a wider approach is needed to contextualise these risk factors in terms of broader trends in employment relations. It recognises that they are the symptoms of a multi-layered system of interconnected psychosocial factors. Likewise, Sönmez et al. (2017) suggest a system dynamic approach to research on occupational health in the hospitality sector because it can help achieve a more comprehensive understanding of the problem that is characterised by interrelated factors.

The following sections address the risk factors in more detail. Where applicable, association with the accommodation and food and beverage services subsectors is made.

5.2 Hazardous working conditions

This theme of risk factors emphasises the important role of working conditions for workers in the hospitality sector. It looks at the risks in both the physical work environment and the working conditions influenced by employment practices. With the physical work environment, the identified risk factors are associated with physical conditions such as manual handling, contact with dangerous substances, temperature/lighting/air quality/noise and use of equipment. Poor employment practices such as temporary and insecure employment, job organisation with a high level of shift work and repetitive tasks, low pay and low job control are also recognised as some of the risk factors for the sector workforce.

Physical work environment

As noted in the previous section discussing the harm profile of hospitality workers, some of the most commonly reported work-related injuries and diseases are multi-site pain, MSDs, dermatitis and hypertension. These health outcomes

are often caused by the workplace physical conditions, some of which are outlined by the European Agency for Safety and Health at Work (Elsler, 2008) as:

- manual handling (eg heavy lifting)
- temperature (eg heat in the kitchen)
- contact with dangerous substances (eg cleaning products)
- use of equipment and technologies (eg laundry operation machinery)
- noise (eg music in nightclubs, bars)
- lighting (eg dark light in nightclubs, bars)
- air quality (eg smoking consumption by customers and employees).

For restaurant workers, manual handling may include lifting heavy kegs, repeatedly pouring pitchers, carrying food and drink whilst stooping, carrying trays above the shoulder and fast-repetitive work (Jayaraman, Dropkin, Siby, Alston, & Markowitz, 2011; Jones, Strickfaden, & Kumar, 2005). In hotels, lifting requirements for housekeepers and cleaners have increased in recent decades as bed sizes increase and more sheets and pillows are added to each bed. The increased furniture size along with no change in room size and lack of ergonomic equipment also creates additional risks as cleaners have to stretch and reach around furniture (Hsieh, Apostolopoulos, & Sönmez, 2013; Lee & Krause, 2002). The labour-intensive demands involved in the work of restaurant and hotel workers are also associated with the nature of tasks they perform, which are often high strain and repetitive (Ambardar, 2015; Jayaraman et al. 2011).

The work environments of hotel room cleaners expose them to various chemical, biological and toxic substances that can potentially lead to respiratory disease, dermatitis or other infectious diseases (Hsieh, Apostolopoulos, & Sönmez, 2013, 2016; Krause et al., 2005). These exposures to cleaning chemicals may also cause asthma (Medina-Ramón et al., 2005; Quirce & Barranco, 2010) and cancers (Rushton et al., 2010). Other physical risks are present in kitchens. In restaurants, chefs have been found to have elevated risks of contact dermatitis from a combination of foods and flour, working with water and soaps from hand cleaning (Meyer, Chen, Holt, Beck, & Cherry, 2000). Other commonly reported exposures of kitchen workers include loud noise, extremely cold and hot liquids, grease and surfaces (Balanay et al., 2014).

WorkSafe commissioned the Centre for Public Health Research at Massey University to conduct the Worker Exposure Survey 2017–2018 focused on seven targeted occupational groups covering community-based nurses, construction workers, collision repair workers, agriculture workers, clerical workers, sawmill workers and hospitality workers (WorkSafe New Zealand, 2019). The purpose of the survey was to gather information to establish the prevalence of a wide range of occupational exposures to common risk factors. The survey found that, with hospitality workers, wet work exposure was a significant risk factor. Participants reported washing their hands on average 26 times per day, and over half reported wet work exposure for an average duration of 2.3 hours per day. Both of these were considered risk factors for contact dermatitis.

Also in the Workforce Exposure Survey 2017-2018, hospitality workers indicated a high prevalence of exposure to cleaning products. More than half reported exposure to biomechanical demands (eg repetitive tasks, working at very high speed), two-thirds reported working in a hot/warm environment at least a quarter of the time, 58% stated that they have to work very fast often or all the time and less than half reported that they decide when to take a break often or all the time. All of these factors have been found in the literature to contribute to work-related pain, MSDs, dermatitis and long-term poor health among hotel cleaners (Gleeson, 2001; Rosemberg et al., 2019).

The use of operative machines (eg kitchen equipment, laundry machines) and equipment in hotels and restaurants is another risk factor in the physical work environment of hospitality workers. A study with restaurant workers in Korea found that facilities and machinery were the main causes of accidents, followed by building/structure surface and tools and equipment (Jeong & Shin, 2016). Ambardar (2015) also suggests that the work of hotel laundry operation often involves using machinery and technologies that can lead to injuries and accidents.

