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Background

Studies show that workplace well-being programmes decrease absenteeism, improve performance (Bevan, 2010, Croucher et al., 2013), and can be cost-effective, especially when targeted at a specific employee population (Sherman, 2013, Loeppke et al., 2010). A healthy workplace also has a significant impact on both the physical and mental health of the workforce (Waddell and Burton, 2006).

The UK has a rich history of small but dynamic migrant businesses which represent an important part of the economic fabric of the country in terms of employment and prospects for economic growth as well as the development of new niche markets. Although there is some research in the areas of 'occupational health and safety at work', 'occupational risks and ethnicity'(Baldock et al., 2006, Szczepura et al., 2004, Vickers et al., 2003) as well as on 'health and the Chinese community'(D'Angelo et al., 2010, Gervais and Jovchelovitch, 1998, Li et al., 1999, Lam et al., 2009), there is limited research on the attitudes of Chinese owned businesses towards workplace health and well-being (Vickers et al., 2003, Szczepura et al., 2004). This is despite the fact that people of Chinese descent account for one of the most rapid rates of migration to the UK, doubling between 1998 and 2011 (Latham and Wu, 2013).

Some literature on Chinese owned businesses in the UK examined the cultural attitude of ethnic minority owned businesses toward health and safety and mentioned the Chinese business population within that. Thus, for example, Baldock et al (2006) concluded that Chinese owned companies might exhibit 'cultural factors' in their attitudes towards Compliance Related Interventions (CRI) in the area of Health and Safety regulation and that this deserved further investigation as it is not known what these cultural factors might be. Yet, Chinese owned businesses have been demonstrated to have greater knowledge of health and safety legislation than other ethnic minorities and White owned businesses. Chinese entrepreneurs are also broadly satisfied with the current regulatory level (Vickers et al., 2003).

Moreover, in assessing the importance of cultural factors and their link to workplace, the literature discussing Chinese interpretation of 'health' and well-being' was reviewed. A discrepancy in reporting existed between quantitative surveys such as the Labour Force Survey and Health Survey for England on the one hand, and qualitative research studies (Mau, 2013; D'Angelo et al., 2010; Chau, 2008; Li et al., 1999; Tran, 2009) on the other. Quantitative surveys show an overall good level of health in the Chinese population, whilst qualitative studies, which had the opportunity to engage deeper in the meanings Chinese people attribute to health, a range of health issues including mental health issues, gambling, lack of physical exercise (D'Angelo et al., 2010).

It is also important to consider the sub-contracting network of SMEs (Croucher et al., 2013). The prevailing attitudes and practice within the network of contactors and clients can have important implications for the level of Occupational Health and Safety (OSH) including workplace well-being and in particular, working conditions. This may be even more important in the context of Chinese owned companies which traditionally rely on tight networks of personal relationships (Guanxi) which are often established with people from the same region within China (Lam et al., 2009) in an attempt to create some basic shared rules in a context characterized by a poor regulatory environment and no 'impartial judiciary' (Xin and Pearce, 1996). Yet, the Chinese business community in the UK and Europe appears to be in perennial change the emergence of a newer groups of well-funded and highly resourceful migrants and transnational business people from East and Southeast Asia and outside the consolidated food, hairdressing and alternative medicine sector (Latham and Wu, 2013).

Given these key gaps in the current research on workplace well-being, this article has two key aims to:

- To understand the context and approach to staff well-being within Chinese owned businesses based in London.

- To identify any potential levers, barriers and triggers for engaging Chinese led businesses in work place well-being initiatives

We adopted the following working definition of workplace well-being drawing on work from Marmot et al: '*a living wage, having control over work, in-work development, flexibility, protection from adverse conditions, ill health prevention and stress management strategies, support for sick and disabled people that facilitates return to work*'(Marmot et al., 2010).

Methods

The article draws upon a range of methods to investigate the attitudes of employers and employees of Chinese descent toward workplace well-being. We initially conducted a literature review which included a search for published articles, books and unpublished reports. The search was partly guided by semi-structured interviews with 12 experts in public health, sociology and business, and opinion leaders from the Chinese community. The aim of the search was to identify literature on Chinese owned businesses and knowledge, attitudes and behaviours related to workplace well-being, from a range of public health and business management databases. Two parallel approaches were planned, one involving searching online databases of published research and one aiming to locate 'grey literature' by requesting opinion leaders and experts who were interviewed as part of the study. The same inclusion criteria were applied to all papers or reports found: relevance to workplace health, the health of the Chinese population in general, and workplace health and well-being in the Chinese business community. Papers which did not contain explicit mention of Chinese or ethnic minorities in the title or abstract were excluded. Similarly, studies specifically focused on China were excluded. Secondly, we scoped the field searching medical and public health datasets including the Cochrane Library, PubMed and Science Direct as well as the business management literature using JSTOR and Proquest. The timeframe of interest was 2004-2014, and we limited the search to journals and reports in English

