

CHAPTER 1

Introduction

Background and Significance of the Research Problem

In this 21st century, due to technological advancement; socio-cultural development; and globalization, the modern world has recognized patterns which have caused changes in people's bio-psychosocial behavior; quality of life (Jodas & Hadadd, 2009) can affect workers' general well-being (Umann, Guido, & Grazziano, 2012). Health care institutions and hospitals are more difficult and challenging than they were in earlier decades (Pilette, 2005). These unusual circumstances of the health work atmosphere greatly affect the types of behavior involved in the decision-making process for job attendance (Primo, Majela, Pinheiro, & Sakurai, 2007). Demands of attendance can take on diverse forms, such as presenteeism and absenteeism. Presenteeism is when due to some health problem the worker either decides to go to work while sick, rather than taking sick leave (Aronsson & Gustafsson, 2005). Recent studies suggest that when employees show higher presenteeism at their work stations it is an indication of better performance in that organization, in comparison to absenteeism (Hafner, Stolk, Saunders, Krapels, & Baruch, 2015; Mandiracioglu, Bolukbas, Demirel, & Gumeli, 2015).

A review of relevant literature shows that the cost of both sickness-related absenteeism and sickness-related presenteeism has been assessed. Health-related work losses due to sickness-related absence have been estimated to cost US employers more than USD \$260 billion each year (Disease Management Association of America [DMAA], 2009; Mattke, Balakrishnan, Bergamo, & Newberry, 2007). Conversely, studies from the USA have reported that sickness presenteeism has resulted in expenditures of over USD \$150 billion per annum (Hemp, 2004). These studies and data clearly indicate that costs due to sickness-related absence are much higher in comparison to those of presenteeism. On the contrary, previous studies have shown that

presenteeism is more insidious; more harmful to organizations; and harder to estimate than absenteeism. Also, the costs originated via presenteeism are more than those of absenteeism globally (Brooks, Hagen, Sathyanarayanan, Schultz, & Edinton, 2010). In addition, the occurrence of presenteeism may result in collateral impacts - for example, an increase in risks of contamination; extended convalescence vacation, or upcoming absenteeism behavior (Gustafsson & Marklund, 2011; Kivimäki et al., 2005).

Presenteeism is defined as ‘an active employee engagement in work with a focus on cognitive, emotional, and behavioral engagement during work’ (Koopman et al., 2002). According to Koopman et al. (2002) presenteeism consists of two dimensions: (1) completing work, which refers to the amount of work accomplished despite some sort of presenteeism effect (work focus); and (2) avoiding distraction, which denotes the ability to concentrate in the process of doing work, despite some sort of presenteeism effect (psychological focus). According to the first dimension of presenteeism, regardless of having any health problem, workers are able to: finish their difficult tasks; focus on achieving their goals; and feel sufficiently energetic to complete the job tasks during their duty hours. On the other hand, for the latter dimension of presenteeism, due to health problems among employees: they perceive the stresses of the job as being much harder to handle. They also feel distraction in taking pleasure in their work; finally, they feel hopeless about finishing certain work tasks (Koopman et al., 2002). Lower presenteeism means low performance - thereby remaining less actively engaged in work that further leads to explicitly reduced productivity (Pelletier & Koopman, 2003). Workforce output can be improved significantly not only through lower absenteeism, but also by increased presenteeism as reinforced by the outcomes of several studies (Cockburn, Bailit, Berndt, & Finkelstein, 1999; Testa & Simonson, 1998).

In order to measure presenteeism among workers, researchers have developed and used different instruments. One has been the Stanford Presenteeism Scale -6 (SPS-6) which has been widely used at global level among various workers, including nurses. A cross-sectional study in Croatia conducted by Brborovic, Brborovic, Brumen, Pavlekovic and Mustajbegovic (2014) has investigated presenteeism and patient safety culture among medical nurses in one general hospital. The researchers found higher

scores of presenteeism through the SPS-6 (Mean = 21.3, SD = 4.58); where it ranged between 7 and 30. In China, Yang, Yao, Li, Si, and Song (2012) in order to measure the current status of health-related productivity loss among nurses, researchers found presenteeism on SPS-6 the average score was 20.05 ± 4.37 (Mean & SD). Watson, Long, Yen, and Pichora (2009) explore presenteeism among medical residents, and found the mean on SPS-6 was 17.3 ± 4.5 (Mean & SD), which is below the population normative mean of 24 ± 3 ($p < 0.0001$) among medical residents in the USA. Based upon previous research results, the level of mean score of presenteeism vary according to discipline.

