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**Work Satisfaction and Health
in the Middle-Aged and Elderly**

Joseph Abramson • Haim Gofin • Jack Habib
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R e p r i n t S e r i e s



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Work Satisfaction and Health in the Middle-Aged and Elderly

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Abramson J H (Department of Social Medicine, Hebrew University-Hadassah School of Public Health and Community Medicine and Hadassah Medical Organization, PO Box 1172, Jerusalem, Israel), Gofin J, Habib J, Noam G and Kark J D. Work satisfaction and health in the middle-aged and elderly. *International Journal of Epidemiology* 1994; **23**: 98-106. *Background* There is evidence that occupational factors that cause psychological strain can affect physical and mental health, but findings are not consistent.

Methods Work satisfaction was used as a convenient global index of job-related psychological strain. Relationships with general, physical and emotional health, appraised by the use of questions, were examined in workers aged ≥ 50 years in a longitudinal community health study in Jerusalem.

Results Positive associations were found both in 1975-1976 and in 1985-1987, with age, origin, education, sex and other variables controlled. The odds ratio in favour of poor general health was 2.8 times as high in dissatisfied workers as in very satisfied ones. Multivariate analyses suggested that the associations were not spurious ones attributable to a proneness to report both dissatisfaction and ill-health. Workers who expressed dissatisfaction in both 1975-1976 and 1985-1987 were particularly unhealthy in 1985-1987.

Conclusions The findings support the impact of work satisfaction or its determinants on current health, and suggest that persistent dissatisfaction may be especially deleterious to health.

Job dissatisfaction is a frequently-used index of job-related psychological strain. There is evidence that occupational factors that cause psychological strain can affect physical and mental health,¹⁻⁴ but results vary in different studies and different occupational groups, and the lack of clear-cut findings⁵⁻⁷ has led to the development and use of models that attribute these effects to particular constellations of specific interacting elements, both in the work setting (e.g. job demands, decision latitude, and support from supervisors and fellow-workers) and outside it.^{4,5,8-11} Overall job satisfaction does not explicitly measure these specific features, but is a simple and convenient global index.

This paper is based on data on work satisfaction collected in surveys conducted in 1975-1976 and 1985-1987 in the framework of a multipurpose longitudinal community health study in Kiryat Hayovel, a Jewish neighbourhood of western Jerusalem.¹² Use is also made of data about the subjects' health in the first round of this study, in 1969-1971. The analyses are limited to people aged ≥ 50 years.

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The work-health relationships observed in a cross-sectional analysis of the 1985-1987 data have been described in detail elsewhere,¹³ and will be reported briefly here. That analysis showed that workers were clearly healthier than non-workers (whatever the stated reason for not working), and workers who said they were satisfied with their work were healthier than those who did not. The new findings presented in this paper are based on a cross-sectional analysis of the 1975-1976 data and a longitudinal analysis of data collected about the same people in successive surveys.

METHODS

Subjects

Each survey was preceded by a household census. In 1969-1971 all adult residents in the neighbourhood were invited to participate; in 1975-1976, adults aged ≥ 35 who had been examined in 1969-1971 were invited; and in 1985-1987, all residents aged ≥ 50 years, irrespective of their participation in previous rounds. The response rates were 90% in 1969-1971¹² and 86% in 1975-1976¹⁴ (for interviews), and 85% in 1985-1987.¹

The study sample for the 1975-1976 cross-sectional analysis comprised 398 men who were then working and aged ≥ 50 ; 30% were aged 50-54 years, 25% 55-59, 26% 60-64, and 19% ≥ 65 . Women were not

asked about work satisfaction in the 1975-1976 survey. The sample for the 1985-1987 cross-sectional analysis included 460 men and 318 women who were then working and aged ≥ 50 ; information on job satisfaction was available for 773 of these 778 subjects, 17% of whom were aged ≥ 65 years.⁵ The working men comprised 93% of all men aged 50-54, 74% of those aged 55-64, 31% of those aged 65-74, and 14% of those aged ≥ 75 years; the corresponding proportions for women were 66%, 42%, 10% and 4%. The sample for the longitudinal analysis consisted of 400 men who participated in both the 1975-1976 and 1985-1987 surveys, were working in 1975-1976, and were aged ≥ 50 years in 1985-1987 (50 self-employed men were excluded from most analyses, since in 1985-1987 they were not asked all the questions about job attitudes); 237 of these were still working in 1985-1987; in 1985-1987 27% of the 400, and 11% of the 237 still working, were aged ≥ 70 . All the men in the longitudinal sample had participated in the 1969-1971 survey.

