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Frequent sickness absence, a signal to take action

Notenbomer, Annette

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Summary

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Frequent SA is often recurring and many employees with frequent SA develop long-term SA in the following four years. The aim of this thesis is to increase scientific knowledge on frequent sickness absence (SA). The overall aim has been divided into three main sections. The aim of the first section was to examine the factors associated with frequent SA (chapters 2 and 3). The aim of the second section was to investigate which employees with frequent SA will develop long-term SA in the future (chapters 4 and 5). The aim of the third section was to evaluate an intervention to reduce SA frequency among employees with frequent SA, using a novel e-health intervention (chapter 6).

Chapter 1 is an introduction to this thesis and addresses the definition of frequent sickness absence (≥ 3 SA spells per year) and provides more context. Frequent SA has negative consequences for the employer (schedules, organization, financial) and for the employee (relation with colleagues, high risk of long-term SA, increased risk of being dismissed). Although no public registers exists, data from a large Dutch occupational health service (OHS) show that the percentage of employees with frequent SA is approximately 6%. More knowledge on factors associated with frequent SA and prediction of long-term SA among employees with frequent SA can help to focus resources adequately to reduce future SA. The Job Demands-Resources (JD-R) model was used in this thesis as the theoretical framework. This model offers an entrée for intervention possibilities at the workplace to reduce SA. Therefore, its components were included in our intervention study. The following research questions were addressed:

1. Which factors are related to frequent sickness absence?
2. Is work ability associated with both frequent and long-term sickness absence?
3. Which factors are associated with future long-term sickness absence among employees with frequent sickness absence?
4. Can we discriminate frequent absentees at risk for long-term sickness absence from frequent absentees who are not at risk of long-term sickness absence?
5. Is a new e-health intervention tool effective in reducing sickness absence frequency among employees with frequent sickness absence?

Chapter 2 describes a qualitative study to learn more from employees with prior frequent SA about the factors that are associated with frequent SA. A total of 15 participants discussed in 3 focus groups their awareness of frequent SA, related factors and solutions. Many participants had not been aware of their prior frequent SA, nor of the risk of future long-term SA. Most

participants did not believe that they would develop long-term SA in the future. According to the participants, high job demands, low job resources, high home demands, poor health, chronic illness, unhealthy lifestyles, and diminished feeling of responsibility to attend work in cases of low job resources -particularly in case of low support from management- were factors related to frequent SA. Addressing these factors and improving their own communication (skills) were regarded as solutions to reduce frequent SA.

Chapter 3 examines the association between work ability and frequent SA with spells <2 weeks and frequent SA including ≥ 1 spell in the prior year of ≥ 2 weeks (combined SA) in a cross-sectional regression analysis. Moreover, we investigated the association between work ability and long-term SA (≥ 2 weeks). Mean (standard deviation) work ability scores were highest in the reference group (43.2 (2.7)), that had neither prior long-term SA nor frequent SA. Mean work ability scores in employees with frequent SA, long-term SA, and combined SA, respectively were 41.2 (3.4), 39.4 (3.9) and 37.2 (5.2). Work ability scores were negatively related to frequent, long-term and combined SA compared to the reference group of employees without frequent or long-term SA. Of the seven work ability index dimensions, 'work ability in relation to demands of work' was significantly associated with frequent SA compared to the reference group as was the dimension 'work impairment due to disease'. 'The number of physician diagnosed diseases' related significantly to combined SA as was 'work impairment due to disease'.

Chapter 4 describes the result of a systematic review that was conducted to identify factors associated with future long-term SA among employees with frequent SA. Studies on factors associated with long-term SA among frequent absentees are scarce. We included 4 studies in the systematic review. Although frequent absentees were not the main subject of interest, the articles included data on factors associated with future long-term SA for the subgroups. We found indications that older age and female gender may be factors associated with long-term SA among frequent absentees. No clear relation existed between SA pattern, i.e. with or without a long-term SA spell- and future long-term SA. The other variables (total sick leave days, marital status, socioeconomic position, urban/rural workplace, seniority, fulltime/part-time employment, occupation, work factors and health care characteristics) were only included as co-variables, not allowing any conclusions on their prospective contribution to future long-term SA.

Chapter 5 shows the development of two prediction models for long-term SA among employees with frequent SA. Occupational health survey data from employees with registered frequent SA, i.e. ≥ 3 SA episodes in a year, were linked with registered SA data in the following year. The factors from the systematic review were included as potential predictor variables. We developed

a model with job demands and resources as predictor variables and a model with burnout and work engagement. Both models discriminated significantly between frequent absentees with and without future long-term SA. After back-ward stepwise reduction the first model included age, gender, education, marital status, prior long-term SA, work pace as a job demand and both role clarity and learning opportunities as job resources. The second model included age, gender, education, marital status, prior long-term SA, burnout and work engagement as predictor variables. Although significant, discrimination between frequent absentees with and without long-term SA during 1-year follow-up was insufficient for practice. Differentiating by gender or by sickness absence cause did not result in better discrimination.

Chapter 6 evaluates the effectiveness of a novel e-health intervention on SA frequency for employees with frequent SA, when used as a stand-alone tool and in combination with an OP consultation. Secondary outcome measures were total SA days, burnout, engagement and work ability at 1-year follow-up. After completing the baseline questionnaire, employees in the intervention groups received immediate fully-automated personalized online feedback and an advice to take actions where appropriate. We found no significant difference between intervention groups and control group in the follow-up year on SA frequency, total number of SA days, burnout, work engagement, and work ability. SA frequency and SA duration decreased in all study arms. Finding no effect may be due to low adherence to the intervention because of insufficient urgency to act. Due to very low adherence to the OP consultation, we could not draw any conclusion on the effect of blended care, i.e. the combination of the EHI-tool with an OP consultation. This was the study arm that was expected to be most effective in reducing SA.

Chapter 7 presents a general discussion of the main findings, reflections on the main findings, methodological considerations and implications for practice and future research. Frequent sickness absence is a multifactorial phenomenon and should be regarded as a signal to take action, as it is often an early signal of future frequent and future long-term SA. At least frequent absentees older than 45 years should be invited for further action. Possibly younger frequent absentees with lower education and female frequent absentees <45 years should also be considered for invitation by the employer. To guide employees with frequent SA, it is important not only to address the underlying multifactorial factors, but also to consider the other motivational phases relevant for frequent absentees. These include increasing awareness of frequent SA, raising readiness to act, prioritizing relevant actions and evaluating the results of the actions. Conversations between employers and employees may suffice to reduce future SA if they conjointly find a solution for problems related to job demands, job resources or home demands. Guidance by OPs may be necessary when managers and frequent absentees cannot

find effective solutions or when chronic diseases or unhealthy lifestyles are involved. In case of communication difficulties, other occupational health professionals may be needed to support the communication between manager and employee.

