

ABSENTEEISM IN A HEALTH CARE SETTING

By

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Absenteeism in a Health Care Setting

By Steven Sherrington

Introduction

The purpose of this paper is to explore factors impacting employee absenteeism in health care settings and in particular the hospital setting in Ontario. Prior to the 1930s most Canadian workers were paid wages for time worked or units produced (Bauman, 1970). There was paid vacation and/or a company pension plan only for a privileged few (Bauman 1970). By 1970, about four-fifths of compensation for work was wage-related and one fifth was for other benefits, such as paid vacation, pensions, shift premiums and started to include some illness and disability protection (Bauman, 1970). Today compensation for sick leave and disability can become very costly for many Canadian companies. According to Statistics Canada, in 2011 the average worker in Ontario missed 6.6 days of work due to illness or disability (Statistics Canada, 2012). In 2012, it was reported that sick leave from Canadian federal government employees alone cost more than one billion dollars per year (Weston, 2012). Therefore, reducing absenteeism could be important for healthcare when endeavouring to re-route more resources from constrained budgets towards patient care.

Dianne Dyck, a specialist in occupational nursing and a disability management consultant in Canada and the United States, analyzed the various components and practices that

contribute to good disability case management (Dyck, 2002). She provides information about the roles of the different stakeholders, prevention of workplace injuries, toxic work environments and employee assistance programs. Included is information a company or organization could act upon. For example, companies demonstrating best results begin their illness interventions within five days and interventions for occupational absences on the first day of employees' absences. However, in the book there are some factors that a company would not necessarily have significant influence over or may not want to influence. Dyck claims that, on average, women are absent more days than men; larger organizations tend to experience more absenteeism; public sector employees tend to miss more days than private sector employees; unionized workplaces are associated with higher absenteeism; shift workers have higher absence rates; and employees with sick leave plans tend to be absent more often.

Most Ontario hospitals employ more women than men, where professions such as nursing are still largely female-dominated professions (College of Nurses of Ontario, 2012). Most hospital employees are also public sector workers. Hospitals operate 24 hours per day such that many employees are shift workers. They are largely unionized and have a good sick leave plan in the Hospitals Of Ontario Disability Income Plan or HOODIP (Ontario Hospital Association, 2013). Thus, using Dyck's (2012) argument, hospitals have a number of factors which are associated with increased absenteeism and which are not likely to significantly change in the near future (e.g. female employees, large organizations, public sector employees, unionized employees, shift workers, and have a sick leave plan). So what can Canadian and Ontario hospitals and other health care

employers do to decrease absenteeism rates? What absenteeism factors does the literature report as important?

Before exploring other factors, the following is a synopsis of the sick leave plan supporting ill and injured employees and absenteeism for a portion of health care in Ontario. The Ontario Hospital Association's 151 member hospitals utilize the Hospitals Of Ontario Disability Income Plan (HOODIP) as their sick leave plan (Ontario Hospital Association, 2013). With HOODIP, employees receive 66.6 to 100 % of pay for 562.5 hours or 15 weeks. Some hospitals pay this portion of the sick leave through a third-party insurance company and some pay it directly. Employees are then on employment insurance for another 15 weeks before going on Long Term Disability (LTD). Case managers, health care practitioners, employers and the employee have 15 weeks to try and attain a successful return to work, while full-time employees receive, depending on their years of service, 66.6 to 100% wage replacement. An imminent decrease in sick leave pay at the 16 week mark, from 66.6 to 100% pay from the Short Term Disability (STD) portion of HOODIP, down to 55% with a capped maximum amount during the employment insurance (EI) portion of HOODIP, should also provide increased motivation to return to work at this juncture, if a return to work is possible. Cases which are more severe in nature, more complex or more chronic (e.g. multiple sclerosis, kidney disease and cancer) would proceed into the employment insurance phase and into the long-term disability, beyond 30 weeks, portion of HOODIP, despite intervention and financial implications. With these cases, intervention could make the path to long-term disability a smoother more supported one.

The STD portion of the HOODIP plan can be used repeatedly during the same year as long as the employee has returned to regular hours and duties for one full shift for a new illness or for three continuous weeks of regular hours and duties for the same or a related illness. Therefore, an employee could potentially go on sick leave for fifteen to thirty weeks, return to work for three weeks, and then go back off work for another fifteen to thirty weeks. This HOODIP plan is a factor to be mindful of as other absenteeism factors the literature report as important are explored.

WHO Framework

The World Health Organization (WHO) Healthy Workplace Framework and model set out five objectives as follows: devise and implement policy instruments on worker's health; protect and promote health at the workplace; promote the performance of and access to occupational health services; provide and communicate evidence for action and practice; incorporate workers' health into other policies (World Health Organization, 2010). The WHO focused on the objective to protect and promote health at the workplace for their healthy workplace model and framework. In this framework health was defined as: "A state of complete physical, mental and social well-being, and not merely the absence of disease."

The WHO proposed that employers and employees could collaborate to influence the workplace towards a healthy workplace through four avenues. These four avenues are the

physical work environment, the psychosocial work environment, personal health resources, and community involvement.

The physical work environment included the structure, air, machines, furniture, products, chemicals, materials and processes present or that occur in the workplace (World Health Organization, 2010). The outdoors was included if that was where the work was completed. The psychosocial work environment included the culture of the workplace in the form of the shared attitudes, beliefs, values and practices. The organization of work formed part of the psychosocial work environment as well. Personal health resources were defined as: “the supportive environment, health services, information, resources, opportunities and flexibility an enterprise provides to workers to support or motivate their efforts to improve or maintain healthy personal lifestyle practices” (World Health Organization, 2010). Access to fitness equipment, healthy snacks, flexible hours, and smoking cessation programs were examples of personal health resources. Lastly, the WHO suggested organizations could impact workers and their families by contributing to the communities in which the workers lived. Similarly to the workplace, the WHO suggested employers could impact the physical and social community environment. Clean air and water programs as well as the building of parks and walking trails could improve the physical environment, while subsidised literacy programs and health care for workers and their families could improve the social environment.

The World Health Organization suggested the healthy workplace model and framework could be applied by both large and small employers and in developed and developing

countries (World Health Organization, 2010). With this framework as guidance, this paper will explore factors impacting employee absenteeism in health care settings and in particular the hospital setting in Ontario. How each of the four avenues– the physical work environment, the psychosocial work environment, personal health resources, and community involvement– impact absenteeism will be explored. Although the World Health Organisation indicates all four avenues are important in developing a healthy workplace, this paper will discuss whether or not each avenue has an impact on absenteeism. Review of the literature will be used to identify and discuss possible factors impacting absenteeism, and recommendations for employers will be made as a resource for any employers enterprising to increase the attendance of their employees and provide a healthier workplace.

Factors Impacting Absenteeism in Health Care

A substantial part of health care and the body of research on absenteeism in health care focuses on nursing. One literature review that appeared to be well done was undertaken by Davey et al. in 2009 and will be used as a starting point for identifying factors impacting absenteeism in health care. Davey et al. (2009) undertook an extensive systematic research review to attempt to identify predictors of nurses' absenteeism in hospital settings. It involved an initial search of studies from 1986 to 2006 through ten online databases based on titles and abstracts which resulted in 2,401 titles. The papers included had to be quantitative and have some measure of a relationship between an independent variable or predictor and absenteeism.

