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RESEARCH PAPER

Workers with health problems: three perspectives on functioning at work

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Purpose: Our aims were (i) to explore why it is that one worker with a health problem is able to stay at work while the other is not, (ii) to identify signals for decreased functioning at work, and (iii) to explore if and how this can be measured.

Method: We conducted three focus groups: with workers with a health problem, occupational physicians, and human resources managers/supervisors. **Results:** Individual differences in coping strategies, motivation, beliefs, attitudes, and values were mentioned. All three groups reported that the supervisor is the key figure in the functioning at work of workers with health problems. The supervisor can facilitate the work accommodation of workers and help optimizing functioning at work. The identified signals might contribute to the development of an instrument. Conditions for use were suggested, i.e. a "safe" setting. **Conclusions:** This focus group study provided insight in why it is that one worker is able to stay at work while the other is not, according to the opinions of three different groups. Although all three groups reported that the supervisor is the key figure in the functioning at work of workers with health problems, there are differences between how the three stakeholders perceive the situation.

Keywords: Occupational decision, occupational health care, return to work, supervisor, work functioning

Introduction

The increase of retirement age and the decrease of possibilities for an early retirement will increase the participation of older workers and workers with health problems in the workforce [1]. It is likely that the health of these workers will have an influence on their functioning at work [2].

From the literature we know that a health condition can have an impact on functioning at work in several ways. For example,

Implications for Rehabilitation

- The supervisor is a key figure in the work functioning of workers with health problems; he/she can facilitate work accommodation of workers and help to optimize functioning at work.
- The three stakeholders show differences in how they perceive functioning at work; e.g. workers tend to focus on their health and working conditions, while the human resources managers/supervisors and occupational physicians also take the workers' motivation, the attributed value of work, and the organizational culture into account.
- An instrument to measure work functioning might be beneficial to help workers with health problems to stay at work.
- These results can help in decision making for use of an existing work functioning instrument.

ill health can limit work functioning as is shown by Munir et al. [3]. They studied the effect of a variety of chronic conditions on work limitations and work adjustments. For many health conditions it were generic symptoms like fatigue that resulted in work limitations [3]. Haslam et al. [4] studied the effect of anxiety and depression in the workplace on the individual and the organization. They found that mostly symptoms and medication were responsible for an impairment in work performance, sometimes resulting in accidents at work. Moreover, the authors also found that stigma and a lack of understanding of anxiety and depression in the workplace might contribute to impaired work performance. Tveito et al. [5] identified workplace challenges for workers with low back pain and the self-management strategies workers develop to continue working despite their pain.

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Instruments are available that measure the impact of health on work functioning. Two types can be distinguished. Instruments that assess overall work performance, with single global rating items (for example the Health and Productivity Questionnaire (HPQ) [6] and the Work Productivity and Activity Impairment Questionnaire (WPAI) [7]); and generic multiple item instruments, designed to measure the degree to which chronic health problems (both mental and physical) interfere with the ability to perform job roles (for example the Endicott Work Productivity Scale (EWPS) [8], the Work Limitations Questionnaire (WLQ) [9] and the Work Role Functioning Questionnaire (WRFQ) [10,11]).

Although most studies on functioning at work with a health problem show only the perspective of the worker, it is important to take the views of different actors with a stake in the problem into account when looking at functioning at work with a health problem. Human resources managers (HRM) and supervisors have to manage the impact of a workers' health condition on the functioning at work. The responsibilities of employers concerning return to work might vary between countries, but HRM and supervisors are faced with the consequences of stay at work and health problems in the workplace. As Haafkens et al. [12] reported, it is part of the HRM/supervisors responsibility to facilitate the worker with a health problem in the workplace. It is often the supervisor who is first confronted with the needs for work accommodations of workers with a health problem. Together with the HRM, supervisors have valuable knowledge about and experience with the daily functioning at work of workers with a health problem.

Another important stakeholder is the occupational health professional. In many countries the occupational health professional has a case-management role, which includes the guidance of the worker during the process of return to work. This role can be fulfilled by several occupational health professionals, e.g. occupational therapists, occupational physicians, occupational psychologists, social workers and case managers. In the Netherlands, it is mostly the occupational physician (OP). According to OP guidelines OPs have a case-management role and it is their task to guide workers on sick leave back to work and to prevent (recurrent) sick leave while at work [13].

