

# Presenteeism in the workplace: A review and research agenda

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## Summary

Presenteeism refers to attending work while ill. Although it is a subject of intense interest to scholars in occupational medicine, relatively few organizational scholars are familiar with the concept. This article traces the development of interest in presenteeism, considers its various conceptualizations, and explains how presenteeism is typically measured. Organizational and occupational correlates of attending work when ill are reviewed, as are medical correlates of resulting productivity loss. It is argued that presenteeism has important implications for organizational theory and practice, and a research agenda for organizational scholars is presented. Copyright © 2009 John Wiley & Sons, Ltd.

## Introduction

Absenteeism, generally defined as not showing up for scheduled work, has a long research history, due in part to its perennial cost to organizations and its status as an indicator of work adjustment (Harrison & Martocchio, 1998; Johns, 1997, 2008, 2009). However, it is only recently that *presenteeism* has become a subject of interest. Although some definitional confusion will be addressed in what follows, the most recent scholarly conception of presenteeism involves showing up for work when one is ill. Excitement concerning the subject has been fueled by claims that working while ill causes much more aggregate productivity loss than absenteeism (e.g., Collins et al., 2005) and by the idea that managing presenteeism effectively could be a distinct source of competitive advantage (Hemp, 2004).

In this article, I trace the development of interest in presenteeism and review its several conceptualizations. Then, I offer a definition to guide research that will contribute to both organizational theory and practice. The challenges involved in measuring presenteeism and related productivity loss are considered, and organizational, occupational, and medical correlates are reviewed. Finally, a research agenda for studying presenteeism is presented. A prominent subtext is that scholars in organizational behavior, human resources, organizational psychology, and health psychology have important theoretical and methodological skills that should be brought to bear in studying presenteeism.

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## Background

Interest in presenteeism stems from two main but somewhat geographically distinct sources: (1) UK and European scholars in management (e.g., Simpson, 1998; Worrall, Cooper, & Campbell, 2000) and epidemiology or occupational health (e.g., Virtanen, Kivimäki, Elovainio, Vahtera, & Ferrie, 2003) who are concerned that job insecurity stemming from downsizing and restructuring forces exaggerated levels of attendance that result in stress and illness and (2) mainly (although not exclusively) American medical scholars and consultants, including those in epidemiology and occupational health, concerned with the impact of illness in general or specific medical conditions (e.g., migraine) on work productivity (e.g., Koopman et al., 2002). Among the latter camp, presentees are people who are “at work, but not working,” at least not up to their full capacity. In sum, the British and Europeans have mainly been interested in the frequency of the *act* of presenteeism as a reflection of job insecurity and other occupational characteristics, and the Americans have mainly been interested in the productivity consequences of this behavior as a function of various illnesses while ignoring the causes of showing up ill. Both lines of enquiry are legitimate, and one purpose of this review is to integrate these lines.

In medicine, pharmaceutical and other medical interventions have traditionally been evaluated in terms of two health-focused criteria, medical efficacy, and safety. In recent years, however, the increasing cost of health care, combined with the provision by employers of employee health plans, has led to a third criterion of interest, economic impact. Accordingly, employee health costs to an employer include the direct cost of any health plan, costs due to employee absenteeism, and costs due to reduced productivity among presentees not working at full capacity (Collins et al., 2005). The drive to find measures of productivity loss that are responsive to pharmaceutical intervention and might permit US Food and Drug Administration (FDA) approved productivity claims (Evans, 2004; Prasad, Wahlqvist, Shikar, & Shih, 2004) has led to a proliferation of measurement instruments in a short period of time.

## What Is Presenteeism?

According to the *Oxford English Dictionary Online*, the term *presentee* was first used by the American author Mark Twain in his humorous 1892 book *The American Claimant*. Subsequently, *presenteeism* made occasional appearances in business-related periodicals, including *Everybody's Business* (1931), the *National Liquor Review* (1943), and *Contemporary Unionism* (1948). In all of these early uses, and through the 1970s, the term was clearly meant either to be the literal antonym of absenteeism, or to connote excellent attendance. It remained until the 1980s for more contemporary definitions to emerge, and, in fact, until the current millennium for the most contemporary.

Table 1 summarizes nine definitions of presenteeism given or implied in the literature, with illustrative references. It can be seen that although all of the definitions pertain to being physically present at work, they differ to a greater or lesser extent from each other, occasioning potential confusion. Presenteeism is variously portrayed as good (definitions *a* and *b*), somewhat obsessive (definitions *c*, *d*, and *e*), at odds with one's health status (definitions *e*, *f*, and *g*), and often less than fully productive (definitions *h* and *i*).

It can be seen that a number of these definitions lack scientific utility. Thus, definitions *a* (presenteeism is the opposite of absenteeism) and *b* (presenteeism equals excellent attendance) are redundant, the former simply denoting the antonym of absence and the latter simply denoting low absenteeism. Similarly, definitions *g* and *i*, respectively, extend definitions *f* and *h* by allowing for the idea that presenteeism might involve attendance and associated productivity decrements in the face of

Table 1. Definitions of Presenteeism

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a.	Attending work, as opposed to being absent (Smith, 1970)
b.	Exhibiting excellent attendance (Canfield & Soash, 1955; Stolz, 1993)
c.	Working elevated hours, thus putting in “face time,” even when unfit (Simpson, 1998; Worrall et al., 2000)
d.	Being reluctant to work part time rather than full time (Sheridan, 2004)
e.	Being unhealthy but exhibiting no sickness absenteeism (Kivimäki et al., 2005)
f.	Going to work despite feeling unhealthy (Aronsson et al., 2000; Dew et al., 2005)
g.	Going to work despite feeling unhealthy or experiencing other events that might normally compel absence (e.g., child care problems) (Evans, 2004; Johansson & Lundberg, 2004)
h.	Reduced productivity at work due to health problems (Turpin et al., 2004)
i.	Reduced productivity at work due to health problems or other events that distract one from full productivity (e.g., office politics) (Hummer, Sherman, & Quinn, 2002; Whitehouse, 2005)

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factors in addition to ill health (e.g., child care demands, office politics). This “definitional creep” beyond ill health is unhelpful, because it has no discernable boundaries and is unparsimonious.

Similar to Aronsson, Gustafsson, and Dallner (2000), the definition of presenteeism I employ is *attending work while ill*. This definition (*f* in Table 1) is the one employed by most organizational scholars and is also either explicit or implicit in all related scholarship published in the occupational health literature. Quite properly, the definition does not ascribe motives to presenteeism. Thus, although it remains an empirical question, it seems feasible that one might show up ill due to love of the job, or feelings of moral obligation, or job insecurity (cf. Johns & Nicholson, 1982, “the meanings of absence”). As will be illustrated later, there is some rudimentary construct validity evidence for measures centered on this definition in that they exhibit some face valid relationships with logical correlates (e.g., Aronsson & Gustafsson, 2005; Aronsson et al., 2000; Caverley, Cunningham, & MacGregor, 2007; Demerouti, Le Blanc, Bakker, Schaufeli, & Hox, 2009; Hansen & Andersen, 2008; Munir et al., 2007; Sanderson, Tilse, Nicholson, Oldenburg, & Graves, 2007).