Excessive noise levels, especially in bar and nightclub environments, have been recognised as a key risk factor for noise-induced hearing loss (Green & Anthony, 2015; Welch et al., 2019). A study by Kelly, Boyd, Henehan and Chambers (2012) found that nightclub employees in Ireland were exposed to a noise level that was nearly four times the legal limit. Noise in the hospitality sector can be comprised of customer/employee conversations, noise from surrounding businesses, audio systems and food preparation (Green & Anthony, 2015).

Hospitality workers have also traditionally been exposed to significant levels of second-hand smoke. Internationally, poor work-related health caused by exposure to second-hand smoke in bars and restaurants has been recognised in the literature (Allwright et al., 2005; Farrelly et al., 2005; López et al., 2012; Mulcahy, Evans, Hammond, Repace, & Byrne, 2005). In New Zealand, a smoke-free bars and restaurants policy was introduced in December 2004, and studies post this policy reveal positive results in terms of reductions in smoking levels and second-hand smoke exposure in the workplace and improved air quality in hospitality venues (Edwards et al., 2008; Thomson & Wilson, 2006). While the risk from second-hand smoke has been reduced significantly since the smoke-free policy was implemented, it has not been completely eliminated and is still a hazard to hospitality workers' health.

Addressing the risk factors associated with the physical working environment in the hospitality sector can be a challenge. A study by Jones et al. (2005) on the physical demands of occupational tasks in neighbourhood pubs recommends that addressing these issues requires a significant redesign of the workplace. They also noted that this would lead to significant costs and disruption to business, making it unappealing even to those businesses interested in addressing MSDs among their workers. Interventions focusing on addressing the physical demands of hospitality work, therefore, would need to recognise the necessity of organisational and management commitment.

Employment practices

Studies show that employment conditions and the nature of work can lead to undesired health outcomes among hospitality workers. In discussing the New Zealand hospitality sector, Poulston (2009) summarised the conditions as:

> "Hotel and restaurant staff are often treated poorly, not just by managers but also by customers. The industry pays poorly, trains poorly, and demands long hours. Furthermore, customers buoyed by alcohol or separated from their inhibitions while away from home can add to the already volatile cocktail of over-worked staff and managers making unfair and inappropriate demands on service providers." (Poulston, 2009, p. 24).

Job organisation (number and characteristics of tasks, working hours) is a significant contributor to hospitality worker health outcomes, as is the increasing intensification and fast work speeds required in many jobs (Krause et al., 2005). In particular, Tomita et al. (2013) found that low back pain was associated with increased work hours and higher job demands. Work and employment practices

such as low pay, long hours, low job control, high job demands and fast work pace have all been found to be associated with higher incidences of stress among hospitality workers (Chiang, Birtch, & Kwan, 2010; Cockburn-Wootten, 2012; Wong & Ko, 2009). The job demand-control-support (JDCS) model[8] suggests that high job demand and low job control can predict adverse health effects on workers such as fatigue, anxiety, depression, sleep disruption and physical illness (Ariza-Montes et al., 2018).

Other studies have found that shift work, particularly fixed night-shift work, is strongly associated with the prevalence of depression among hotel workers (Moon, Lee, Lee, Lee, & Kim, 2015). According to Moon et al. (2015), the ratio of shift work among hotel workers is high, with the existence of various types such as continuous day shift without night work, rotating night shift, every-other-day shift and fixed night shift. These authors suggest that shift work may lead to feelings of fatigue, sleepiness, insomnia, disorientation, digestion troubles, irritability, decreased mental agility and reduced performance efficiency.

Night shifts, in particular, are of great concern. Statistics from the Survey of Working Life between October and December 2018 (Stats NZ, 2019) reveal that evening work (between 7–11pm) more than six times per week was statistically more prevalent in the hospitality sector (54%) compared to other industries (41%).[9] Night shifts have been associated with increased blood pressure (McCubbin, Pilcher, & Moore, 2010), increased obesity, smoking, drinking and drug use (Fransen et al., 2006; Smith, Fritschi, Reid, & Mustard, 2013) and violence (LeBlanc & Barling, 2005). They also present a potential risk to employees' safety in general when they have to leave the workplace and return home late at night (Elsler, 2008).

Part-time work and the expectation of working overtime are common in the sector, with culinary workers being the most likely group to work 65 or more hours per week (Murray-Gibbons & Gibbons, 2007). Murray-Gibbons and Gibbons (2007) found that over one-third of their small sample of UK chefs reported working without an employment contract. There is also ample evidence that employers employ workers based on demographic features. For instance, most New York restaurant workers were mostly non-white migrants in back-of-house positions, whereas white American workers dominated the customer-focused front-of-house roles (Jayaraman et al., 2011).

