CHAPTER 5

Sickness Presenteeism and Attendance Pressure Factors: Implications for Practice

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Failure to report for work as scheduled, or absenteeism, has been a research topic since the 1920s (Johns, 2008b). Scholars from various fields have been interested in identifying the causes for this behaviour and its organizational and individual consequences. Absenteeism as a behavioural pattern has been studied by scholars from multiple disciplines such as sociology, economics, law, psychology, industrial relations and medicine (Johns, 2008a). More recently, sickness presenteeism has become an increasingly popular theme. The term was first coined by Cary Cooper in the 1990s to describe the growing propensity of workers who spent long hours in the workplace when they feared for their job (Chapman, 2005). Since then, many other definitions of sickness presenteeism have been developed and the term has been used inconsistently in the scientific literature. Although, the term seems to be increasingly popular, the concept is used in various ways and etiological knowledge is still scarce. In the present chapter, we review the literature to explore how the term has been used, its consequences, and the determinants which have been found to influence it. The implications for health promotion and occupational health programmes are discussed.
5.1 DEFINING SICKNESS PRESENTEEISM

The definition given by Cooper describes the behaviour of workers who perceive their job to be in jeopardy. Although the association between job insecurity, absenteeism and presenteeism is quite complex and will be discussed later, Cooper’s conceptualization of presenteeism implied that presenteeism was a behaviour determined by specific determinants (i.e. long-working hours culture and a context of uncertainty). This tendency to stay at work longer than required to display visible commitment is what Simpson (1998) calls ‘competitive presenteeism’, where people compete on who will stay in the office the longest. Research has documented that organizational culture plays an important role in shaping the decision as to whether or not a person will come to work while ill (Nicolson & Johns, 1985). For example, McKevitt et al. (1997) found that even though high levels of occupational stress can lead to increased rates of absence, economic uncertainty and organizational culture can foster presenteeism and induce artificially low absence rates. Dew, Keefe and Small (2005), in a study based on focus groups and interviews, also illustrated how economic and social constraints as well as workplace cultures influence how presenteeism is rationalized by workers from different occupational groups. These studies are also conceptualizing presenteeism as a behaviour which is influenced by a variety of factors. This is in line with the definition given by Aronsson, Gustafsson and Dallner (2000), for whom presenteeism refers to ‘the phenomenon of people, who despite complaints and ill health that should prompt rest and absence from work, are still turning up at their jobs’ (p. 503).

In much of the existing literature, presenteeism is not conceptualized as behaviour but as the associated costs it represents in terms of productivity losses. For example, the American College of Occupational and Environmental Medicine defines presenteeism as ‘the measurable extent to which health symptoms, conditions and diseases adversely affect the productivity of individuals who choose to remain at work when ill’ (Chapman, 2005, p. 2). However, productivity loss and cutback days are in fact consequences of people’s decision to turn up to work despite their ill health. Given that absenteeism is generally considered as behaviour, considering both absenteeism and presenteeism behaviours which lead to costly consequences is conceptually more consistent. For the purpose of consistency with absenteeism research, the behavioural definition of presenteeism is here used to refer to people who work through illness.

As far as measurement of the consequences of presenteeism, many different instruments of productivity loss engendered by it have been developed and validated. They generally measure either the number of cutback days (number of days where usual tasks were impaired by a health condition) (Lim,
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Sanderson & Andrews, 2000), or the extent to which the quality or quantity of work was affected in general or in terms of specific tasks which cannot be performed due to the health impairment (Turpin et al., 2004). For example, Loepkke (2006) mentions injury rates, product waste, unsatisfactory work culture as consequences of health-productivity losses. Reduced work output, errors, failure to meet company production standards are all measurable consequences of presenteeism. Sometimes, researchers have considered presenteeism as the absence of sick leave in persons with health conditions (Kivimäki et al., 2005; McKevitt et al., 1997). It is useful to distinguish between sickness presenteeism and people who are what may be called long-term healthy. Aronsson and Lindh (2004) have defined them as people who haven’t been away from work for more than five days during a two-year period. Even though it is rare, there are people who are very rarely away from work. Most of us are present at work and require a few days of illness each year due to minor and temporary ailments. Existing instruments and their specific strengths and limitations have been reviewed (Lofland, Pizzi & Frick, 2004; Prasad et al., 2004).

