

This item was submitted to Loughborough's Institutional Repository (<https://dspace.lboro.ac.uk/>) by the author and is made available under the following Creative Commons Licence conditions.



For the full text of this licence, please go to:
<http://creativecommons.org/licenses/by-nc-nd/2.5/>

SICKNESS ABSENCE MANAGEMENT: ENCOURAGING ATTENDANCE OR ‘RISK-TAKING’ PRESENTEEISM IN EMPLOYEES WITH CHRONIC ILLNESS?

¹Dr Fehmidah Munir PhD., ²Dr Joanna Yarker, PhD., ¹Professor Cheryl Haslam PhD.,

¹Department of Human Sciences, Brockington Building, Loughborough University, Loughborough,
Leicestershire LE11 3TU, UK.

²Goldsmiths College, University of London, New Cross, London SE14 7NW, UK.

Correspondence to: Dr Fehmidah Munir

Department of Human Sciences, Brockington Building, Loughborough University, Loughborough,
Leicestershire LE11 3TU, UK.

Tel: +44 (0)1509 228228

Fax: +44 (0)1509 223940

email: F.Munir@lboro.ac.uk

Key words: sickness absence, presenteeism, organisational policies, chronic illness, employees

Word Count: 7352

SICKNESS ABSENCE MANAGEMENT: ENCOURAGING ATTENDANCE OR ‘RISK-TAKING’ PRESENTEEISM IN EMPLOYEES WITH CHRONIC ILLNESS?

Abstract

Purpose: To investigate the organisational perspectives on the effectiveness of their attendance management policies for chronically ill employees.

Methods: A mixed-method approach was employed involving questionnaire survey with employees and in-depth interviews with key stakeholders of the organisational policies.

Results: Participants reported that attendance management policies and the point at which systems were triggered, posed problems for employees managing chronic illness. These systems presented risk to health: employees were more likely to turn up for work despite feeling unwell (presenteeism) to avoid a disciplinary situation but absence-related support was only provided once illness progressed to long-term sick leave. Attendance management policies also raised ethical concerns for 'forced' illness disclosure and immense pressures on line managers to manage attendance.

Conclusions: Participants felt their current attendance management policies were unfavourable toward those managing a chronic illness. The policies heavily focused on attendance despite illness and on providing return to work support following long-term sick leave. Drawing on the results, the authors conclude that attendance management should promote job retention rather than merely prevent absence per se. They outline areas of improvement in the attendance management of employees with chronic illness.

Word Count: 188

Introduction

To address the extent and cost of workplace absenteeism, policies on improving and increasing employee attendance have recently been introduced by Government and employers [1, 2]. As a result, much has been published on the effectiveness of such policies in reducing sickness absence, its associated costs and its effect on productivity [3-5]. There is now, however, a recognition that presenteeism i.e. attending work despite feeling unwell; may be increasing due to inflexible absence policies impacting on genuine cases of short-term sickness absence [1, 6-8]. In particular, high rates of presenteeism have been reported for major chronic illnesses such as heart disease, depression and anxiety and back pain [9]; the very same illnesses that are reported as leading causes of long-term sickness absence [10].

The relationship between low short-term sickness absence, high presenteeism and long-term sickness absence has not been adequately explored. Furthermore, this relationship might not be linear, but complicated by factors such as illness disclosure, fear of job security and job promotion that may influence presenteeism. Work factors such as difficulties in staff replacement, time pressure to meet job demands and organisational norms and workplace cultural barriers also influence attendance behaviour. Although emerging evidence has found a number of these factors linked to high presenteeism and low short-term absence [1, 8 9], the complex interplay between these relationships are yet to be explored in sufficient detail. For example, it is not known whether those who choose to disclose their illness have done so to explain their frequent absence (i.e. forced disclosure). Furthermore, whether such disclosure results in lower levels of absence or presenteeism because of subsequent workplace support. While there is need for further research, it is likely that attending work when feeling ill without appropriate support or work adjustments may lead to an exacerbation in illness symptoms and subsequently reduce capacity to remain at work in the long-term. Pressures to attend work despite feeling unwell may also increase feelings of job dissatisfaction, low psychological well-being and other symptoms related to stress.

Little is known of the extent to which employers are aware of, and acknowledge, the impact sickness absence policies may have on potentially increasing rates of presenteeism and long-term sickness absence among employees managing a chronic illness. The authors have found no research pertaining to how those responsible for implementing or monitoring attendance policies perceive the effectiveness of such policies for those managing a chronic illness and whether difficulties in carrying out the policies are experienced. If organisations are to develop interventions that are effective in helping employees remain at work and reduce long-term sickness absence, they will need to have a good understanding of these factors.

This research aims to investigate the organisational perspectives on the effectiveness of their attendance management policies for chronically ill employees. The research draws from two studies adopting a mixed-method approach. First, a survey method was used to compare the levels of absence and presenteeism reported by employees with and without a chronic illness. While this is not the focus of this research paper, this provides vital information about the context in which to understand the stakeholder perceptions. It was predicted that both absence and presenteeism would be higher among those with chronic illness. In addition, absence and presenteeism were explored between those who had disclosed their illness to their employers and those who had not. Second, interviews were carried out with key stakeholders to collect new and in-depth data on knowledge and understanding of chronic illness, perspectives on sickness absence, presenteeism and the individual and organisational barriers and facilitators to effective absence management. The key research questions aimed to delineate stakeholders' (e.g. line managers, human resource managers, occupational health staff) implementation of their attendance management policy; their knowledge of the type and prevalence of chronic illness in their workplace; their awareness of how attendance management policies impact upon such employees' work and well-being; and the available resources to help support such employees. This mixed-method approach has three benefits: different methods or tools are suited to different tasks, both necessary in order answer complex and new questions; combining approaches aims to result in a synergistic effect due to the interaction of

both approaches [11]; and also enables feedback between assumptions and data thereby enhancing the validity of results.