Hence, the perspectives of professionals on the organizational level and the occupational health care level are also of great interest. The knowledge and experience of these professionals are valuable to get a better understanding of functioning at work with a health problem. Other perspectives are important because they can complement each other. Together they can provide directions for the management of workers with health problems at work and actions to optimize work functioning.

Our aims were (i) to explore why it is that one worker is able to stay at work, while the other is not, (ii) to identify signals for decreased functioning at work, and (iii) to explore if and how work functioning can be measured. All three aims are explored from the perspectives of three groups: workers with one or more health problem(s), occupational physicians and HRM/supervisors. A focus group approach was used to address these study aims.

Methods

Focus group method

We used the focus group method. A focus group is a group discussion, designed to gather information and share perspectives without the pressure to reach consensus [14,15]. An important benefit from a group discussion is that participants interact and a group discussions yield extra information. Three focus groups were conducted with respectively workers, occupational physicians, and HRM/supervisors. The focus groups were held in a conference room in a university medical center in the northern part of the Netherlands. Prior to the group discussion, participants were asked to fill out a short questionnaire on socio-demographics (gender, age, educational level) and work characteristics (job, sector, job tenure). All participants signed an informed consent. The participants in the worker group received a small incentive after the focus group. An interview schedule tailored to each group was developed. Each focus group lasted approximately 90 min. The discussions were led by an experienced professional moderator.

Inclusion criteria and recruitment

The inclusion criteria for the three groups were:

- Workers working more than 12 h per week with one or more health problem(s)
- Occupational physicians guiding workers with health problems
- HRM and supervisors managing workers with health problems

Several recruitment techniques were used. Participants were recruited via occupational physicians in professional network, and leaflets left in outpatient clinics, GP waiting rooms and pharmacies. Every eligible person who could attend the meeting was invited. Recruitment stopped when a minimum of six and a maximum of 10 persons agreed to participate. No patients of the participating occupational physicians were recruited for the worker group.

Data analysis

To get a better understanding of the concept of health-related work functioning and the assessment we asked three main questions in the three groups:

- (i) Why is it that one worker is able to stay at work, while the other is not able to stay at work?
- (ii) What are signals for decreased functioning at work?
- (iii) Is it meaningful to measure functioning at work? Why and how?

For the data analysis, we used the qualitative description method as described by Sandelowski [16]. All focus groups were taped, transcribed verbatim, and thematically analyzed. The first phase was to listen to the tapes several times to get an overview of the scope and to become familiar with the data. To answer the three research questions, we thematically

coded and analyzed the transcripts using the key questions addressed, supplemented (or refined) with concepts that arose in the group discussions. No computer-assisted qualitative data analysis was used since there were only three group discussions. Each transcript was coded by two independent reviewers labeling fragments with codes. In an iterative process we compared, contrasted, refined and grouped the codes into themes, to help the analysis. During this process we used audit trail to ensure that the themes reflected the actual data and were not the interpretation of ourselves [17]. That is, we frequently went back to the original transcripts and notes made by the researchers during the focus groups to ensure that the codes reflected the actual data. After the initial coding of the transcripts three authors reviewed all codes and themes and reached consensus. The data under each theme were summarized and quotes were used to illustrate the themes. The identified themes are illustrated in the text for each group with quotes from the participants.

Results

Participants

Seven workers with health problems, six occupational physicians, one occupational psychologist, and five HRM/supervisors participated in the focus groups. One OP and one worker, who agreed to participate, did not attend the focus group.

All workers reported one or more health problems: hearing problems (1), diabetes (1), thyroid disease (3), asthma (1), arthritis (1), rheumatoid arthritis (3), chronic uveitis (auto-immune illness) (1), and psychiatric disorders (2). The mean age of the workers was 47 years (SD = 14.4). They worked for

an average of 25.1 h (SD = 8.0) per week in a variety of jobs (e.g. social work, administrative work, health care work). Five workers finished higher level education, three finished middle level education.