In the study, 70 predictors or independent variables were examined. These variables provided common themes including: work attitudes, personal attendance history, job stress and burnout, and work retention factors. A nurse's prior attendance record was reported to be associated with how they would attend in the future. Work attitudes included job satisfaction, organizational commitment, and job involvement. Nine different studies in the review examined retention factors using the topics of staff retention, staff turnover, and promotional opportunity, although specific retention factors were not reported by Davey et al. (2009). Job stress and burnout appeared to increase absenteeism. Three studies in the review examined burnout, stress and workplace stress, however Davey et al. did not define burnout or stress nor did they provide specific factors these studies examined. More interestingly, Davey et al. found the research "provides no

conclusive evidence about the predictors of staff nurse absenteeism” as results from studies were mixed or did not demonstrate statistical significance with regards to reduced or increased absenteeism. Davey et al. (2009) concluded that none of these studies have identified significant factors impacting absenteeism. They indicated an individual nurse’s attendance history is one of the best predictors of their future absenteeism. Davey et al. (2009) reported if an employee had a history of poor attendance, this trend was likely to continue for that employee in the future.

Common themes Davey et al. (2009) identified in the research included: work attitude, retention factors, job stress and burnout and were used for this paper as a starting point to organise the research in relation to possible reductions in absenteeism. Work attitudes and retention factors were common themes as possibly reducing absenteeism, while job stress and burnout were common themes as possible factors to increase absenteeism. Given the dearth of information, both health care and non-health care related research will be discussed in this paper in relation to absenteeism.

Work Attitudes

Davey et al. (2009) reported that work attitude included common themes such as job satisfaction, organizational commitment, and job involvement. One factor that could influence work attitude is aversive work conditions (e.g. extreme temperatures, electrocution, workplace stress and chronic work related physical conditions) and another

is supervisor support (e.g. caring, training, compensate for overtime and work rearrangement).

Although not based on health care workers, Bamberger and Biron (2012) in a cross-sectional study, examined whether aversive work conditions contributed to absenteeism while taking into account peer referent groups (i.e., peers in the workplace whose opinions influenced an individual) and supervisor support. They suggested that workers may avoid coming to work when that work involves hazards (e.g. extreme temperatures, electrocution and workplace stress) or poor working conditions and that this could be due to one of or a combination of three reasons. Workers may wish to minimize their exposure to the hazards; they may want to take time off to tend to psychosomatic health symptoms generated by job hazards; and/or to attend to acute or chronic physical problems. A combination of two or even three of these reasons was also possible.

Based on this, Bamberger and Biron (2012) hypothesised that: “There is a positive association between perceived workplace hazards and employee absenteeism.” A prospective cohort design was used to randomly sample workers from union membership files of workers at a transit authority for a large unidentified municipality in the United States. As with their study in 2007, they observed the influence of peer referent groups, such that workers would be influenced by their co-workers with whom they have contact in the workplace and whose opinions and attitudes towards absenteeism they value. In 2012, Bamberger and Biron added that supervisor support could also influence absenteeism. If the worker’s supervisor was supportive and fostered a team effort, then

the worker should find it more difficult to miss work. In this study, 1,093 workers who had been employed by the company for at least twelve months were given a questionnaire to complete, with confidentiality guaranteed by the union. The survey had a 50% response rate. Data were gathered for 24 months following questionnaire administration. This is an improvement over the six month follow-up in Bamberger and Biron's 2007 study. Results indicated job hazards were not strongly related to absenteeism. However, the attitudes and permissiveness (i.e., encouraging or affirming of absenteeism) of peers were associated with absenteeism. Support from the supervisor alone was not associated with absenteeism, but the worker's perceived level of support from the supervisor, amplified or minimized the effects of aversive workplace conditions in a small group, where support from the supervisor on its own was statistically significant for reducing employee absenteeism. These workers' perceived low levels of supervisor support were associated with increased levels of absenteeism. However, the group where absenteeism was influenced by hazards was small, and peer referent norms for that group had more influence on absenteeism than supervisor support. Out of 600 employees in the sample, information from 22% could not be used due to missing data or other problem, including 14% of participants who were excluded because they retired or went on disability during the two-year study such that selection bias may have occurred. Future studies may also wish to include those who went off on disability as they would be considered absent from the workplace and should be factored in to absenteeism rates.

Work attitude could also be influenced by workload or a worker's perceived workload.

Rauhala et al. (2007) examined the effect of workload on absenteeism in an observational

cohort study. Their study involved 877 registered nurses and registered practical nurses in 31 wards from five public hospitals in Finland in 2004. A medical note was required for absences of more than three days. Employees had full salary sick pay for up to 60 days and were allowed up to three days absence for an acutely ill child under the age of ten. Rauhala et al. administered the RAFAELA (Aschan et al., 2009) patient classification system to measure workload. The RAFAELA system determines workload and optimum workload based on the nurses' self-assessment. Under such a system, two nurses with the same workload could rate that workload differently as optimum, below optimum, or above optimum workload. Under this system, how the worker perceived the workload was more important than the actual workload. Rauhala et al. observed a linear relationship between increased workload over the optimal workload and increased sick time. In particular, workloads greater than 15% above the worker's perceived optimal workload increased the risk (RR (rate ratio) = 1.30, 95% confidence interval (CI): 1.02-1.66) of illness absences amongst nurses. Therefore, the employees' perceived workload is an important consideration when trying to decrease worker absenteeism in nurses. Working with Bamberger and Biron's peer referent groups system, how the people in workers' peer referent group perceived the workload could also be important. If the employee's peer referent group perceived the workload to be well above the optimum workload, then employees in that group would be more likely to be absent more often. In Ontario as in many areas, attempts are being made to control health care spending. Therefore health care and hospital budgets mean that many departments in a hospital may have been reduced in staff and pushed for efficiency, such that hiring more staff to decrease workload is not likely to be a viable solution. More creative methods at

decreasing workload or perception of workload will need to be identified. Although, if job satisfaction could be improved and organizational commitment increased, then the perception of the workload for more workers may shift towards optimal.

One of the factors Davey et al. (2009) reported that could influence a nurse's work attitude was job satisfaction, although they did not define job satisfaction or indicate what job satisfaction encompassed. Cummings et al. (2008) aimed to develop a model of work environment factors that influence nurses' job satisfaction. They used a prospective descriptive research design to conduct two cross-sectional surveys of Canadian nurses in 2004 and 2006. Permission was obtained from several provincial cancer care agencies. In total, 2002 surveys were mailed out but only 615 were returned, yielding a low 31% response rate. Out of these 615 returned surveys, Cummings et al (2008) selected 515 where nurses reported at least 60% of the time they provided direct care to oncology patients. The authors found that having enough nurses to provide good care and that positive relationships between nurses, managers and physicians had the most influence on job satisfaction. With positive leadership communication, good orientation and professional improvement opportunity, perhaps the overall satisfaction of nurses could be improved and burnout decreased.