Methods

Participant organisations

To carry out both survey questionnaire and stakeholder interviews, fifty organisations in the UK were randomly selected and invited to participate in the study by the research team. The organisations were selected from the Thomson Business Search Pro CD Rom directory (2003) and recruitment techniques included mail shots, telephone calls and e-mails to organisations. Eight organisations expressed an interest in the study out of which four were selected to take part. The selected organisations were chosen to represent a range of organisational size and work sectors: two organisations were in the private sector (manufacturing) and two in the public sector (public administration and transport) [12]. A summary of the absence management policies within these organisations can be found in table 1. This work received approval from the University's ethics committee.

[Insert table 1 about here]

Study 1: Employee survey

Research participants

A review of organisational policies and practices across the four organisations revealed no organisational systems in keeping annual records of employees reporting a chronic illness. Therefore, in order to gauge the prevalence of chronic illness in each organisation and maintain employee confidentiality and anonymity, employees were randomly sent a questionnaire through their occupational health departments. The strategy for sending questionnaires varied according to organisational size. All workers in the two manufacturing companies were sent a questionnaire (employing 3,600 and 5,600 workers), and a random sample of approximately 1:3 workers in the local government (employing 14,000 workers) and 1:2 workers in the transport organisation (employing 12,000 workers) were sent questionnaires (26,200 questionnaires were sent in total across the four organisations). Workers were invited to volunteer for the study by completing the questionnaire. This was distributed through the occupational health departments and completed

questionnaires were returned directly and anonymously to the research team. All employees independent of their health status, were asked questions on demographics (e.g. age and gender) occupation and absence. Employees managing a chronic illness were asked additional questions about their health and work. A 28% response rate (response rates ranged from 26% to 30%) was achieved for returned questionnaires ($N=7,336$), of which 21% ($N=5,264$) were completed questionnaires. While this is a below average response rate for mailed surveys in organisational research of this type [13, 14], discussions with the organisational stakeholders indicate that response rates for questionnaires outside of annual employee surveys are in the region of 27-31% due to survey fatigue [15]. The low response rate in this study may also be expected given the study's focus on chronic illness, which may have seemed irrelevant to many workers.

Measures

Chronic illness

Participants were asked to self-report on any medically diagnosed chronic illness and to indicate which primary condition (if more than one was listed) *most* affected their work. This measure was developed to be consistent with other self-report measures of chronic illness [16-18]. Out of the completed questionnaires ($N=5,264$), 28% (1474 participants) reported at least one chronic illness. A total of 17 different groups of chronic illnesses were identified from the sample using the International Classification of Diseases [19] and are presented in Table 2 along with demographics.

[Insert table 2 about here]

Absence data

As data on the prevalence of chronic illness was collected using self-report measures, absence data was also collected through self-report. While it is acknowledged that organisational absence records are more accurate, it would not have been possible to compare absence data between those reporting a chronic illness and those not; and maintain confidentiality for those employees not

wishing to disclose their illness. Absence was measured by asking all participants (those with and without a chronic illness) to estimate the number of times they had been absent from work over the last 12 months. Data was collected on spells of absence lasting less than 5 days (non-certified absence) and spells of 5 days or more absence (as an indicator of long-term certified sickness absence). This captures both absence frequency and absence duration [20, 21], and is consistent with other self-report sickness absence measures [22, 23]. Such measures, when compared with organisational records of absence data have a convergent validity of .62 and above [22, 24].

Presenteeism data

Presenteeism was measured by asking participants to estimate the number of times they had attended work despite feeling unwell over the last 12 months. Data was collected on spells of presenteeism lasting less than 5 days and spells of 5-days or more presenteeism.

Since the absence and presenteeism data had a skewed distribution, a constant was added to each score and then log transformations were applied.

Disclosure of chronic illness

Participants were asked to indicate to what extent they had shared information about their illness with their line manager or occupational health (two items, measured on a five point Likert scale). A mean score was calculated to represent a single score of disclosure. For the purpose of the present study, disclosure was dichotomised (yes and no).

Results: Study 1

The demographic profile of those who had completed a questionnaire (n= 5,264) was compared with employee data obtained from each organisation's Human Resources department (non-

responders, data not shown). Participants who had completed a questionnaire did not significantly differ from their respective colleagues in terms of gender and occupational status (all $p > .05$).

Data between those reporting a chronic illness ($n=1474$) were compared with those not reporting a chronic illness ($n=3790$) in the survey using t-tests. Participants with chronic illnesses did not significantly differ from their respective colleagues in terms of age, gender and occupational status (all $p > .05$). Univariate analysis of co-variance (ANCOVA) was used to compare absence and presenteeism data between these two groups (Table 3). Age, gender, socio-economic status, type of organisation and education were entered as covariates. The ANCOVA revealed a significantly higher spells of non-certified absence [$F(1, 5067) = 78.58, p < .0001$] and certified absence [$F(1, 5067) = 258.81, p < .0001$] by employees with chronic illness. Significant differences were also found between the groups in presenteeism with higher spells of <5 days presenteeism [$F(1, 5072) = 257.28, p < .0001$] and ≥ 5 days presenteeism [$F(1, 5072) = 109.79, p < .0001$] reported by employees managing a chronic illness.

Within the sample reporting a chronic illness ($n=1474$), we compared mean spells of absence and presenteeism between those who had disclosed their illness to their line manager and those who had not, using ANCOVA. Age, gender, socio-economic status, type of organisation, education and illness severity were entered as covariates. The ANCOVA revealed a significant difference between the two groups, with significantly higher spells of non-certified absence [$F(1, 1291) = 21.64, p < .0001$] and certified absence [$F(1, 1291) = 58.36, p < .0001$] reported by employees who had disclosed their illness (see table 4). No significant differences were found between the groups in spells of <5 days presenteeism [$F(1, 1291) = 1.96, ns$] and spells of ≥ 5 days presenteeism [$F(1, 1291) = 2.10, ns$].