5.2 CONSEQUENCES OF PRESENTEEISM AND ABSENTEEISM

The vast majority of research on the consequences of presenteeism has been concentrated on the financial costs it represents for organizations. The costs of lost productivity can be measured by considering absenteeism (short and long term and workers’ compensation), but this only provides a partial indication of the total costs (Burton et al., 1999; Edington & Burton, 2003; Schultz, 2007). The costs resulting from absenteeism are diversified but include direct costs (e.g. insurance premiums so that the employees’ wage is covered during the disability period) and indirect costs (e.g. overtime for colleagues, training the replacement worker including the lost productive time this involves) (Brun, 2008). Few studies have shown that productivity losses associated with workers whose health problems have not necessarily led to absenteeism are much higher than those associated with absenteeism. For example, the Sainsbury Centre for Mental Health in the UK estimates that the cost of presenteeism could be 1.8 times the cost of absenteeism (Cooper & Dewe, 2008). In the USA, Stewart et al. (2003) showed that the costs of lost productive time could be up to three times the costs of absence-related productivity loss. Sickness presenteeism also seems to be a prevalent phenomenon. Hansen and Anderson (2008) conducted a cross-sectional study with a sample of 12,935 people in Denmark’s workforce and found that 70% of the workforce went to work whilst suffering from ill
health at least once over the past 12 months. Other studies have also reported such high rates (Aronsson et al., 2000; Biron, Brun & Ivers, 2006; Caverley, Cunningham & MacGregor, 2007).

Aronsson and Gustafsson (2005) highlight the gap in research on the relationship between sickness presenteeism and health. Other than research on the financial costs, there is a striking scarcity of studies evaluating the effects of presenteeism on workers’ health and well-being (Johns, 2008b). Some evidence of negative consequences of working through illness is offered by Kivimäki et al. (2005). Their study showed 17% of unhealthy employees took no absence during the three-year duration of the follow-up period. Their incidence of serious coronary events was twice as high as unhealthy employees who showed moderate levels of sickness absenteeism. A recent research by Bergström et al. (2009) also suggests that the sickness presentees of today are the absentees of the future. This prospective research used public and private sector data (surveys and employers’ register) with an overall sample of 6,242 employees. The results showed that employees who had more than five days of sickness presence during the baseline year had significantly higher risk of reporting more than 30 days of sick leave at follow-up measures (18-months and three years later). This risk was still significant after adjusting for several confounding variables. Hansen and Andersen (2008) reported that certain risks factors such as ‘insufficient time and resources’ not only lead to increased spells of presenteeism, but also to higher levels of musculoskeletal pain, spells of sickness absence and probability of suffering from chronic illness. Given the scarcity of research on presenteeism, it is difficult to say whether on a long-term basis, working despite illness bears certain negative health consequences. As Johns (2008b) points out, being ill, perceiving oneself as ill, and deciding to attend work or not are rather loosely coupled phenomena. Moreover, the impact of presenteeism on the workplace, colleagues and customers has not been studied yet. Since job performance and productivity are hindered by various types of illness, it is likely that presenteeism can be disruptive for colleagues who might have to compensate for the lost productive time.

Another area which has been left out in research is the possible positive effects of maintaining the employment relationship in cases where the health impairment is benign. For example, Sanderson et al. (2008) recently underlined the possibility that when the psychosocial work environment is healthy, maintaining the employment relationship could prove to be a healthy strategy, particularly in the case of people with mental illness. Indeed, in a prospective study in 10 call centres, adverse psychosocial work environments were associated with worse mental health and
lower productivity from presenteeism. Presenteeism at baseline increased the risk for subsequent mental health problems, but there was some evidence that this association was only significant in the presence of an adverse work environment. In that sense, presenteeism could have either positive or negative consequences on workers and organizations. For example, employees with mental health problems who are exposed to a positive psychosocial work environment could find the routine provided by work and a supportive climate to be helpful even though their productivity is impaired while on the job with a mental illness.

