EDITORIAL

Well-being—absenteeism, presenteeism, costs and challenges

Despite the many initiatives taken to invest in the health and well-being of employees, workplace data still record the fact that 420,000 employees in Britain in 2006 believed that they were experiencing stress, depression or anxiety at work at levels that were making them ill [1]. If workplace health and safety data indicate that the most ‘widespread workplace hazard is stress’ [2], then what are the costs to employees, organizations and society?

Identifying costs can help make the case for the benefits that can be gained from improving the quality of working life. ‘Health and well-being extend far beyond avoiding or reducing the costs of absence or poor performance’ states the recent Black report but this ‘requires a changed perception of health and well-being and a willingness from both employers and employees to invest resources and change behaviours’ [3].

Health & Safety Executive statistics show that for 2006/07 almost 30 million days were lost because of work-related illness [4]. Stress, depression or anxiety accounted for 13.8 million days lost or 46% of all reported illnesses making this the single largest cause of all absences attributable to work-related illness. Over the last 5 years, work-related stress, depression or anxiety remains for each year the single most reported complaint.

Both the Chartered Institute of Personnel & Development (CIPD) [5] and the Confederation of British Industry (CBI)/AXA [6] suggest that stress, depression and anxiety account for ~40% and 37.5% of sickness absence, respectively, making it one of the top five major causes. The Sainsbury Centre for Mental Health suggests a ‘reasonable estimate is that stress turnover’ is one of the causes of sickness absence that can be attributed to mental health conditions could be as high as 44% and suggests that ‘in the absence of more detailed information’, a figure of 40% represents a good point to start from. For the UK working population, ~175 million working days are lost each year because of sickness absence with ~70 million days lost (40%) to mental health problems [7]. With the HSE 2006–07 figures suggesting ~13.8 million lost days, then work-related causes represent ~20% of days lost to mental health problems.

If 175 million days are lost each year to sickness absence, then what is the cost? The CIPD calculated the cost of absence at an average level of £659 per employee per year ‘though less than half [45%] of organizations [in their sample] actually monitor the cost of absence’ [5]. The CBI/AXA report calculated an average direct cost of absence at £537 per employee per year for 2006, adding that in terms of indirect costs ‘very few respondents were able to provide an estimate, but those who did reported it added £270 per employee per year’ [6]. Both surveys indicate that absence costs vary noticeably across sectors. Combining average direct and indirect costs, the CBI/AXA report estimates that applying cost across the workforce would bring the estimated cost of sickness absence to £20.2 billion in 2006. If the proportion of sickness absence that can be attributable to mental illness is estimated to be ~40% of all absences, then this category alone would represent an annual cost of ~£8.8 billion. If 10–20% of this cost could be directly attributable to work causes, then sickness absence would cost employers ~£800 million to £1.6 billion a year.

The CIPD survey also explored the costs associated with employee turnover and placed the estimated overall cost of turnover per employee at £7750 [8]. While this cost does include, among others, training and induction costs, the more difficult turnover cost to calculate is the cost associated with the time needed for a replacement employee to reach the productivity level of the previously employed employee. In all probability, the CIPD figure represents a fairly conservative estimate of what the costs of turnover may be.

The CIPD and the CBI/AXA survey reports put average turnover rates at ~18.1 and 14.1%, respectively [6,8]. The Sainsbury Centre for Mental Health suggests a ‘reasonable estimate might be that, at most mental health problems including stress account for five percent of total stress turnover’ [7]. On this estimate assuming a conservative turnover rate of 14% of which 5% is attributable to stress and mental health, the overall annual cost of employee turnover attributable to stress and mental health could be in the region of ~£1.35 billion.

Presenteeism is defined in terms of lost productivity that occurs when employees come to work ill and perform below par because of that illness. As the interest in the relationship between employee health and productivity has developed, so too has the need to develop instruments ‘to measure lost health-related work productivity’ [9]. Despite difficulties in measuring productivity [10] and the lack of a ‘standard metric’ for reporting presenteeism across different instruments [11], a number of instruments have been developed and reviewed and there is now general agreement that ‘progress has been made in the science of measuring lost productivity’ [9].
The common feature of these instruments is that they are designed to measure the scale and cost of presenteeism by assessing the notion of workplace productivity losses as affected by health or the effects of a particular health condition on productivity loss. Depending on how the data are expressed, the findings that emerge point to the sheer scale of the problem. Most of the presenteeism research comes from the USA, Canada and Australia with little published UK data to draw on. However, the Sainsbury Centre reworked the data from USA research and arrived at a figure for the UK that implied that the costs of presenteeism were likely to be ‘1.8 times as important as absenteeism’ [7]. Whatever the ratio, two points are clear: health-related presenteeism has, relative to absence, the larger effect and mental ill-health is ‘particularly likely to be manifest in the form of presenteeism rather than absenteeism’ [7].