Data collection: The literature review and experts' interviews then informed the qualitative interviews with employers and employees of Chinese descent. A qualitative method was chosen to enable a deeper understanding of respondents' experience in relation to personal health, workplace well-being, discrimination, bullying, harassment, mental health and well-being, physical activity, healthy eating, alcohol and substance misuse. We adopted different strategies based on purposive and snowballing sampling to undertake a number of face to face interviews in London between February and March 2014. Semi-structured interviews were administered to a purposefully selected group of interviewees including 11 employees and 17 employers and two focus groups with a total of 10 employees. The focus groups were supported by an interpreter to enable further discussions between researchers and participants (see table 1 and 2 for more details). We stopped recruiting when new respondents provided similar information to previous respondents, a process known as saturation (Mason, 2010).

Data analysis: we followed a thematic content analysis approach as follows: (i) data was transcribed, (ii) themes identified and agreed by two researchers independently to ensure inter-rater reliability; and (iii) a coding framework was developed to aid analysis and writing up.

Ethical consideration: researchers explained the nature of the research to each respondent who was also given time to read an information sheet, ask questions and sign a consent form. All respondents were pseudo-anonymised and told that they could withdraw from the interview at any time. The study was approved by the University of East London Ethics Committee (UREC)

[insert tables here]

Results

This section summarises the key findings from the literature review and interviews with opinion leaders and compare these with primary data drawn from the survey of employers and employees.

Attitudes and barriers of Chinese owned businesses to workplace well-being

The literature review did not find any studies which focused specifically on the attitude of Chinese owned businesses in relation to workplace well-being (see also Szczepura et al., 2004). However, some research described the cultural attitude of ethnic minority owned businesses towards health and safety more generally and also included Chinese owned companies (Baldock et al., 2006; Vickers et al., 2003; Szczepura et al., 2004). Ethnic minority owned companies were reported to adopt less formal approaches to management, including the preference of an owner/manager for autonomous decision-making and close employer/employee relations in small businesses (Vickers et al., 2003). Overall, the same study found that differences in attitudes towards health and safety may not only be due to cultural attitudes but also to other factors such as the business size and sector.

In response to the lack of evidence on Chinese companies specifically and the potential differences in terms of cultural values, size and sector, we concentrated interviews with employers and employees on understanding the conditions of workplace well-being in small Chinese companies. As the definition of workplace well-being used was quite broad, we asked a range of questions to both employers and employees about the following aspects: health and safety, hygiene, attitudes towards mental well-being, physical activity, bullying, discrimination and harassment. As mentioned in the limitations section, we could not interview large businesses, and could only concentrate on specific sectors thus our findings are limited to small companies operating in food wholesale/retail, and traditional medicine which remain nevertheless a significant proportion of Chinese owned companies in the UK. Nevertheless, we were able to assess whether the attitude towards workplace wellbeing of small size Chinese owned companies is similar to the small firm sector in general.

Most employers (11/14) interviewed reported that the person responsible for workplace well-being was the owner, except one larger business which had appointed a health and safety manager with responsibility for workplace well-being. Some employees (6/12) confirmed this picture but others responded that no one person was in charge of workplace well-being. Most managers had a knowledge of basic health and safety and hygiene issues. The majority of employers (11/14) interpreted workplace health as absence of sickness and a safe workplace where employees were protected from the risk of injury. When probed further, the majority of small business owners/managers (9/15) understood workplace well-being as limited to 'physical activity' or attending leisure activities (e.g. karaoke) outside (rather than at) work. With the exception of smoking cessation services, employers did not offer any well-being interventions (e.g. physical activity or healthy eating advice) and did not think it was their responsibility to do so. In relation to other aspects of workplace well-being such as discrimination, bullying and harassment in the workplace, only two employers recognised the importance of creating a good working environment. This evidence was again confirmed by interviews with employees who reported general interest towards physical activity and healthy eating, but only outside the workplace, and were rather critical of the quality of their working environment.