Verhaeghe et al (2006) approached job satisfaction differently. They wanted to determine the effects of frequent changes within a nursing environment on psychological well-being, including job satisfaction and level of sick leave. In contrast to Cummings et al (2008), Verhaeghe et al. (2006) had a response rate of 51% using a cross-sectional survey

in 2003, with a sample size of 7,863, and focused on a subsample of inpatient unit nurses in Belgium. Unfortunately, a weakness with their study was they only considered change over the previous six months. This may have been to allow respondents to have good recall, but there would not necessarily be significant change over a six month period to impact a nurse's work habits. As a result of the short timeframe, the largest change reported in the study was a change in co-workers. In general, change in the workplace was related to increased distress, but did not relate to absenteeism or job satisfaction. However, in a group of nurses who viewed recent changes as a challenge, the changes were related to increased job satisfaction. This could be an effect of these nurses having an overall positive attitude. Alternatively, in a group of nurses who viewed recent changes as threatening, this view was related to decreased job satisfaction and increased stress indicators. Again, this could be related to an overall negative attitude and/or could be related to a past negative experience with a change. Despite the study limitations, finding change challenging may be important with regard to job satisfaction and absenteeism. This could be seen as an important role for leadership in the way that change is presented or communicated to staff. If the manager sees the change as a challenge or positive change, or at least frames it that way, this could influence staff views towards the change. The result could be increased job satisfaction and a more positive attitude towards change with decreased absenteeism as a result.

Overall, work attitude was not found to have a statistically significant association with absenteeism.

Retention Factors

Along with work attitude, Davey et al. (2009) reported retention factors were a common theme in the absenteeism research. Retaining staff would decrease time spent orienting and training new staff. It would also decrease change which Verhaeghe et al. (2006) proposed would increase job satisfaction. One thing that could help retain employees and help decrease absenteeism is employee recognition programs. Werner (1992) proposed a fairly simple system of employee recognition might maintain worker attendance. A group A-B-A study design was used over the years of 1985, 1986 then 1987, where 1985 was a baseline year for attendance, an employee recognition program was implemented for 1986, and then the recognition program was removed in 1987. Subjects were 73 employees of an anonymous 347- bed mental health and addiction centre in the United States. Werner considered a system where employee recognition for model attendance was utilized. The system was explained at a regular staff meeting. At subsequent staff meetings, certificates were presented to employees with two or fewer sick days for that quarter. The certificates were then displayed behind glass in an accessible area that was visible to co-workers. The result according to Werner was a 28 % decrease in sick leave over one year for the group involved. It is unknown if such a system could have lasting effects beyond one year or would lose its appeal over time, as the recognition system was only in place for one year. Certainly, the simplicity of such a system may be appealing to many employers if the effects were lasting. Repeating the study with a larger sample size could be helpful.

Hassink and Koning (2009) studied a financial recognition system which used a lottery to reward employees who did not miss time from work. The attendance of 481 workers at a Dutch manufacturing company was observed from July 1, 2001 to July 31, 2003. In this lottery reward system employees with no sick time during the previous three month period had their name entered in a draw for one of seven coupon gifts with a value of 75 euros each. The names of the lottery winners were announced company wide. Winners were no longer eligible for future draws. Results indicated a 4.3% decrease in absenteeism during the first seven months after the lottery was introduced, followed by a 1.0% decrease during the second seven months. Winning the lottery was associated with a subsequent increase in absenteeism which Hassink and Koning (2009) proposed was the result of no longer being eligible to win the lottery. Whether this system would be effective at decreasing absenteeism in a health care setting and over a longer period of time if winners remained eligible for the lottery would be of interest.

Engelland and Riphahn (2004) discussed an employer incentive program utilizing performance based financial bonuses. Personnel data from between 1999 and 2002 for 6,425 employees of a Swiss international company was examined. The type of company was not disclosed but the organization comprised of production, administration and research departments. Two forms of bonuses were available to be paid at the discretion of supervisors. The first was a surprise bonus of between 1,400 to 3,400 euros which could be paid to employees for special achievements. Secondly, were bonuses paid based on annual performance appraisals and goals set the previous years. According to Engelland and Riphahn (2004) results indicated employees from departments that paid out both

types of bonuses more often, worked more overtime and had lower absenteeism. Whether this system would be effective in a health care setting would have to be studied. However, a system with substantial financial bonuses such as this one would be difficult to incorporate into the budget constraints of Ontario hospitals. Additionally, Engellandt and Riphahn (2004) did not indicate whether money saved on absenteeism was financially significant compared to production levels and the bonuses paid.

Rondeau and Wagar (2001) studied the effects of human resource management programs on Canadian nursing home performance using a cross-sectional survey. In 1997, they collected data by mailing 498 questionnaires to both for-profit and not-for-profit long-term care homes to be completed by Chief Executive Officers or site administrators. If no reply was received from a facility after six weeks, the questionnaire was remailed. In total, 283 (57% response rate) usable questionnaires were received. The sample included facilities where 33.9% had less than 100 employees, 41.3% had 100 to 199 employees and 24.8% had 200 or more employees. Results revealed no significant relationship between human resource management practices (e.g., performance appraisal systems, workplace suggestion systems, self-managing groups and quality improvement teams) and operating costs. Based on the data, increased human resource programs were only effective if they were supported by an organization and management that creates a climate that values employee participation, empowerment and accountability. If the day-to-day practices in the workplace did not support the human resource programs, they were not effective and could actually be detrimental. If human resource programs were introduced but not supported in the workplace, morale could decrease and absenteeism

could actually increase. Rondeau and Wagar (2001) utilized self-reported data and they acknowledged there was a difference between what managers say they do and what they actually do. Therefore, they could not be certain all the human resource programs reported were actually put in place, which could have influenced their results. Rondeau and Wagar suggested future research could include methodology to assess what human resource practices were actually put in place and include different health care settings.

Many departments in hospitals operate 24-hours. The result is staff work shift work in order to maintain operations and continue patient care. Some departments such as ambulatory care units, outpatient clinics, and administration may only be open during the day. Cleaning staff, laboratory staff and diagnostic imaging staff are generally available at reduced levels evenings and through the night for urgent services. As expected, many nursing staff work shift work to continue patient care on a 24-hour basis. Much has been written about the health effects of shift work, but Admi et al. (2008) wanted to examine the effect of shift work on the performance of nurses. Their study design was not indicated but it appears to have been a cross-sectional survey. They studied a sample of 738 nurses from a hospital in Israel in 2003. Of the initial sample, 688 completed all the questionnaires, with an excellent response rate of 93.2%. Of the 688 nurses, 195 (28%) worked steady day shift and 493 (72%) worked rotating shifts. Their questionnaire collected information about demographics, sleep disorders and sleep habits. Data about workplace incidents and errors, as well as absenteeism data were acquired from hospital databases. Results were not as expected such that shift workers did not have significantly more errors or incidents at work and had lower absenteeism rates. Gender, age and weight

were found to be significant (although p values were not provided) predictors of the nurses' health issues, including sleep and absenteeism, but when these were controlled for, shift work was not statistically significant. Day-shift workers were older ($p < 0.0001$) and had higher weights (i.e., body mass indices) ($p < 0.02$) which could explain some of the results. As age and weight were reported to be significant predictors of absenteeism, larger representation of heavier and older nurses in the day shift group could have been reflected in the increased absenteeism. It could be interesting to compare the results for nurses working steady days to nurses in the same age range, weight range and similar work area working shift work.