As specified by Johns (2008b), although it seems surprising that presenteeism could be positive for well-being, working on less demanding tasks or with a lowered output still prevents the accumulation of work engendered by an absence, therefore making the return to work less abrupt. This notion of adjusting the tasks to help workers with minor ailments is in line with Johansson and Lundberg’s (2004) concept of adjustment latitude. In a study of almost 5000 participants, they found that women with low adjustment latitude had higher rates of absenteeism. Adjustment latitude was defined as the ‘opportunities people have to reduce or in other ways alter their work effort when feeling ill’. Johansson and Lundberg measured it with a single item and found some evidence (for women only) that not having the possibility to adjust one’s work when ill increases the risk of absenteeism. Research should be conducted to explore how employers can offer flexible work arrangements to workers and on which health conditions these adjustments can be applied in order to promote health and not undermine it. Adapting the work environment and the work tasks in order to help the worker recover from certain minor illness without having to take sick leave could bear positive effects for both the worker and the employer. Not all health impairments would benefit from a maintained link with the workplace (e.g. not severe, acute or infectious health disorders) but this seems like a promising avenue which should be investigated further.

The amount of evidence showing the impacts that absenteeism can have is more substantial compared to presenteeism. It seems obvious that absenteeism helps in the recovery of workers with a severe illness. A common perception about absenteeism is that it helps workers to cope with high levels of work and non work-related stress. Since many studies have shown an association between psychological distress and absenteeism (e.g. Hardy, Woods & Wall, 2003; Johns & Xie, 1998), and between exposure to adverse psychosocial work environment and absenteeism (North et al., 1996), it would seem plausible that a reversed causal relationship would exist. However, so far there is not that much support to show that being absent from work actually reduces distress levels. If this was to be the case, there would
be important implications for organizations that use strict control measures to diminish absenteeism since it could unintentionally increase workers’ distress and thus result in decreased performance (Hardy et al., 2003). Hacket and Bycio (1996) conducted a study with a small sample of nurses (N = 20) to evaluate if absenteeism can serve to restore high levels of emotional and physical fatigue. They collected self-reports of personal problems, tiredness, ill health, sleep disruption, stress and job dissatisfaction on a daily basis during four to five months, and then compared them before, during and after the absence. Their results demonstrate that a spell of absence might not serve as a coping mechanism which results in the reduction of strain, but as a maintenance function which helps employees regain some control over their doldrums and maintain stress-related symptoms at a manageable level. Kristensen (1991) also highlights the possibility that absence might serve as an individual coping strategy, in the sense that it might help workers cope with adverse work environments.

Although occasional and impromptu absenteeism possibly serves as a coping mechanism, it is unknown what the optimal level of absenteeism would be from a health perspective. On the other hand, however, there is evidence showing that absenteeism is not only costly for organizations but also for individuals. Indeed, evidence reviewed by Johns (2001) supports the notion of a withdrawal continuum where being late for work precedes absence, which in return precedes turnover. Moreover, absenteeism is often viewed as a negative and deviant behaviour, which can explain why most people tend to underreport absenteeism and overestimate their attendance record (Johns, 1994). Being absent from work with negative perceptions from the supervisor (Bycio, 1982) can be quite disruptive for teamwork (Grinyer & Singleton, 2000). Certified sickness absence has also been used as a measure of health status (Marmot et al., 1995), and as a predictor of mortality among male and female employees (Vahtera, Pentti & Kivimäki, 2004). This, however, quite possibly reflects the effects of outliers (people who are very sick and show high levels of absenteeism) (Johns, 2008b). Martocchio and Jimeno (2003) propose a model where absenteeism could have positive and negative effects depending on the affective experience associated with it. Depending on their personality, some people might be more likely to feel recharged and be less stressed and more productive upon returning to work. Other personality characteristics such as neuroticism might instead bring one to make the decision to take time off work hastily and impulsively, and then be stressed and fearful about work being piled up upon return. Although these propositions remain to be tested, Martocchio and Jimeno’s model suggest absenteeism could be either functional or dysfunctional and have differential consequences on individuals. In sum, the decision to be absent or present at work when ill is a personal decision and it is possible that both positive...
and negative outcomes will result from that decision. There are many factors other than illness and disease which influence that judgement call.

