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Research report

Factors associated with presenteeism among employed Australian adults reporting lifetime major depression with 12-month symptoms

Fiona Cocker [a,*], Angela Martin [b], Jenn Scott [c], Alison Venn [a], Petr Otahal [a], Kristy Sanderson [a]

[a] Menzies Research Institute Tasmania, University of Tasmania, Australia
[b] School of Management, University of Tasmania, Australia
[c] School of Psychology, University of Tasmania, Australia

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ABSTRACT

Background: Employees experiencing depression can take a sickness absence or continue working ('presenteeism'). However, little is known about the factors associated with these behaviors within this population. This study aimed to determine the relative importance of socio-demographic, financial, work and health-related factors associated with presenteeism.
Methods: The 2007 Australian National Survey of Mental Health and Wellbeing provided data from employed individuals reporting lifetime major depression with 12-month symptoms (N = 320). Survey adjusted multivariable logistic regression assessed classification of 12-month, depression-related presenteeism on the basis of socio-demographic, financial, work and health factors.
Results: Acceptable classification of cases was 70% or greater. Classification of cases based on socio-demographic factors, age, sex and marital status, was reasonable (62%). Adding work factors (work hours and occupation type) produced a 1% increase in successfully classified cases (63%). Health factors further increased correctly classified cases (67%). Marital status, housing tenure and co-morbid mental disorders were important indicators of presenteeism behavior.
Limitations: Work-related variables were restricted to available measures. Potentially important psychosocial work environment factors were unavailable. Cross-sectional data precluded causal inference.
Conclusions: Using available factors, model discrimination did not reach an acceptable level i.e. 70% of presenteeism cases successfully classified. This highlighted the contribution of unmeasured factors to presenteeism behavior. Future research should explore the relative importance of psychosocial work environment and personality factors such as work demands, effort/reward imbalance and conscientiousness. The identified associations between socio-demographic, financial and health factors on work attendance behaviors could inform disease management guidelines for employers via recognition of employees at risk of presenteeism.
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1. Introduction

Depression is common in the working population. The 12-month prevalence of major depression was 5.8% and 6.4% among Australian and US workers respectively (Australian Bureau of Statistics, 2007a, 2007b; Kessler et al., 2006). Consequently, much of the economic consequences of major depression are borne by the workforce.

While actively engaged in the workforce, employed individuals experiencing depression can take a sickness absence or continue working when ill (presenteeism). Both are potentially costly due to declining productivity. Annual direct and indirect costs of depression-related work attendance behavior exceed $18.2 billion (USD), 15.1 billion UK pounds (Cox et al., 2010) and $12.6 billion Australian dollars (LaMontagne et al., 2010), and are attributable to work impairment, disability and lost

* Corresponding author at: Menzies Research Institute Tasmania, Private Bag 23, Hobart, 7000, Australia. Tel.: +61 3 6226 7761; fax: +61 3 6226 7705.
E-mail address: fcocker@utas.edu.au (F. Cocker).

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productive time (Stewart et al., 2003). Most studies measuring the economic impact of absenteeism and presenteeism report presenteeism creates the higher cost burden (Goetzel et al., 2004; Kessler et al., 1996; Kessler et al., 2006), accounting for 80% of costs alone (Stewart et al., 2003). Moreover, presenteeism costs are consistently higher than health care costs for most conditions, including depression (Goetzel et al., 2004). This is most likely due to the fact that individuals reporting depression often continue working and are more likely to do so than workers experiencing other chronic health conditions (Aronsson and Gustafsson, 2005; Collins et al., 2005; Sanderson et al., 2007; Stewart et al., 2003).