In focus groups with hotel room attendants, managers, employer representatives and union officials in Sydney, Oxenbridge and Moensted (2011) found that the practice of paying piece rates was common, which resulted in staff constantly rushing as they were paid a (often unrealistic) fixed rate to clean rooms. The same study also found that, whilst staff suffered pain and MSDs, this seemed to be seen as a normal part of the job and therefore not worth risking employment by raising it with management. A quarter of respondents in a study of the restaurant industry in New York by Jayaraman et al. (2011) also reported being pressured to work overtime. All of these factors were correlated with poorer psychosocial health.

Overall prolonged exposure to hazardous working conditions are all correlated with poor psychological health and increased incidences of MSDs across industries including hospitality (Burgel et al., 2010; Krause et al., 2005; Pearson, Angulo, Bourcier, Freeman & Valdez, 2007). It is acknowledged that a stressful working environment can also be considered a hazardous working condition. The issue of stress in the hospitality sector appears to be rather prevalent and is addressed in detail later on in a separate section.

[8] The JDCS model is a theoretical approach used to understand the relationship among work characteristics, health and wellbeing (Ariza-Montes et al., 2018).

[9] Based on data from the Survey of Working Life – December 2018 quarter, Stats NZ.

5.3 Workplace culture and management

The risk factors addressed in this section emphasise the role of leadership and management in health and safety in the hospitality sector. Workplace culture where tolerance for harassment and abuse was expected and accepted has been found to be rather common in the sector. Of specific note is the cheffing culture in the kitchen environment that justifies much of the bullying, abusive and violent behaviour in the sector. The risk factors related to the management aspect focus on the limited training and the effort-reward imbalance within the sector.

Workplace culture

Some of the issues related to workplace culture that may cause poor psychosocial outcomes for workers in the hospitality sector are bullying, harassment and discrimination. According to the Workforce Exposure Survey 2017-2018, one quarter of the sample reported that they had experienced bullying at work, and 13% of respondents reported having experienced sexual harassment at work (WorkSafe New Zealand, 2019). Hospitality is one of the four sectors in which workplace bullying was found to be relatively high in New Zealand by international standards (O'Driscoll et al., 2011).

Bullying behaviour was often associated with poor leadership and work organisation (Bentley et al., 2012). Abuse and bullying have appeared to be more prevalent in the kitchen environment where the culture is central to and ingrained in the self-image of chefs. The chefs interviewed by Palmer, Cooper and Burns (2010) were of the opinion that physical violence was both increasingly uncommon and unacceptable. Importantly, many verbal features that would be considered abuse or bullying from an occupational health and safety context were taken as signs of belonging and affection within the chef culture. For many chefs, it is often expected and accepted that the job requires sacrifice and justifies mood swings, volatility and arrogance toward others. Abuse was also viewed as having a necessary disciplinary effect on staff, reinforcing the respect and authority of the chefs' position.

Discrimination is another psychosocial stressor and contributes to general poor health and personal outcomes in the hospitality sector. A study of Latina hotel housekeepers in the US by Hsieh et al. (2016) revealed that they faced discrimination from managers and other staff members (both Latina and non-Latina). As described in the strategic context section above, demographics of the hospitality workforce in New Zealand are rather diverse with a high proportion of migrant workers, young workers and female workers. These differences in cultural background, age and gender contribute to increasing the likelihood of discrimination among workers.

It should be noted that the discrimination hospitality workers may experience comes not only from their colleagues but also from their customers (Madera, Lee, & Kapoor, 2017). Discrimination from customers is enabled by a culture of seeing customers as being always right and that tolerance of abusive customer behaviour is expected (Madera et al., 2017). This issue is associated with the power inequalities between guests and low-status hospitality workers (Poulston, 2008).

Sexual harassment is common in the hospitality sector, with several studies suggesting that a majority of women working in hospitality have been sexually harassed (Poulston, 2009; Waudby & Poulston, 2017). A survey of New Zealand hospitality workers suggests that power imbalances play an important role in encouraging sexual harassment (Poulston, 2008). Moreover, the prevalence of harassment from managers, peer groups and customers suggests that the perceived tradition of hospitality as being a sexualised industry likely also

contributes (Poulston, 2008). New Zealand hospitality staff were frequently told to put up with sexual harassment to improve sales, and several felt that managers hired and promoted female staff based on their appearance (Poulston, 2009).

In addition, Waudby and Poulston (2017) interviewed bar staff in New Zealand about their experience of sexual harassment, finding that it was a common enough occurrence to be considered part of the job. They found a common feeling among employees (and some managers) that management actions often encouraged sexual harassment in a number of ways, particularly:

- hiring young, attractive staff to encourage greater spending
- requiring staff to always be friendly (received as flirtatious by customers)
- protecting regular customers, particularly high-spending regulars who harassed or assaulted staff.