When asked about the barriers towards workplace wellbeing, employers reported the following: (i) lack of time to encourage workplace well-being as fierce competition compels employers to focus on key aspects of running their business; (ii) the cost of running workplace well-being initiatives in a context of ever declining profit margins; (iii) the lack of space which prevented them from setting up workplace interventions; (iv) wide variations in language, place of origin and cultural attitudes of the workforce; (v) the need to cover for staff in a small business was a concern from employers, whilst communication in English was a problem for employees' access to training outside Chinese businesses.

Workplace well-being was not a high priority for most employers who were chiefly concerned with profit and long-term sustainability. Despite these issues, however, a substantial number of employers were prepared to consider the introduction of workplace well-being interventions if a convincing business case (e.g. lower absenteeism, increased staff productivity) could be demonstrated.

Guanxi and a workplace well-being context in perennial transformation

Other research pointed to the role of culture. Thus, for example, Baldock et al. (2006) concluded that Chinese owned companies might exhibit 'cultural factors' in their attitudes towards Compliance Related Interventions (CRI) in the area of Health and Safety regulation and that this deserved further investigation but did not explain what some of these cultural factors might be. Others considered cultural factors in relation to sub-contracting networks of SMEs (Croucher et al., 2013). The prevailing attitudes and practice within the network of contractors and clients can have important implications for the level of Occupational Health and Safety (OSH) including workplace well-being. This may be even more important in the context of Chinese owned companies which have traditionally relied on tight networks of personal relationships (Guanxi). Guanxi is often established with people from the same region within China (Lam et al., 2009) in an attempt to create some basic shared rules in a context characterized by a poor regulatory environment and no 'impartial judiciary' (Xin and Pearce, 1996). This is particularly relevant in the context of this research because Guanxi relationships between businesses and between employers and employees have often replaced the system based on legislation which is the convention in the UK. This leads to a range of implications for workplace well-being: first, Chinese companies may appear not to pay attention to the UK legal system but may have a regulatory framework that is based on a different system of trust and reciprocity, reputation and hierarchy.

In relation to this, responses from Chinese employers were mixed. Despite the alleged sharing between tight network of Chinese companies as part of Guanxi, one of the employers reported that 'secrecy' exists even within the Chinese networks:

'*It does not exist* [co-ethnic networks]. *People do not want to share business secrets. They do not want you to be in competition with them. They won't even give the number for a chef. Everyone keeps to themselves. Chinese people and everyone will not give you any information relating to themselves*' (employer).

Other respondents pointed to other more positive aspects of Guanxi related to a strong relationship between employer and employee based on 'trust' and sense of 'duty' which led in some instances to the employer supporting the employee almost as a 'family' member.

'S*ometimes staff get sick and they need extra money. And sometimes they cannot pay rents and they are worried. These can all affect their well-being and how the company helps them*' (employer).

This picture is further complicated when other aspects of the literature review and responses from qualitative interviews are considered. In exploring people's responses to injuries at work in Hong Kong, Cheng (1997) showed that Guanxi also has implications for reporting problems in the workplace as there is a tendency among Chinese employees towards the maintenance of a harmonious and stable relationship with their employer (Szczepura et al., 2004). However, there are some signs that this system is changing. Mackinnon (2008) argues that trust and reciprocity remain particularly important in a Chinese business strategy but 'face' (i.e. reputation) and hierarchical relationships are not as important any longer. MacKinnon concludes that there might be a change in business strategy towards an environment regulated by a legal system rather than Guanxi. Along similar lines, Cheng & Zhang (1998) confirm that a group of newer migrants into the UK who are more qualified and come from a middle class background engage in more Westernised business behaviour based on market principles rather than the more traditional Guanxi.

The literature also highlighted a generational aspect as early Chinese business activity in the UK was mainly concentrated around seafaring and the laundering business whilst this later developed into catering (restaurants, takeaways, and food wholesale and retail) and Traditional Chinese Medicine (TCM), hairdressing salons and other beauty treatments as well as the import-export trade (Latham and Wu., 2013) with catering remaining the largest Chinese sector according to the Census 2001. Although the Chinese catering industry might appear as a homogenous group to an outsider, it is in fact heterogeneous and reflects different waves of migration of Chinese people to the UK initially from Hong Kong in the 1960s and later Southeast Asia (Malaysia, Vietnam, and Singapore). More recently, the catering sector has also experienced the involvement of British born Chinese (BBC), although a significant number of these have also opted for other career paths (Mau, 2013) and set up more mainstream business activities. This demonstrates how the Chinese business community is in perennial change and adapts to new business environments and regulatory requirements. Thus, it is reasonable to expect that they will adopt a more Westernised attitude towards health and safety and this is also likely to be the case in relation to workplace well-being, particularly around aspects such as flatter (less hierarchical) organisational structures and greater attention towards formal arrangements in the workplace. This has also been recognized to apply to ethnic minorities more widely in what has been conceptualized as the 'mixed embeddedness approach' (Kloostermann, Leun Van der and Rath, 1999; Ram et al., 2008).