Empirical literature has shown that several factors are associated with presenteeism, including unhealthy lifestyles; illnesses; allergies and asthma; and poor work-life (Econtech, 2011); burnout (Demerouti, Blanc, Bakker, Schaufeli, & Hox, 2009) occupational stress, work impairment and perceived productivity (Benefits Canada, 2015; Kwon & Kim, 2010) and job stress (Econtech, 2011; Elstad & Vabo, 2008). Among the above factors, job stress was most prominent justifying its selection by the researcher. Because the significance of management of job stress (JS) is documented in eminent literature. Neglecting the problem of job stress might result in negative consequences for organizations as well as workers including nurses. These negative aspects can be reduced productivity, loss of working hours, arousal of diseases, and occupational accidents (Moustaka & Constantinidis, 2010); absenteeism, turnover, and diminished job satisfaction (Alves, 2005); and low morale and burnout (Sutherland & Cooper, 1990).

Job stress is prevalent in many countries worldwide; and there is no exception in Asian countries (Lim, Bogossian, & Ahern, 2010). Nursing is globally acknowledged to be one of the most stressful professions. (Bartram, Joiner, & Stanton, 2004; Lambert, Lambert, & Ito, 2004). Pragmatic literature has identified various factors that may be likely to increase the levels of job stress among nurses. These include the rising use of sophisticated healthcare technologies; budget cuts; increasing workload; constant organizational changes in some healthcare environments; physical labor, the suffering and emotional demands of patients and their families; work hours; shiftwork; interpersonal relationships; and other pressures (Guppy & Gutteridge, 1991; Hipwell,

Tyler, & Wilson, 1989; Jennings, 2007, 1994; Schaufeli, Keijsers, Reis-Miranda, 1995). The significance of management of job stress is well documented. Literature shows that neglecting this problem may result in negative consequences for organizations, as well as workers (including nurses) - such as reduced productivity; loss of working hours; arousal of diseases; and occupational accidents (Moustaka & Constantinidis, 2010). Other consequences can include absenteeism, turnover, and diminished job satisfaction (Alves, 2005); and low morale and burnout (Sutherland & Cooper, 1990).

In a recent study in the USA, Yang et al. (2016) found that job stress has a significantly direct positive relationship with presenteeism among the aging workforce. Additionally, the researchers conducting previous studies found some similar results. For example, Elstad and Vabo (2008) in four Nordic countries: Denmark, Finland, Norway, and Sweden found that, with increasing levels of job stress, the level of sickness presenteeism increased more abruptly than that of sickness-related absence among elder care workers. Conversely, Koopman et al. (2002) in the USA found that the mean score of presenteeism measured by SPS-6 correlated negatively with job stress among general employees. Finally, a joint study in Australia and the UK by Wan, Downey, and Stough (2014) found that self-reported levels of job stress were not significantly related to presenteeism among employees. The result from previous research regarding the relationship between presenteeism and job stress was inconsistent as some have found a positive relationship, while others have shown a negative relationship. Still, some studies did not find any relationship at all. In order to confirm the association between two variables, more research studies are needed.

Job stress in general and stress in particular is the psychological and emotional state that is internally represented as part of a stressful transaction (Lazarus & Folkman, 1984). Moreover, demands or stressors in the physical, social, or psychological environment are evaluated through cognitive appraisal processes in light of one's resources as harm/loss, threat or challenge. On the other hand, the individual and his or her environment are seen as coexisting in a dynamic relationship. Using the theory of Lazarus and Folkman (1984) psychological stress and coping by incorporating the stress process, French, Lenton, Walters, and Eyles (2000) developed the measurement of job stress among nurses – namely, the Extended Nursing Stress Scale (ENSS). The ENSS is

an expanded and reorganized revision of the classic Nursing Stress Scale (NSS) developed by Gray-Toft and Anderson (1981). It consists of nine job stressors, including: (1) death and dying; (2) conflict with physicians; (3) inadequate emotional preparation; (4) problems relating to peers; (5) problems relating to supervisors; (6) workload; (7) uncertainty concerning treatment; (8) patients and their families; and (9) discrimination. Much nursing research has used ENSS to measure job stress. For example, Rita, Atindanbila, Portia, and Abepuoring (2013) found high job stress among nurses in two hospitals in Ghana. Leung-Chun (2013) found moderate job stress among nurses in an acute public care hospital in Hong Kong. In Serbia, Milutinjnović, Golubović, Brkić, and Prokeš (2012) found that the 9 factors on the ENSS accounted for 52 % of nursing job stress variance in Intensive Care Units among nurses. These studies clearly show that job stress is more prevalent among nurses' in hospitals at global level.

