

Self-reported job insecurity and health in the Whitehall II study: potential explanations of the relationship

Jane E. Ferrie^{a,*}, Martin J. Shipley^a, Katherine Newman^b,
Stephen A. Stansfeld^c, Michael Marmot^a

^a*International Centre for Health and Society and Department of Epidemiology and Public Health, University College London Medical School, 1-19 Torrington Place, London WC1E 6BT, UK*

^b*Department of Public Policy, Kennedy School of Government, Harvard University, UK*

^c*Department of Psychiatry, Queen Mary University of London, UK*

Available online 30 November 2004

Abstract

This paper examines the potential of demographic, personal, material and behavioural characteristics, other psychosocial features of the work environment and job satisfaction to explain associations between self-reported job insecurity and health in a longitudinal study of British white-collar civil servants. Strong associations were found between self-reported job insecurity and both poor self-rated health and minor psychiatric morbidity. After adjustment for age, employment grade and health during a prior phase of secure employment, pessimism, heightened vigilance, primary deprivation, financial security, social support and job satisfaction explained 68% of the association between job insecurity and self-rated health in women, and 36% in men. With the addition of job control, these factors explained 60% of the association between job insecurity and minor psychiatric morbidity, and just over 80% of the association with depression in both sexes.

© 2004 Published by Elsevier Ltd.

Keywords: Job insecurity; Health; Whitehall II study; UK

Introduction

Most studies that have examined the effects of self-reported job insecurity on health have documented consistent adverse effects on measures of psychological morbidity. Evidence of adverse effects of self-reported job insecurity on other measures of morbidity is starting to accumulate, with reasonably consistent results being obtained for a number of health outcomes in both cross-sectional and longitudinal studies (Platt, Pavis, &

Akram, 1998; De Witte, 1999; Ferrie, 2001; Amick III et al., 1998). However, while evidence of the adverse effects of self-reported job insecurity on self-reported mental and physical morbidity is beginning to accumulate, work examining potential explanations of the association between job insecurity and health remains patchy (Platt et al., 1998; Kivimaki, Vahtera, Pennti, & Ferrie, 2000a; McDonough, 2000).

Previous work in the Whitehall II study of British civil servants has shown self-reported job insecurity to be associated with poor self-rated health and minor psychiatric morbidity (Ferrie, Shipley, Stansfeld, & Marmot, 2002). A series of qualitative interviews with 38 British civil servants, whose current job was insecure, indicated a range of potential explanations of the job

*Corresponding author. Tel.: +0171-504-5643; fax: +0207-813-0288.

E-mail address: j.ferrie@public-health.ucl.ac.uk (J.E. Ferrie).

insecurity–health relationship (Marmot, Ferrie, Newman, & Stansfeld, 2001). These included: demographic, personal, material and behavioural characteristics, other psychosocial features of the work environment and job satisfaction. The aim of this paper is to examine the potential of these factors to explain associations between self-reported job insecurity and health.

Methods

Whitehall II study

The target population for the Whitehall II study was all London-based office staff, aged 35–55, working in 20 Civil Service departments. With a response rate of 73%, the final cohort consisted of 10,308: 6895 men and 3413 women (Marmot et al., 1991). The true response rate is higher, however, because around 4% of those invited were not eligible for inclusion. Although mostly white-collar, respondents covered a wide range of grades from office support to permanent secretary.

Baseline screening (Phase 1) took place between late 1985 and early 1988. This involved a clinical examination and a self-administered questionnaire containing sections on demographic characteristics, health, lifestyle factors, work characteristics, social support, job satisfaction, life events and chronic difficulties. Successive phases of the study have alternated between collecting data by self-administered questionnaire only and collecting data via a clinical screening in addition to questionnaire completion. The most recent phase of data collection to include a clinical screening was completed between 1997 and 1999, Phase 5. Additional questions at Phase 5 collected detailed data on education, income, wealth, material deprivation and personal characteristics.

Measures

Job insecurity: Self-reported job insecurity was measured among participants still in paid employment at Phase 5 using the single item ‘How secure do you feel in your present job?’. Four response categories ranged from very insecure to very secure.

Health outcomes: Self-reported health outcomes from the Phase 1 and 5 questionnaires include: self-rated health over the past 12 months (average, poor or very poor versus good or very good), presence of long-standing illness and minor psychiatric morbidity. The latter, assessed using the 30-item general health questionnaire (GHQ) (Goldberg, 1972), comprised GHQ total score and a subscale of the GHQ measuring depressive symptoms. For the GHQ total score each GHQ question, which asked about ‘the past few weeks’, was scored (0,0,1,1) and summed for analysis (Goldberg,

1972). The depression subscale was measured by four items derived by factor analysis. The four depressive symptom items loaded onto a single component in both sexes, (Stansfeld, Head, & Marmot, 1998) and comprised ‘thinking of yourself as a worthless person’, ‘felt life is entirely hopeless’, ‘felt life is not worth living’, ‘found at times you could not do anything because your nerves were too bad’. For the depression subscale, the four items were scored on a Likert scale from 0 to 3 and summed for analysis. The depression subscale had an alpha coefficient of 0.88. Both the GHQ-30 and depressive symptoms were used as continuous scores.

Potential explanatory factors: The following factors from the Phase 5 questionnaire were examined for their potential to explain associations between self-reported job insecurity and health. **Sociodemographic factors:** Education was the highest qualification achieved at the time of questionnaire completion. Qualification categories were: no qualifications, ‘O’ level (exams usually taken at age 16), ‘A/S’ level, ONC/HND (exams usually taken at age 18, plus technical qualifications short of a degree), BA/BSc (first degree) and higher degree. Marital status was categorised as ‘married/co-habiting’, ‘single’, ‘divorced/separated’, and ‘widowed’. **Personal characteristics:** These included two subscales of the reactive responding scale: vigilance and emotional action. The vigilance scale measures the tendency of individuals to monitor the environment for threatening cues as a result of exposure to a high level of environmental demands coupled with urgency or danger. The emotional action scale measures the tendency to respond emotionally in demanding situations. In addition, a single item on optimism–pessimism, asking about expectations of positive or negative experiences over the next 5–10 years was included. This measure taps a dispositional dimension of hopelessness/negativity that has been shown to be a predictor of morbidity (Everson et al., 1996). **Psychosocial work environment:** Decision authority, skill discretion and job demands were adapted from the Job Content Instrument of Karasek (Karasek, 1979). Work social support comprised three components: support from colleagues, support from supervisors, and clarity and consistency of information from supervisors. Responses on a four-point scale from ‘often’ to ‘never/almost never’ were combined into summary scales and then divided into tertiles, high, moderate and low. A global measure of job satisfaction was obtained using eight items, each with four response categories. Responses were summed and divided into tertiles. **Material factors:** Primary deprivation was measured by summing responses to three questions, which asked about problems with housing, difficulties with the payment of bills, and how often the participant lacked sufficient money to afford the kind of food or clothing s/he or the family should have. Lack of access to common, desirable, but inessential items, such as a

Download English Version:

<https://daneshyari.com/en/article/10473272>

Download Persian Version:

<https://daneshyari.com/article/10473272>

[Daneshyari.com](https://daneshyari.com)