5.3 PREDICTORS OF SICKNESS PRESENTEEISM

5.3.1 Attendance Pressure Factors

Attendance pressure factors are variables which pressurize people into work despite their health condition (Saksvik, 1996). They can be grouped into (at least) three main categories: (i) personal/family and situational circumstances; (ii) dispositional and attitudinal factors; and (iii) work-related factors. It seems important here to distinguish between positive factors that trigger workers to choose work because it truly is perceived as the best option, and factors that trigger attendance pressure. Attendance pressure factors are not salutogenic and exclude the notion of flexibility from the part of the employer in order to accommodate the worker to accomplish the job with lowered productivity given the illness or ailment. As the following theoretical review will show, there is a delicate balancing act between these factors in the workplace that stimulate workers to come to work and yet don’t result in negative health.

Personal and situational circumstances can influence sickness presenteeism. For example, workers with children or in situations where home is more taxing than work, employees with poorer health status, workers who had higher number of days of sickness absence in the past year, part-time and lower-wage workers tend to show higher rates of presenteeism (Aronsson & Gustafsson, 2005; Aronsson et al., 2000; Biron et al., 2006; Burton et al., 2006; Burton et al., 2005; Hansen & Andersen, 2008). Dispositional factors such as boundaryless people (who can’t say no) or over-committed workers, or having a conservative attitude towards absenteeism can also increase people’s tendency to work through illness (Aronsson & Gustafsson, 2005; Hansen & Andersen, 2008). Occupational status can also predict higher rates of presenteeism. Aronsson et al. (2000) found that workers in the education sector and in the care and welfare sector had the highest presenteeism rates. Members of these occupational sectors require the provision of care to other people and have a higher tendency to work through illness (Elstad & Vabo, 2008). In line with this, McKevitt et al. (1997) found that medical doctors and company fee earners had very low absenteeism rates but these were artificially induced since over 80% of all respondents had worked through illness. These occupations require that the worker is present in the workplace and that tasks cannot be performed from some other location. However, for knowledge workers, increased sophistication in information and
Communication technology reduces the need to work from a traditional office (O’Driscoll, Biron & Cooper, in press). Mobile technology means people can now be performing tasks from anywhere, including a train journey, home or an airport (Harrison, Wheeler & Whitehead, 2004). This has considerable implications on how presenteeism is defined and measured, and on how it affects health and well-being.

The is growing evidence showing that characteristics of the psychosocial work environment are not only closely related to job stress and absenteeism, but are also significant attendance pressure factors. Insufficient time and resources, excessive workload, difficulties to be replaced and role conflict have been consistently related with increases in sickness presenteeism (Aronsson & Gustafsson, 2005; Biron et al., 2006; Elstad & Vabo, 2008; Hansen & Andersen, 2008). Thus, in organizational settings characterized by lean production and understaffing, presenteeism is quite likely to be high. Job control, in traditional stress models (Karasek, 1979; Karasek & Theorell, 1990), is considered a positive work characteristic, since it decreases the risk of physical and mental illness when job demands are high. Higher control is generally associated with lower risks of absenteeism (Bond, Flaxman & Loivette, 2006; Nielsen et al., 2004) but also with lower presenteeism rates (Aronsson & Gustafsson, 2005). Indeed, workers who have high job control are likely to be able to adjust the type of tasks and the working pace which can help them get through a day of illness at work. Skill discretion has also been found to be a significant determinant of presenteeism. This is in line with the possibility to be replaced. Indeed, it is likely that highly skilled people cannot find co-workers to accomplish their tasks if they are ill, and must therefore catch up on their workload on their return.