Also quite properly, the definition given above does not ascribe consequences to presenteeism. However, one of the goals of this article is to integrate the interests of organizational scholars who have been concerned with precursors of the act of presenteeism and health scholars who have been concerned with the act’s consequences for employee productivity. As such, any resulting productivity loss implies productivity in comparison to what one would exhibit without the medical condition (e.g., outside the hay fever season); compared to being absent, a presentee might be relatively (or even fully) productive. Similar to the act of presenteeism, diverse motives might also underpin unequal degrees of productivity loss exhibited by people with ostensibly identical medical conditions.

It bears emphasis that occupational health scholars who are interested in productivity loss often label this loss itself as presenteeism (hence definition *h* in Table 1). However, this conflation of cause and effect under a single label is particularly unhelpful, because it strongly connotes that presenteeism is a negative event from the organization’s perspective, even though presentees will surely be more productive than absentees. Such framing (dominated by the intersection of medicine and economics) precludes more open and creative psychological and behavioral views of presenteeism. I assert that the causes and consequences of presenteeism must be established by empirical evidence, not by definition.

From an employee perspective, presenteeism is important in that it might exacerbate existing medical conditions, damage the quality of working life, and lead to impressions of ineffectiveness at work due to reduced productivity. In addition, many organizational practices and policies that are designed to curtail absenteeism could in fact stimulate attendance while sick. On the other hand, under some circumstances, presenteeism might be viewed as an act of organizational citizenship and garner praise. Hence, focusing narrowly on productivity loss, as opposed to productivity gain compared to absenteeism, is unduly restrictive.

From an organizational viewpoint, Hemp (2004) opines that the relative invisibility of presenteeism compared to absence makes its management an important source of competitive advantage, especially given an estimated \$150 billion cost in the US alone. The vehicle for this is said to be state-of-the-art pharmaceutical treatment that attenuates productivity loss when attending while ill: 'Emerging evidence suggests that relatively small investments in screening, treatment, and education can reap substantial productivity gains' (Hemp, 2004, p. 50). Indeed, Burton, Morrison, and Wertheimer (2003) review evidence that pharmaceuticals can stem productivity loss accompanying presenteeism. Most researched medical conditions are episodic or chronic problems such as depression, migraine, and allergies. However, the specter of contagion due to acute medical conditions is also a source of worry (Lovell, 2004; Wessel, 2004), and an outbreak of the deadly sudden acute respiratory syndrome (SARS) in Toronto in 2003 prompted much public concern about employees (including medical personnel) showing up at work while exhibiting typical symptoms (Owens, 2003).

Presenteeism has the potential to serve as a catalyst for theoretical advances. For one thing, it has the capacity to contribute to the literature on absenteeism by addressing the gray area that exists between no productivity (i.e., absenteeism) and full work engagement. In part, this could occur by filling the serious gaps in our understanding of how absence episodes start and how decisions to return to work are effected. From a health viewpoint, the attention to presenteeism provides a vehicle for probing the loosely coupled but important connections among having a medical condition, defining oneself as ill, and engaging in work behaviors associated with assuming a sick role (e.g., Johnson, 2008).

## **The Measurement of Presenteeism and Associated Productivity Loss**

In the literature, the act of presenteeism and any resulting productivity loss have been subjected to separate streams of measurement.

### *The act of presenteeism*

Aronsson and colleagues appended to Statistics Sweden's labor market survey the following question meant to probe the frequency of presenteeism: 'Has it happened over the previous 12 months that you have gone to work despite feeling that you really should have taken sick leave because of your state of health?' (Aronsson & Gustafsson, 2005; Aronsson et al., 2000). The response format consisted of never, once, 2–5 times, or over 5 times. Variations of this retrospective frequency measure have also been used by other researchers (e.g., Demerouti et al., 2009; Hansen & Andersen, 2008; Johansson & Lundberg, 2004; Munir et al., 2007; Sanderson et al., 2007). In the earlier Aronsson study, 37 per cent of respondents reported attending work while sick more than once. In the later Aronsson study, 53 per cent made the same declaration (38 per cent 2–5 times and 15 per cent more than 5 times). The reason for this increase is unclear.

### *Productivity loss ascribed to presenteeism*

At least 14 health-related work productivity loss measures have been generated in recent years, and their most common impetus has been to serve as criterion variables in clinical trials meant to assess the impact of pharmaceutical treatment on work productivity (Amick, Lerner, Rogers, Rooney, & Katz, 2000). Several rather descriptive reviews of these productivity loss instruments have appeared in the literature (Amick et al., 2000; Lofland, Pizzi, & Frick, 2004; Prasad et al., 2004; see also table 1 of

Ozminkowski, Goetzel, Chang, & Long, 2004). Productivity loss instruments generally ask respondents to self-report some information concerning their health and to estimate how their health has affected their productivity. Some measures are “generic” in that they examine the impact of general health status on productivity; others pertain to specific health conditions such as migraine, allergies, or depression. On the productivity side, some instruments are qualitatively anchored while others ask for or impute some estimate of time lost or percentage of productivity decrement that is in principle translatable into dollars. While some instruments use a job analysis-like logic to measure the impact of illness on various aspects of work functioning (e.g., The Work Limitations Questionnaire [WLQ], Lerner, Amick, Rogers, Malspeis, Bungay, & Cynn, 2001), others rely on a global productivity rating (e.g., the World Health Organization Health and Work Performance Questionnaire [HPQ], Kessler et al., 2004), and single-item measures are common.

Current work loss instruments neither describe illnesses similarly nor share a standard outcome metric (Goetzel, Long, Ozminkowski, Hawkins, Wang, & Lynch, 2004). For instance, the short form of the Stanford Presenteeism Scale (SPS-6) is a 6-item scale to which respondents reply on a Likert format indicating degree of agreement pertaining to a primary health condition. A sample item is “Despite having my (health problem), I was able to finish hard tasks in my work” (Koopman et al., 2002, p.20). The WLQ (Lerner et al., 2001) asks respondents to report health conditions requiring medication or treatment by a physician and to estimate the impact of these conditions on multiple items pertaining to their time management, physical activities, mental and interpersonal activities, and overall work output. The five-point response scale ranges from “all of the time (100 per cent)” to “none of the time (0 per cent).” Scholars in the area readily impute percentages of productivity loss to such responses and attach dollar figures to the loss (e.g., Ozminkowski et al., 2004).

Recall periods generally vary between 1 week and 1 month, although periods of up to a year have been used (Goetzel et al., 2004; Ozminkowski et al., 2004). It is unclear how much stability might be expected for health-related work loss. Hence, Koopman et al. (2002) declined to measure the test–retest reliability of the SPS-6 as they assumed no stability over time, but Collins et al. (2005) annualized 4-week productivity decrement estimates.

Occasionally, work loss estimates have been correlated with objective productivity data, such as insurance claims processed, or with supervisory appraisals. Although some significant associations have been observed (Evans, 2004), it is not certain that these objective criteria are exactly commensurate with work loss estimates. This is because objective output and appraisals essentially reflect between-employee differences in typical performance while work loss estimates are meant to reflect within-employee differences. Thus, two call center employees who report a 20 per cent loss of productivity due to asthma might be starting from different baselines.

A few studies have compared the results stemming from the administration of two or more work loss instruments in the same sample. Limited convergent validity and substantial differences in the amount of lost productivity appear to be the norm. For instance, Ozminkowski et al. (2004) reported a correlation of only .30 between two instruments and a significant difference in productivity loss. Brouwer, Koopmanschap, and Rutten (1999) reported measures that differed up to a factor of 7 on reported hours lost and hours worked while ill, and Meerding, IJzelenberg, Koopmanschap, Severns, and Burdof (2005) found two to three times as many workers claimed productivity loss on one measure as opposed to another.