Many employees felt that sexual banter and at times harassment were perceived as part of the job although their reception of this varied from 'okay' to 'unavoidable', which was also supported by Poulston's earlier work on the subject (Poulston, 2008). Staff perceptions of acceptability were complex, with older staff generally being better able to cope and more confident in rejecting advances and many staff seeing some actions as acceptable by regulars (people they knew) but unacceptable from strangers. The choice of clothing was also seen as affecting the chance of harassment, with modest, conservative uniforms seen by staff as reducing such chance (Waudby & Poulston, 2017).

Risk factors associated with workplace culture also arise from the commonality of Taylorist[10] approaches to management among hospitality businesses (ie that there is 'one right way' to do things), especially in the food and beverage services subsector. These approaches are characterised by a transactional style to leadership that promotes the ascription to tight rules, rewards for good behaviour and lack of empowerment (Mayhew & Quinlan, 2002). The strict adherence to a set of prescribed rules provides little support against less-controlled harms and increases the risk of health-related problems such as mental health issues, MSDs and violence.

Indeed, given that "low job control, low supervisor support, hurry at work, and mental stress predicted the occurrence of multi-site MSD pain three months later" among kitchen workers, Taylorist work practices are likely to increase the risk of many long-term health problems (Haukka et al., 2011). On the other hand, a contrary view argues that such work practices may make the management and control of physical hazards and the training of workers easier. As a result, they may provide some protection from injury when compared to less-controlled environments. The extent to which the Taylorist-like approaches should be applied to health and safety management needs careful consideration.

The culture of cheffing serves to separate class-taught OHS standards from the perceived necessities of the cheffing role. As Howard and Galbraith (2004) note, there is a perception by chefs that OHS regulations are both unsuited for the kitchen environment and changing frequently enough that they are best ignored in favour of real-world experience. However, a hostile attitude towards this culture is unlikely to be productive because it will strengthen the 'us versus them' mentality and foster resistance and distrust among the sector. Instead, tailoring the approach to the cheffing culture and recognising the importance of the cheffing role may result in more positive results (Howard & Galbraith, 2004).

[10] Fordism and Taylorist approaches refer to the mass production of standardised products using equally standardised work routines and inflexible technologies (Mayhew & Quinlan, 2002).

Lack of training

Training plays an important role in reducing both physical and psychological harms in the workplace. Studies show that there has been a lack of training provided to hospitality workers, and this is applied to training related to both their job and workplace health and safety (Chang, Minkler, & Salvatore, 2013; Sobaih, 2011; Zampoukos & Ioannides, 2011). In a study by OnsØyen, Mykletun and Steiro (2009), hotel room cleaners in Norway reported receiving only one day of training and not being informed about some of the workplace risks such as exposure to harmful cleaning substances. A high proportion of the respondents (over 70%) in Ambardar's study (2015) also reported that limited training was provided to ensure proper labelling and handling of cleaning chemicals among hotel laundry workers.

Wangchuk and Wetprasit (2019) found that the hotel workers in their Bhutan-based study reported limited levels of training received, with the content mostly covering only the basics such as orientation and induction programmes. Furthermore, training programmes, when provided, were ad hoc and often in the form of on-the-job training or a buddy system (Sobaih, 2011). They were also normally less likely and less often to be provided to part-time and temporary workers who seem to make up a significant amount of the hospitality sector (Lai, Soltani, & Baum, 2008; Sobaih, 2011).

According to Woods and Buckle (2006), high turnover creates challenges for training provision within organisations. With businesses in the hospitality sector whose turnover rate has been found to be significant (as shown in LEED data provided earlier), providing sufficient training to staff may be less of a priority. Hence, lack of training can be considered as doubling the risk of experiencing poor health and safety in the workplace. It limits not only employees' ability to perform their job properly and well, but also their awareness of potential risks at the workplace and how to avoid them. Challenges in providing appropriate training programmes to hospitality workers (eg high number of temporary workers, small businesses, and high staff turnover) should be taken into account when developing relevant interventions.

Effort-reward imbalance (ERI)

Businesses in the hospitality sector are not only known for paying low wages but also often have inadequate reward policies. Poor health overall has been found to be associated with effort-reward imbalances (where effort is not seen to be adequately rewarded). Krause, Rugulies and Maslach (2010) found that hotel housekeepers have extremely poor effort-reward balances and that greater effort-reward imbalances were associated with worse health outcomes. A significant relationship between ERI and negative physical and mental health was also found in an Australian-based study by Bohle et al. (2017).