Worker retention is reported to be a problem for the nursing home industry in the United States, so Castle (2013) examined the effects of consistent assignments for nurse aides in nursing homes on their absenteeism and turnover. Castle defined consistent assignment as "the same caregivers consistently caring for the same residents almost every time they are on duty." It is reported to be promoted in nursing homes, as it is believed to improve the quality of care and lessen the workload of the nurse aides (Castle, 2013). It was believed that the nurse aides would get to know the residents, their needs and their tendencies and the residents would get to know their caregivers and receive consistent care. The nurse aides would form stronger relationships with residents, feel more empowered with their care and feel more valued due to these relationships. Castle (2013) wanted to evaluate if the proposed benefits of consistent assignment also resulted in decreased staff turnover and lower absenteeism. If staff felt more empowered and more responsible for their residents, they should have had higher job satisfaction, felt more personally responsible

for their residents and thus less likely to miss work. A 2008 cross-sectional survey was conducted of nursing home administrators in the United States, as well as data collected separately during visits to the same nursing homes as part of a process necessary to be certified to bill Medicaid and/or Medicare. The resulting sample included 3,941 nursing homes of at least 30 beds or more, where a 66% response rate was achieved. What Castle (2013) found was consistent resident assignment was in fact related to lower staff turnover and lower staff absenteeism ($p < .01$), which Castle reported were two major issues for nursing homes in the United States. Castle (2013) did indicate data regarding the use of consistent assignment was self-reported by nursing home administrators and actual rates of consistent resident assignment could not be confirmed.

In summary, work retention factors would be worth further investigation with regard to absenteeism in a health care setting. Recognition programs such as Hassink and Koning's (2009) as well as Werner's (1992) would need to be implemented and examined further to determine if absenteeism would be significantly reduced in an Ontario hospital setting and over longer periods of time, if the programs are left in place longer. As well, further research would be useful to explore if consistent client assignment would reduce employee absenteeism in professions other than health care aides and settings other than nursing homes.

Job Stress and Burnout

The third common theme in health care absenteeism identified by Davies et al. (2009) was job stress and burnout. They reported it was proposed in many research papers that job stress and burnout could be associated with increased absenteeism. Much of the research reviewed thus far has involved methods of facilitating employees' attendance.

Raak and Raak (2003) examined the impact of employees attending work despite having a headache. In their study of Swedish workers, they distributed 800 questionnaires in a cross-sectional survey equally to 400 private sector employees of a technology company and 400 public sector hospital employees. Response rates were reported as strong and included 315 (79%) of private employees and 257 (64%) of public employees, with a total of 84% men and 16% women. The researchers found that employees who attended work with a headache reported a decrease of 21% to 27% in work effectiveness. Thus, even though employees came to work there was a decrease in effectiveness, which possibly could have been avoided if they did not come to work. However, this loss of effectiveness was only assessed using a self-assessment tool. Future research may wish to incorporate quantitative data about the loss of productivity experienced by the employer. Additionally, even if there was a 27% decrease in effectiveness, to pay an employee to stay home sick and then pay another employee to come in would likely outweigh the loss of productivity associated with a sick employee attending work, particularly in a private company where a profit margin would be involved. In some cases, the employer may not even be able to call in a replacement worker resulting in no

work effectiveness, as opposed to a 27% decrease in work effectiveness. There could be a level of headache where an employer would not want employees to come to work as they would be marginally effective or ineffective and might distract others around them. If the headache was severe enough, they may even make mistakes which might require later correction. In the hospital setting, there would also be a safety factor where at a certain level of headache patient safety could be jeopardized and care could be compromised. Finding a threshold where an employee should stay home with their headache is a difficult task that often depends on the individual. Some may cope and function with a great deal of pain, while others may be significantly distracted by minimal levels of pain.

Johns (2011) used a web-based cross-sectional survey with 444 employed business graduates from a large Canadian university business school to examine presenteeism, defined as “attending work when ill.” Out of 4,784 subjects contacted, 444 completed the survey between February 23 and March 31, 2009, yielding an exceptionally poor response rate of 9.3%. Johns wanted to examine some factors that affect presenteeism and collect data about how respondents reported being ill while at work affected their work. Johns was trying to gather some factors that should be considered when studying programs designed for decreasing absenteeism as such programs may increase presenteeism. Johns observed overall health as a key factor, where those who reported being healthier had fewer sick days. Those who reported being healthy also had fewer days of presenteeism so when they were sick they would stay home. Respondents who had views that absenteeism was legitimate also reported more days absent. Johns did not provide a

definition or explanation of legitimate absenteeism in his paper. An unexpected result for Johns was respondents who felt they were easily replaced had more days of presenteeism; attending work when ill. Even though respondents felt they were easily replaced, they reported they came to work sick. Johns did offer some caution regarding the data as Master of Business Administration (MBA) graduates were over-represented in the sample and there was such a low 9.3% response rate. This likely resulted in selection bias as the initial sample sought were employed business graduates not specifically MBA graduates. He also acknowledged that all data was self-reported, but qualified this indicating “virtually all studies on presenteeism in the literature use self-report data” (Johns, 2011, p496).

Therefore, the results of Raak and Raak (2003) indicate presenteeism needs to be considered as well as absenteeism. The job stress of working while ill appears to decrease work effectiveness or productivity. The work of Johns (2011) did not contribute substantially due to a poor response rate and possible selection bias, however it did provide an alternative perspective to Raak and Raak.

In summary, the common themes identified as possibly impacting absenteeism by Davey et al. (2009) though their research included: work attitude, retention factors, job stress and burnout. Perceived workload (Rauhala et al., 2007), proper staffing and positive relationships among supervisor, doctors and nurses (Cummings et al., 2008) appear to be associated with nurses’ job satisfaction. However, job satisfaction and other workload factors did not appear to be significantly associated with absenteeism. Job stress in the

form presenteeism, or working while ill, appears to decrease workplace effectiveness or productivity so may warrant some consideration along with absenteeism. Work retention factors as a theme showed the most promise with regard to reducing absenteeism.

Recognition programs such as Hassink and Koning's (2009), as well as Werner's (1992), would need more research to determine if they would be effective in an Ontario hospital setting and over longer periods of time. Consistent patient assignment such as the practice described in the paper by Castle (2013) would need follow-up to see if it would reduce absenteeism with other professions such as nursing and in different setting such as hospitals.

Employer Interventions

The common themes with regard to workplace absenteeism in nursing identified by Davey et al. (2009) of work attitude, retention factors and job stress and burnout have been examined. Some interventions employers have used to ameliorate absenteeism will now be examined. The interventions discussed will not all be related to health care as such research is limited. There were papers related to factors possibly impacting absenteeism in health care, but little on interventions employers have tried or should try. Therefore both health care and non-health care interventions were explored, as there are likely to be some common themes amongst employers as not all absenteeism issues in the health care sector are necessarily unique to that sector.

Workplace Wellness Programs

Many large employers have implemented various interventions to address employee absenteeism. The aim of the wellness programs should be to protect and promote health at the workplace (World Health Organization, 2010), hopefully supported by employers, resulting in a more productive workforce with fewer illnesses and injuries. The absenteeism factor trends identified by Davey et al. (2009) of work retention, work attitude, stress, and burnout should also be impacted as a well employee should have a better work attitude, have less stress, be less likely to burn out and be more likely to stay at that job or employer.