Interviews with employers and employees broadly confirm this complex and ever changing context. The attitudes of employers towards regulation and aspects of workplace well-being varied with place of origin. There was a wide recognition that the Chinese population is heterogeneous and characterised by different waves of migration from different parts of China, with varied skill levels, languages and local traditions. For instance, place of origin was an important determinant of the relationship between employer and employee.

Differences between people: 'My staff is okay actually because they all came from Fujian. They know each other so it's more harmonious working together' (employer).

Other employers emphasised the positive association between British Born Chinese and compliance with UK legislation reporting a difference between first generation Chinese and British Born Chinese with the latter being more compliant with UK legislation.

First of all, I would like to say that I am luckier than lots of workers. My boss is the second generation. They are young. They took over established business from their father. The business has stability. It's a retail supermarket with cash and carry and restaurant. Young bosses are British Born Chinese and they follow all labour laws – 6 hours job with ½ hour break. When the worker is unwell, they accept sick notes from surgery or hospital. There is maternity as well as paternity leave. At work, special hard shoes, laminated yellow jackets, and trolley were provided (employee)

Contradictory evidence in relation to the respondents' understanding of workplace well-being

We explored the literature on the types of health and well-being problems which are reported by the Chinese community to identify possible links with the workplace and possible health needs which can be tackled through the workplace. This is particularly important considering that participation of ethnic groups in workplace health activities is low as demonstrated by Peersman et al. (1998) who found that employees involved in health promotion interventions in the workplace tend to be older, more educated, white collar workers who are already committed to healthy lifestyles.

Research evidence on the health of Chinese people is contradictory as there is a large difference in the conclusions which can be drawn from quantitative and qualitative evidence. The overall message from quantitative data is that Chinese people are both physically and mentally healthy. Thus, for example, data between 1994 and 2000 from the Labour Force Survey (LFS) shows that Chinese

workers report the lowest workplace injury rates of all ethnic groups including the White group (Szczepura et al., 2004). A variety of statistical data from the census, Health Survey for England and other sources suggests that Chinese people are healthier than all the other ethnic groups including Whites. The lowest rates of Limiting Long-Term Illnesses are observed in the Chinese working age population in 1991 and 2001 (Szczepura et al., 2004) and were again confirmed in the most recent 2011 census (Kagan et al., 2011). Moreover, Chinese respondents exhibit low rates of reporting that their health was 'not good' in comparison to other ethnic groups (1 in 10 Chinese, 1 in 4 Asians and 1 in 5 for Black or Black British). Finally, two Health Surveys for England found substantially lower rates of psycho-social distress among Chinese men and women than in the general population (Tran, 2009). They used a Chinese Health Questionnaire which is a variation of the General Health Questionnaire, an extensively validated tool used in large scale surveys across the UK and beyond, asking respondents 12 questions to gain a picture of psychological distress.

By contrast, qualitative research studies and interviews with opinion leaders conducted as part of this research, provide a rather different picture of health in the Chinese population. This literature review identified a variety of reasons for this discrepancy including that:

(i) Routinely collected statistical data is often based on self-reported health which might be affected by different cultural interpretations of questions related to illness (D'Angelo et al., 2010). For example, an opinion leader from a Chinese background interviewed for this research remarked that '*there is not even a word for mental illness in the Chinese language*'. This suggests that there may be difficulties in responding to questions posed in English within a somewhat different cultural context.
(ii) In some cases data collection might be skewed when interviews are only conducted with Chinese people who are proficient in English (e.g. Vickers et al., 2003) as this would exclude a number and range of opinions and experiences, especially from the lower socio-economic groups.
(iii) Some statistical data especially from the Census revealed a large proportion of Chinese in professional occupations and very few in catering and related activities. This contradicts other data collected (e.g. EHRC, 2011) and may mean that Chinese professionals are more likely than Chinese in the catering sector to fill in the Census questionnaire. This results in under-representation of a substantial number of Chinese workers (food wholesale and retail, catering and other low threshold activities) who are arguably more affected by poor working conditions.