As the absence and presenteeism data were positively skewed despite transformation, we replicated all comparisons using nonparametric tests (data not reported). The results from these did not significantly differ from the parametric tests.

[Insert table 3 and 4 about here]

Study 2: Interviews with stakeholders

Research participants

From each of the four organisations we recruited and conducted semi-structured interviews with those with an interest in organisational responsiveness toward employees with chronic illness. These were occupational health staff, attendance managers, health and safety managers, line managers and representatives from human resources. Interviews were also carried out with trade union representatives to capture an employee representative perspective on the impact of sickness absence policies on employees managing a chronic illness. Participants were recruited by the research team through the occupational health service in each organisation. Staff within each organisation were made aware of the research by the occupational health service and volunteered to participate in the study.

Fifty-eight participants were interviewed in total. Across the four organisations, 36 of the participants were female and 22 male. Participant age ranged from 25 to 57 years and tenure ranged from 3 to 30 years. The number of interviews carried out in each organisation depended upon the size of the organisation and the number of staff having responsibility for employees with chronic illnesses (see table 5).

[Insert table 5 about here]

Interview schedule and analysis

The interview schedule was developed drawing on findings from a previous study on the management of chronic illness at work [16]. A semi-structured interview schedule allowed participants to reveal as much information they were comfortable in discussing. The questions aimed to elicit information on knowledge of chronic illnesses (e.g. How have you gained your knowledge on chronic illness?), attendance management (e.g. what would typically happen if a member of staff with a chronic illness was often absent for short spells?), disclosure (e.g. who would staff normally disclose to?) return to work policies and systems (e.g. what support is offered to staff returning from long-term sick leave?), and training and skills in managing such employees (e.g. are there ways in which you feel support could be improved for staff with chronic illness). All participants received the same interview schedule with some questions rephrased according to the participants' job role. For trade union representatives, the questions were slightly adjusted to obtain their view of some of the problems employees have encountered with their organisation's attendance management policy. The schedule was piloted and refined. Interviews took place either at their workplace or over the phone. Each interview lasted approximately 45 minutes and was recorded with the agreement of participants.

The recorded material was fully transcribed and analysed using template analysis [25].

According to this approach, the researcher develops a list of codes, the "template", to capture the themes identified in the textual data. While some codes are defined a priori, subsequent interpretation of the material allows expansion of the codes [25]. The first phase of data analysis involved careful reading and re-reading of all transcripts. Initial codes were guided by the research questions from the interview schedule and from study's objectives. These codes were modified and refined as additional ones emerged from the data. These included codes for

topics arising from prompt questions and for topics arising spontaneously during the interviews. The second phase involved organising and subdividing the coded data into text segments for each emergent theme and sub-themes to aid the interpretive process. The data under each theme was summarised and verbatim quotes used to illustrate the theme being described. The reliability of the analysis was ensured through systematic review of the data by three members of the research team.

Results: Study 2

Seven main themes were identified from the interviews. The themes are summarised below along with illustrative quotes. No major differences were found in the themes between organisations. However, trade union and occupational health staff had slightly negative views of line managers' role in attendance management for employees with chronic illness. These are highlighted in the results where relevant.

Knowledge and awareness of chronic illness

None of the participants interviewed had a clear idea of the prevalence of chronic illness at their workplace. Estimates were made ranging from a handful of employees working under a particular line manager, to a rough percentage across the organisation typically ranging from 5-20%. This was due to a combination of employees choosing not to disclose their illness and no organisational policy that necessitates organisations to monitor the prevalence of chronic illnesses other than those that fall under the UK Disability Discrimination Act [26]. In terms of specific chronic illnesses, participants were largely aware of employees managing musculoskeletal pain and depression and anxiety, as these were most frequently encountered among employees requiring work adjustments or who were on long-term sick leave, as one trades union representative described:

“I would say that the biggest one we deal with is depression generally, its people having time off work and their general health is deteriorating because they’re depressed....”.

Except for occupational health staff, actual knowledge of how illnesses affected the employee both personally and in relation to work was limited, particularly for stress, anxiety and depression. A human resources manager described some of the problems in understanding depression and recognising genuine sickness absence:

“I think it’s probably just the unknown around what depression is really... because a lot of people come in with sick notes and they say they are depressed – but are they just fobbing you off or are they genuine?”.

None of the participants in this study (except for Occupational Health staff) had access to general information about chronic illnesses. General knowledge about most illnesses and their symptoms was acquired through the participants’ own motivation or need for knowledge. Some participants were able to ask their occupational health for general information (if not already supplied), but usually information was sought from external support groups, GP surgeries or from the internet, as one trade union representative described:

“If we get a case where we’re not sure on, we always look on the internet for it and pull information. I’ve got one lady whose got thalamic-something disorder, and I did not have a clue, so me and the convenor, we did some research and got a pack together, understanding why she was having these issues”.

Attendance management and chronic illness

The majority of the participants felt their organisation had fairly good policies in supporting employees with a chronic illness or a disability. However, many felt that the available systems and policies for support were not being implemented effectively enough. One of the largest grey areas within each organisation was the attendance (absence) management policy. All four organisations had attendance management policies whereby employees were flagged if more than three spells of absence were taken (table 1). Participants felt that attendance management policies were strict and did not account for employees managing a chronic illness. While the policy helped to monitor and keep employees with minor ailments largely at work, it usually exacerbated the symptoms and management of a chronic illness. Such employees were more likely to turn up for work in order to avoid a disciplinary situation, or subsequently took long-term sick leave as their condition had deteriorated, as one line manager described:

“We have an attendance policy where if you’re sick for one day and then again, you get booked like someone who takes a month off”. (Line manager)

“[Crohn’s disease] They are almost penalised for being sick too many times! We’ve had one of these ‘sympathetic warnings’ to say ‘yes, we know you’re sick, we know you’ve not been very well but that’s no good to the business’. And sometimes that is sad and we don’t get any input on that other than try and support and say ‘look, please lay off, because this person really isn’t well’ but also the company has to be treating everybody the same”. (Occupational health staff)

“If you have a long-term illness you’re likely to take time off sick and that messes up their targets for attendance... the more people have time off, the more it can move into a disciplinary situation”. (Trade union representative).