The perceived fairness of the organisation's actions toward its staff can play a significant role in staff happiness and turnover as well as their dedication to an organisation. Nadiri and Tanova (2010) have termed this "organisational justice" and have identified three types of justice: fairness of distribution, fairness of procedure and fairness of personal treatment. In their survey of Cypriot hotel employees and managers, they found that distributive and interpersonal justice were both associated with higher levels of job satisfaction, lower levels of stress and lower turnover rates. Whilst not directly related to occupational health and safety, their study highlights the importance of fair treatment and rewarding of staff in addressing the risk factors for most common OHS conditions.

5.4 Vulnerable labour market

As mentioned in the strategic context section above, the labour market of the hospitality sector in New Zealand is distinctive with several defining characteristics: predominantly young, female and migrant workers, employed through agency work arrangements, and a higher prevalence of small businesses. These traits are also common in the hospitality sector worldwide, which is often characterised by high level of labour turnover, largely unskilled jobs, high proportions of young/precarious and migrant workers, seasonal/temporary nature and being under-regulated (Ariza-Montes et al., 2018; Balanay et al., 2014; Kusluvan, Kusluvan, Ilhan, & Buyruk, 2010). The hospitality sector itself has generally not been given priority by regulators, and many businesses in the sector have been either exempt or largely ignored by OHS regulations (Gleeson, 2001). Together, these characteristics entail a number of potential occupational health and safety risks to the sector workforce, which are addressed in this section.

Studies have found that females are more likely to have depression than males (Weissman et al., 1996). In a study with hotel workers in Korea, the prevalence rate of depression associated with shift work was higher among females (22.1%) than among males (12.9%) (Moon et al., 2015). Female hospitality workers have often been found to be acutely vulnerable to sexual harassment, as discussed earlier in the workplace culture and management section. Given the dominance of female workers in the hospitality sector, these risks become more prevalent.

Young, precarious workers are more likely to be exposed to poor management practices, putting them at greater risk of psychosocial and other health problems. They are also at a higher risk of violence (LeBlanc & Barling, 2005), and most report receiving abuse from customers (Mayhew & Quinlan, 2002). University students who work in fast food have also stated dissatisfaction with the industrial relations at their workplace and frequently report injuries and poor management practices such as working extra time without pay or forcing staff to work faster than they are comfortable doing (Cameron, Bamber, & Timo, 2006). They were also rarely aware of their health and safety rights, had little knowledge of their ability to receive workers' compensation and had very limited involvement in health and safety matters (Mayhew & Quinlan, 2002).

The large proportion of young workers, use of contract/part-time work arrangements by employers and seasonality of work add to the insecure/precarious nature of jobs in the hospitality sector. Precarious workers are often heavily affected by labour laws restricting union ability to represent workers or enter workplaces, coupled with a lack of regulation to support alternative forms of representation or meaningful worker participation and fewer protections from arbitrary dismissal (Johnstone, Quinlan, & Walters, 2005; Quinlan, Mayhew, & Bohle, 2001; Underhill & Quinlan, 2011). As a result, employees are more fearful of speaking up due to the potential of losing their job and the lack of visible regulatory enforcement to protect them from any unjust actions by their employer (Johnstone et al., 2005).

Workers in the hospitality sector also appear to be highly exposed to exploitation for several reasons. Hospitality workers are often employed on the basis of temporary work contracts and through the use of contract work firms, also called labour hire firms (McNamara, Bohle, & Quinlan, 2011). These firms are often not adequately covered by labour and OHS laws (even taking into account newer, broader legislation), which originated in a mid-20th century paradigm that assumed permanent full-time work with a single employer (Johnstone et al., 2005). Second, a high proportion of the labour force in the hospitality sector is comprised of migrant workers who have been found to be more likely to experience poor working conditions and exploitative practices (Searle, McLeod, & Stichbury, 2015).

Contributing to the vulnerability of workers in the hospitality industry is the predominance of small businesses and seasonality of the work. A common challenge to OHS for small businesses is limited resources, which can influence their compliance with related regulations (Baldock, James, Smallbone, & Vickers, 2006). The lack of resources in small hospitality enterprises is also often associated with the lack of training provided to staff (Bush, Paleo, Baker, Dewey, Toktogonova & Cornelio, 2009; Sobaih; 2011). Moreover, seasonality means fluctuation in revenue, which is another challenge for hospitality businesses (Bharwani & Mathews, 2012). It also influences the amount of employees in the sector employed on a part-time or casual basis. Research indicates that part-time and casual workers receive less training than full-time staff, which is mainly due to lower return on investment (Sobaih, 2011).

5.5 The nature of work

There are several risk factors that are related to the nature of work in the hospitality sector. First is the unsocial working hours. Although working hours may depend on job organisation, given the nature of the sector, quite often workers still have to work outside normal business hours and during holiday periods. Hotel businesses, for instance, run 24 hours daily regardless of holidays (Moon et al., 2015). Working unsocial hours may result in, or be associated with, the lack of social support (an important element of psychological wellbeing according to Ariza-Montes et al., 2018) being available to hospitality workers. Hotel employees find it hard to balance work requirements with family and/or social commitments due to unsocial work hours and workloads (Cleveland et al., 2007; Karatepe & Uludag, 2007). While the nature of unsocial work hours may be hard to change, the impact of it can be fairly compensated. This is associated with the effort-reward imbalance issue.