### *Commentary on measurement*

#### **The act of presenteeism**

The retrospective, discontinuous frequency scales typically used to measure the prevalence of presenteeism are suboptimal. First, the scaling is too crude to accurately capture what is apparently a

fairly low base rate behavior. Second, it is well established that providing a particular range of responses when probing the frequency of behavior affects responses because the range connotes (often inaccurate) information about what frequency of behavior is normal (Schwarz, 1999). In light of these problems, Johns (1994) recommended using an open ended, fill-in-the-blank response format to measure self-reported absenteeism, and the same would apply for presenteeism (e.g., Caverley et al., 2007). Effort must be devoted to uncovering the appropriate time frame for presenteeism probes and understanding its temporal stability. Demerouti et al. (2009) reported test–retest reliabilities of .58 or greater for 6 month and 1 year intervals for the Aronsson frequency measure.

### **Productivity loss**

Given various self-serving biases, work researchers have not much emphasized the development of self-report measures of job performance (Johns, 1999; Murphy & Cleveland, 1995). However, the necessity to isolate those performance and attendance effects that are attributable to health will often necessitate such self-report. This said, one of the most worrisome aspects concerning the measurement of work loss due to presenteeism is the potential for common method variance stemming from asking people to self-diagnose their health and then estimate its impact on their own productivity. The priming of the health probe, the drive to respond consistently, implicit theories about the connection between health and performance, and the inherent vagueness of what constitutes full productivity (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003) all suggest that the impact of health on productivity might be exaggerated.

Speaking generally, multiple item productivity loss instruments that (at least conceptually) are based on a job analysis-like logic seem preferable, in that they require respondents to reflect on how their condition affects mental performance, physical performance, and so on (e.g., the WLQ, Lerner et al., 2001). Among other advantages, this requirement for more elaborate processing might counter method variance. Sanderson et al. (2007) reported that the WLQ was more sensitive than several simpler instruments (e.g., the SPS-6) to gradations of depression and changes in depressive symptoms.

## **The Correlates of Presenteeism**

It has sometimes been assumed that any factor that constrains the opportunity to be absent could stimulate presenteeism (Koopmanschap, Burdorf, Jacob, Meerding, Brouwer, & Severens, 2005), an assumption Caverley et al. (2007) call the *substitution hypothesis*. In part, this suggests that both behaviors might share some common causes (Caverley et al., 2007), with context dictating which behavior is enacted (Dew, Keefe, & Small, 2005). However, a complementary perspective might include a search for likely causes of perseverance (e.g., attitudes, personality) in the face of absence-inducing conditions. In what follows, the researched correlates and assumed causes of presenteeism are divided into (1) organizational policies, (2) job design features, and (3) presenteeism cultures.

### *Organizational policies and presenteeism*

Organizational policies concerning pay, sick pay, attendance control, downsizing, and permanency of employment have all been suggested to foster presenteeism.

### **Pay, sick pay, and attendance control**

It might be assumed that people who are better paid would be more inclined to indulge in absence and forego the tribulations of presenteeism. However, on the first point, there is considerable evidence that those earning *higher* wages generally exhibit *less* absenteeism (Johns, 1997). Although comparable

data are lacking on presenteeism *per se*, Aronsson et al., (2000) reported that occupational groups exhibiting the most presenteeism were among the poorest paid, a finding not replicated by Hansen & Andersen, (2008). Aronsson and Gustafsson (2005) found that reported trouble handling domestic expenses was positively associated with presenteeism.

The details of sick pay and related attendance control systems should be related to the exhibition of presenteeism. Johns (1997) summarizes numerous studies showing that less liberal sick pay plans result in less absence. The associated expectation is that they could also stimulate presenteeism (Chatterji & Tilley, 2002). Lovell (2004) cites a lack of paid sick leave as a particular stimulus for presenteeism among female workers. She also notes that workers report going to work ill to “save” any sick leave they have for dealing with children’s health problems, something that is covered by few sick leave plans, especially for those earning low wages.

Grinyer and Singleton’s (2000) qualitative study illustrated how systems put in place to stimulate good attendance can contribute to presenteeism. Especially worrisome were fixed “trigger points” for a certain number of absence episodes that led to disciplinary action. Such trigger points stimulated presenteeism, and they also converted potential presenteeism into absence in that employees were concerned to return to work too soon (and thus risk going absent again) for fear of accruing two absence episodes instead of one. Munir et al. (2007) inferred similar trigger point dynamics in a quantitative study of four UK organizations.

### **Downsizing**

Another policy decision that has been examined in relation to presenteeism concerns downsizing, the intentional policy reduction in workforce size for supposedly strategic reasons. On one hand, downsizing might be expected to stimulate absenteeism due to damaged job attitudes, perceptions of injustice, breached psychological contracts, and stress-related illness (cf. Kammeyer-Mueller, Liao, & Arvey, 2001). Conversely, it might reduce absenteeism due to fear of job loss, job design changes that make absence less viable (see below), increased workload, or flatter organizational structures that increase competition for promotions and demand visible symbols of commitment (cf. Simpson, 1998). Implicit or explicit is the idea that some portion of this increased attendance would comprise presenteeism—people attending work despite ill health and working long hours while not being very productive (Simpson, 1998).

Many studies reveal an *increase* in absenteeism following downsizing (Bourbonnais, Brisson, Vézina, Masse, & Blanchette, 2005; Firms, Travaglione, & O’Neill, 2006; Kivimäki, Vahtera, Pentti, & Ferrie, 2000; Kivimäki, Vahtera, Thomson, Griffiths, Cox, & Pentti, 1997; Vahtera, Kivimäki, & Pentti, 1997; Vahtera et al., 2004), some also finding a shift to longer spells (Kivimäki, Vahtera, Griffiths, Cox, & Thomson, 2001; Stansfeld, Head, & Ferrie, 1999). Vahtera et al. (2004) found that the rate of sickness absenteeism increased in occupational groups in which there had been the greatest amount of downsizing, but only among permanent employees. They inferred that temporary employees might have been engaging in presenteeism, as they were most vulnerable to job cuts.

### **Permanency of employment**

In line with the Vahtera et al. (2004) results, a number of authors have speculated about how permanency of employment status, another condition stemming from policy decisions, affects presenteeism. Again, the general assumption is that, due to job insecurity, temporary and fixed contract workers will be more inclined to attend work when sick than will permanent employees. As with downsizing, most of the extant research involves speculation because inferences about presenteeism stem from the examination of absenteeism patterns rather than the more direct measurement of attendance while ill.

Several studies have found that contingent or non-permanent employees exhibit less sickness absence than their more permanent counterparts (e.g., Benavides, Benach, Diez-Roux, & Roman, 2000; Gimeno, Benavides, Amick, Benach, & Martinez, 2004; Virtanen, Kivimäki, Elovainio, Vahtera, & Cooper, 2001; Virtanen, Vahtera, Nakari, Pentti, & Kivimäki, 2004). Furthermore, in a prospective study that followed hospital employees who changed their employment from a fixed term contract to permanent status, it was observed that their recorded absence rate nearly doubled (along with their perceptions of job security) to approximate that of permanent employees (Virtanen et al., 2003). The authors inferred presenteeism on the part of the fixed term employees prior to conversion to permanency.