In some cases, when employees need to take sick leave and managers discourage it because of pressure to meet attendance targets, occupational health staff have intervened and sent employees home. This causes its own set of problems with managers who assume employees cannot carry out their duties.

“Policies are there to ensure consistency and fairness, but sometimes the way they are applied by individual managers doesn’t seem to be very fair. Working on those kinds of areas are very important”. (Occupational health staff).

“Because they want to keep up their attendance rates you know, but we feel they are unwell so we will write a memo and send them home”. (Occupational health staff).

However, participants acknowledge that not all employees with similar illnesses, are affected by their illness to the same degree or manage their illness in the same way. This can mean that absence patterns can vary from person to person, thus making it difficult to assess an absence policy specifically for employees with chronic illnesses.

“I think it depends on the individual. You have one person with diabetes who could be off a lot, but another will be diabetic and they’ll never lose any time”. (Occupational health staff).

“People with diabetes... they know what to do to manage their illness... they get that from their own GP.... They don’t necessarily require a lot of time off, whereas people with chronic asthma require more time off especially at certain times of the year”. (Attendance manager).

The public sector organisation had the most supportive attendance management policy for employees with chronic illness. However, attendance levels still caused problems as one attendance manager explained:

“He’s had quite a lot of short-term intermittent absences, but he is supported by both his colleagues and his manager. If they’ve got appointments at the hospital we don’t count them as sick days. We do everything to support them, but we can’t live with excessive absences because the operation can’t sustain it indefinitely. At the end of the day, there is much pressure on us to reduce absence levels”.

Attendance management, illness disclosure and presenteeism

Participants felt that most employees managing a chronic illness at work had disclosed their illness either to their line manager or to Occupational Health. This was partly because the organisations encouraged disclosure through some of their policies (e.g. during induction programmes, pre-medical check-ups for new employees, drug and alcohol policies). The approach taken was described as a supportive one i.e. so that the provision of appropriate work adjustments and workplace support could be made. However, all four organisations relied on their attendance management policy to encourage or ‘force’ disclosure, as one line manager summarised:

“When they’ve been off three times they get put into the warning system. People that don’t want to talk about it, I think once they get into the warning system, they say ‘oh yes, I have got a problem’”.

“Quite a lot of it is quite reactionary. Someone goes off long-term sick and we find out they’re off sick, we then try and determine what it is”. (Line manager).

It was recognised there may be a significant proportion of employees within each organisation that had not yet disclosed their illness, despite needing help and support or becoming a health and safety risk. Reasons for non-disclosure were discussed by the participants and included fear of unemployment, mistrust of line manager, stigma attached to certain conditions and feeling useless to the organisation.

A lot of people think that because they have been diagnosed, they are going to lose their job.... they think they are going to be victimised, or made redundant or sacked or whatever...”. (Occupational health staff).

However, the strict attendance policies have created mixed reactions from employees. Participants were aware that this was a catch-22 situation: Employees who were in fear of losing their job, being stigmatised or creating ‘problems’ for managers and their colleagues in asking for help, were not disclosing their illness despite needing help and support. This was either leading to high short-term sickness absence because they were not managing their illness at work, or if they were attending work despite feeling unwell, a worsening of their condition thus leading to long-term sick leave:

“I think the difficulty is where people don’t want anyone to know what the problem is I think sometimes people might be suffering from the same sort of stress or whatever that they don’t want anyone to know about”.
(Health and safety manager).

“People don’t understand and we don’t discuss it because it’s confidential. Some colleagues won’t ask for adjustments because of it, even if they need it”. (Line manager).

“It’s quite hard to say to your boss ‘I’m not up to the job anymore’, because you might not have a job. I would probably just sit on it and not even go to my doctor in case it got back to my employer”. (Line manager).

As managers are perceived to be the primary contact point in managing attendance and in providing support, there was much concern from other participants, particularly from trade union representatives and occupational health, about the unsupportive attitude of some managers toward employees with chronic illnesses, thus making disclosure more difficult:

“Manager think: ‘we’re all depressed, they should just get on with it’. In the majority, managers are not sympathetic. Anything they can’t see they don’t understand. It’s the same as the chronic digestive disorders”. (Occupational health staff).

Differences were observed in the prescribed route for disclosure of illness across the different organisations, e.g. being able to choose to disclose to either occupational health or line managers. Participants noted the difficulty created for line managers in making allowances in attendance management when an employee disclosed to occupational health. As the occupational health services are bound by confidentiality, only limited information can be given about the employee to the line manager as one manager noted:

“OH are very strict on patient confidentiality so if someone went to see them, we are sometimes not informed what the illness is. All we’re aware of is that this person is feeling unwell and unable to attend work. It can cause frustration and feelings of resentment when a manager is not told why someone is absent from work or unable to complete a full day’s work”.

Many of the line managers recognised the importance of being approachable to encourage employee disclosure of illness. Some line managers were people-orientated and were able to either pick up on problems caused by illnesses before they escalated, or were willing to provide minor work adjustments to their discretion, to help minimise the impact of the illness on the employee and their job, and thus reduce presenteeism and absence as one line manager summarised:

“If they find a manager that they feel they can talk to and they feel relaxed with, they’ll divulge more information than with people they don’t feel comfortable with. Even if I don’t cover that shift, I’ve actually had people off other shifts tell me about some problems they’ve got and asked me to sort it out for them...”