Chung et al. (2009) studied one of the Canadian Auto Workers union and Daimler Chrysler Canada's worksite programs called "Tune Up Your Heart," which was one part of an ongoing wellness program. The study was a cohort study conducted between February 2003 and August 2004. Volunteers from Daimler Chrysler's Windsor, Ontario plant were screened for and data collected about cardiovascular risk factors upon entry into the program and then again 18 months later. Some heart health initiatives were aimed at the entire workforce including education seminars, company newsletters and access to a toll free number to ask cardiovascular disease questions. In addition to this, the intervention group received more targeted education and individual interventions such as a medication review, education kit, a pill organizer and fridge magnets. Out of 1,074 employees 580 were identified to participate and 343 had baseline and end study data collected. The average age of the intervention group was 47.4 years and 88% of them were male. Chung et al. reported a 12.7% decrease in cardiovascular risk factors in the intervention group however two of the major risk factors, hypertension and cholesterol state, were self-reported. A model of cost savings was done which indicated there were some minimal savings during the study period but larger savings would be long term. However, when estimating cost savings they did not include the cost of delivering the Tune up Your Heart program. The authors reported possible selection bias as participants were volunteers and the study was funded by a grant from a pharmaceutical company whom Chung worked for at the time. After the study Chung went to work for the company employed to do the cost estimates for the study.

Osilla et al. (2012) conducted a systematic review of studies examining workplace wellness programs. In the final 33 articles examined, 63 outcomes were evaluated with the main ones being exercise, diet and physiologic markers. Osilla et al. (2012) reported research designs were not strong and many were observational designs with observational design studies reporting more positive outcomes than studies with randomized trials. Notably, 64% of the studies examined used self-report data for at least one of the outcomes, which could have been subject to recall and selection bias. They concluded that results were mixed with no strong evidence that wellness programs reduced medical costs or reduced absenteeism.

Research on wellness programs did not provide substantial insight into how employers could decrease absenteeism. Osilla et al. (2012) were critical of the research in this area and Chung et al. (2009) reported some employees showed decreased risk factors for cardiovascular disease but reported unknown cost savings and effects on absenteeism.

Workplace Mental Health Interventions

Mental health issues are more openly discussed in more recent years as an active topic in the media, with companies such as Bell in Canada in 2010 initiating campaigns using some celebrities and athletes to spark discussion on mental health (Bell Canada, 2013). On January 16, 2013 a voluntary national standard entitled: “Psychological Health and Safety in the Workplace” was released by The Mental Health Commission of Canada (MHCC), the Bureau de normalisation du Quebec (BNQ), and the Canadian Standards

Association (CSA) (CSA Group, 2013). This standard provided employers with a framework and systematic approach to create and improve a psychologically safe workplace. In the release of the CSA voluntary standard it was indicated one in five Canadians experience a mental health problem in any given year. Next the focus will be on workplace mental health and mental health interventions in the workplace.

Pomaki et al. (2011) performed a literature review with regard to workplace prevention interventions aimed at common mental health conditions (CMHC). They defined common mental health conditions as depressive and anxiety disorders along with adjustment and other mood disorders. They reviewed eight studies that focused on 3,000 participants, 76% of whom were from Europe and 66% were female. Pomaki et al. reported three main elements of the interventions in the studies. Firstly, were interventions that facilitated workers access to clinical treatment, such as interventions which provided psychiatric assessments, provided treatment option information to the employee's family physician or facilitated entry into treatment programs. Secondly, were workplace based high intensity psychological interventions, such as workplace cognitive behavioural therapy, telephone cognitive behavioural therapy or a psychoeducational workbook for employees who declined in-person treatment. Thirdly, there were interventions that facilitated workers navigation through the disability management system that was in place at the employer. These three types of interventions were associated with improvements in quality of life and work functioning, but none resulted in significant reductions in workplace absences from common mental health conditions, although some absence reduction was reported from the third type of intervention.

Pomaki et al. (2011) reported most studies had a limited follow-up period where they collected data with most limited to just one year. They recommended employers improve communication with workers during return to work processes either in person or by phone. Providing information to absent workers regarding the processes and to plan return to work could be a low cost way to decrease absence durations.

Nash-Wright (2011) wrote an article about the importance of early intervention with employees who have anxiety disorders that impair their work function or cause them to be absent from work. She reported mental illness is the second cause of disability in the United States, but less than 50% of people with an identified psychological disorder receive treatment from a mental health professional. Nash-Wright reports that early, how early is not mentioned, assessment and treatment of mental health disorders is recommended for best results. Access to and/or use of mental health professionals appeared to be a factor in absenteeism and work performance. Nash-Wright (2011) reported workplace conflict and avoidant behaviour could be factors in extending absence from work. Addressing workplace issues, whether worker to worker conflicts or conflicts with management, can assist with the treatment progress and expedite return to work if a return to work is possible. Prolonged absence can reinforce a workers anxiety and avoidant behaviour, with a workplace conflict possibly resulting in the absence being extended further or a less successful return to work. Nash-Wright (2011) reported that early and regular contact with the employee is encouraged. Communication between the employee and employer is encouraged and should begin early in an absence and continue on a regular basis. Exact time intervals were not specified. She indicated the people

communicating with the employee should maintain an empathetic manner, but at the same time hold the employee accountable for participating in treatment and making progress towards return to work.

Bhui et al. (2012) conducted a review of review articles reporting on anxiety, depression and absenteeism. They tried to identify consistent findings across reviews for managing stress at work. The review focused on papers since 1990. The result was 23 reviews including a total of 499 studies. Individual interventions such as cognitive behavioural therapy improved individual mental health, but did not improve absenteeism.

Organizational interventions ranging from fitness programs, to problem solving committees, to the formation of smaller work teams, appeared to reduce absenteeism, but there were a lack of mental health organizational interventions and a lack of studies on the outcomes of such interventions. The authors noted the possibility of selection bias, as the most stressful workplaces were less likely to participate in studies.

The research regarding mental health interventions stressed the importance of communication between the employer and employee during an absence and the return to work process. Therefore, employers may be well advised to devise procedures for managers, supervisors, human resources or occupational health personnel to maintain regular contact with absent employees.

Less Commonly Utilized Workplace Interventions

Workplace wellness programs, heart health programs and mental health initiatives are examples of some common employers' intervention methods previously discussed. Some other workplaces and employee groups may require a more innovative or novel approach to their issues for success.

Michie et al. (2004) evaluated workplace interventions with hospital cleaning staff from the National Health Service in the United Kingdom. The study included 221 cleaning staff from an inner-city acute care hospital and a control group of 91 catering staff. Fifty-six percent of the cleaning staff was full-time. They did not indicate how many in the control group were full-time. They noted that there is little evidence that traditional individual approaches to absenteeism, such as return to work interviews, attendance monitoring and referrals to occupational health and safety are effective. The cleaning staff studied worked in isolation, were not part of a team, had little control over the structure of their day and although they were assigned a supervisor, they did not report in or out of work. Breaks were short and many staff was observed to take their breaks and eat their lunch alone, some even under the stairs. In an effort to try and improve the cleaning staff's feeling of control and sense of teamwork, they introduced five initial changes. They introduced a system to report problems and request help through leaders and supervisors. They were consulted with regard to the design and colour of new uniforms. They were allowed to change in and out of their uniforms during compensated work hours which would have decreased workers' total hours in the workplace. An annual

Christmas party was funded by the employer and was organized by the staff. They were also given a choice of morning and lunch break times. Three changes to increase social supports were also put in place. Firstly, staff had to check in and out of work in order to increase contact with other staff and their supervisor. Secondly, the employer opened a dedicated recreation room for the staff. Thirdly, they extended morning coffee break from 15 to 30 minutes to allow time for recreation room use. The study was quasi-experimental with data collected one year retrospectively and one year prospectively from the point of the intervention. Percent sickness absences before and after the intervention were compared and with no significant change in the cleaning staff, nor the catering control group.