One perspective highlighted by the literature is that Chinese people tend to view health as the 'absence of illness' rather than a more positive view of 'wellness' (Tran, 2009). This may cause them to be less likely than other groups to describe themselves as in poor health (D'Angelo et al., 2010). This results in a reactive use of health services which places less emphasis on preventative services such as physical activity and mental well-being which are key components of workplace well-being interventions (Gervais and Jovchelovitch, 1998). In relation to workplace injuries, Cheng (1997) argues that Chinese workers are not comfortable with confronting their employer and often blame 'fate' and/or 'luck' for accidents in the workplace.

It is also important to consider that 'reaching beyond the community for assistance may be regarded as shameful' for Chinese people (Gervais and Jovchelovitch, 1998; p.17). This was confirmed by other research in relation to access to mental health where 'face' and 'pride' discouraged people of Chinese descent from accessing help and advice. '*Mental health problems are kept inside the individuals and relieved by gambling, alcohol or angry outbursts*' (D'Angelo et al 2010; p.25). Moreover, in a study exploring the views of Chinese older people, mental and physical health were not considered as a separate entity (Tran, 2009) and somatisation (i.e. the expression of psychological distress by complaining about physical pain) led to poor detection of psychiatric illness by general practitioners (Tran, 2009).

Findings from interviewees with employers and employees confirmed the qualitative studies mentioned above and thus the discrepancy with quantitative data. Most respondents reported that they

were healthy and engaged in physical activity, did not have problems with the quality of food they consumed, and did not initially even talk about mental health.

However, when questioned in greater detail, a different picture emerged, particularly in relation to a stressful working environment, scant attention to health and well-being in the workplace, the prevalence of behaviours such as gambling which are recognised to put health at risk, and chronic diseases such as arthritis. Thus, for instance waitressing in restaurants was cited as leading to varicose veins and pain in the arms which in the long term had lead to arthritis. As one of the respondents put it

Also, staying too long in the kitchen, most of us have big veins on our legs. The arms were in pain too. Need to carry heavy cooking utensils'.

Stressful working conditions were also reported by a number of respondents. As one employees summarised

'But they [employers] gave you so much stress and pressure. They maximise the work and profit but minimise the number of workers. This is called business, man!'

Mental ill health and high rates of smoking were also identified as a consequence of gambling especially in the catering sector.

Gambling is the biggest problem here, it leads them to smoking. Once they lose money they smoke heavily because they are stressed'.

'On their break they go to William Hill. William Hill is a gambling place. They bet all their money on dogs, horses, whatever. This is the Chinese culture. They love their gambling. They don't use their breaks productively' (employer)

Enduring poor health and working conditions

An important aspect of workplace well-being is the working conditions of Chinese as employees in Chinese owned businesses. We found that although new generations of Chinese entrepreneurs are moving steadily towards mainstream business activities, the majority of business activity is still confined within catering (e.g. restaurants, take away, food wholesale and retail), Traditional Chinese Medicine (e.g. acupuncture, herbal medicine and massage), hairdressing and beauty treatments. These sectors are characterised by comparatively low pay, poor working conditions, and long working hours. Both literature searches and interviews with opinion leaders show that the most pressing issues Chinese employees face on a daily basis are the poor working conditions rather than the need to introduce workplace well-being interventions to increase physical activity or improve healthy eating practices.

Regardless of qualification, ethnic minority men experience pay gaps in comparison to the White group. Chinese men experience an 11% pay gap in relation to the White group, only slightly less than the Bangladeshi and Pakistani groups. In 2010, average pay for Chinese men was £9 per hour, and £7 for women (EHRC, 2011) which is close to the national minimum wage of £6.31 (£8.80 in London). Given that about a third of Chinese people live in London (Latham and Wu, 2013), pay levels for most Chinese people are very low and below the minimum wage in London for women. In addition, all women, regardless of their minority ethnic/religious group experienced large pay gaps with Chinese and Pakistani Muslim women experiencing the largest gap. If individuals with a disability who remain in work are considered, the differential drop in hourly pay rate is greatest for Chinese

males and females and Bangladeshi males. Thus, there is evidence of further exclusion of the most marginalized groups within the Chinese population. This is likely to be predominantly due to the attitudes of Chinese employers and indicates discrimination and institutional racism as the majority of Chinese employees work in Chinese owned businesses (Szczepura et al., 2004).

Other studies present a different picture. For instance, a study from EHRC (2011) shows that Chinese women made the greatest gains in securing managerial positions (13%) in 2009. Moreover, the same report found that the Chinese are nearly twice as likely as White British men to be in professional jobs and this advantage rose by 6% between 2003 and 2008. However, as acknowledged by the same report, these jobs include managerial positions which can provide a misleading picture as managers from a Chinese takeaway and a manager from a blue chip company may experience significant differences in earnings and status.