The distribution of occupations was in keeping with Jerusalem's status as a governmental and university centre with little heavy industry. Using the Israel Standard Classification of Occupations,¹⁵ 55% of the working men in the 1975-1976 sample were scientific, academic or other professional workers, administrators, managers, or clerical workers; 11% were service workers, 4% were in sales, 23% were skilled workers in industry, building, transport, etc. and 4% were unskilled workers. Among male workers in the 1985-1987 sample the percentages were similar, namely 59%, 10%, 6%, 23% and 3% respectively; in women they were 49%, 40%, 6%, 4% and 1%.¹³ In terms of the British Registrar General's rating of social class, 11% of workers in the 1975-1976 sample were in class I (the highest), 24% in II, 48% in III, 10% in IV and 7% in class V; this distribution was similar in 1985-1987.¹³ Almost all (96%) had lived in Israel for over 20 years; nearly a quarter were Israel-born. In terms of father's country of birth, 48% were of European or American origin (mainly central or eastern European), 31% of middle Eastern, and 20% of north African origin. Of the men, 35% had < 9 years of education, 40% 9-12 years, and 26% > 12 years; the figures for the women were 49%, 36% and 15% respectively.¹³

The survey questionnaires embraced numerous health-related topics. Questions on overall health were placed near the start, followed soon after by those on occupation. Neither the interviewers who administered the questionnaires nor the subjects were informed of hypotheses about work-health associations.

Occupational Variables

The subjects were asked whether they were working and what kind of work they did. In 1975-1976 and 1985-1987 workers were also asked: Are you in general satisfied with your work—very satisfied, satisfied, fairly satisfied, not so satisfied, or not satisfied at all? Unless otherwise stated, those who clearly affirmed their satisfaction ('very satisfied' or 'satisfied') are categorized 'satisfied', and others as 'less satisfied'.

In 1975-1976 workers were asked four additional questions about job attitudes: 1) Is there a chance of advancement in your place of work—a very good chance, a good chance, a slight chance, or almost no chance? Answers were dichotomized as 'good prospects' (the first two response categories) or 'poor prospects' (the latter two). The question was not asked of self-employed workers. 2) Is your present work interesting—all the time, usually, sometimes but sometimes boring, or always boring? Answers were dichotomized as 'interesting' (the first two categories) or 'not interesting' (the latter two). 3) Is your work too simple for you—yes or no? 4) If you could now choose another kind of work (with the same terms of employment) would you do so—yes or no?

In 1985-1987 people who were no longer working were asked if they had stopped for reasons connected with health or age, or for extrinsic reasons ('reasons not connected with you, e.g. closing of a company, reorganization of a department or a company, retrenchment or dismissal'); they could give more than one reason. The responses fell into three categories: 'health reasons (with or without other reasons)', 'age only' and 'extrinsic reasons only'.

Health Variables

The question 'Is your general health at present very good, good, not so good, bad, or very bad?' was asked in each survey. Simple self-appraisals are the most commonly used indices of general health,^{16,17} and responses have been shown to be correlated with health ratings based on physicians' examinations, measures of functional capacity, and other variables,^{18,19} and to be predictive of subsequent mortality.¹⁸⁻²³ In the US National Health and Nutrition Examination Survey, mortality risks increased for individuals with progressively poorer self-perceptions of health. In elderly men and women and middle-aged women the predictive effect could be explained by differences in medical diagnoses, sociodemographic characteristics, and health behaviours; in middle-aged men the predictive effect remained obvious when these other factors were held constant.²³ In a study of elderly adults in Israel the rate ratios for death in the next 5