Attendance pressures on line managers

Many participants felt there was too much pressure on the managers to carry out their jobs and meet attendance targets without adequate resources and support for themselves or their staff. Trade union representatives and occupational health staff felt many line managers to be generally unsupportive and it seemed to be due to a mixture of meeting work pressures and general limited understanding of chronic illnesses and its impact upon the individual at work:

“Unfortunately, our managers are given such strict targets and tasks to achieve, and there’s hell to pay if they don’t, that they expect someone to be one hundred percent. So although they do care, they are not there to care about people in the same way as we are. And sometimes its easier for one of their staff to be off [long-term] sick than to be accommodated. So when we say ‘they’ve got to do this and you’ve got to accommodate this’, we’re putting an awful lot of pressure on these poor people”. (Occupational health staff).

“I think managers need to be more approachable, more friendly and with more life experience. They’re too judgemental. Sometimes, it’s like if you get an issue when you phone in you’re ill, you genuinely can’t cope, and its like ‘well, you’ve had so many days off you’re going into warning’. Sometimes I think they need to think to themselves ‘What would I feel like if I was in this position?’”. (Trade union representative).

Such employees were more likely to turn up for work in order to avoid a disciplinary situation, or subsequently took long-term sick leave because their condition had deteriorated. It was acknowledged by participants that although employees attending work despite feeling unwell were a health and safety risk, some managers only took the issue of making allowances in attendance targets or in providing support when it was either too late (reactive support) or when it affected their staffing levels:

“Managers are not always sympathetic. They tend to listen more if the employee’s gone on sick which doesn’t make sense.... That annoys us sometimes because we’ll say ‘we told you, we let you know they weren’t well and now they’ve gone on the sick’. I know managers have a hard task... they have to get the production out”. (Occupational health staff).

“Sometimes you are down to the bare bones of staff through illness or whatever, and you’ve got to utilise these people and keep the production lines going... it’s quite difficult in being able to organise things” (Line manager).

Trade union representatives recognised that many of the differences arising between managers’ attitude toward employees with chronic illness was attributed to the attendance policy, where some

managers' offered termination of employment to keep their attendance record down, instead of offering work adjustments or flexibility in working hours.

"We talk about adjustments in [organisation] but sometimes some people think that's not viable for this person's condition and may say 'oh medical termination...' I mean diabetes, as long as someone takes their medication, you can have a reasonable adjustment". (Trade union representative).

On the other hand, many managers themselves are at risk of high presenteeism and long-term absence because of the pressures of the job. As line managers are expected to work under considerable pressure to meet performance standards and targets, many managers feel they cannot discuss their health problems and are unable to take short-term sick leave when feeling unwell so continue working until its too late.

"I find a lot of managers are ill but we sort of hide it. Some have gone to the limit and gone on sick, medical termination.... whereas they should say early on 'I can't manage this' and have a break really". (Line manager).

"The pressure they put on people is amazing. They say I need 96% attendance. The thing is, I should only be judged on the process of attendance we follow, because you can't stop people going off sick". (Line manager).

Employee responsibility in managing chronic illness

Participants recognised that some of the responsibility of managing illnesses also fall upon the employee themselves. Without their own contribution, willingness to disclose and management of

illness at work, any flexibility offered in attendance management or any support or rehabilitation programme won't be entirely beneficial to them as one occupational health staff discussed:

“We had an employee a couple of years ago who just wouldn't take her medication... I have had to talk to her about losing (work) time and she said it was her diabetes, but I knew it was because she wasn't taking her medication properly, going out and staying out late and wasn't doing what she was supposed to be doing...”.

However, the emphasis on good line manager and employee relationship came through strongly from all participants in ensuring the right support is received by employees with a chronic illness to help manage both absence and presenteeism:

“Its down to the managers and the person with the chronic illness to really open up and be ready to receive the help and guidance – a two-way thing really”.

(Human resources staff)

Chronic illness, sick leave and rehabilitation

Overall, participants across all four organisations raised the issue of organisations being most concerned with illnesses that resulted in long-term sick leave such as depression or back pain, than in providing support to chronically ill employees who had not yet gone on long-term sick leave. The emphasis here was on getting such employees back to work as quickly as possible and many of the organisations' resources were spent on providing return to work support. This heavy focus on attendance management and return to work (rehabilitation) was acknowledged by the participants and there was a general consensus that attention should be directed in identifying illnesses early on (where possible), and providing support at that level before it progresses to long-term sick leave:

“I think we could do better if we could catch people early on in their illness. We do it for back pain but we seem to let the others slide”. (Line manager).

“They have this policy where if you are off with three different things within one rolling year, say if you’re off with a sore throat in April, back pain in August and with swollen glands in January for instance, then you get a written warning. At no point has anyone asked OH ‘Could these things really be connected? Could they be the same illnesses? Could this person be suffering with chronic fatigue, M.E. or depression?’” (Occupational health staff).

“One person who had CHD, the length of time she was off for sick, months, it cost the company over £7,000 and that didn’t include indirect costs such as an agency staff to cover for her time etc... and that didn’t cover the cost to the employee and their family, time off work.... A CHD check costs £1.64, so I now do that with every employee that comes for a medical. We’ve proved it in monetary terms. If we can stop this, see and diagnose these people before it happens. We have people on cholesterol tablets who before were open to strokes and heart conditions, for the sake of £1.64 for a wee stick...” (Occupational health staff).

Supporting organisations in flexible attendance management policies

All participants recognised that early recognition or disclosure of illnesses and early provision of support was essential if organisations wanted to retain employees and minimise presenteeism, long term sick leave, redeployment or unemployment. However, there were some difficulties in understanding how attendance policies could be made more flexible for employees with chronic illness and participants felt more knowledge and guidance from the government, occupational health staff or from human resources was required as one line manager summarised:

“We really need clear guidelines. Its written that way but its really woolly its ‘consider this, consider that’, not very clear at all. I think perhaps a flexible look at how we apply our policies rather than the support itself is needed”.