The results of three large-scale Scandinavian studies that measured presenteeism directly rather than inferred it from patterns of absence are of special interest. In an earlier study (Aronsson et al., 2000), permanent employees were *more* inclined than temporary staff to report having shown up at work while ill in the past year. In later studies (Aronsson & Gustafsson, 2005; Hansen & Andersen, 2008), no difference was observed for permanency status.

These results raise questions about the inferences that have been made about presenteeism solely from differential absence rates exhibited by permanent and temporary workers. More generally, the contradictory effects of downsizing and impermanent employment on absence suggest that the insecurity thesis requires greater scrutiny.

### *Job design and presenteeism*

Job design features that have been examined with respect to presenteeism include job demands, adjustment latitude, ease of replacement, and teamwork.

#### **Job demands**

Job demands include physical, cognitive, and social features of a job that necessitate protracted physical and psychological effort. Demerouti et al. (2009) reasoned that employees in high-demand jobs would be inclined to attend when ill to maintain high levels of performance. In a longitudinal study of nurses, they found that high job demands were associated with presenteeism and burnout. This finding is interesting in light of mixed evidence that job demands are sometimes positively and sometimes negatively associated with absenteeism (Smulders & Nijhuis, 1999). Demands that compel attendance (such as care giving, see below) might result in presenteeism.

#### **Adjustment latitude**

Adjustment latitude refers to opportunities that employees have to reduce their work output or alter work procedures in response to being unwell (Johansson & Lundberg, 2004). However, the fine points of context count (Johns, 2006), and Vingård, Alexanderson, and Norlund (2004) note that the common cold that would permit attendance on many jobs (e.g., internet help desk) is counterindicated on a neonatal hospital ward.

It might be expected that adjustment latitude would be positively correlated with showing up at work unwell and also with any accompanying productivity reduction. In other words, individuals might be inclined to show up but take it easy on the job. Johansson and Lundberg (2004) were able to confirm only a very weak positive connection between adjustment latitude and presenteeism when requirements for attendance were controlled. However, both measures consisted of single items, and the recall period was a lengthy 12 months. This noted, Aronsson and Gustafsson (2005) found that *less* control over the pace of work was associated with more presenteeism. Johansson and Lundberg make the good point that people with ample adjustment latitude may not see themselves as being sick, as the opportunity for



adjustment might change the self-diagnosis. Also, it is surely possible that adjustment latitude (or its likely correlates) confers the opportunity to take time off rather than attend while feeling ill.

### **Ease of replacement**

Research has also examined the impact on presenteeism of ease of replacement, defined as the extent to which work missed due to absenteeism has to be made up upon return to work. These studies (Aronsson & Gustafsson, 2005; Aronsson et al., 2000) illustrate that people are inclined to attend the job while ill when they know the work is piling up. This condition can stem either from lean staffing, high specialization, or a lack of cross-training. However, there are contextual subtleties to replaceability. McKevitt, Morgan, Dundas, and Holland (1997) found that UK specialist physicians working in hospitals gave a lack of backup as their major reason for not using sick leave. General practitioners, though, cited unfairness to colleagues as their major reason, even though medical practice partners constituted a ready source of backup. Following downsizing among Canadian civil servants, Caverley et al. (2007) found that lack of backup was the most common reason cited for presenteeism. A lack of backup or lean staffing may also be behind Hansen and Andersen's (2008) finding that time pressure at work contributed to presenteeism. All in all, a nexus of heavy workload, associated time pressure, and lack of assistance seem to contribute to presenteeism.

### **Teamwork**

Unfairness to colleagues is likely to be salient under self-managed, team-based work designs, giving added prominence to matters concerning attendance. Hence, Barker's (1993) ethnographic study of a manufacturing firm's conversion to self-managed assembly teams revealed the teams' emerging obsession with reliable, on-time attendance by their members. Draconian monitoring by peers, that would seem to stimulate presenteeism, surpassed the managerial bureaucracy of the pre-team assembly line structure as a stimulus for reliable attendance. More directly, Grinyer and Singleton (2000) report qualitative data from a UK public sector employment office that strongly implicated the change to teamwork as a mitigating factor in presenteeism: "being the member of a team instilled an obligation to fellow team members which resulted in a reluctance to take sick leave" (p. 13). Many respondents in turn felt that the compulsion for presenteeism led to longer-term downstream sickness absence.

### *Presenteeism cultures*

Norm-based "absence cultures" said to operate at a collective level have been proposed to account for variance in individual attendance (Chadwick-Jones, Nicholson, & Brown, 1982; Johns & Nicholson, 1982; Nicholson & Johns, 1985). A growing amount of evidence (reviewed by Johns, 1997, 2001, 2002, 2003, 2008; Kaiser, 1998; Rentsch & Steel, 2003) supports the viability of the absence culture concept. The previous discussion of team dynamics suggests the potential value of a cultural focus on presenteeism as well.

The rather striking occupational differences in the incidence of presenteeism observed by Aronsson et al. (2000) are suggestive of but not proof of variations in presenteeism cultures, since mediating collective mechanisms were not examined. The authors found, for example, that the base rate of attending work while ill was 55 per cent among pre-primary teachers, while those in engineering and computing specialties averaged 27 per cent. Also, nursing home aides, nurses, and school teachers were 3–4 times as likely to engage in presenteeism as managers, even controlling for a number of other ostensible causes of the behavior. Occupations in the caring, helping, and primary teaching sectors were most prone to presenteeism, suggesting a culture predicated in part on loyalty to and concern for vulnerable clients (i.e., patients and children). However, the authors also explain that these jobs were

among those most threatened by downsizing during the sampling period and perhaps most prone to understaffing. One proximal mediator of occupational differences in presenteeism might be professional self-identity (Van Maanen & Barley, 1984). McKeivitt et al. (1997) cited unwillingness to accept a patient role as a contributing factor for high rates of presenteeism among physicians.

Dew et al. (2005) conducted interviews and focus groups concerning presenteeism in a public hospital, a private hospital, and a small manufacturing firm, all located in New Zealand. They concluded that the public hospital exhibited a “battleground” culture in which a distant management did little to encourage attendance but in which professional identity, ethnic identity, and institutional loyalty fostered presenteeism. The private hospital was found to have a “sanctuary” culture in which there was little management pressure for presenteeism but a strong teamwork ethos and sense of loyalty to co-workers that motivated attendance in the face of stress and illness. Finally, they noted a “ghetto” culture in the manufacturing firm, with uncaring management and poor working conditions in which few employment options and attendant insecurity translated into attendance in the face of sickness. Parallels to the Nicholson and Johns (1985) typology of absence cultures are apparent in this research, in that the three sites manifested differences in the nature of emergent psychological contracts and the extent to which employees took attendance cues from each other.

Studying British managers in organizations that had experienced downsizing, Simpson (1998) found evidence of “competitive presenteeism” cultures dominated by higher-level male managers. Such cultures demanded long work hours, the foregoing of recuperation time after grueling business trips, and working while unwell. Younger males were seen to comply with presenteeism pressures, while women resisted them to the extent that the behavior was “more likely to be recognized by women but practiced by men” (Simpson, 1998, p. S48). This corresponds indirectly to the well-established finding that absenteeism tends to be higher among women than men (Côté & Haccoun, 1991). It corresponds more directly to an analysis of over 100 years of *New York Times* articles that pointed to US societal-level differences in expectations for attendance for women versus men (Patton & Johns, 2007).