years, in relation to answers to the questions, 'Do you consider yourself a healthy, fairly healthy, sick or very sick person?', were: healthy, 1.0; fairly healthy, 1.4; sick, 2.5; very sick, 4.4. When age, sex and other variables were controlled the scale became a virtual dichotomy, the respective relative risks being 1.0, 1.1, 2.1 and 2.1.¹⁹ A dichotomy was used for most purposes in the present study, clear affirmations of good general health ('very good' or 'good') being categorized as 'good', and other responses as 'poor'. In some analyses a 5-point scale ('very good', 'good', 'not so good', 'bad', or 'very bad') was used.

Physical and emotional health was appraised in the 1985-1987 survey. The physical health score, based on six questions about the ability to perform physical activities 'normal for people in good health', has been validated in this study population.²⁴ The emotional health score was based on the 27-item demoralization scale of the Psychiatric Epidemiology Research Interview.^{25,26} Each item is scaled from 0 to 4, and the person's mean score per item is used as an index of non-specific psychological distress. We subtracted this mean from 4, so that a higher score means better health. In tests of the scale in the US and Israel, Cronbach's alpha was about 0.90 in all subgroups.²⁵ Studies in Israel support the scale's construct validity.²⁶⁻²⁸ Responses to all 27 questions were not always available, because of difficulty in asking the questions or (at the outset) a lack of forms. People who replied to <14 items were excluded from analyses involving this variable; they differed little from other subjects in their demographic characteristics and in their responses concerning job satisfaction.

Statistical Methods

Directly standardized rates and means, controlling for sex and age, were based on the sex-age composition of currently working respondents in 1985-1987;¹³ the standardized rates in Table 5 are based on the age composition of men studied in both 1975-1976 and 1985-1987 and aged 50-69 and still working in 1985-1987. Standard errors were computed for the standardized statistics.²⁹

The strength of associations (controlling for age or for sex and age) was expressed as the Mantel-Haenszel odds ratio (OR) or the adjusted difference between scores, which was estimated (for physical health and, on a 5-point scale, for general health) by the Mantel regression coefficient³⁰ or (for emotional health) by the difference between standardized means. To assist in appraising differences between scores, their magnitude will be compared with that of the differences (expressive of the processes responsible for

the 'healthy worker effect') observed between the age- and sex-standardized scores of workers and non-workers in 1985-1987;¹³ the latter differences, which were highly significant, were 0.41, 0.79 and 0.28 points for general, physical and emotional health respectively.

Significance was tested by Mantel-Haenszel, Mantel extension and z tests, all controlling for age or sex and age. Analysis of covariance was done by the general linear models (GLM) procedure of SAS and (for the 1975-1976 analysis) by the ANOVA procedure of SPSS (general health was rated 1-5).

Subjects with missing values were omitted from the relevant analyses. Only one variable, the emotional health score, had (for the reasons stated above) an appreciable number of missing values.

RESULTS

We will first provide a brief summary of the 1985-1987 findings concerning work satisfaction,¹³ and then present the new findings of the 1975-1976 cross-sectional analysis and the longitudinal analysis.

Cross-Sectional Analysis, 1985-1987

Most (78%) of the working men interviewed in 1985-1987, and 47% of the working women, expressed satisfaction with their work. Those who did so were clearly healthier than those who did not, with respect to general, physical and emotional health (Table 1).

Controlling for age and sex in order to minimize any confounding effects attributable to relationships of these variables to health and work satisfaction, the OR in favour of good general health in satisfied workers was 2.4 (95% confidence interval [CI]: 1.7-3.6). The ratio was similar in workers aged 50-64 and ≥ 65 years. Using four 'satisfaction' categories instead of a dichotomy, the odds in favour of poor general health was 2.8 times as high in the least satisfied as in the most satisfied workers (Table 2). The difference between the physical health scores of satisfied and less satisfied workers, controlling for age and sex, was 0.41 points (about half the difference observed between workers and non-workers). The odds in favour of a physical health score of ≤ 4 (the lowest quartile in all workers) was 1.7 times as high in less satisfied as in satisfied workers (95% CI: 1.2-2.5). The difference between the emotional health scores of satisfied and less satisfied workers was 0.29 (almost the same as the difference observed between workers and non-workers).