Workplace Absenteeism Strategies

Brouwers et al. (2009) considered factors thought to predict reintegration of employees to the workplace following minor psychological disorders such as: emotional distress, general anxiety disorders, mild depression or other mild mental health disorders as diagnosed by general practitioners. The data were a subset of data obtained from a randomized clinical trial study in the city of Almere, the Netherlands. The subset contained data from 70 general practitioners on 194 subjects. The researchers found that workers who predicted they would be back in a certain amount of time were more likely to return to work at some point as opposed to remaining off work permanently. Their results suggested that optimism may be an important determinant of a return to work when a less severe, or minor, mental disorder is experienced by workers. However,

workers who had more longstanding problems prior to their absence were less likely to return to work successfully. Brouwers and his collaborators also noted that workers who took longer than three weeks to seek help were less likely to return to work. This was interpreted as avoidant behaviour which could potentially also influence the expedience of a return to work. Future research may wish to consider this. Brouwers et al. (2009) also proposed that workers who saw the occupational physician early on, with no mention by authors of how early on, may have insight into or understood the seriousness of their illness and sought the assistance of the occupational physician. However, workers may also be trying to demonstrate to the occupational physician the legitimacy of their illness and trying to convince employers it will take more time to recover from than some other workers illnesses. The authors acknowledged that they did not collect an absenteeism history on the workers in the study, nor did they collect data about work factors (e.g., work stress and supervisor behaviour) and job satisfaction, and did not record whether the worker remained at work once they returned to work from an illness, such that sustainability of the return to work was not examined. Brouwers et al. (2009) recommended frequent contact by the employer with sick employees to benefit the employer to employee social relationship as a possible step to make return to work less difficult.

Wendt et al. (2010) evaluated the Shell Oil Company's disability management program that was implemented in 2002. The authors reviewed data from eight of Shell's manufacturing sites between 2004 and 2008 and compared it to pre-program data in 2002. The company required employees to keep track of non-occupational illness and injury

absences in a time-keeping system and absences of four workdays or more required a physician's note and a diagnosis. The overall average number of absences of hourly employees decreased 31% (slope = -0.06, 95% confidence interval: -0.08 to -0.03), while the average number of staff employee absences increased by 26% (slope = 0.04, 95% confidence interval: 0.02 to 0.07). As there were many more hourly employees than staff employees, the result was 6,042 days saved in 2006 and 11438 days saved in 2008.

Wendt et al. (2010) expressed concern, as in 2002 absences were not tracked in the same system and days of absence in 2002 were calculated based on work hours versus missed shifts in the new system. In 2002, when shift length was not known a nine hour shift length was assumed. The majority of the population involved were white males, with more than half aged 45 or older who worked at manufacturing sites. Transferring this system to the health care sector and a largely female population would not necessarily result in similar outcomes. Interestingly, they noted that absenteeism decreased significantly in the first year (2003) of the program, then increased between 2004 and 2006. Wendt et al. proposed that the initial decrease in absenteeism might have reflected Shell ending an unpopular program administered by an external vendor.

Johnson et al. (2003) wrote a paper based on a literature review in an effort to provide information knowledge to nurse managers about factors impacting absenteeism in the National Health Service (NHS) which is the largest employer in Europe. The NHS' largest group of employees included nurses, midwives and health visitors. Health visitors in Europe are nurses or midwives with additional training and education, who often work and visit clients in their own homes (Prospects, 2013). These workers were employed in

the United Kingdom, where Johnson et al. report sick absences are also a problem, as 177 work days were lost due to illness in 1994, with an estimated cost of 11 billion pounds. They reported long-term absences were more likely to be associated with medical problems. Short-term absences were more likely to be associated with social and personal factors therefore they would be more open to being decreased with management strategies. They observed that females and young people were more likely to be absent. Women who experienced bullying in the workplace were linked to double the risk of high incidence of sick leave. Johnson et al. concluded that sickness absences are multi-causal and highly variable. They maintained that management strategies need to consider social, physical and psychological causes of sickness.

The research reviewed on employer interventions did not provide statistically significant associations between specific workplace interventions and lasting decreases in absenteeism. However, the research did reveal, in particular in the paper by Johnson et al. (2003), that the physical and psychosocial workplaces need to be considered when strategizing to decrease absenteeism. This is consistent with guidance provided by the World Health Organization in its Healthy Workplace Framework (World Health Organization, 2010)

Overall, no one particular workplace intervention is recommended over another or showed consistent significant association with decreased absenteeism. Workplace interventions such as wellness programs (Chung et al., 2009; Osilla et al., 2012) and psychological workplace interventions (Pomaki et al., 2001; Bhui et al., 2012) decreased

personal health risk factors and increased employees' feelings of wellness and function but were not shown to decrease absenteeism. Disability management systems such as Shell's were associated with some initial decreases in absenteeism, but the effects did not last (Wendt et al., 2010). Even a program which involved multiple (apparently positive) changes and consultation with the hospital cleaning staff, was not associated with decreased absenteeism (Michie et al., 2004).

World Health Organization Healthy Workplace Framework Revisited

The World Health Organization (WHO) healthy workplace framework (World Health Organization, 2010) provided guidance for this paper. This framework outlined five objectives for a healthy workplace but recommended an initial focus on the objective to protect and promote health at the workplace. The WHO proposed employers and employees could collaborate to influence the workplace towards a healthy workplace through four avenues. These four avenues included the physical work environment, the psychosocial work environment, personal health resources, and community involvement. Community involvement research was not directly explored in this paper.

The physical work environment included the structure, air, machines, furniture, products, chemicals, materials and processes present or that occur the workplace (World Health Organization, 2010). Research by Michie et al. (2004) examined the effects of changes to the physical work environment for hospital cleaning staff. Physical changes included where workers reported to, an onsite place to change into work clothes, new uniforms, and even a recreation room. Research involving system changes at a large corporation (Wendt et al., 2010) and wellness initiatives at another large corporation (Chung et al., 2009) involved some change to the physical work environment as well.

The psychosocial work environment included the culture of the workplace in the form of the shared attitudes, beliefs, values and practices. The organization of work formed part of the psychosocial work environment as well (World Health Organization, 2010).

Factors related to the psychosocial work environment were explored by Cummings et al., (2008) with regard to job satisfaction and leadership, and Bamberger and Biron (2012) with regard to leadership and aversive work conditions. Workload factors were explored (Rauhala et al., 2007), as well as workplace change (Verhaeghe et al., 2006) (Castle, 2013), and the influence of peer groups (Bamberger & Biron, 2007 and 2012) (Johns, 2011).