The way attendance pressure factors affect groups and individuals can also vary according to individual characteristics. Saksvik (1996) measured attendance pressure, job satisfaction, absenteeism and intentions to quit before and after a major restructuration in a large public organization (N = 401, N = 301). The results of a factor analysis showed there were four types of attendance pressure factors: importance pressure, censure pressure, moral pressure and security pressure. Importance pressure concerns issues like having a lot of responsibility at work, difficulties in obtaining temporary staff etc.; censure pressure is about ‘hearing it’ from the management or colleagues and being accused of shirking if away from work; moral pressure refers to one’s own conscience while security pressure concerns fear of losing one’s job unless present at work. Results suggest that low moral pressure and high censure pressure significantly predicted sickness absenteeism. The study indicated that employees who were absent during the reorganization period could be characterized as ‘vulnerable’, in the sense of having low
job satisfaction, low personal work ethics with significant health problems. For practice, this suggests that adding more censure pressure, for example by implementing tighter control on absenteeism patterns, might worsen the situation.

Aronsson and Gustafsson (2005) formulated a model which can be tested in future studies. The model suggests that illness and loss of capacity are the strongest and most direct factors regarding both sickness presenteeism and sickness absenteeism. Sickness presenteeism and sickness absenteeism are mutual options when people are sick; and personal, work-related and dispositional factors will influence the individual’s decision. The researchers further point out that there is a difference between positive and negative attendance factors. Negative attendance pressure factors can be conceptualized as ‘double risk’ since they constitute a risk for health (e.g. time pressure, overload, low job control), and influence people’s decision to come to work while ill. Poorer health can lead to higher frequency of having to choose between being present and absent from work. Positive attendance factors, however, are salutogenic factors which influence people’s decision to come to work regardless of their health condition. It is worth mentioning that Kristensen (1991) distinguishes between positive and negative attendance and absence factors, however, the distinction between the pressure factors and the stimulating, positive factors in relation to attendance is not so clear. Kristensen highlights interesting and stimulating work, high job satisfaction, rewards for low absence frequency and a good conscience. We believe that the last two factors are included in what we call attendance pressure factors. According to Kristensen, negative attendance factors include a high risk of getting fired and a strict control over absence from work, which, in our understanding, also constitutes attendance pressure factors. He also importantly points out that there are factors outside of work which can also contribute, and that interesting spare-time activities can be a positive absence factor.

5.3.2 Salutogenic Factors

Aronsson and Lindh (2004) highlight that research has been largely focused on bad health and how bad health occurs at the workplace. There has been far less focus on trying to define and operationalize health and to generate knowledge about health-promoting conditions in the workplace. Aronsson and Lindh have analysed both sickness presenteeism and long-term health, mainly derived from an analysis of the working conditions of the people ending up in these categories. Long-term health was defined as a combination of low sickness absenteeism and low sickness presenteeism over a period of
two years. A total of 28% of the sample was hailed as long-term healthy. Regarding conditions in the workplace, the largest differences in percent (without controlling for other variables) between those who were long-term healthy and those who weren’t, were found in the variable ‘the possibility of receiving support from supervisor when the job feels difficult’. Among the workers who received support from their supervisor 42% belonged to the group long-term healthy. Large differences were also found regarding qualitative aspects of the work. Resources enabling people to a good job, being happy with the quality of their work, having the possibility to control their own work pace, and not being confronted with irreconcilable demands were also found to be important factors in long-term healthiness.

Managerial leadership has also been found to be a strong determinant of both illness and wellness. A study looking into the leader’s significance with regards to good health has been conducted by Dellve, Skagert and Vilhelmsson (2007). This prospective study looked at how leadership qualities and strategies may act as key processes in the implementation of workplace health promotion. The study measured the effects of leaders on long-term presence at work. Long-term presence was defined as employees who had taken none or a maximum of seven days of sickness absence during the last year. The results showed that leaders who had clearly defined targets, and made use of rewards, recognition, and respect had higher prevalence of employee attendance. The leaders’ attitudes towards and view of the employees’ health was also important for implementation of interventions promoting health in the workplace. Multi-focused strategies had the greatest effect on workplace presence. Strategies that focus solely on either strengthening the individual or organizational resources were not related to an increase in long-term workplace presence. Along the same line, Nyberg et al. (2008), in a prospective study including just over 3000 Swedish males, showed that managers’ consideration for employees, provision of clarity in roles and expectations, supplying information, promotion of employees’ control and ability to carry out changes in a healthy way lowered the incidence of ischemic heart diseases. This is in line with other studies showing that the importance of managers’ behaviours such as the capacity to manage changes in a healthy way (Saksvik et al., 2007) and treating employees fairly (Kivimäki et al., 2008; Vogli et al., 2007), are essential in order for the job to be a positive factor for employees’ health and well-being.