### *Commentary on occupational and organizational correlates*

Intuitively, it seems reasonable that organizational policies, the design of jobs, and the social climate of an organization might affect the propensity to attend while ill. However, as indicated, research has barely scratched the surface of these matters. The studies by Grinyer and Singleton (2000) and Munir et al. (2007) clearly suggest that policies meant to affect absenteeism can also affect presenteeism, and more such research is warranted. Inferences about presenteeism from absenteeism patterns, characteristic of the downsizing and job permanency literature, should be avoided, and both variables should always be assessed together. Among job design variables, ease of replacement and teamwork requirements show good promise and might be supplemented with direct measures of task interdependence, which would seem to stimulate presenteeism. Adjustment latitude appears to have suffered from weak measurement rather than inherent irrelevance to presenteeism. Finally, evidence on presenteeism cultures is encouraging in light of the dominant trend to view the behavior as a product of personal health.

## **Medical Conditions and Productivity Loss When Present**

A number of studies have been conducted to estimate the extent and cost of productivity loss associated with various medical conditions. Some of this research has relied on representative populations and

examined the impact of a particular medical condition. Other work has been conducted in the context of organizational health audits designed to clarify how various illnesses affect individual productivity. The general logic underpinning such research is that various health problems might have a differential impact on the execution of particular work competencies or skills (Burton, Pransky, Conti, Chen, & Edington, 2004). There has been a plethora of such research in recent years, most of it funded by pharmaceutical interests. A review of some of this work can be found in Schultz and Edington (2007). What follows is a summary of some of the more ambitious and prominent projects.

Using the WLQ, Lerner et al. (2004) studied the impact of depression on work productivity in a mostly female sample recruited from health plan physicians' offices. Compared with a group with arthritis and a healthy control, those with depression reported more specific work limitations and productivity reduction in the 6–10 per cent range compared to 2–4 per cent. In a follow-up, they were also more likely to have become unemployed or changed jobs to ones with lower earnings, perhaps due to reduced work effectiveness.

Allen, Hubbard, and Sullivan (2005) examined the impact of pain on presenteeism in a *Fortune 100* company. Questionnaire respondents were deemed to suffer pain (28.6 per cent of the sample) if they reported some pain over the previous 4 weeks *and* felt pain on the day of the survey. Severity of pain was also measured. Severity showed a predominantly positive, linear relation to work limitations on all four subscales of the WLQ. Over 4 weeks, it was estimated that those meeting the pain criterion effectively lost 3.14 days of work due to presenteeism and 0.84 days due to absenteeism, versus 0.29 and 0.06 days for the healthy comparison group. The most burdensome conditions in the aggregate were deemed to be (in order) allergy, neck and spine problems, low back pain, depression, and arthritis. More broadly, musculoskeletal and “mental and nervous” problems topped the list.

Another large-scale corporate health audit at Bank One (now JPMorgan Chase) was reported by Burton et al. (2004). Using the WLQ, the study highlighted the particular impact of depression, especially on the WLQ mental/interpersonal dimension and on overall work output. Another Bank One study highlighted the toll of migraine on productivity, especially among women employees (Burton, Conti, Chen, Schultz, & Edington, 2002). At over \$24 million, presenteeism costs exceeded those due to absence by \$3 million.

In what its authors described as “the most comprehensive attempt by a company to assess the prevalence of work impairment from chronic health conditions” (p. 554), Collins et al. (2005) explain Dow Chemical Company's attempt to assess the impact of health on presenteeism and absenteeism. Both variables were measured with the SPS, and some respondents also completed the WLQ. Among individuals with a chronic health problem, time lost to absence over a 4-week period ranged from 0.9 to 5.9 hours, depending on condition. Work impairment attributed to presenteeism ranged from 17.8 to 36.4 per cent and increased with the number of chronic conditions reported. This highest impairment was due to anxiety, depression, or emotional problems, followed by breathing problems (23.8 per cent) and migraines (23.4 per cent). The authors estimated that the average Dow worker's health cost the company \$6721 due to presenteeism, \$661 due to absenteeism, and \$2278 due to direct health care costs (2002 dollars).

Finally, Goetzel et al. (2004) integrated the results of five large independent studies of presenteeism that each measured multiple medical conditions. The average productivity loss across 10 conditions was 12 per cent, and the top five productivity sappers were migraine and headaches (20.5 per cent), respiratory problems (17.2 per cent), depression and mental illness (15.3 per cent), diabetes (11.4 per cent), and arthritis (11.2 per cent). These averages masked a considerable range in estimates across investigations (e.g., 20.2 per cent for migraines and headaches; average variation across conditions and studies = 12.1 per cent), not surprising given the use of different measures. Based on the US hourly average wage rate of \$23.15 (2001), the average daily productivity loss due to health was estimated at \$22, with a range from \$11 to \$33 depending on the prevalence estimate. In a striking

contrast to Collins et al. (2005), the yearly cost of the most “expensive” medical conditions was in the \$200 range per person. Finally, Goetzel et al. (2004) estimated that anywhere from 18 to 61 per cent of employers’ total medical costs were attributable to presenteeism, although even the low presenteeism estimate exceeded cost due to absence.

### *Commentary on medical precursors of productivity loss*

#### **Variation across studies**

One must be struck by the remarkable variation in the reported effects of presenteeism on productivity and the consequent costs associated with presenteeism. This is not exactly surprising given the variation in measures, procedures, and cost derivation techniques (Schultz & Edington, 2007). For instance, the cost differences between Goetzel et al. (2004) and Collins et al. (2005) are apparently attributable to different accounting procedures.

#### **Productivity loss: Absence versus presence**

There is considerable agreement across studies that presenteeism accounts for more aggregate productivity loss than absenteeism. On the face of it, this suggests an iceberg effect in which the more visible portion of work loss (absenteeism) is dwarfed by that portion beneath the surface (presenteeism). On one hand, this differential might reflect the fact that there are more organizational constraints on not showing up than there are on taking it easy on the job (cf. Johns, 1991). On the other hand, the self-estimation of productivity loss may be more prone to perceptual distortion than the enumeration of days absent, which people are in any event inclined to *underreport* (Johns, 1994; Van Goor & Verhage, 1999). The popular press has often interpreted the finding that presenteeism costs more productivity than absenteeism as a reason to be absent when sick (e.g., Nebenzahl, 2004), confusing aggregate findings with individual behavior.

#### **Predictability: Absence versus presence**

Several studies suggest that presenteeism is more “predictable” than absence. Thus, Caverley et al. (2007) found that health accounted for three times the variance in presenteeism compared to sickness absence. Collins et al. (2005) reported that a regression model containing demographic variables and 10 chronic medical conditions accounted for 18 per cent of the variance in presenteeism and 11 per cent of the variance in absenteeism. Parallel but weaker results were reported by Boles, Pelletier, and Lynch (2004). Related to this, Hackett, Bycio, and Guion (1989) reported that desire to be absent on a day when one attended (surely an occasion for presenteeism) was more predictable than actual absence. Again, the reasons for this differential are uncertain. Method variance might be at play (see below). As well, distributional and reliability differences between absence and presenteeism might contribute. Finally, absence has a variety of causes, only one of which is illness, and this would attenuate its association with medical conditions.

#### **The depression connection**

It is possible that depression and related psychological problems figure so heavily in presenteeism (see also Conti & Burton, 1994) in part because they are not seen as legitimate reasons to be absent. Johns and Xie (1998) found that workers in both Canada and China rated depression lower than the following factors as a good reason to be absent from work: Serious illness, family illness, doctor’s visit, minor illness, bad weather, poor transportation. This is in line with the Hackett et al. (1989) finding that personal problems and the doldrums (feeling low, being physically and emotionally fatigued) were better predictors of the desire to be absent on a given day than they were of actual absence. However, it

is also possible that the elevated depression–presenteeism connection is a manifestation of method variance such that the pessimistic mood and negative affectivity known to be associated with depression carry over into associated productivity estimates (Burton et al., 2004).