“I don’t think we have fostered understanding of diversity or the requirements of diverse thinking effectively enough. We’re still quite ‘well, you should appear at eight or nine in the morning and leave by four or five...’. We like to run a tight ship and I don’t think that’s a very good climate for general understanding”.

(Human resource manager)

In addition, the majority of participants agreed that more could be done to help both managers and employees with chronic illness to manage some of the difficulties encountered with strict attendance policies and its associated problems. Participants recognised the need for adequate training and support for line managers who were crucial in the provision of support and subsequently in retaining employees managing a chronic illness at work:

“I think there’s definitely room for more awareness, simply because yes, they may be aware of the impact it has on work because they have to try and manage it, but I think that’s where it sort of ends. I don’t always think they look beyond the workplace and look at the impact it has on their life in general which in turn has a greater impact on their work. Its not just their condition, it’s the knock on effect, it comes full circle”. (Occupational health staff).

“Perhaps (the organisation) should offer some more advice to the managers. Managers just don’t know. They haven’t had the experience. No-one tells them how broad a manager’s job is”. (Line manager).

Discussion

The study has highlighted ways in which certain attendance management procedures may disadvantage employees with chronic illness by placing greater emphasis on reducing absence levels rather than facilitating disability management. In order to avoid hitting stringent absence ‘trigger points’, employees may come to work despite feeling that they need to take sickness absence [9, 27]. Indeed, published figures from the Labour Force Survey and the Confederation of British Industries [28] suggest that the rates for sickness absence have fallen in recent years and this may be due to employers tightening up their absence management policies, or employees apparently taking a shorter time to recover from their illnesses due to the pressures to attend work or to return to work earlier than in previous years [1, 9, 29]. As demonstrated in the interviews, managers may also be under pressure to uphold stringent attendance targets.

The participating organisations did not monitor the prevalence of chronic illness. The lack of adequate monitoring systems for chronic illness has two important implications: the organisations do not have a clear picture of the prevalence of chronic illness; and as a subsequence, they are unaware of the impact of chronic illness on work performance or employee health and safety. Our findings suggest that a flexible attendance management policy that takes these issues into account may work to reduce absence and presenteeism and improve health of chronically ill employees. Data from study 1, the employee survey, has found chronic illnesses among employees to be prevalent and such employees report higher levels of both absence and presenteeism compared with employees not reporting a chronic illness. While this finding may be unsurprising in isolation, when combined with data from study 2, the stakeholder interviews, in which findings indicate that those responsible for absence management systems are neither aware of the prevalence chronic illness in their workplaces or the impact chronic illnesses have on persons ability to manage their work, they present a very real issue for organisations.

Although the participating organisations have a number of policies and procedures for encouraging illness disclosure, they were at risk of relying on attendance management to force disclosure when an employee reached an absence ‘trigger point’. Data from the survey showed that those who had disclosed their illness reported higher levels of both non-certified and certified absence compared to those who had not yet disclosed. Interviewees recognised that there may be a significant number of employees who have not yet disclosed their chronic illness despite requiring support to enable them to remain healthy and safe at work. This is supported by findings from the survey which indicate that only half of employees managing a chronic illness have disclosed their illness to their line manager or occupational health (table 4). This presents a health and safety risk concern in that employers rely on this reactive warning system to indicate that someone requires support, instead of providing proactive support through early intervention. Indeed, the participating organisations’ attendance management policies place great emphasis on return to work procedures with the aim of encouraging an early return. However the opportunity to take short-term absence may enable employees to recover more quickly and may prevent subsequent periods of long-term absence, therefore reducing the need for costly reintegration back into the workforce.

Early disclosure of chronic illness can prompt early intervention which may lessen the risk of long-term absence. However, encouraging disclosure alone is not enough. If an organisation fails to provide adequate support within the workplace to help employees manage their chronic illness, these employees may experience an exacerbation of their condition which may result in longer term absence and may also impact on their ability to retain their job [29-31]. Future research should explore the long-term health effects, its consequences and related employer costs of inflexible short-term absence policies for those with chronic illnesses. Research interventions are also required that encourage early disclosure of illness. Any such intervention would also need to address organisational barriers to disclosure such as job insecurity, lack of trust in line managers and perceived organisational stigma attached to certain conditions (particularly depression and anxiety).

Recommendations

The results suggest that strict and inflexible attendance management policies may have a detrimental impact on employees managing a chronic illness. Policies on attendance management should take into account the needs of those with chronic illness, i.e. absence 'trigger' systems should not penalise employees for taking flexible short-term absence in order to prevent a worsening of their condition and subsequent long-term absence. Attendance management should promote job retention rather than merely preventing absence per se.

In order to support early intervention, more attention should be diverted towards enabling managers to identify chronic illnesses early on, so that an employee has a greater chance of receiving support at an early stage. Occupational health services are instrumental in providing this knowledge and also in acting as a point of reference should managers have particular cases where they need expert input prior to raising the subject with the employee. This knowledge and guidance may enable managers to gently push for disclosure, and ultimately to access the support their employee may need, at an early stage. This knowledge can be incorporated into work design and management, particularly in organisations where shift work, or lack of privacy, may be common. More research and intervention is needed to address the training needs and management competencies of line managers in the understanding of chronic illnesses and in providing appropriate proactive support. However unless managers have adequate resources at their disposal to enable them to provide support following disclosure, for example cover for employees who have been given lighter duties, it may seem easier (in the short term) for them to deal with employees' absence rather than put in place adjustments or offer redeployment. Therefore it is important to consider the organisational infrastructure and resource constraints within which the manager works.