The quality of working conditions has been a long standing problem for Chinese migrants, especially those with more vulnerable status such as illegal immigrants (Gomez and Benton, 2011; Wu, 2013). The rapid rise of China on the world stage, in the last decade or so, contributed to the arrival of a growing population of Chinese students and entrepreneurs in the UK as well as a significant number of illegal migrants as a result of a rural-urban shift in China with poor Chinese farmers seeking employment beyond their homeland (Lam et al., 2009; Wu, 2013).

Opinion leaders' interviews echoed the findings highlighted by the literature, in which arrangements between employers and employees may be different from what is conventionally regarded as appropriate for workplace well-being in the UK legislative context, with their relationship being based on 'trust' between employer and employee as well as a sense of 'duty' from the latter, i.e., Guanxi discussed above. This generally leads to an employee remaining with the same employer for a long time and a mutual sense of respect is established and maintained over time and leads the employer to help an employee in unexpected ways such as paying for health needs after retirement or providing accommodation, which is not a component of the UK system of work regulation or practice.

Racism and discrimination in the workplace were also significant problems causing mental illness in the workforce (Mau, 2013) and are an important cause of inequalities in health (Nazroo and Karlsen, 2001) (Nazroo, 2001). Furthermore, waves of migration from different regions of China, and variations in dialects and religious beliefs and practices have undermined the relationship and social bonding among the Chinese in the UK (D'Angelo et al., 2010). This observation was echoed by a survey of the Chinese in Nottingham by Wu (2013) which showed a general lack of communication, interaction and cooperation between different groups within the Chinese community. Interestingly, racism was not just experienced by first generation migrants or Chinese working in lower paid, lower status jobs but continues to be a difficulty faced by British born Chinese (Mau, 2013).

Moreover, one opinion leader interviewed mentioned the poor working conditions suffered by many Chinese doctors working in the TCM sector in the UK. Whilst in China, they enjoy the same status as all other medical doctors, but when they come to the UK they often work long hours in small shops for a low salary and have to spend more time in attracting clients to the business rather than on the work they are qualified for. This results in various types of mental ill health, especially depression.

Informed by the literature review, interviews with employers and employees focussed on their pay, working conditions, racism and discrimination, communication between employer and employee and between employees in the workplace. Most of the responses from employees confirmed the evidence from literature review and interviews with opinion leaders. It was clear that employees' views about the quality of working conditions were notably different from those of employers. Employees highlighted issues such as long working hours, poor working environments, substantial gender pay differentials, as well as limited or absent sick leave

'1-3 days sick leave allowed per year' (employee)'

or

'But they gave you so much stress and pressure. They maximise the work and profit but minimise the number of workers. This is called business, man!'

Respondents employed in restaurants reported working 11-12 hours per day, and, in some cases, receiving about £3 per hour and only for hours worked with little or no employment rights to protect them.

Discussion

The approach of employers towards workplace well-being was predominantly reactive rather than proactive, informal rather than formal, and characterised by in-house on-the-job training. As reported above, some employers acknowledged they would make changes if a convincing business case could be made. However, they were currently unable to do so as cost, profit, lack of time and space as well as difficulties with language prevented them from putting in place workplace well-being interventions. These results are broadly consistent with the conclusions of previously published research on the general population of small and medium sized enterprises (Szczepura et al., 2004).

Few employers demonstrated awareness of the impact of issues such as salary levels, working conditions (e.g. long working hours), workers' rights (e.g. rights to sick pay), and relationships between colleagues at work which, in contrast, were revealed as key concerns of employees participating in the study. This finding is not confined to Chinese owned companies but is reported more widely. Figures from the Chartered Institute of Personnel and Development (CIPD, 2013) show that in 2012 'zero hours contracts' were most common in hotel, catering and leisure industries, followed by education and healthcare. Research on the impact of prolonged periods of working and overtime has demonstrated negative short-term effects (such as increased injury risk) as well as adverse long-term health effects (such as depression, strokes and heart attacks) and decreased productivity (Croucher et al., 2013). Whilst this appears to apply across the catering sector irrespective of ethnicity, newly arrived migrants from China face significant exploitation (EHRC, 2010). They are typically trapped in low wage, low skilled occupations which ultimately lead to a range of physical and mental health problems as shown by the abundant literature on health inequalities (D'Angelo et al., 2010).