## Discussion

Adelman et al. (1996) published a bellwether study that set the stage for subsequent research on presenteeism. The study was a clinical trial of the effects of the migraine drug sumatriptan on work productivity. Amick et al. (2000) describe the essence of the results:

No differences were found when comparing the two groups. . . using only absence data. Researchers also asked a question about how effective the worker felt (from 0 to 100 per cent) when having migraine symptoms. The number of hours worked was multiplied by the self-reported percentage of effectiveness, and this generated additional time when the worker was not productive. When this additional lost productivity was added to the absence data, significant differences were observed [in favor of the treatment group] (p. 3155).

The Adelman et al. (1996) research was a symbolic tipping point in the study of presenteeism because it showed that productivity loss at work supplemented in a clinically responsive way the first work variable studied in clinical trials—absenteeism. The enthusiasm for this observation is apparent in the unbridled development and application of a host of productivity loss measures. Although these measures vary in quality, most have somewhat limited reliability and validity evidence. Furthermore, single-item measures, unwarranted dichotomization, selection on the dependent variable, questionable use of change scores, and rather facile conversions of self-report questionnaire responses into dollars are not uncommon in the health-focused research on presenteeism. However, rather than dwelling on these limitations, I want to discuss in this section the contributions that organizational behavior and human resources scholars, industrial-organizational psychologists, and health psychologists might make to presenteeism research, suggesting a tentative theory-driven research agenda.

### *Toward a theory of presenteeism*

Research and speculation concerning presenteeism have been markedly atheoretical. Thus, virtually all health-related research on the phenomenon has been dedicated to documenting the impact of self-reported illness on self-reported productivity. Similarly, the smaller amount of organizational research on the topic (often not measuring presenteeism directly) has focused on job insecurity as a cause of presenteeism and generated contradictory results, as demonstrated earlier.

Space limitations preclude the development of a formal theory of presenteeism. However, the model presented in Figure 1 is meant to suggest some of the key variables that might be incorporated into such a theory and to signal some of the phenomena that such a theory should address. The model assumes that fully productive regular attendance is interrupted by a “health event” that is either acute (e.g., the flu), episodic (e.g., migraine), or chronic (e.g., the onset of diabetes). To some extent, the nature of the health event will dictate whether absenteeism or presenteeism ensues. Thus, severe stomach flu is likely to provoke absence and the early diagnosis of diabetes is likely to prompt presence. In less extreme medical cases, context will come into play. Nicholson (1977) presented a theory concerning absenteeism that attempts to specify where given incidents might fall on a continuum of avoidability. Avoidability is seen to be a joint effect of the precipitating personal event and the context surrounding the event. Thus (borrowing from Nicholson), a sore throat will stimulate absenteeism for a singer and

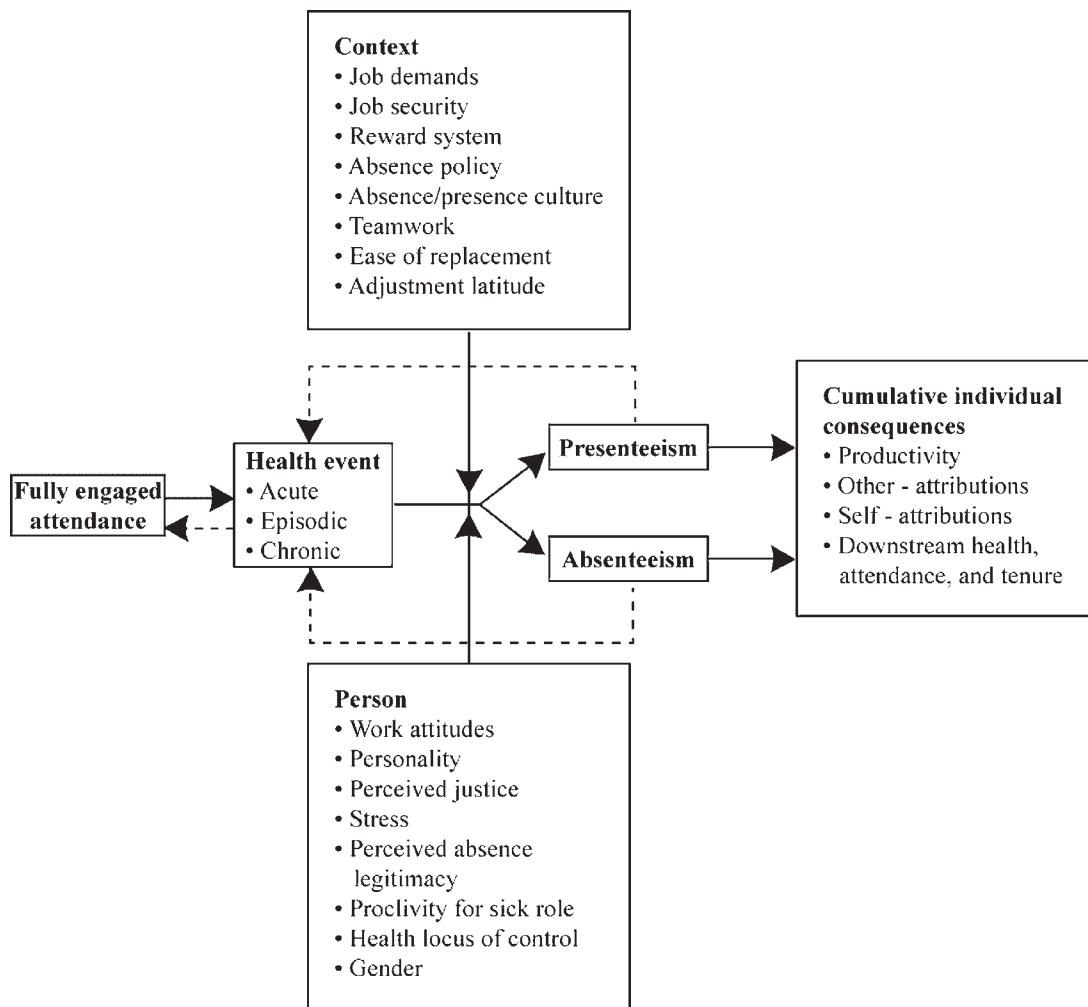


Figure 1. A dynamic model of presenteeism and absenteeism

presenteeism for a pianist. Contextual constraints on both behaviors (Johns, 1991) would be a key part of such choices, which ultimately reflect an interaction between the person (the exact illness) and the situation (in this case, occupation).

After accounting for the nature of the illness, it is proposed that work context factors and personal factors (attitudes, personality, gender) further influence the choice between absenteeism and presenteeism. Despite the spotty research on work context reviewed earlier, it is proposed that, on the margin, job insecurity, strict attendance policies, teamwork, dependent clients, a positive attendance culture, and adjustment latitude in the job tend to favor the occurrence of presenteeism, while easy replacement favors absence. Extant evidence suggests that the impact of job demands on this choice might be moderated by job control or backup provisions. Outside of illness, the role of personal factors has been little researched. However, it seems reasonable to expect that those with positive work attitudes and favorable justice perceptions would, on the margin, exhibit presenteeism, as would workaholics, the conscientious, and the psychological hardy. On the other hand, absenteeism might be

the default for the stressed and those with external health locus of control, the proclivity for adopting a sick role, and the perception that absenteeism is legitimate behavior. The logic pertaining to some of these predictions will be touched on in the prescriptions provided below.