High social support from colleagues was found to increase presenteeism (Hansen & Andersen, 2008). Similarly, Biron et al. (2006) found a significant interaction between the number of sick days, the quality of relationship with colleagues and presenteeism propensity. Workers with good relationships and who reported a small number of sick days had a higher tendency to work through illness compared to workers with a higher number of sick days.
Caverley et al. (2007) also found that trust in colleagues and supervisor’s support was positively associated with presenteeism.

Along the same line, Lindberg et al. (2006) have conducted an epidemiological study (N = 5638) trying to identify factors promoting excellent work ability and factors preventing poor work ability (based on sick leave at 18-month follow-up). The results showed promoting excellent work ability seemed to be more dependent on factors such as not having a physically demanding job, having a good work position, having clarity of goals, expectations and responsibilities, and having a superior who appreciates work performance. Preventing poor work ability seemed to be more dependent on job security and psychosocial factors such as mastering the job and having a certain degree of decision making. The results also showed that lifestyle factors such as physical activity, even just once a week, being fully rested when starting work, and having energy throughout the working day was associated with excellent work ability. Although some factors predicted both poor and excellent ability to work, different patterns of factors predicting excellent and poor work ability were found and most of them were factors which can be influenced. This has important implications since it ‘opens up the possibility of interventions for promoting excellent work ability and preventing poor work ability’ (Lindberg et al., 2006, p. 120). This is an important issue because traditionally occupational health and safety programmes focus on reducing the exposure to physical and psychosocial risks with a view to improving employees’ health, whereas worksite health promotion programmes tend to address individual risk factors. In this sense, promoting wellness and preventing illness should not be viewed as mutually exclusive but as an integrated holistic approach (Gibbs & Burnett, forthcoming). Furthermore, evidence suggests that successful programmes are comprehensive and include both preventive and promotive factors (Giga et al., 2003a; Giga et al., 2003b; Lamontagne et al., 2007). As summarized in Table 5.1, the evidence gathered so far illustrates some of the salutogenic and attendance factors which have been found to increase the tendency to work while ill. Salutogenic factors have a positive impact on health, whereas some of the attendance pressures (e.g. psychosocial risks at work) have been found to be a double risk and increase both sickness presenteeism and probability of ill health. Finding the right balance between optimal levels of presenteeism and absenteeism, from a well-being perspective, is a challenge.

### 5.4 IMPLICATIONS FOR PRACTICE

The following section will explore implications for organizational actions. A particular stance towards interventions implying stress and the psychosocial
### Table 5.1  Determinants of presenteeism

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<thead>
<tr>
<th>Factors contributing to well-being</th>
<th>Work-related</th>
<th>Attitudinal/Dispositional</th>
<th>Situational</th>
</tr>
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<tbody>
<tr>
<td>Job satisfaction</td>
<td>Professionalism</td>
<td>High standard of the professional health and safety system</td>
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<tr>
<td>Good leadership</td>
<td>Training/educated for multiple work tasks</td>
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<tr>
<td>Group cohesiveness</td>
<td>Hardiness</td>
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<tr>
<td>Quality of relationship with colleagues</td>
<td>Interest derived from work</td>
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<tr>
<td>Flexibility in work arrangements</td>
<td>Physical activity/training</td>
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<td>The possibility to do less demanding work tasks for a period</td>
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<tr>
<td>Attendance pressure factors</td>
<td>Workload</td>
<td>Guilt and moral pressure factors</td>
<td>Financial insecurity</td>
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<tr>
<td>Job (in)security (evidence for both)</td>
<td>Perceived seriousness of the ailment</td>
<td>Severe mental/physical illness</td>
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<td>Censure pressure (fear of being perceived as shirking)</td>
<td>Conservative attitude</td>
<td>Caring for sick family member</td>
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<td>Clientele awaiting</td>
<td>Fear of negative repercussions at work</td>
<td>Being self-employed</td>
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<td>Difficulty of replacement</td>
<td>Over-committed/ boundaryless traits</td>
<td>Working in small firm</td>
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<td>Role conflict</td>
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<td>Job control</td>
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<td>Low absenteeism reward system</td>
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</table>