Our findings revealed substantial health challenges in this population, but also demonstrated evidence of a fluid and rapidly changing working environment driven by the cultural diversity within the Chinese population (e.g. South and North China, Hong Kong, Malaysia) as well as the generation of the owner, whether first, second or third generation migrant (i.e. British Born Chinese). Broadly in line with other research(Mackinnon, 2008, Chen and Zhang, 1998), this study demonstrates that although some sectors such as restaurants are still mainly run by first generation migrants, where the importance of 'reputation', 'trust' and 'duty' (i.e. Guanxi) may remain dominant, this is changing as increasing numbers of businesses are led by British Born Chinese who have been more exposed to the UK regulatory system and are consequently more likely to comply with it.

Although both employers and employees initially responded positively about their health, when questions were included as part of an exercise gathering narrative evidence of their lives, health issues did surface along similar lines to other studies (Lam et al., 2009; D'Angelo et al., 2010; Law, 2004) So, for example, a question using a narrative approach such as 'could you tell us about your relationship with colleagues?' provided a better picture of the true health status of survey participants when compared with a question more akin to the Census, such as 'in general would you say your

health is excellent, very good, good, fair, poor, very poor?'). This may also be a likely explanation of the contrast between findings from qualitative and quantitative research (including the Census) mentioned in the literature review. Thus, greater emphasis on a narrative approach to evidence gathering may be more helpful in uncovering the health needs of the Chinese community and facilitating a better understanding of Chinese meanings and interpretations of words used to describe physical and mental health.

Research limitations

This study begins addressing the paucity of research on workplace well-being in the Chinese business community. It also triangulates different sources of information, using a variety of methods including one-to-one interviews and focus group discussions with opinion leaders and employees and employers in Chinese owned companies.

However, there are a number of limitations to the study. It is a study which involved only a small number of participants and this may limit the generalisability of its results. Thus, caution is required in interpreting its findings or in assuming that they may be applicable to the Chinese population as a whole. Furthermore, most of the fieldwork was carried out in one of the busiest commercial districts of central London where the competitiveness and attitudes of respondents may differ from those of people working in other parts of the country. Thus, it is possible that the strong competition faced by Chinese restaurants in central London, for example, might not be experienced outside it, with implications for working conditions including pay levels and working hours.
We initially set out to use an existing business database of nationwide contacts to conduct telephone interviews with both employers and employees of Chinese descent to compare and contrast their views about workplace well-being policies and procedures. However, considerable language barriers meant that we could not conduct such interviews effectively and therefore pursued a different strategy based on snowballing techniques and face to face interviews. Despite this, we still faced major difficulties in recruiting study participants and conducting interviews, particularly with employers. Three factors might explain this: language difficulties, mistrust of outsiders and a general diffidence in the Chinese community, and wariness of intrusion given the topic under investigation. As a result, those employers who were ready to talk to us were probably a self-selected group with better workplace practices and less to hide from public scrutiny. These limitations may also apply to employees, but were mitigated by collaboration with a Chinese representative organisation which recruited employees from harder to reach groups. This provided a valuable and rare insight into workplace behaviours and attitudes, particularly in relation to the catering sector. On the other hand, there may be involuntary biases as the translator worked for the organization which arranged the focus group discussion, and the influence of working in such an environment may have undermined their objectivity and ability to provide unbiased translations of the participants' views and statements. This risk is often involuntary and is a well recognised problem of qualitative research (Robson, 2011).

Practical Implications

This article examined various aspects of workplace well-being as defined by Marmot et al (2010): '*a living wage, having control over work, in-work development, flexibility, protection from adverse conditions, ill health prevention and stress management strategies, support for sick and disabled people that facilitates return to work*'.

Although small size Chinese owned businesses share some similarities to conventional small businesses in relation to informal health and safety training, most Chinese companies in the sample exhibit extremely poor working conditions and low salary levels. These issues lead to significant lifestyle risks such as poor diet, physical ill health such as musculoskeletal problems including

arthritis and backache and mental illness including depression and anxiety. Employers need to be made aware of their responsibilities in relation to improving the work environment through enforcement and spot checks. However, the literature suggests that these strategies may not be effective (Croucher et al., 2013) and other more 'light touch' interventions may generate greater cooperation. In practice, this may include campaigns (in both Mandarin and Cantonese) tailored to Chinese employers and focusing on two key aspects: first, the economic argument in support of workplace well-being such as the reduction of absenteeism and increased productivity; second, utilising established co-ethnic networks to encourage greater cooperation with workplace well-being initiatives. The participation of Chinese employees also needs to be promoted through information campaigns in Chinese languages. Long term strategies to address health inequalities may also include other strategies such as English classes at a suitable time and cost for a poor and overworked population.