An effective attendance management policy should also be underpinned by robust management information systems. Accurate monitoring of the prevalence and impact of chronic illnesses would also enable organisations to evaluate the benefits of effective attendance management in terms of

impact on levels of long-term sickness absence and job retention. Ultimately this may contribute to the business case for a more flexible attendance management policy that takes into account the impact of chronic illness within the workforce.

Limitations of the study

This study relied on self-report data from four participating organisations recruited from a limited range of occupational sectors. The participants interviewed were volunteers who were perhaps more likely to participate than those who had a more favourable view of attendance management policies. Therefore, the authors make no claims that these findings can be generalised more widely. The study did not collect qualitative data from employees managing a chronic illness and their experiences of attendance management policies. Thus, any discussion of attendance management policies or recommendations remain general rather than illness-specific as there was little if any differentiation made between illnesses by the participants interviewed. Despite incentives to employees to complete the questionnaire and repeated reminders, the study achieved a low response rate which may represent a potential source of response bias. Discussions with participating organisations confirmed observations of survey fatigue. This is an increasing problem faced by researchers conducting organisational based research, despite usage of response-inducing techniques [15]. In addition, although the questionnaire asked for information from those with and without a chronic illness, the main focus of the questionnaire concerned chronic illness management and it may be that many non-responders felt the questionnaire was irrelevant. Despite the evidence that higher spells of absenteeism were associated with illness disclosure, as the study was cross-sectional, the causality of the relationships cannot be ascertained. Further longitudinal research is needed to delineate the direction of these relationships.

Conclusions

European and national governmental policy is increasingly being directed towards the continued employment of individuals with long term illnesses and disabilities. By adopting a mixed-method approach, this research has shows that greater emphasis is needed in the areas of chronic illness and on preventive, proactive retention strategies. Organisations should be supported and encouraged to develop chronic illness management frameworks that in cost benefit terms can be seen as a worthwhile investment. This research calls for a redistribution of emphasis; while rehabilitative efforts to reintegrate employees with chronic illness back into work are worthwhile and important, they should be seen as complementary to, and not a substitute for, effective retention activity.

ACKNOWLEDGEMENTS

This work was supported by a grant from the European Social Fund. We would like to thank all participants for their support and for the time they gave to the study.

REFERENCES

1. Grinyer A, Singleton V. Sickness absence as risk-taking behaviour: a study of organisational and cultural factors in the public sector. *Health Risk Society* 2000; 2: 7-21.
2. Whitaker SC. The management of sickness absence. *Occup Environ Med* 2006; 58: 420-24.
3. Chatterji M, Tilley CJ. Sickness, absenteeism, presenteeism, and sick pay. *Oxford Economic Papers* 2002; 54: 669-87.
4. Kessler RC Greenberg PE, Mickelson K, Meneades LM, Wang PS. The effects of chronic medical conditions on work loss and work cutback. *J Occup Environ Med* 2001; 43: 218-25.
5. Goetzel RZ, Long SR, Ozminkowski RJ, Hawkins K, Wang S, Lynch W. Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U.S. employers. *J Occup Environ Med* 2004; 46: 398-412.
6. Burton WN, Chen C-Y, Conti DJ, Schultz A, Edington D. The association between health risk change and presenteeism change. *J Occup Environ Med* 2006; 48: 252-63.
7. Dew K, Keefe V, Small K. 'Choosing' to work when sick: workplace presenteeism. *Soc Sci Med* 2005; 60: 2273-82.
8. McKevitt C, Morgan M, Dundas D, Holland WW. Sickness absence and 'working through' illness: a comparison of two professional groups. *J Public Health Med* 1997; 19: 295-300.
9. Aronsson G, Gustafsson K. Sickness presenteeism: prevalence, attendance-pressure factors, and an outline of a model for research. *J Occup Environ Med* 2005; 9: 958-66.

10. HSE. Self-reported work-related illness 2003/2004. <http://www.hse.gov.uk/statistics>, 2004.
11. De Vries H, Wijts W, Dijkstra M, Kok G. The utilization of qualitative and quantitative data for health education program planning, implementation, and evaluation: a spiral approach. *Health Educ Q*; 19: 101-15.
12. Munir F, Haslam C, Long H, Griffiths A, Leka S, Cox S. Managing chronic illness at work: exploring effective strategies for employees and organisations. European Social Fund Report, 2005.
13. Baruch Y: Response rate in academic studies – a comparative analysis. *Hum Rel*. 1999; 52: 345-353.
14. Roth PL, BeVier CA: Response rates in HRM/OB survey research: Norms and correlates, 1990-1994. *J Manage*. 1998; 24: 97-117.
15. Ibeh K, Brock JK-U, Zhou YJ: The drop and collect survey among industrial populations: theory and empirical evidence. *Ind Market Manage*. 2004; 33: 155-165.
16. Munir F, Leka S, Griffiths A. Dealing with self-management of chronic illness at work: predictors for self-disclosure. *Soc Sci Med* 2005; 60: 1397-07.
17. Dewa CS, Lin E: Chronic physical illness, psychiatric disorder and disability in the workplace. *Soc Sci Med*. 2000; 51: 41-50.
18. Lerner D, Amick BC, Malspeis S, Rogers WH. A national survey of health-related work limitations among employed persons in the United States. *Disabil Rehab*. 2000; 22: 225-232.
19. World Health Organization. International Classification of Diseases – version 10.. Geneva: World Health Organization, 1999.
20. Thomson L, Griffiths A, Davison S: Employee absence, age and tenure: a study of nonlinear effects and trivariate models. *Work Stress*. 2000, 14: 16-34.
21. Hanebuth D, Meinel M, Fischer JE. Health-related quality of life, psychosocial work conditions, and absenteeism in an industrial sample of blue- and white-collar