Work environment is undertaken. This approach is favoured given that stress, depression and anxiety account for 46% of all reported illnesses according to a recent report by the Health & Safety Executive in the UK (Cooper and Dewe, 2008). In our understanding, the emphasis for organizations should be to focus on the prevention of working conditions which undermine the physical and mental health of employees (primary prevention), and the reduction of symptoms and illnesses (secondary and tertiary prevention). A recent systematic review by Lamontagne et al. (2007) has shown that intervention programmes which are more comprehensive (i.e. including primary, secondary and tertiary levels of prevention) are more effective and have stronger effects on the intended outcomes. Individual-focused interventions tended to favourably affect individual-level outcomes (such as somatic...
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symptoms, physiological changes (e.g., blood pressure, cholesterol levels), skills (e.g., coping ability) and psychological outcomes (e.g., general mental health, anxiety). However, only more encompassing programmes (including more organizationally focused interventions) tended to be beneficial for both individual and organizational outcomes such as sickness absenteeism. Dame Carol Black, author of the *Working for a Healthier Tomorrow* report presented to the UK government in March 2008, states that

Good health improves an individual’s quality of life, and a focus on their well-being can also add value to organizations by promoting better health and increasing motivation and engagement of employees, in turn helping to drive increases in productivity and profitability. In other words the benefits of health and well-being extend far beyond avoiding or reducing the costs of absence or poor performance. But this requires a changed perception of health and well-being, and a willingness from both employers and employees to invest resources and change behaviour (Black, 2008, p. 51).

On the one hand, it would seem common sense that working while ill would not allow a chance of recovering to full health. Of course, the particular ailment which affects the individual (benign or severe, acute or chronic) must be taken into consideration. Studies have shown that productivity losses vary according to the specific type of ailment (Burton *et al.*, 2006; Burton *et al.*, 1999, Burton *et al.*, 2004). It is plausible that certain conditions necessitate rest and absenteeism from work until full recovery whereas other chronic conditions have a very slight probability of never being completely restored. In these cases where the ailment is benign and not sufficient to justify an absence from work, productivity losses could be reduced by adjusting certain aspects of the workplace. Although there is convincing evidence on the negative consequences of a pathogenic psychosocial work environment, there is also, however, compelling evidence that work is good for us. Indeed, work can have a beneficial impact on people’s physical and mental health, development of identity and sense of self-worth. For example, the recent review, *Is Work Good for Your Health and Well-Being?* by Waddell and Burton (2006), concluded that good and safe work was generally beneficial for both physical and mental well-being and outweighed the negative effects of being without work or of prolonged sickness absence. Caverley *et al.* (2007) investigated the relationship between sickness presenteeism, sickness absenteeism, and employee health. They particularly wanted to investigate to what extent the employees replaced sickness absenteeism with sickness presenteeism. The results indicated that the workforce was of average health, but that sickness absenteeism in the organization was less than half of the national average, and this difference could be explained by sickness presenteeism. The average number of days that employees were
attending work when they were ill or injured was actually higher than the number of days of sick leave. This result supported the assumption that the employees substituted sickness absenteeism by sickness presenteeism also. The sickness presenteeism also correlated significantly with a reduction of work-related factors like job security, supervisor support and job satisfaction. This means that a reduction in these factors increased attendance pressure among employees. It may also be that high job security, supervisor support and job satisfaction are important factors concerning interventions in order to get sickness absentees back to work without worsening their health. According to Caverley et al. (2007) sickness presenteeism seems to be more strongly associated with health than sickness absenteeism, which indicates that the effort being done to improve workplace health may have a more immediate effect on sickness presenteeism than on sickness absenteeism.