Drawing on data from the Office of National Statistics [12] that showed that 22.3% of all people in paid employment have some kind of mental health problem (15.4% if alcohol and drug dependency are excluded), the Sainsbury Centre make the point that ‘in other words, employers should expect to find on average that nearly 1 in 6 of their workforce is affected by depression, anxiety or other mental health conditions . . . or around 1 in 5 if alcohol and drug dependency are included’ [7].

The concern is that these levels of mental ill-health in the workplace are just not recognized by employers. The Shaw Trust concluded that ‘employers seriously underestimate the extent to which employees and fellow managers are experiencing stress, anxiety, depression and other forms of mental ill-health’ [13] and the damaging impact that mental ill-health may be having on their business.

More and more organizations are developing policies to raise awareness about stress and mental health, with the rise of interest in ‘well-being’ in the workplace as well ‘as a greater introduction of stress management tools and other preventative measures within the workplace’ [14]. Within the organization, the training of line managers becomes a key initiative, coupled with providing all employees with information and opportunities to engage in activities that help prevent mental health problems. Access to ‘outside’ expertise includes programmes and professionals who are able to support and provide advice on mental health issues and give practical help in recruiting and retaining those with mental health problems [14]. A need also exists for guidance in identifying mental health problems and ensuring that these are not simply treated as poor performance. Guidelines on dealing with stress and mental health at work are more likely to be effective and have a greater impact if ‘accompanied by management training’ [15].

What does the evidence say about what workplace interventions work? An overview of the results of an evidence-based review by Seymour et al. [16] found ‘moderate’ evidence that a range of stress management programmes embracing a number of approaches including improving the ability to cope with stress and identifying potential work stressors could have a beneficial and practical impact. Whether these types of programmes prevent common mental health problems remains unclear. Moderate evidence supported the view that programmes that are comprehensive combining a range of approaches addressing both individual and organizational factors were effective. There was ‘limited’ evidence to suggest that individual approaches rather than organizational or organizational development approaches were more effective in managing common mental health problems. For employees experiencing mental health problems, there was ‘strong’ evidence that brief individual therapy particularly cognitive behavioural therapy was most effective. In their review of the evidence base assessing the effectiveness of workplace interventions, Hill et al. [17] reached similar findings. But it is worth adding from their key findings that a partnership approach between employer and employee was likely to be more effective, that it was important to consider not just employee health issues but attitudes and values as well, that improved communications and cooperation between employers, employees and a range of agencies could result in faster recovery and that lessons could be learnt by basing policy on evidence rather than convention [17].

The review by Rolfe et al. [15] also highlighted the importance of the manager’s role in dealing with mental health problems at work and how the day-to-day management of such problems depended on the ‘skills of the manager and relationship with the employee’. There is, they go on to add, ‘a clear business case’ for improving practice particularly when it comes to issues surrounding identifying and addressing mental health problems and the management issues of retention, discrimination, training and support. Without good management practices in place, the risk of those with mental health problems leaving the organization simply increases.

While it is important, as we have been doing, to draw attention to the health-related costs of work, it is just as important not to lose sight of the considerable number of ways in which work benefits and contributes to our health and well-being. The message is clear ‘good health is good work’ and there is growing evidence to support the case that workplace well-being interventions make good business sense.

While ‘best practice’ will continue to evolve, the theme that emerges is that organizations must look both within and outside when developing intervention strategies. Partnerships between employers, employees and health providers and agencies must be developed to capture the necessary expertise. Health and well-being management must begin by changing attitudes, advancing our understanding of mental health problems and providing
the training and education at all levels so that organizations fulfil their obligation by providing workplaces where all can grow and flourish.

Cary Cooper¹
Philip Dewe²

¹Lancaster Management School, Lancaster University, Lancaster LA1 4YW, UK
²Department of Organizational Psychology, Birkbeck, University of London, Malet Street, London WC1E 7HX, UK
e-mail: c.cooper1@lancaster.ac.uk

References