Personal health resources were defined as: “the supportive environment, health services, information, resources, opportunities and flexibility an enterprise provides to workers to support or motivate their efforts to improve or maintain healthy personal lifestyle practices” (World Health Organization, 2010). Personal mental health resource factors were explored by Brouwers et al. (2009) with predicting return to work, Verhaeghe et al. (2006) with reaction to change, and Nash-Wright (2011) and Bhui et al. (2012) with regards to mental health treatment and contact. Personal health resources through workplace wellness programs were explored as well by Chung et al. (2009), Wendt et al. (2010), and Osilla et al. (2012).

Overall, three of the four avenues recommended by the World Health Organization Healthy Workplace Framework have been examined in this paper, including the physical work and psychosocial work environments as well as personal health resources. The research reviewed did not demonstrate an association between factors or interventions and a significant or sustained change in absenteeism. Based on the research reviewed, the psychosocial work environment and personal health resources appear to be the two

avenues of most potential with regard to decreasing absenteeism. The psychosocial work environment through the influence of leadership, peer groups and job satisfaction.

Personal health resources through employer and employee communication as well as guidance through disability systems. Despite results to date, the World Health Organization Healthy Workplace Framework provides guidance and best practices to explore further.

Future Research, Recommendations and Conclusions

Future Research

The literature was reviewed about human resource programs (Rondeau & Wagar, 2001), human resource outsourcing (Kinange & V, 2011), employer programs (Wendt et al., 2010) (Chung et al., 2009) (Nash-Wright, 2011) and employee recognition (Hassink and Kinong, 2009) (Werner, 1992), with none demonstrating a statistically significant association with neither decreased absenteeism nor a sustained reduction in absenteeism. Research regarding factors such as workload (Rauhala et al., 2007), job satisfaction (Cummings et al., 2008), recognition (Werner, 1992) (Hassink and Koning, 2009), shift work (Admi et al., 2008) and consistent client assignment (Castle, 2013) was explored with none demonstrating a sustained decreased absenteeism. Werner (1992) did demonstrate a decrease in absenteeism over the course of one year, but the intervention was then removed. Davey et al. (2009) examined 70 independent variables from 14 studies which showed trends towards a nurse's attendance history continuing, work attitudes and retention factors reducing absenteeism and job stress and burnout increasing absenteeism. However they reported that: "our findings suggest that research on hospital nurse absenteeism provides no conclusive evidence about predictors of staff nurse absenteeism" as results from studies were mixed or did not demonstrate statistical significance with regards to reduced absenteeism. Osilla et al. (2012) reported there was insufficient evidence for workplace wellness programs having effects on absenteeism and mental health as studies reviewed utilized poor evaluation designs and provided mixed

results. These are powerful statements but consistent with the literature review of this paper. Davey et al. (2009) indicated there were no specific demographic characteristics that were consistently associated with absenteeism. They reported many studies could have had type 2 error due to self-report bias. Many studies used self-report data, including self-reported attendance data, with a retrospective design. They also reported many studies did not link their data, self-reported or not, to actual employer attendance data. With many employers maintaining payroll data in an electronic database examination of actual payroll absenteeism data should be attainable. Davey et al. (2009) also reported published studies tend to over-report positive findings. Care should also be taken not to exclude a paper if it contains information which is useful to a subject, but has some study limitations which do not significantly impact the results or the section of interest.

I would recommend future study focus on shorter (i.e., one to five days) absences as based on absenteeism data from the hospital of my employment and the Ontario Hospital Association survey (Ontario Hospital Association, 2011), this is the period when the majority of absenteeism occurs. It would be helpful if studies incorporate a quantitative component associated directly to employee absenteeism data and statistical analysis. Computerized payroll and/or scheduling systems at many employers make this possible. Funding and time permitting, qualitative data from employees, management and unions could provide more in-depth insight into the various participants' experiences with the system.

My personal experience leading up to this paper may provide useful information for researchers looking to do work in this area. I work for an employer with approximately 4000 employees where payroll data is maintained in a database. This employer originally managed employee sick leave internally through the occupational health department. At one point they hired an external third-party provider to assist in managing employee sick leave by communicating with employees by phone, collecting medical forms and providing feedback to the employer regarding the supportability of each sick leave. My original intention was to complete a thesis examining the impact on employee absenteeism of introducing this third-party provider. Sick leave data from before and after the third party was introduced, was to be compared. Methods to utilize the employer payroll data while maintaining privacy were developed and approved by both the employer and the university ethics committee. Unfortunately by the time this initial work was completed and the literature review carried out, the employer payroll database software was upgraded and the sections of past payroll data required were no longer available without a substantial amount of work by the information technology department, rendering the data unavailable to this researcher. Due to this complication and other barriers, my efforts were redirected towards this major paper.

In preparation for the defence of this major paper my supervising professor discovered “A dynamic model of presenteeism and absenteeism” included in a paper by Johns in 2009. In particular, his paper discusses presenteeism and its relationship to job insecurity and loss of productivity. If and how presenteeism may be associated with absenteeism is also explored. Johns includes considerable discussion regarding the literature on

presenteeism. The reference for this paper has been included in the references section for this paper as it contains many of the themes and factors discussed in this paper, as well as substantial discussion on presenteeism and would likely be useful for future research.

Recommendations for Health Care Employers and Managers

In her book on disability management, Dyck (2002) claimed that on average women are absent more days than men, larger organizations tend to experience more absenteeism, public sector employees tend to miss more days than private sector employees, unionized workplaces are associated with higher absenteeism, shift workers have higher absence rates and employees with sick leave plans tend to be absent more. Johnson et al. (2003) reported females and young people are more likely to be absent from work. These factors are not easily influenced by employers and hospitals. In Ontario professions such as nursing are still largely female dominated professions (College of Nurses of Ontario, 2012). Hospitals and many other health care facilities such as nursing homes operate 24 hours per day such that many employees are shift workers, who are largely unionized and often have a good sick leave plans such as the Hospitals Of Ontario Disability Income Plan (Ontario Hospital Association, 2013) in Ontario hospitals. Thus health care in Ontario appears to have a number of factors, large female portion of workforce, public sector, largely unionized, shift work, and good sick leave plan, which are associated with increased absenteeism which are not likely to change markedly in the near future.

Davey et al. (2009) reported the most significant factor associated with absenteeism in nursing with greater than 50% significant results was the nurse's attendance history. Therefore, employers need to pay attention to attendance history and address individuals with a poor attendance record or it will likely persist. The second absenteeism factor for nurse absenteeism Davey et al. (2009) reported as a common theme in the research was work attitude. Work attitude included job satisfaction, organizational commitment and work/job involvement. As job satisfaction, organizational commitment and work/job involvement increased, absenteeism decreased. Castle (2013) could argue that all of these could be influenced using consistent patient assignments to nurses which would increase the nurses' commitment to "their" patients and becoming more involved in the job. This could result in increased job satisfaction and eventually increased organizational commitment which Castle reported resulted in decreased turnover in nursing aides at nursing homes. Decreased staff turnover would decrease one source of workplace change reported by Verhaeghe et al. (2006). Although their study examined change for hospital nurses over a limited amount of time (six months), decreased change was associated with decreased absenteeism. According to Bamberger and Biron (2012) supervisor support could influence work attitude in some employee groups. If supervisors were perceived as supportive by some employee groups this was associated with decreased absenteeism. Cummings et al. (2008) reported positive relationships among managers and oncology nurses along with a visible leadership style were associated with decreased absenteeism. Based on this, the literature review, and my own work experiences, employers should have well trained supervisors to support the programs they have in place, who also have a positive attitude which is visible to employees. This could positively impact employees'

work attitude. Once a workplace has influenced some employees work attitudes, Bamberger and Biron (2006) argued the peer groups of those employees would also be influenced. Open communication and a positive visible relationship between supervisors and unions, in a unionized workplace, could be very beneficial as unions could be the largest and highly influential peer groups in some workplaces.