The Islamic Republic of Pakistan is a sovereign country located in South Asia with a population exceeding 199 million people, as the sixth most populous country (US and World Population Clock, 2015). The healthcare system in Pakistan has both public and private health facilities, including government (public) and private hospitals. Basic Health Units (BHU) and Rural Health Centers (RHC) provide primary health care facilities; whereas, Tehsil Headquarters (THQ) and District Headquarters (DHQ) hospitals secondary care. Still, Tertiary Care Hospitals (TCHs) provide tertiary care services (Meghani, Sehar, & Punjani, 2014). The Ministry of Health at each provincial level is responsible for the management of all health personnel including nurses. The Federal Ministry of Health takes care of health facilities mainly located in Islamabad. According to Gul (2008), nursing in the country comprises three cadres; general nursing; midwifery; and public health nursing. The major approach of nursing education - whether in the public or private sector - is categorized by three years of study for a Diploma in General Nursing. On the other hand, a few schools have recently began to offer a four-year Bachelor of Science in Nursing (BScN) degree. All three cadres of nursing personnel are controlled by the Pakistan Nursing Council as registered nurses (RNs); registered midwives (RMs); and Lady Health Visitors (LHVs.). Nurses usually work in hospital settings; whereas, LHVs and midwives are deployed in community settings.

According to Trading Economics (2015) World Bank statistics in 2009 show that Pakistan has 0.56 nursing and midwifery personnel and 0.5 physicians per 1,000 population. The existing nurse-patient ratio in the general wards in Pakistan is approximately 1:50, whereas the Pakistan Nursing Council has recommended 1:10 and as per a government notification, Pakistan lacks 60,000 nurses (Khuwaja, 2013). Urban-based hospitals are facing an acute shortage of nurses (Nishtar, Boerma, Sohail, & Mirza, 2013). One reason for this shortage is the environment in which nurses perform their duties (Alwani, 2009). Nurses perform various roles in wards/units, as described by Pakistan Nursing Council (1999). These include - but are not limited to - assisting physicians during daily rounds; carrying out their orders in regard to medication; checking vital signs; maintaining and keeping updated patient records; and mentoring student nurses. In some hospitals, nurses even have to do simple tasks, such as bedding. The nurses are bound to do 12-hour night duty for one month on a rotation basis, which causes a lot of problems for them, including job stress (Malik, 2006). In regard to some fringe benefits, nurses are provided with 25 days of casual leave (leave on urgent work and/or health problem basis with full pay). Additionally, there is a case-by-case policy for granting sick leave to nurses.

In regard to the management and administration of nurses, physicians and administrators are considered the dominant group in health care settings. Quite often, members of this dominant group exhibit aggression and violent behavior towards nurses (Somani & Khowaja, 2012). Other studies show that there is high workload for nurses; a biased and rigid attitude among nursing management; and lack of appreciation or monetary incentives for nurses while working in tertiary care hospitals (Bahalkani et al., 2011; Kumar, Ahmed, Shaikh, Hafeez, & Hafeez, 2013). According to Clegg (2001) some of these factors can lead to develop and/or increase job stress among nurses. However, little is known about the extent of job stress, according to the dimensions suggested by French et al. (2000) among nurses in tertiary care hospitals in Pakistan.

In order to measure the general health status and the frequency of coronary heart disease risk factors among nurses in Pakistan, Khan et al. (2012) have found the following proportion of nurses with various conditions: hypertension, 18.8%; coronary artery disease, 33.3%; diabetes, 10.9%. The mean body mass index was found to be

28.80 ± 4.77 (Mean, SD). Each nurse knowing her or his own health practices may have a profound effect on the consumers of nursing services (Connolly, Gulanick, Keough, & Holm, 1997). Nurses work in demanding shifts; they are exposed to life-threatening infections, but they still diligently perform their jobs (Chauhan, 2014). One can expect that nurses who know their risk factors and who follow healthy lifestyle behaviors can be more effective in counseling roles (Abuissa, Lavie, Spertus, & O'Keefe, 2006). This results in better productivity later on through their performance by active engagement (Mandiracioglu et al. 2015). These studies and data show that nurses in Pakistan have moderate to high sickness rates. Additionally, they also perform their jobs in demanding shifts (Malik, 2006). However, little is known whether the occurrences of sickness affect their work performance.