Absenteeism and presenteeism behavior has also negative health effects, although no study has explored these among employees reporting depression. Poorer general health has been observed among absenteeism reporters (Bergstrom et al., 2009a, 2009b), although Kivimaki (2005) found that presenteeism reporters had a 50% increase in incidence of coronary events compared to those who took time off, and an increased risk of long-term sickness absence. The latter finding is supported by the identified "health-protective" effect of small amounts of sick leave (Kivimaki et al., 2003). One explanation for these outcomes is that presenteeism leads to a build-up of stress and allostatic load (Bergstrom et al., 2009a, 2009b) when individuals do not take required recovery time (McEwen, 2000). Increased allostatic load has been associated with accelerated disease processes, unhealthy behaviors such as smoking and excess alcohol consumption (McEwen, 2008), and an increased risk of cardiovascular disease (McEwen, 2000). Sickness presenteeism may accentuate the strain an individual is experiencing and failure to manage an illness in its early stage may prompt a more severe disease and greater health and economic consequences.

Investigation of the health and economic consequences of depression-related absenteeism and presenteeism, and identification of work and non-work factors associated with these work attendance behaviors are necessary to better understand them and develop a profile of the individuals likely to engage in them. Organizational policies, health and life events (MacGregor et al., 2008), personal circumstances and attitudes have received attention regarding their ability to influence work attendance. However, presenteeism has been less studied compared to sickness absenteeism; fewer studies focus on the determinants of continued work attendance, despite its recognized impact.

Organizational factors and policies including the absence of sick leave (Johns, 2009), and casual or contingent employment, are associated with increased presenteeism (Virtanen et al., 2001) as are difficult to postpone tasks, time pressure, reliance on teamwork, and long hours (Aronsson et al., 2000; Bockerman and Laukkanen, 2010; Nicholson et al., 2006). Welfare, teaching occupations (Aronsson et al., 2000), or jobs with supervisory responsibilities are associated with higher rates of presenteeism, due to perceived duty to clients, colleagues, or students. Finally, attitudes towards absenteeism (Hansen and Andersen, 2008) and personality attributes such as conscientiousness, psychological hardiness and over-commitment (Bockerman and Laukkanen, 2009) influence work attendance behavior (Johns, 2009).

A recent systematic review (Lagerveld et al., 2010) identified 30 studies exploring factors associated with absenteeism and presenteeism among depressed workers and found the majority of studies reported on relationships with disorder-related factors. Personal or work-related factors were addressed less frequently, highlighting the need for more thorough investigation of the association between potentially modifiable factors within this population. Furthermore, no study has investigated the relative importance of socio-demographic, financial, work and health-related factors compared to other factors for presenteeism, or the degree to which depression-specific factors influence an employee's behavior. Understanding the relative association of work and non-work characteristics with work attendance behaviors may identify which factors may be amenable to change and/or intervention, potentially improving illness management through the development of informed practice guidelines. Workplace practices which support employees experiencing depression and provide access to evidenced-based care could improve workers' quality of life and reduce costs to employers associated with absenteeism, disability and lost productivity (LaMontagne et al., 2010).

Using data from a large national mental health survey, (2007 Australian National Survey of Mental Health and Wellbeing: NSMHWB), this study aimed to determine which factors are associated with depression-specific presenteeism and the relative importance of socio-demographic, financial, work and health-related factors. In doing so we hoped to develop a profile of individuals likely to continue working when sick so that workplace health promotion and intervention programs can be better targeted, and to make informed recommendations as to how these programs could improve the management of employees experiencing depression.

2. Methods

2.1. Sample

Cross sectional, population-based data (n = 8841) from the NSMHWB identified employed individuals reporting lifetime major depression, with symptoms in the past 12 months (N = 320) (Australian Bureau of Statistics, 2007a, 2007b).

2.2. Data

The 2007 NSMHWB is a stratified, random household survey conducted by the Australian Bureau of Statistics (ABS). It was designed to provide updated lifetime prevalence estimates of affective, anxiety, and substance abuse disorders within the Australian population, using the Composite International Diagnostic Interview (3.0) (Kessler et al., 2006). Twelve-month diagnoses were based on lifetime diagnosis and the presence of symptoms in the 12 months prior to the survey interview.

Information was collected about impairment and severity associated with common mental disorders and related service utilization, physical conditions, social networks and caregiving, demographic and socio-economic characteristics. A response rate of 60% was achieved, representing a projected Australian adult resident population of 16,015,300. Survey weights accounted for the probability of an individual household's members being selected and to comply with

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