Temporally, absenteeism and presenteeism have to be viewed as discrete events occurring in a sequence over time such that the occurrence of one behavior might affect the likelihood of the other (cf. Hackett & Bycio, 1996; Hackett et al., 1989). Hence, the dotted lines in Figure 1 show the potential impact of enacting presenteeism or absenteeism on the precipitating health event and subsequent attendance behavior. For instance, a couple of days of absence might alleviate the health problem and lead to fully engaged attendance. On the other hand, several days of presenteeism might exacerbate the health event and lead to absenteeism. Daily diary studies such as those used by Hackett and colleagues would be invaluable for studying such temporality.

Although both attendance behaviors might have some immediate consequences (e.g., harsh co-worker reaction to showing up at work with obvious signs of the flu), Figure 1 is meant to focus on more cumulative consequences to the individual that might follow chronic and episodic health events. While the impact of absence on individual productivity is straightforward, this is less so for presenteeism. Thus, a worker experiencing inequity who feels compelled to attend when ill due to a rigorous absenteeism policy is likely to be less productive than a person experiencing equity, even though both may be experiencing somatically identical health events. It is this psychological dimension to productivity loss that is missing from medical treatments of presenteeism. Although not shown explicitly in Figure 1, several other of the non-medical person variables listed might also affect the productivity of presentees. Again, it should be emphasized that the productivity of presentees need not be framed as a loss but can be seen as a gain compared to absenteeism.

Figure 1 also highlights the cumulative importance of attributions made concerning absenteeism and presenteeism, both by actors and by observers, such as managers and teammates. What do repeated acts of absence or presence signal about oneself? And how do others interpret such behavior? The perceived legitimacy of both behaviors would figure prominently in such attributions. There is much evidence that absenteeism is viewed as mildly deviant behavior, and this contributes to its under-reporting (Johns, 1994). This said, people view illness as among the most legitimate reasons for absence (Johns & Xie, 1998), although they tend to make fine distinctions about the legitimacy of various minor health conditions (Harvey & Nicholson, 1999). The legitimacy of presenteeism is unclear. On one hand, showing up at work in the face of discomfort might be seen as a consummate example of organizational citizenship behavior (Organ, 1988). On the other hand, much research suggests that people are generally disinclined to admit to lowered productivity (Johns, 1999), such as that which might accompany the act of presenteeism. However, reporting one's productivity decrement in the context of a good medical reason provides for legitimacy.

Finally, Figure 1 suggests that the chronic exhibition of presenteeism or absenteeism might have subsequent effects on downstream health status, attendance dynamics, and organizational membership. In a health-based scenario, chronic presenteeism further damages one's health, prompting a spiral of lowered productivity, increased absenteeism, and possibility disability. In an attitude-based scenario, dissatisfied or insecure employees feel pressured to attend when ill and sequentially lower their productivity, succumb to absence, and then quit. This continuum of withdrawal will be detailed below.

In the following paragraphs, some prescriptions for theory building concerning presenteeism are presented. Several of these prescriptions speak further to the attendance dynamics portrayed in Figure 1.

### **A theory of presenteeism should recognize the subjectivity of health**

Theory in this domain must recognize the essential subjectivity of people's evaluation of their own health status (Fleten, Johnsen, & Førde, 2004; Kaplan & Baron-Epel, 2003) and accommodate

well-established individual differences in the propensity for self-disclosure of chronic illness at work (Munir, Leka, & Griffiths, 2005), perceptions of how work affects health (Ettner & Grzywacz, 2001), and the tendency to adopt a sick role (Levine & Kozloff, 1978). As signaled in Figure 1, particularly useful would be applications of attribution theory that would predict how self-conceptions of health get translated into absenteeism and presenteeism and how others in the workplace react to these work behaviors. For example, those who tend to adopt a sick role are inclined to attribute much of their behavior to their health. Such persons would seem to be more inclined toward absenteeism than presenteeism, and more inclined toward productivity loss if present while ill.

### **A theory of presenteeism should account for the relationship between absenteeism and presenteeism**

Extant research on presenteeism has made very scant use of existing and well-developed theory on absenteeism, a curious omission indeed. In doing the accompanying review, I encountered only three individual-level point estimates of the association between absenteeism and presenteeism ( $r = .18$ , Caverley et al., 2007;  $r = .14$  and  $r = .24$ , Munir et al. 2007). (Employing controls and odds ratio statistics, Hansen and Andersen (2008) reported an even stronger positive association). As noted earlier, some researchers have assumed that factors that curtail absence stimulate presenteeism. Although this is plausible, it is far from necessary, and it implies unstated boundary conditions, conditions that good theory exposes (in this case, that the absence reduction is achieved by *pressure* to attend). It also bears emphasis that individual-level associations might not necessarily replicate at other levels of analysis. For example, Aronsson et al. (2000) reported that the occurrence of presenteeism tended to be highest in occupations in which absence was also elevated. Such a finding calls for replication as well as extension to the organizational level. Do organizations and other social units differ or concur in the sign between absenteeism and presenteeism?

### **A theory of presenteeism should refine the job insecurity thesis**

As suggested in the model shown in Figure 1, the idea that job insecurity might curtail absence and motivate people to go to work when ill is compelling. However, as we have seen, studies of downsizing and impermanency of employment, both thought to stimulate insecurity, have revealed contradictory effects on absenteeism. The inference of presenteeism solely from differential absence rates carries an impossible burden of proof, and it places a particular premium on isolating *sickness* absence, because this is the appropriate baseline against which to infer presenteeism. In other words, any absence reduction due to insecurity must involve sickness absence if presenteeism is to be claimed, given that its definition pertains to attending while ill. Thus, studies examining the insecurity thesis should measure *both* absence and presence and measure job security *directly* (e.g., Probst, 2003) rather than infer its occurrence from organizational practices. Encouragingly, Caverley et al. (2007) reported an  $r$  of  $-.31$  between a single-item measure of job security and reports of going to work ill in the past year, similar to a finding by Hansen and Andersen (2008).

Several further observations pertain particularly to permanency of employment. First, inferring presenteeism from lower absence fails to account for the possibility that secure employment simply elevates the absence of permanent employees (Virtanen et al., 2001). This would be in line with the well-established finding that unionized workers have higher absence levels than those who are not union members (Johns, 1997). Next, past studies have not accounted for preferences for non-permanent employment, even though such preferences have been shown to have an impact on worker satisfaction and well being (Thorsteinson, 2003). Finally, the predominant logic ignores research suggesting that it can sometimes be the *permanent* employees who are insecure in the face of part-time or contract staff who can assume their jobs (Davis-Blake, Broschak, & George, 2003; George, 2003). Direct measures of absence, presence, and security would go a long way toward resolving these problems.