The occupational physicians' were on average 49 years (SD = 6.0). Although three OP's worked in several sectors, five worked mainly in a health care setting (hospital). Job tenure was 12.2 years (SD = 4.6). All OPs finished higher education. The mean age of the HRM/supervisors was 44 years (SD = 6.5), job tenure was 10.8 years (SD = 7.2). All but one finished a higher education, one finished middle level. They worked in business services, health care, government or as entrepreneur in food (supermarket). Table I provides an overview of the participant characteristics.

Workers

Stay at work

Workers reported that they sometimes found it hard to combine working with their health problems and set limits for themselves when to stop: *"I'm crossing my borders. If I have an infection of some sort I keep working, while I know it would be better to stay home and take my rest."* (Worker 5).

Beliefs and attitudes towards illness were also reported by the workers as reasons for staying at work. They do not want to be labeled as *"the ill worker."* Several workers admitted that they did not mention their health problems during their job interview:

"I don't look 'unhealthy', although I am very 'unhealthy'. People do not see it, and that is my attitude I guess. . . . Of course, you do not want people to see an illness when they look at you." (Worker 6)

Table I. Participant characteristics.

Group: workers	Gender	Age	Education	Job	Sector	Tenure (years)
1	Female	27	High	Social worker	Welfare	1
2	Female	60	Middle	Administrative	Facility management	21
3	Female	52	High	Healthcare worker at school for disabled children	Health care	1
4	Female	54	High	Research assistant	University	17
5	Female	55	High	Administrative work	University (for applied science)	10
6	Female	54	High	Entrepreneur	Retail	3
7	Female	25	Middle	Assistant teacher at nursery school	Welfare	4
Group: OP's	Gender	Age	Education	Job	Sector	Tenure (years)
1	Male	56	High	Occupational physician	Welfare, government, education	18
2	Male	50	High	Occupational physician	Health care	16
3	Male	52	High	Occupational psychologist	Telecommunication, business services, health care, education	8
4	Male	43	High	Occupational physician	Health care	11
5	Female	42	High	Occupational physician	Health care, installation work	8
6	Male	-	High	Occupational physician	Call centers	20
7	Male	-	High	Occupational physician	Health care	10
Group: HRM/supervisors	Gender	Age	Education	Job	Sector	Tenure (years)
1	Male	40	Middle	Entrepreneur/line manager	Food (supermarket)	23
2	Female	47	High	Manager sickness absence	Government	6
3	Female	44	High	HR manager	Health care	5
4	Male	53	High	Head HR department	Business services	10
5	Male	36	High	Sr consultant HR	Business services	10

Several workers noted that they really liked their work and were very motivated to continue to work despite their health problems. For some this was not possible, which they regretted deeply.

Support from a supervisor was seen as very important. For example, is he or she able to communicate with a worker, can he or she create a “safe” and open situation for a dialogue:

“I had a supervisor who called me aside when I was not feeling well and asked me what was wrong. She gave me the opportunity to share what I wanted to share. If I told what was wrong, my supervisor made it a shared problem and gave me advice. . . .”

By doing that [calling me aside], she also made it safe. From that moment on I went to her to talk, even earlier. We had a little chat for 10 minutes, and everything was fine. That way you can handle more. . . . It is very important [that a supervisor can create a ‘safe’ situation].” (Worker 5)

“It is very important that it is safe. When it is not safe it is only a disadvantage that you have opened up. I’m very cautious with revealing my signals. In the past, after my illness started, I was very open about the signals. But it went wrong several times. . . . In my experience it is not safe, especially with mental or psychiatric diseases.” (Worker 4)

Also support from colleagues was experienced as important. Colleagues are often the first to notice changes in how a worker with a health problem is functioning at work and sometimes even take over tasks without being asked: *“My colleagues are very considerate about me, they do everything for me. Even certain things I should do, but can not do anymore, they do it for me.” (Worker 2)*

Finally, the support from the occupational physician was stated. Workers noted that the OP can provide help and assist in how to function at work with a health problem.