Second is the higher level of emotional demands involved in hospitality work (Chu, Baker, & Murrmann, 2012; Shani, Uriely, Reichel, & Ginsburg, 2014). Workers in casinos, for instance, reported feeling emotionally drained and stressed having to be constantly pleasant and to keep “high rollers” and other important customers “on side” (Tiyce, Hing, Cairncross, & Breen, 2013). Ariza-Montes et al. (2018) argue that people who work in jobs with strong emotional demands are likely to feel mentally and physically exhausted, which consequently increases the likelihood of them giving up on their jobs. O’Neill and Xiao (2010) mentioned “face time” as one of the factors that adds to the pressure of the job being emotionally demanding and consequently may lead to emotional exhaustion, depersonalisation and detachment. This factor, however, appeared to be more prevalent at managerial levels according to these authors.

Several observational studies have noted that hotel housekeepers tend to work alone and perform the same series of tasks each shift (Hsieh et al., 2016; Krause et al., 2010; Woods & Buckle, 2006). Such isolation and lack of variety can contribute to poor psychosocial health outcomes as well as increasing the risk of developing MSDs (Woods & Buckle, 2006). Furthermore, there is evidence that the ethnic and linguistic diversity of hotel room cleaners, their, at times, insecure residency status and the isolated nature of their work may all contribute to a lack of collective action and support between cleaners (Hsieh et al., 2016; Krause et al., 2010).

The hospitality sector is also well known for its demand variations throughout the season. As discussed in the previous section, seasonality is recognised as a risk to levels of revenue activities among hospitality businesses (Bharwani & Mathews, 2012). For this reason, employers often emphasise the flexibility required from the workforce, and in many firms (especially small businesses), there are not many opportunities for promotion or pay increases for dependent workers (Zampoukos & Ioannides, 2011). These are related to the precarious employment practices (in terms of working hours) as well as training provision.

5.6 Stress

Psychosocial harm has been noted as a growing concern for hospitality workers by academics and researchers. Stress, in particular, is a significant risk factor that may lead to both physical and psychological harms (Brand et al., 2008; Haruyama et al., 2014; Kotera et al., 2018; Rosemberg et al., 2019). For example, Haruyama et al. (2014) found that job stressors were correlated with a higher occurrence of cuts and burns among Japanese school and hospital kitchen workers. Stress has also been found to have a strong correlation with burnout, depression, anxiety and chronic conditions in several studies (Brand et al., 2008; Kotera et al., 2018; Rosemberg et al., 2019). Similarly, according to O'Neill and Davis (2011), stress within the hospitality sector may result in various physiological symptoms such as headaches, fatigue, indigestion, ulcers, high blood pressure, heart attacks and strokes.

Not only contributing to employees' poor physical and psychosocial health, stress is also associated with low productivity and high staff turnover rates for hospitality businesses (Rosemberg et al., 2019). These costs, in turn, create challenges for employers to provide sustainable working conditions for their employees and to reduce their stress levels. This section is dedicated to addressing different levels of likelihood and severity for stress among hospitality workers. It also explains how stress is interrelated with other risk factors addressed earlier. It should be noted that, while being addressed as a risk factor in this section, stress is also a poor health outcome for workers.

Johanson, Youn and Woods (2010) suggested that hospitality workers appeared to experience a higher level of stress compared to workers in other sectors. Some immediate contributory factors to stress experienced by hospitality workers include personal job fit, low job control, bullying, high job demands and management styles (Bentley et al., 2012; Kara, Uysal, Sirgy, & Lee, 2013; Mohamed, 2015; O'Driscoll et al., 2011). Work environments, working conditions, work roles and expectations, interaction with customers and colleagues and limited workplace resources have also been noted as being key workplace stressors (Tiyce et al., 2013). The overabundance of psychosocial and stress risk factors that hospitality workers are exposed to is exacerbated by the vulnerability of many young, migrant and insecurely employed workers in the sector as well as the low effort-reward balance for those workers. This indicates the interrelation between stress and other themes of risk factors discussed in previous sections.

The cheffing culture is an important consideration when looking to address these risk factors in the kitchen environment. This culture justifies much of the bullying, abusive and violent behaviour in the sector as part of creating and supporting chefs. Indeed, research commissioned by the UK Health and Safety Executive has identified the cultural role of chefs as a critical consideration when planning interventions into the hospitality sector (Howard & Galbraith, 2004). Sources of stress for chefs may also include pay issues, competition with other hospitality establishments, number of work hours per week and work shifts (Chuang & Lei, 2011; Tiyce et al., 2013). The majority of hotel casino chefs in a study by Chuang and Lei (2011) reported a medium (63.2% of the respondents) or high (18.4% of the respondents) level of job stress, and some common stress-related symptoms include fatigue followed by insomnia, alcohol consumption and anxiety.