### **A theory of presenteeism should incorporate work attitudes and experiences**

Despite its connection with illness, there is every reason to believe that presenteeism should show associations with work attitudes and experiences that affect other forms of organizational behavior. This suggests a motivational component of presenteeism similar to that which can be inferred for ostensible sickness absenteeism (Johns, 1997, 2009). For instance, presenteeism has been shown to be positively related to conservative attitudes toward taking absences (Hansen and Andersen, 2008). Also, it is negatively related to job satisfaction and positively related to job stress and burnout (Caverley et al., 2007; Demerouti et al., 2009; Koopman et al., 2002). Stress is worthy of particular attention. A meta-analysis by Darr and Johns (2008) reveals a rather modest negative correlation between work stress (specifically, strain) and absence. This small association might be due to the fact that stress is not seen as an especially legitimate reason to be absent (Johns & Xie, 1998), a potential recipe for presenteeism. Indeed, work stress is often implicated in the occurrence of depression and migraine, reliable correlates of presenteeism.

As suggested earlier, the study of presenteeism has the capacity to contribute to our understanding of the so-called continuum of withdrawal. This continuum posits that unfavorable work attitudes stimulate an adaptation cycle in which successively more elaborate forms of work withdrawal are exhibited until adjustment is achieved (Hanisch & Hulin, 1991; Hulin, 1991; Rosse & Miller, 1984). Thus, minor acts of withdrawal (e.g., daydreaming or surfing the internet on company time) are expected to foreshadow more serious acts such as absenteeism and, ultimately, turnover. There is fairly good empirical support for the right side of this continuum (Johns, 2001), in that elevated lateness is likely to precede absenteeism and elevated absence is likely to precede turnover (Harrison, Newman, & Roth, 2006; Koslowsky, Sagie, Krausz, & Singer, 1997; Krausz, Koslowsky, & Eiser, 1998). It is at the far left side of the continuum where presenteeism might offer some value added, in that any reduced productivity accompanying presenteeism could conceivably foreshadow no productivity, as evidenced by absenteeism. In fact, Harrison et al. (2006) recently demonstrated that the withdrawal of citizenship behaviors preceded lateness and absenteeism, and similar dynamics might be operative for some cases of presenteeism. The implication is that work attitudes would interact with medical condition to affect productivity loss in advance of absenteeism. Thus, job dissatisfaction would elevate the connection between severity of illness and productivity loss, which would normally be considered in-role performance. Also, it would exacerbate productivity loss when the option of absenteeism is unavailable. What is mainly cross-sectional research does show a negative relationship between employee performance and absenteeism (Bycio, 1992), results that are consistent with but not proof of progression of withdrawal.

Recent research has particularly implicated injustice and social disorganization in the workplace as solid predictors of absence (Johns, 2008, 2009), and it is interesting to consider their implications for presenteeism. A viable prediction is that those experiencing more injustice are less likely to exhibit the act of presenteeism but more likely to exhibit productivity loss when they do so. Low cohesion and poor consensus are antecedents of some of the highest absence rates, and such poor social integration is highly unlikely to stimulate attendance when ill.

### **A theory of presenteeism should incorporate personality**

Personality and disposition exhibit modest associations with absenteeism. Thus, the conscientious, those high in positive affect, and those high on internal control are somewhat more prone to attend work (reviewed by Johns, 2008). What about presenteeism? In many cases, presenteeism connotes perseverance in the face of adversity. Such perseverance might be seen in the case of the conscientious, those with a strong work ethic, those with internal health locus of control, workaholics, and those who exhibit the trait of psychological hardiness. Also, compliance might be a factor, and those with low self-esteem might be prone to presenteeism. For example, Aronsson and Gustafsson (2005) determined that

those who found it difficult to say no to others (“individual boundarylessness”) were prone to attend while ill. In fact, in the context of illness, such traits might account for more variance in presenteeism than in absenteeism, since illness might supply trait-related cues for these traits (Tett & Burnett, 2003). However, some fine points might be at work here. For example, conscientious people might be inclined to attend while ill but admit that their productivity suffers. Workaholics might also be inclined to attend but deny productivity loss.

Incorporating both personality and work attitudes into the study of presenteeism allows for the consideration of “good presenteeism” by those who are conscientious or satisfied with their jobs. Virtually 100 per cent of the medical and organizational literature treats the phenomenon negatively, either with regard to the organization or the employee. However, attending work while experiencing minor discomfort, even with reduced productivity, may be beneficial to both the employee and the employer compared to going absent.

### **A theory of presenteeism should attend to its social dynamics**

Like much medical research, the health-related research on presenteeism risks undue emphasis on individual sickness. The history of absenteeism research suggests this is a bad idea, as real value-added has been gleaned from recognizing the behavior’s social manifestations (Johns, 1997, 2001, 2002, 2003, 2008). Thus, the preliminary work on presenteeism cultures (Dew et al., 2005; Simpson, 1998) is to be commended and extended. Particularly interesting is the Dew et al. finding that rather different collective motives can underpin presenteeism.

One aspect of social dynamics that merits particular attention is gender, treated as a social category (cf. Simpson, 1998). There is a massive amount of evidence that, at least in western societies, women are absent more than men, and conventional explanations do not find strong research support (Patton & Johns, 2007). However, in a study analyzing over 100 years of absenteeism coverage in the *New York Times*, Patton and Johns (2007) concluded that there is a generalized *social expectation* that women will be absent more, based on gender stereotypes. Does this provide women with more perceived freedom to take time off when ill and thus engage in less presenteeism, an idea that would follow from women’s established tendencies to engage in more health promotive behavior (e.g., Rodin & Ickovics, 1990)? Indeed, Simpson (1998) equates the act of presenteeism with “face time” and sees it as a typically male behavior. However, Lovell (2004) argues that a lack of paid sick leave contributes to presenteeism, and that women are less likely to receive paid leave. Also, depression and migraine are among the medical conditions associated most strongly with both absenteeism and presenteeism, and women are more inclined toward both illnesses than men (e.g., Burton et al., 2002). This scenario has women more inclined toward both work behaviors than their male counterparts, and there is some tentative evidence for this. Aronsson and Gustafsson (2005) found that women were somewhat more inclined than men to report attending while ill, and women were greatly overrepresented in occupations with the very highest presenteeism. Voss, Floderus, and Diderichsen (2004) determined that 37 per cent of women versus 56 per cent of men reported engaging in presenteeism. Burton et al. (2004) reported more productivity deficits for women on all WLQ subscales. Bramley, Lerner, and Sarnes (2002) presented data suggesting that women suffering from common colds were more inclined to miss hours due to absence and men due to presenteeism. Boles et al. (2004) found that women suffered considerably more productivity loss due to both absence and presence than men. More systematic research is needed on this subject, which has not been of central interest in the cited literature.

As suggested in Figure 1 (“other-attributions”), another aspect of social dynamics that bears scrutiny is the reaction of colleagues and clients to the act of presenteeism, both as encouragers and discouragers. As noted earlier, interdependent work designs (e.g., teamwork) and vulnerable clients might encourage presenteeism. Conversely, the popular press contains many stories in which employees bemoan the attendance of obviously contagious fellow workers. Serious research on such

matters would be welcome. The social consequences of accompanying productivity loss also deserve attention. Are co-workers and superiors aware of the connection between a person's medical condition and his or her productivity? Are accommodations ever made, such as in job design or adjusted performance appraisals?

## Concluding Comment

Hemp's 2004 article in the influential *Harvard Business Review*, meant to introduce executives to the costs of presenteeism, signaled the arrival of the subject in corporate America. This attention is welcome, but the presenteeism phenomenon is too interesting and too important for theoretical and practical reasons to be left in the sole hands of medical researchers and health care consultants. Organizational scholars have the conceptual and methodological skills necessary to make important contributions in this area grounded in a firm understanding of how people interact with organizations. Now is the time to apply these skills.

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