- employees: A comparison of potential predictors. *J Occup Environ Med.* 2006; 48: 28-37.
22. Johns G: Absenteeism estimates by employers and managers: divergent perspectives and self-serving perceptions. *J Appl Psychol.* 1994; 79: 229-239.
23. Kirchmeyer C, Cohen A: Different strategies for managing the work/non-work interface: A test for unique pathways to work outcomes. *Work Stress.* 1999; 13: 59-73.
24. Johns G: How often were you absent? A review of self-reported absence data. *J Appl Psychol.* 1994; 79: 574-591.
25. Crabtree BF, Miller WL. A template approach to text analysis: developing and using codebooks. In BF Crabtree & WL Miller (Eds.), *Doing qualitative research: Multiple strategies* (pp. 93-109). Newbury Park, CA: Sage, 1992.
26. HMSO. Disability Discrimination Act 1995. London.
27. European Foundation for the improvement of Living and Working Conditions. *Illness, disability and social inclusion.* Luxembourg Office for Official Publications of the European Communities, 2003.
28. Confederation of British Industries Absence trend surveys <http://www.cbi.org.uk>, 2002.
29. Lewis J. Job retention in the context of long-term illness. Nottingham: DfEE Publications, 2000.
30. Daly MC, Bound J. Worker adaptation and employer accommodation following the onset of a health impairment. *J Gerontology* 1996; 51B: S53-S60.
31. McCormick J. *On the sick: incapacity and inclusion.* Edinburgh: Scottish Council Foundation, 2000.

Table 1: Absence and disability related policies across the four organisations

Policies/Services	Organisation 1	Organisation 2	Organisation 3	Organisation 4
Attendance Management	Short-term and long-term sickness procedure. Employees are flagged if 3 spells of sickness absence is taken. Policy contains information on additional support for employees with medical conditions	Employees are flagged if 3 spells of sickness absence is taken. Policy has guidelines relating to managed rehabilitations for underlying medical conditions that have a significant effect on an employee's attendance	Employees are flagged if 3 spells of sickness absence is taken. The policy has separate guidelines for long-term sickness absence (over 8 weeks)	Employees are flagged if 3 spells of sickness absence is taken. Emphasis on importance of return to work interviews. Policies includes specific guidelines for long-term sickness absence (over 4 weeks)
Return to Work	Rehabilitation /phased return to work	Rehabilitation /phased return to work	Rehabilitation /phased return to work	Rehabilitation /phased return to work
Diversity Management	No	No	No	No
Job Retention	No	No	No	No

**Table 2: Distribution of chronic illness and demographic details across employees
(participants reporting a chronic illness only, n= 1474)**

	<i>n</i>	%	<i>M</i>	SD
Chronic illness				
Musculoskeletal pain	324	22		
Arthritis & rheumatism	192	13		
Asthma	174	12		
Depression & anxiety	152	10		
Irritable bowel syndrome	115	8		
Heart disease	96	7		
Diabetes	91	6		
Migraine	80	5		
Thyroid disease	51	4		
Inflammatory bowel disease	43	3		
Cancer	25	1.7		
Reproductive & gynaecological	17	1.2		
Multiple Sclerosis	17	1.2		
Eye problems	16	1.0		
Chronic fatigue syndrome	16	1.0		
HIV & hepatitis	16	1.0		
Epilepsy	14	0.9		
Other ⁺	35	2.0		
Age (years)			46.2	9.1
Tenure (years)			13.4	9.9
Length of time managing a chronic illness (years)			11.2	10.4
Gender				
Male	638	43.3		
Female	830	56.3		
Education				
None	252	17.6		
GCSE or equivalent	439	30.7		
A level or equivalent	284	19.9		
Degree or higher	457	31.9		
Employment status				
Non-manual	878	59.0		
Manual	543	41.0		

Table 3: Comparison of non-certified (spells of 1-4 days absence) and certified absence (spells of $5 \geq$ days absence) and presenteeism between those with chronic illness (n=1474) and without chronic illness (n=3790)

	With Chronic Illness	Without Chronic Illness	<i>p</i> -value*
	Mean (SD)	Mean (SD)	
Non-certified absence	1.08 (1.57)	0.73 (1.07)	.0001
Certified absence	0.25 (0.79)	0.08 (0.46)	.0001
<5 days presenteeism	1.13 (1.68)	0.55 (1.07)	.0001
≥ 5 days presenteeism	0.24 (0.79)	0.08 (0.46)	.0001

*Controlling for age, gender, type of organisation, educational level, SES status

Table 4: Comparison of spells of absence and presenteeism by disclosure of chronic illness
(n=1474)

	Disclosure (n = 732)	Non-disclosure (n = 742)	<i>p</i> -value*
	Mean (SD)	Mean (SD)	
Non-certified absence	1.32 (1.81)	0.86 (1.31)	.0001
Certified absence	0.74 (1.05)	0.38 (0.83)	.0001
<5 days presenteeism	1.27 (1.81)	1.02 (1.55)	ns
≥5 days presenteeism	0.28 (0.85)	0.20 (0.72)	ns

*Controlling for age, gender, type of organisation, educational level, SES status, illness severity and pain

Table 5: Stakeholder participant details across the four organisations (n=58)

Sample	Line manager	Human Resource	Health & safety	Attendance manager	Trade Union	Occupational Health	Total per organisation
Organisation 1	5 (2 female, 3 male)	2 (1 female, 1 male)		5 (4 female, 1 male)	-	3 female	15
Organisation 2	5 (2 female, 3 male)	7 (6 female, 1 male)		-	-	9 female	21
Organisation 3	5 male	1 male		-	2 (1 female, 1 male)	2 (1 female, 1 male)	10
Organisation 4	4 (2 female, 2 male)	2 (1 female, 1 male)	2 (1 female, 1 male)		2 male	2 female	12
Total per occupational group	19	12	2	5	4	16	58 in total