Maguire and Howard (2001) explored chefs' attitudes to health and safety. They found that chefs generally accepted risks from their job and were dismissive of, or even hostile to, the notion that chefs should seek to complain or sue over hazardous conditions. The notion of 'heat' was a key component of their understanding – both a literal understanding that kitchens would be uncomfortably hot and the notion of being able to 'handle the heat' of time pressures, abuse and low-level injuries as part of the job.

Time pressures commonly conflicted with health and safety demands. As meal times approached, the time demands on chefs increased, and they changed their behaviour towards health and safety rules (Maguire & Howard, 2001). More specifically, they became more negligent about addressing hazards and more accepting of unsafe noise and heat, all of which result in high levels of fatigue. The acceptance of risks and harm was interwoven with a pride in the job, with chefs often seeing their role as a 'calling' that requires discipline and drive beyond what is expected of other food preparation workers (Maguire & Howard, 2001). Working in such an environment and having this kind of mind-set make chefs particularly exposed to stress.

Job insecurity is also common across the accommodation and food and beverage services subsectors. It is a source of stress that contributes to increased work speed and presenteeism, However, individual workers' reactions to precarious working arrangements vary. Similar findings were reported by Lee and Krause (2002), with 83% of surveyed cleaners reporting constant time pressure, 52% reporting poor job security and 40% reporting a lack of support from supervisors. All of these have contributed to increasing stress levels experienced by workers. Avoiding these outcomes when precariously employed requires high-level support from government, family and communities (Clarke, Lewchuk, Wolff, & King, 2007).

The main stressors in the hospitality sector are well recognised by both long-term managers and entrants to the sector. Interviews with American hotel managers in a study by Cleveland et al. (2007) found that:

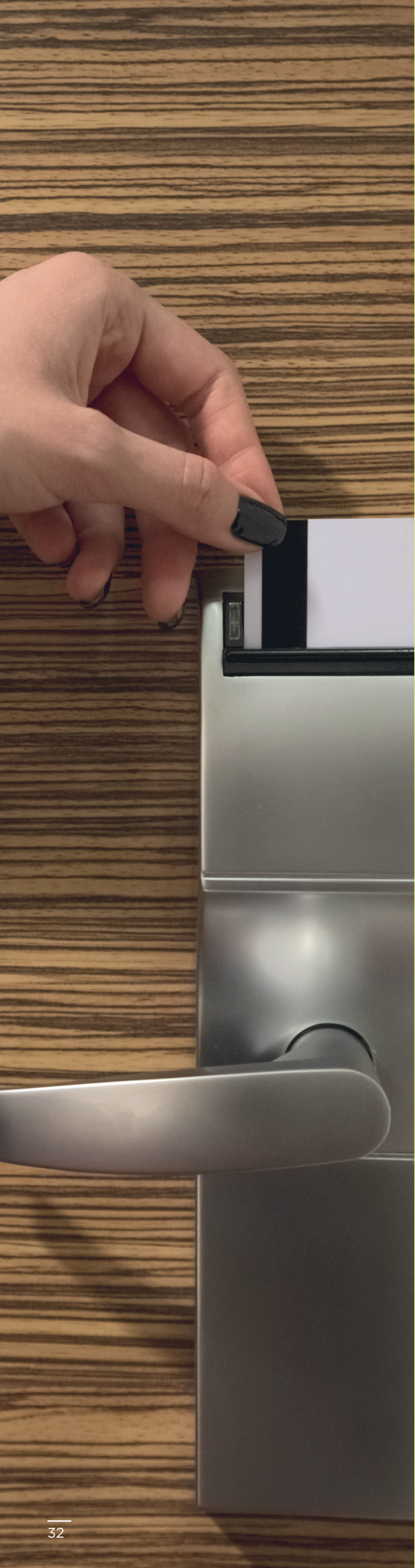
> "The need or requirement to work long, irregular, and unpredictable hours emerged consistently as the most prevalent job stressor for managers in a variety of types of hotels and locations. Managers and [their] spouses largely agreed on this point, and entrants were well aware of these expectations." (Cleveland et al., 2007, p. 293)

Indeed, entrants and students frequently reported warnings about the dangers of alcohol and drug dependency as ways of coping with stressful hours (Cleveland et al., 2007). This indicates a link between the level of stress experienced and the extent of alcohol and drug use among hospitality workers. Shani (2016) highlighted a number of studies and surveys conducted in Australia and the USA indicating an exceptionally high rate of substance use by hospitality workers compared to both the general population and other occupational groups. Research also shows that substance-abusing employees are 3.6 times more likely to be involved in work-related accidents or injuries (Kitterlin, Moll, & Moreno, 2015) and to file compensation claims (Belhassen & Shani, 2012).