From the above handful studies and literature review, one can conclude that nurses in Pakistan not only have health problems. They also experience high workloads; problems with supervisors; and non-conducive work environments (Bahalkani et al., 2011; Kumar et al. 2013). Literature confirms that some such factors are likely to produce job stress among the nurses (Clegg, 2001). Numerous studies have revealed that nursing is strenuous work; hence, job stress is prevalent among nurses (AbuAIRub, 2004; Lee, 2003; Li & Lambert, 2008). Current empirical evidence shows that job stress negatively affects the health of workers (Golbasi, Kelleci, & Dogan, 2008; Lambert et al. 2004). Being unhealthy but still on duty (presenteeism) reduces work productivity (Mandiracioglu et al., 2015).

The existing literature on job stress and presenteeism comes mainly from other parts of the world - specifically, Western contexts. Therefore, this literature may not accurately reflect the prevalence of presenteeism and job stress in other regions or countries of the world in relation to different factors - such as tertiary care hospitals, culture, and economic status. Even though the factor of job stress has been identified in some of these studies, very few studies have examined the level of job stress among tertiary care hospitals in Pakistan. While much research is available that has explored the rates of sickness, workload, and management, there is a paucity of reported academic research work in the area of job stress and presenteeism among tertiary care hospitals. Hence, there are conspicuous gaps in the knowledge we have regarding job

stress and presenteeism among nurses in tertiary care hospitals in Pakistan. Therefore, it is necessary to conduct a nursing research study to explore the job stress and presenteeism among nurses working in tertiary care hospitals.

The findings of the study may contribute to the body of knowledge and provide the better understanding the association between job stress and presenteeism. Furthermore, this study result may provide the evidence for nurse administrator to further develop strategies to reduce stress and encourage better performance of present nurse in organization.

Research Objectives

1. To examine job stress among nurses in the tertiary care hospitals, the Islamic Republic of Pakistan.
2. To examine presenteeism among nurses in the tertiary care hospitals, the Islamic Republic of Pakistan.
3. To explore the relationship between job stress and presenteeism among nurses in tertiary care hospitals, the Islamic Republic of Pakistan.

Research Questions

1. What is the level of job stress among nurses in the tertiary care hospitals, the Islamic Republic of Pakistan?
2. What is the level of presenteeism among nurses in the tertiary care hospitals, the Islamic Republic of Pakistan?
3. Is there any association between job stress and presenteeism among nurses in the tertiary care hospitals, the Islamic Republic of Pakistan?

Definition of Terms

Job stress is defined as the degree of registered nurses appraise to job stressors through their experience working in tertiary care hospitals, including nine subscales, namely: (1) Death and Dying, (2) Conflict with Physicians, (3) Inadequate Emotional

Preparation, (4) Problems Relating to Peers, (5) Problems Relating to Supervisors, (6) Work Load, (7) Uncertainty Concerning Treatment, (8) Patients and their Families, and (9) Discrimination. Job stress, in this study, was measured by using the Expanded Nursing Stress Scale (ENSS), developed by French et al. (2000) that contains nine subscales.

Presenteeism is defined as an active engagement of nurses in work with a focus on cognitive, emotional, and behavioral engagement during work (Koopman et al., 2002). Presenteeism consists of two dimensions (1) Completing Work, and (2) Avoiding Distraction In this study, presenteeism was measured by using Stanford Presenteeism Scale [SPS-6] (Koopman et al., 2002).

Nurse is a person who has been trained and held at least three years General Nursing Diploma being registered with Pakistan Nursing Council commonly known as staff nurse at local level and working as a staff nurse in any of three tertiary care hospitals.

Tertiary care hospitals. These are public health care hospitals administered under provincial government of Sindh located in Karachi with specialized services in various aspects. They are also teaching hospitals. The tertiary care hospitals in this study included Jinnah Postgraduate and Medical Centre (JPMC) Karachi, Civil Hospital Karachi (CHK) and Abbasi Shaheed Hospital Karachi (ASH).

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