A job that matches the needs and capacities of a worker can also help facilitate the worker to continue and stay at work, even if there is a health problem. Also the possibilities for work accommodations are mentioned. The workers explained that a good fit, the ability to adjust the work pace, working hours and tasks according to their needs and capacities, was helpful in order to be able to function well and stay at work: *“I believe it depends on the type of job. For me, I work for an employer, but I am free to schedule my work hours. That depends on the nature of the job.” (Worker 1)*

Signals

Workers described that work functioning was well if they felt *“well rested”, “have no pain”, and could “find a balance”*.

Measuring work functioning

When asked if it would be useful to measure how they are functioning at work, the workers were talking about an instrument to use as a mirror to provide them direct feedback on their work functioning. Several conditions for use of such an instrument were discussed. There was no consensus in the worker group regarding the user of the instrument i.e. who should provide (give) the instrument to the worker. The workers referred to the OP, colleagues, supervisor, friends/family, and themselves – without consensus among the workers. Moreover, several modes of administration were discussed: self-assessment on paper or via internet, again without

consensus. Workers did agree that a *“safe, confident and open”* environment is a necessary condition for the use of such an instrument.

Occupational physicians

Stay at work

One OP remarks that the diagnosis per se is not predictive of a worker’s functioning at work, rather work functioning depends on how the worker deals with the diagnosis: *“The phenomenon of diagnosis alone is not predictive of how people cope with [a health problem]. This depends on the individual.” (OP 1)*. The OP continues that workers develop strategies to cope with their health and its impact on the way they function at work: *“Somehow they [the workers] mentally arrange something that allows them to continue working with their health problem.”* Some other OPs agree that they see big differences between individuals.

OPs noticed that workers who have work high on their list of priorities and are motivated to work are more likely to continue to work or quickly return to work despite their (remaining) health problems: *“In the end it is the motivation of a worker, or as OP 1 said, it is the priority work has . . . that determines if the worker returns to work easy.” (OP 4)*. Communicating with the worker is also an essential condition for staying at work and good functioning at work.

The OPs noted that the leadership style and role of a supervisor can influence whether a worker stays at work and how he/she functions at work. A supervisor with a person-oriented leadership style is better able to keep a worker at work in comparison with supervisors without person orientation:

“There are supervisors who see their employees as numbers, to put it impolite. They think that everyone has to perform in the same way. There are also supervisors who are able to view the employee as an individual, with strengths and weaknesses. When a supervisor has a person-oriented leadership style, you see it is easier for a worker to stay at work.” (OP 6)

OPs also view themselves as an important source of support to help a worker stay at work. Unfortunately they are not always able to perform this role and have to focus on sickness absence and return to work. They would like to act in a more preventive role and look at the employability of a worker who has a health problem. They want to guide the worker at work and give advice about the content and amount of work that would be suitable for the situation:

“The problem is that workers who continue to work with a chronic health problem can develop a disbalance [between work and private life]. At that point, it might be disadvantageous for them to stay at work, while they do not view this as problematic. In my opinion this is a problem for us as OP. The workers come to see us when it is already too late. We want them to benefit from our expertise at an earlier moment.” (OP 7)

The OPs notice that the type of job and the fit between the job and the individual is of influence to whether a worker is able to continue to work. For example, working in a team, job tasks, replacement by any other worker, or that their work is on hold when absent and has to be completed after return to work.

Finally, OPs believe that the organizational culture has a major influence on work functioning of workers and stay at work behavior. OPs mentioned that they experience large cultural differences between departments and organizations:

“It depends on the organization. If the organization wants to operate at a proactive or excellent level, it is seen as positive that you [the OP] are able to keep the worker at work. In that sense it is determined by culture.” (OP 5)

Signals

Possible signals of reduced work functioning were seen as changes in behavior: *“compensating hours”, “not taking all vacation days”, “frequency of absenteeism”, “emotional instability”, “being easily agitated”, and “quality of work”*. The OPs viewed the measurement of work functioning as a task for the supervisor or the workers themselves.

Measuring work functioning

When asked if it would be useful to have a tool that can measure how a worker is functioning at work with a health problem, the OPs explained that the instrument could be used as a detection instrument for workers who are at risk for absenteeism, who might need an intervention to stay at work. They would also like an instrument that can follow these workers over time, to monitor them and to indicate for interventions when necessary. The instrument should therefore be able to *“pick up relevant signals”, “identify workers at risk”, “monitor health-related work functioning over time”, and “show directions for interventions”*. The OPs viewed the measurement of work functioning as a task for the supervisor or the workers themselves.