This study also attempted to explore how Chinese people understand and interpret the notions of workplace well-being and health, and to find explanations for the discrepancies between qualitative and quantitative studies found in the literature review. The conclusion here is that whilst large scale surveys on workplace injury rates and psycho-social distress report lower levels of morbidity within the Chinese community (Szczepura et al., 2004; Kagan et al., 2011; Tran, 2009), qualitative studies provide a rather different picture highlighting physical and mental health problems, poor working conditions, and low wages (Law, 2004; Lam et al., 2009; Szczepura et al., 2004). Other studies have also reported work-associated health problems such as varicose veins eventually leading to arthritis (Lam et al., 2009; Vickers et al., 2003; Szczepura et al., 2004). Racism and discrimination in the workplace were also significant problems causing mental illness in the workforce (Mau, 2013) and are important factors associated with inequalities in health (Nazroo and Karlsen, 2001).

In addition to this different interpretation of notions of workplace well-being and health, this study uncovered other important factors that influence workplace well-being. Migratory flows, the continuous transformation of Chinese business and network practices which may result in the erosion of cultural traditions such as Guanxi, and the trend in the Chinese business community to expand into non-traditional sectors show that this population is in perennial change. As this research focussed on specific sectors and small companies, further research should target other business sectors and sizes to assess whether the findings from this study apply more widely and can underpin evidence-based strategies to improve workplace health in this population.

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TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF EMPLOYEES (ONE-TO-ONE INTERVIEWS)

Business sector of participant	*Job Role*	*Age group*	*Gender*	*Country of Birth*	*How long lived in UK (years)*	*Level of Education*	*Gross income per month*
Grocery retail store	Shop attendant	65-75	Male	Thailand	45	A level	830-1249
Medicine	Chinese herbal doctor	35-45	Female	China	10	Degree	830-1,249
Grocery wholesale & retail	Shop floor assistant	25-35	Male	China	6.5	Degree	1,250 -1,649
Restaurant	Supervisor	25-35	Male	China	7	Degree	1,250-1,649
Bubble tea shop	Waiter/ Take away assistant	25-35	Male	UK	From birth	Degree	830-1,249
Grocery store	Shop assistant	25-35	Male	China	4	Degree	830-1,249
Chinese Association	Office assistant	65-75	Female	China	43	A Level	200- 399
General Wholesale distributor	office assistant	25-35	Male	China	10	Degree	1,250-1,649
Chinese Medicine/ Pharmacy	Project Manager/ Pharmacist	25-35	Male	China	1	Degree	1,650-2099
Dentistry	Practice Manager	25-35	Female	UK	From birth	A level	1,250-1649
Dentistry	Dental Nurse	25-35	Female	UK	From birth	A level	830-1,249

TABLE 2: CHARACTERISTICS OF BUSINESSES AND EMPLOYERS INTERVIEWED

	Type of businesses	Number of Staff	Country of origin of respondent*	Gender	Age group	Turnover change from previous year
1	Supermarket	40	(C), Guangxi	M	30-40	Not available
2	Hair salon	13	(C), Fujian	M	35-45	Not applicable
3	Computer/phone repair	1	Malaysia	M	40-50	Increased a little
4	Restaurant	15	Hong Kong	M	55-65	Increased a little
5	Cake shop	10	Malaysia	F	30-40	Stayed the same
6	Traditional Chinese Medicine	1	(C), Shanghai	M	50-60	Increased a lot
7	Traditional Chinese Medicine	7	(C), Jiangsu	F	45-55	Decreased a lot
8	Travel agency	10	(C), Tianjin	F	25-35	Not available
9	Restaurant	8	Hong Kong	M	40-50	Decreased a little
10	Grocery	1	(C), Fujian,	F	40-50	Decreased a lot
11	Traditional Chinese Medicine	1	Hong Kong	M	45-55	Decreased a little
12	Accountancy	7	Hong Kong	M	55-65	Stayed the same
13	Photography	3	Hong Kong	M	45-55	Decreased a lot
14	Restaurant	6	Britain	M	35-45	Decreased a little
15	Food Wholesale and retail	25	(C)	F	25-35	Increased a lot
16	Pharmaceutical	8	Hong Kong	M	35-45	Increased a lot
17	Dentistry	8	Hong Kong	M	40-50	Decreased a little

*C: China