The last absenteeism factor trend Davey et al. (2009) reported was job stress level which they broke down into retention factors and burnout. They did not indicate which retention factors were examined in the studies nor did they provide a definition of burnout.

Workload could influence both retention and burnout. If employees have manageable workloads, job stress may be decreased, workers could be less likely to leave that employer or department, and burnout might be less likely. Rauhala et al. (2007) could add that it is the employee's perceived workload that is important in reducing absenteeism as in their study, if a Finnish nurse perceived their workload as 15% or more above their optimal workload, there was an increased risk of absenteeism. This could be difficult for some employers to address as employees could perceive the same workload differently.

In addition, over time employees may become accustomed to the new workload level and again perceive or rate it at a higher level. Furthermore, new workers who never experienced the old workload could perceive it as less manageable. Employer budgets, particularly in government health care facilities, may not allow for increased staffing to decrease workload. Therefore more creative solutions often need to be identified to decrease the workload or influence the employees' perception of the workload. For example, processes could be made more efficient, administrative duties decreased, or

physical distances between patients for patient assignments managed more closely if possible.

With advances in technology computer and mobile applications for medications, procedures and other information could replace the use of books. Electronic charting and tracking of patient information could allow for quicker access compared to flipping through a paper chart of a patient. This could decrease both the employee's actual workload and perceived workload, but could increase job stress for older or less educated groups who are not as familiar, or comfortable, with computers and technology. This strategy would require an investment for employers to ensure staff was well trained with the new technology and applications particularly in health care where patient safety and care is paramount. Training might make the older or less educated group more comfortable over time.

One long absence is more likely to be due to medical illness (Johnson et al., 2003). The recognition system examined by Werner (1992) and other reward type systems (Hassink and Koning, 2009) are strategies that could be used to address shorter intermittent absences but a simple attendance feedback system could be effective as well to decrease intermittent absences. Annually, semi-annually, or quarterly employees could be given a report of what their level of absenteeism is overall, compared to averages for others in their department, or compared to averages for others with a similar job type. Being informed of their level of attendance may stimulate employees to improve their

attendance. Such a system could be used in conjunction with a recognition system. Everyone could receive their attendance data and those at the upper level of attendance chosen by the employer as a goal could be given recognition or some type of reward. In Werner's (1992) program, employees with two sick days or fewer during the past quarter were given a good attendance certificate that were distributed at staff meetings and notices were also posted in an area visible to co-workers. This practice resulted in a 28% decrease in sick leave. The recognition program was put in place for only one year such that the long-term impact was not available. If employees with good attendance received a prize of some sort or a monetary bonus, one wonders if a larger decrease in sick leave be achieved? The rewards for such a program would have to be less than, or minimally equal to, the resulting sick leave savings. In publicly funded government facilities, such as hospitals, these types of systems are not allowed for the majority of workers. In private industry, they might be possible. Some employers, public and private alike, use or have used a cumulative sick leave system. Under these types of systems, employees accumulate a certain number of sick days per year and they are kept in a sort of sick leave bank in case they are needed. Under such a system, if an employee has a lengthy absence early in their career they do not have enough sick leave banked to cover subsequent absences. Late in an employee's career they could have so much accumulated sick leave that they could feel they earned the right to use them and begin to demonstrate increased sick leave, especially if all the sick leave days saved will be lost upon retirement. In order to avoid this situation, some employers utilize a type of reward system. At retirement half, or another percentage, of the sick leave days in an employee's sick bank might be paid out as a reward for good attendance. With such a system employers are actually

paying out a certain rate of absenteeism without having the loss of the employee, or productivity. Some employers however, put a maximum, or cap, on how much can be paid out. Such a system could lead to employees using increased sick time later in their careers once they have accumulated the maximum allowed to be paid out at retirement.

Conclusions

With regard to health care absenteeism in general, after reviewing the literature and an extensive systematic research review by Davey et al. (2009) and Osilla et al. (2012), no significant absenteeism factors in health care were identified – but some trends were observed. Unfortunately, no published research was found related to the use of third-party case management companies or outsourcing disability management in health care. Based on the literature reviewed, there does not appear to be one absenteeism management system or intervention that employers should put in place that is shown to have a lasting significant impact. Some trends in absenteeism factors in health care were identified that may provide a starting point: the worker's prior attendance history, job stress, work attitude, consistent patient assignment, and supervisor/leadership support. If a nurse has a poor attendance history, poor attendance is likely to continue in the future (Davey et al., 2009). The research reviewed was specific to nurses but could be considered in relation to other health care jobs. Low work stress, a good work attitude, employees feeling valued in the workplace and supported by supervisors could all contribute to employees having a good workplace experience. Providing a positive and quality place to work for employees could increase staff retention, lower absenteeism, and

increase productivity if maintained. Employers should choose a system for reducing absenteeism that best fits with their workplace style, philosophy and goals. Once a system is chosen it needs to be supported in the workplace by management (Bamberger and Biron, 2012) (Cummings et al., 2008). Management needs to be well trained about the system, use it consistently and display a positive and supportive attitude towards it. If management is not perceived as supportive of the system, employees are not likely to be supportive or engaged either (Bamberger or Biron, 2012) (Cummings et al., 2008).

Accessing the absenteeism system needs to be efficient and easy to implement and manage in order to facilitate its' use. If it is cumbersome or time-consuming, it is not likely to be used by frontline supervisors or managers as this is only one of a number of tasks required of them in operating a facility and managing employees. Finding out which departments or employee groups are problem areas and piloting the new system there could be of value. If it impacts such employees, Bamberger and Biron (2007, 2012) noted that it will likely impact a larger group of employees, namely the peer group of these employees. Given that many health care facilities are unionized, open and good communication regarding whichever absenteeism system is chosen by an employer could allow for unions to be supportive of, or indifferent to, the system (Dyck, 2002). In the case of Ontario hospitals, this could mean the largest peer groups, the unions, could positively impact a large employee population. Early and regular communication between the employee and the workplace is also recommended. A consistent, efficient and professional absenteeism system could be supported by management, unions and employees

Overall, this paper did not result in any particular workplace intervention being recommended to health care employers or hospitals in Ontario. Common themes in the research have been outlined, such as: work attitude factors, work retention factors, job stress and burnout, and these could be the potential focus for employers seeking to make changes to their workplace absenteeism strategies to explore further. Notably, it can be hard to determine if an intervention is successful if many interventions are evaluated concurrently. If employers are initiating workplace absenteeism strategies, the World Health Organization Healthy Workplace Framework (World Health Organization, 2010) and the National Standard of Canada for Psychological Health and Safety in the Workplace (Canadian Standards Association Group, 2013) are also recommended for guidance.

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