HRM/supervisors

Stay at work

HRM/supervisors pointed out that the worker's beliefs, attitudes, norms and values are of great influence if a worker stays at work or calls in sick: *“It is mainly the attitude of the worker. Is he [the worker] focused on his own employability, what he still can do, or is he thinking negatively i.e. about the things he can not do anymore.” (HRM/supervisor 2)*

The attributed value or meaning of work influences the decision to stay at work and how a worker is functioning with a health problem. If they have a high motivation to work, they are more likely to be at work and stay at work. Often work gives them *“meaning”, they “belong” to something: “They are my highest motivated workers; they become part of a group” (HRM/supervisor 6)*. The HRM/supervisors also reported goal orientation of workers influencing work functioning. Workers who set high goals for themselves, for example in their careers, are less likely to report sick and more likely to stay at work: *“Some workers are very preoccupied with career paths. They will think twice before calling in sick.” (HRM/supervisor 5)*.

The HRM/supervisors mentioned an important role for the supervisor in helping workers functioning at work. They did acknowledge that sometimes it is difficult for the supervisor to contact a worker who is absent or is not functioning as he or she should due to his or her health problems and discuss the problems. They believe that the OP can be helpful

in supporting the supervisor how to manage workers with a health problem in a day-to-day setting: *“The OP can say that this worker cannot work, but he should also explain to me what I can do, as supervisor.” (HRM/supervisor 3)*

HRM/supervisors also believe that the organizational policies and culture has a major influence on how workers function at work and whether or not they call in sick. They sometimes experience large cultural differences between departments and organizations.

Signals

Possible signals of reduced work functioning were seen as changes in behavior: *“loss of attention”, “working slower”, “leaving early”, the “work output”, and “complaints from customers or colleagues”*.

Measuring work functioning

When asked if it would be useful to have a tool that can measure how a worker is functioning at work with a health problem, the HRM/supervisors did not agree. Some wanted an instrument to help them communicate with the worker, for instance as a starting point for a dialogue. Others did not feel the need to measure this with a new instrument.

Discussion

To our best knowledge this is the first focus group study to take three stakeholder perspectives into account, when looking at functioning at work of workers with a health problem. The results of this focus group study provided insight in differences between workers' decision to stay at work and in differences between how the three stakeholders perceive the situation. For example the workers tend to focus on their health and on their working conditions, while the HRM/supervisors and OPs also take the workers motivation, the attributed value of work, and the organizational culture into account. The role of the supervisor was viewed as important in all three groups for managing and optimizing work functioning given a health problem and providing the conditions to help the worker stay at work. The participants also provided *“signals”* for decreased work functioning, which might contribute to the development of a new instrument to measure work functioning. Existing instruments are readily available that try to capture several of the identified signals. For example, several instruments that deal with the reported limitations to meet the work demands and overall job performance (e.g. WLQ [9] WRFQ [10,11], HPQ [6] or WPAI [7]). Conditions for use of such an instrument were suggested.

It is interesting to note, that when exploring functioning at work with a health problem and identifying signals of reduced functioning, HRM/supervisors found it difficult not to discuss absenteeism and how to act when a worker is on sick leave or returns to work, while the OPs and workers were discussing work functioning as a broader construct, with workers not necessarily being absent from work due to their health problem. Although socio-political changes in the Netherlands are creating a paradigm shift from a compensation model towards a participation model and facilitating early return to

work, HRM/supervisors still consider sickness absence management very important. This might be a result of the focus on sickness absence management in the Netherlands in previous years. Managing workers with a health problem at work is not seen as their main focus, notwithstanding the fact that more and more workers will be at work with health problems. A shift towards participation is needed to let these workers stay at work in a sustainable way.

The OPs mentioned that the diagnosis *per se* was not seen as a predictor of functioning at work with a health problem. The way workers cope with their situation was viewed as more important than the diagnosis. This is in line with results from a study by Löfgren et al. [18] among working woman with fibromyalgia. They described several strategies workers developed to manage work, social life and their symptoms. Work was considered as meaningful and workers had high motivation to keep on working. In this study too, work motivation and the meaning of work were identified as important attributes to stay at work.