Many studies have commented on the high levels of drug, tobacco and alcohol use in the food and beverage services subsector. It is likely that the stressful environment of the kitchen, coupled with cultural acceptance contributes to the higher than average use of alcohol and drugs among food and beverage services workers (Gawde & Kurlikar, 2016; Pidd, Roche, & Kostadinov, 2014). Australian trainees have also reported higher levels of psychological distress than the general population and also far higher average alcohol and drug use rates, suggesting that these may be employed as coping mechanisms (Belhassen & Shani, 2012; Gawde & Kurlikar, 2016; Gregoris, Deschamps, Salles, & Sanchez, 2017; Pidd, Roche, Fischer, & McCarthy, 2014).

All branches of hospitality workers have reported high levels of job-related stress, primarily from the fast pace and insufficient time to complete their work (Hu & Cheng, 2010; Pearson et al., 2007). O'Neill and Davis (2011) emphasise that stress in the hospitality sector is not only among employees but also particularly acute for managers due to their generally high levels of responsibility. Their study also found that hotel employees are relatively stressed out, with hotel workers reporting stressors on 40–62% of days. However, at the same time, there was a perception that the most stressful and difficult jobs were the best way 'to the top' and an acknowledgement that such stressors became less prevalent as managers were promoted (Cleveland et al., 2007).

In some studies such as Lo and Lamm (2005) and Cleveland et al. (2007), self-reported stress was not particularly high among surveyed hotel workers, which could be explained through a combination of general acceptance of stress among hotel workers and staff leaving as a result of becoming stressed (contributing to the high turnover rate). Lo and Lamm (2005) also noted that the hotels generally treated stress as requiring individual adaptation (taking deep breaths etc.) and were reluctant to develop structures to control stress beyond compliance with legal requirements.



6.0 Conclusion

This literature review has provided some background on the harm profile and risk factors in the hospitality sector, specifically the accommodation and food and beverage services subsectors.

The evidence suggests that hospitality workers face both physical and psychological harm. This literature review places a particular emphasis on the psychological harm, as it has been under-reported and thus has received limited attention despite its significance. Physical harm experienced by workers in the accommodation and food and beverage services subsectors mainly includes cuts, burns and MSDs/pain. In addition, stress, depression, anxiety and emotional exhaustion are fairly common psychosocial harm for hospitality workers.

The underlying risk factors to both physical and psychosocial health of hospitality workers identified in this literature review can be grouped into the themes of:

- hazardous working conditions
- workplace culture and management
- vulnerable labour market
- the nature of work
- stress.

The international and New Zealand literature has revealed how these risk factors can contribute to poor health and safety outcomes for workers in the sector. It also emphasises the interrelation of these risk factors in the ways that they mutually influence each other. An understanding of how these risk factors are interconnected would enable a fuller consideration of their impacts on workers' health and safety outcomes.

Interventions aiming to make changes from the organisational level may not eliminate the risks existing at the higher level (industry level) in the safety system but can mitigate them to some extent. In particular, based on this literature review, a greater focus on addressing the following issues will result in positive outcomes for workers.

- Poor psychosocial health (especially stress) as both a disease and a risk factor for physical injury and ill health.
- Unhealthy employment practices including shift work, temporary/insecure work, repetitive tasks and low job control.

- The perceived image of chefs and a culture of accepting behaviour among workers in the sector towards bullying, long hours and high job demands, the ‘harden up or get out’ mindset in the kitchen environment and abusive behaviour from customers.
- Negligence from management in terms of training provision, reward-effort balance and negative workplace culture that tolerates behaviours such as bullying, discrimination, harassment and abuse. The issue of sexual harassment towards female workers (from both customers and co-workers), in particular, needs more attention.

Unique to the food and beverage services subsector is the cultural and leadership role of chefs. The cheffing culture is itself a key risk factor for many incidences of poor health. The pride and self-perception of chefs may lead to resistance if challenged or identified as being part of the problem. Such perceptions need to be accommodated into any attempted intervention. The in-group cohesion of cheffing may be a fruitful avenue for an intervention, using existing chefs to promote chef-specific health and safety messages.

Overall, the results of this literature review enable a better understanding of OHS issues in the hospitality sector and, accordingly, a better focus for intervention development. It also calls for a robust collection of data to support a greater understanding of the current situation regarding hospitality workers’ psychological health in New Zealand as well as the link between their psychological health and the identified risk factors. Such an understanding is crucial to help develop intervention programmes that are better targeted at addressing workplace-related harm.

Appendix

IN THIS SECTION:

Appendix 1: References

Appendix 1: References

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Notes

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