A study by Burton et al. (2004) illustrates the significance of individual adjustments for sickness presentees. This study was done in order to compare patterns and severities of self-reported reduction of productivity with different medical conditions. It was assumed that each of the different medical conditions that were included would affect the four areas of workplace performance in different ways, and the results indicate that this was the case. Burton et al. (2004) point out that worksite interventions aimed at helping employees to handle their medical condition (disease management programmes) should be tailored to the specific medical condition. The study showed that the group that suffered from depression rate themselves as most impaired in the work domain of mental/interpersonal functioning (concentration and teamwork). The results from this study indicate that employees with different medical conditions could benefit from different individual interventions in order to function in their work.

Along with efforts in risk prevention, health promotion and disease management, organizations have to consider the importance of return to work programmes after prolonged sick leaves. According to St-Arnaud (2007), workers who indicate that work was the major cause of their absence have much less chance of a successful return to the workplace. Moreover, almost 44% of workers who had returned to their job considered that they still had a mental health problem which had not been resolved during the absence. This has important implications in terms of sickness presenteeism. Furthermore, the study showed that psychosocial risks, which contributed to the absence, are also contributing to the reintegration process and to the improvement of mental health problems and, thus, to job retention. This type of results calls for early detection of workers who develop ill health and supports comprehensive and holistic approaches to health and well-being. Table 5.2 illustrates some examples of interventions which can be applied for a whole
Table 5.2 Examples of interventions

<table>
<thead>
<tr>
<th>Primary prevention</th>
<th>Secondary/tertiary prevention (reduce the consequences of the stress factor)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Corporate actions</strong> (affecting all staff members or a particular job class)</td>
<td>Reorganize the line of authority to allow job control</td>
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<tr>
<td></td>
<td>Fairer reward system which doesn’t encourage undue sickness presenteeism</td>
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<td></td>
<td>Training to improve management skills and managerial leadership</td>
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<td></td>
<td>Improve physical and environmental constraints</td>
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<td></td>
<td>Work–family conciliation policy</td>
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<td></td>
<td>Flexitime</td>
</tr>
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<td></td>
<td>Allowing telework</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Local actions (affecting staff in a particular sector / department or in a work team)</th>
<th>Changes in task organization</th>
<th>Allowing individuals to adjust their tasks and pace if ill</th>
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<tbody>
<tr>
<td></td>
<td>Ensuring clear roles</td>
<td>Working hours adapted to particular cases</td>
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<td></td>
<td>Constructive retrospective action concerning staff performance</td>
<td>Resolving interpersonal conflicts</td>
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<td></td>
<td>Co-development/team cohesion building programmes</td>
<td>Taking into account the psychosocial work environment when planning return to work</td>
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<td></td>
<td>Staff training in various tasks/equipment to diminish disruption during absence and allow adjustment for sickness presentees</td>
<td></td>
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<tr>
<td></td>
<td>Reorganizing a unit’s working hours</td>
<td></td>
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<td></td>
<td>Task rotation</td>
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<tr>
<td></td>
<td>Training with a view to improving the atmosphere in the work team</td>
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</tr>
</tbody>
</table>

*Sources: Adapted from Brun et al., 2008; Jordan et al., 2003 and Kompier and Marcelissen, 1990.*
organization or locally within teams and units, for each level of prevention (primary, secondary and tertiary).

In conclusion, sickness presenteeism is a frequent phenomenon, and low levels of absence can often imply higher levels of presenteeism. The two phenomena should therefore be studied together since they appear to be two sides of the same coin. Psychosocial risks in the workplace have been found to impair mental and physical health, increase absenteeism, and recent research has shown they are also determinants of higher presenteeism rates. Organizations should prioritize the reduction of psychosocial risks and other attendance pressure factors since they increase sickness attendance and impair health. On the other hand, there are aspects of work which can be salutogenic to health. Given the negative consequences of prolonged absence and the high costs of productivity losses engendered by workers with health impairments, employers should put resources into interventions which will help keeping people healthy and well. Promoting positive health must not, however, be strictly focused on improving individuals’ health and thus exclude the prevention and reduction of all the work-related risk factors which are known to cause ill health. Health promotion and occupational health programmes should be comprehensive and include prevention of ill health, promotion of health, organization-, work- and worker-oriented strategies.

REFERENCES