The importance of support has also been identified in other studies. For example, Tveito et al. [5] found that workers with pain could better manage their pain at the workplace when they experienced support at the workplace. Munir et al. [19] found a relationship between line manager support and the self-managing behaviors at work and workers' self-efficacy in making work adjustments to better manage their chronic illness at work. They also found an influence of occupational health support on self-efficacy for making work adjustments. Yarker et al. [20] identified the importance of support from occupational health, line managers and colleagues in a group of cancer survivors during their return to work, although not everyone experienced this support. The authors also discuss a wear-off effect of support; even though the side effects and symptoms were still there, support started to wear-off over time. Shaw et al. [21] identified in an interview study the importance of the supervisor to prevent work disability after injury. By accommodating the worker at work, communicating with the worker and providing support, the supervisor can play an important role in aiding the worker to stay at work.

Stigma and disclosure in the workplace was discussed in an interview study among patients with bipolar disorder [22]. In that study, participants stated that they felt that stigma relating to bipolar disorder had negative consequences for their career and disclosure often resulted in a disrupted relationship with colleagues. In the current article, participants stated that for disclosure a safe and open environment is necessary.

In Yarker et al. [20] workers stated that the communication between occupational health and line managers was often poor. In this study both the OPs and HRM/supervisors identified the importance of good communication between occupational health and HRM/supervisors.

This article showed that a good person-work fit and the availability of work accommodations are necessary for staying at work and functioning well at work, despite a health problem. The ability to adjust work tasks or modify duties can be beneficial to accomplish a good fit. Earlier studies have also

proven the value of work accommodations in keeping workers stay at work with a health problem or maybe even prevent sickness absence [23–26].

The impact of organizational policies and culture is supported by results from earlier studies as well. In an interview study with both managers and employees [20] participants mentioned that organizational policies could provide guidance and support for both the worker and manager during return to work, for example by allowing to return on reduced hours or duties. In a study with line managers and HRM, the HRM identified the need for a good company policy and a culture of trust, openness and communication as very important for a sustained employability for chronically ill workers [12].

In all three groups, the possible benefits for measuring work functioning were discussed. All signals are considered equally important, as they reflect the three perspectives. No consensus could be reached between and within the three participant groups about the user of the instrument and the mode of administration of the instrument. However, the workers were clear on the condition for use of an instrument in a “safe and open environment”. This safe setting can be provided within the confidentiality of the occupational physicians' office, but might also be created within the relationship between worker and HRM/supervisor. In addition, workers mentioned the use of this instrument as a mirror to reflect on their situation, while HRM/supervisors and OPs would like to see it as a tool to collect and share information and, if possible, to help workers to stay at work. These aims are not necessary in conflict with each other, as long as the conditions for use are taken into consideration.

Strengths and limitations

A strength of this focus group study is the inclusion of different perspectives. Not only the worker was included whose health might affect the functioning at work on a day-to-day basis, but also the HRM/supervisors and occupational health perspective. Therefore, the article reflects the view of three main stakeholder perspectives.

A possible limitation of the study is the limited number of groups. Only one group discussion was conducted for each perspective. Moreover, the worker group comprised only women and most participants had a high educational level. Therefore the result might be difficult to generalize to male workers and workers with a low educational level. In addition, the study was performed with volunteers, which might have led to a selection of participants with a special interest in the topic. For future research it is recommended to include also male workers and workers with a low educational level.

Conclusion

This focus group study provided insight in why it is that one worker is able to stay at work while the other is not, according to the opinions of three different groups. Although all three groups reported that the supervisor is the key figure in the functioning at work of workers with health problems, differences in views of the concept of work functioning between workers, OPs and HRM/supervisors are a point of interest.

Participants also identified signals for decreased work functioning, which might contribute to the development of a new instrument to measure work functioning. Direction is provided for the content and conditions for use of an instrument. Overall, the results indicate that an instrument to measure work functioning of workers with a health problem could be helpful for occupational health professionals and HRM/supervisors by monitoring how workers are functioning, to start a dialogue, to share information and provide directions for interventions for helping these workers to stay at-work.

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