The associations with health remained significant when origin and education were controlled as well as age and sex (Table 3). The associations with general and emotional health were highly significant, and the

TABLE 1 Health status of workers in 1985-1987, by stated satisfaction with work (age- and sex-standardized)

Work satisfaction	Good general health			Physical health score ^a			Emotional health score ^b		
	No.	Rate (%)	SE ^c (%)	No.	Mean	SE	No.	Mean	SE
Satisfied	604	79.6	1.60	592	5.17	0.051	571	3.18	0.020
Less satisfied	169	63.0	3.47	164	4.74	0.111	156	2.89	0.043
<i>P</i>		<0.00001			0.0004			<0.00001	

Based on 773 subjects; data on general health were available for all subjects, but data on physical health were missing for 17 subjects (2%) and data on emotional health for 46 (6%).

^a Highest possible score, 6.

^b Highest possible score, 4.

^c Standard error.

TABLE 2 Relationship between general health and stated work satisfaction (four response categories), 1985-1987; 773 currently employed workers

Work satisfaction	No.	Odds ratio ^a in favour of poor general health
Very satisfied ^b	237	1.00
Satisfied	367	1.24
Fairly satisfied	84	2.62
Not so satisfied, or not satisfied at all	85	2.81

^a Adjusted for age and sex by Mantel-Haenszel procedure. $P < 0.00001$.

^b Reference category.

TABLE 3 Associations between job satisfaction and health, 1985-1987. Analyses of covariance, controlling for sex, age, origin, and education

Dependent variable	r^2	Effect of job satisfaction		
		<i>P</i>	Explained variance ^a (%)	Coefficient ^b
General health ^c	0.11	0.0001	2.2	0.25
Physical health	0.16	0.014	0.8	0.29
Emotional health	0.16	0.0001	3.6	0.24

The basic data set comprised 773 subjects; see footnote to Table 1.

^a Partial r^2 (the proportion of variance accounted for by job satisfaction).

^b Difference between mean health scores of satisfied and less satisfied workers, adjusted for effects connected with all other variables in the model.

^c Five-point scale.

association with physical health less so ($P = 0.014$). The adjusted differences shown in Table 3 between the mean scores of satisfied and less satisfied workers (0.25 for general, 0.24 for emotional, and 0.29 for physical health) were (respectively) 61%, 86% and 36% of the differences observed between workers and non-workers. The association with general health remained significant when emotional or physical health was controlled as well as sex, age, origin and education, and the association with emotional health remained significant when general and physical health were controlled. The association between job satisfaction and physical health, however, became non-significant when general health was controlled in the analysis.

Job satisfaction was not significantly associated with typical symptoms of angina pectoris,³¹ a chest pain history suggesting possible myocardial infarction,³¹ hypertension (systolic ≥ 140 mm Hg and/or diastolic ≥ 90 mm Hg, using the mean of two measurements) or a history of frequently or always having backache.

Cross-Sectional Analysis, 1975-1976

Satisfaction with their work was expressed by 67% of the men in the 1975-1976 sample; 72% said they had little chance of advancement, and adverse responses to the other three questions on job attitudes were received from between 32% and 39% of workers. The correlations between the responses to the five questions were not strong, ranging from -0.05 to 0.43 (mean 0.20), and hence a useful five-item satisfaction scale could not be constructed. Cronbach's alpha coefficient for the five items was only 0.60, and the responses did not comprise a good Guttman scale: the Guttman coefficient of scalability was 0.67 (coefficient of reproducibility 0.79; coefficient of chance reproducibility³² 0.36); only

51% of subjects fell into perfect Guttman scale types. The five items were therefore handled separately in the analysis.

As in 1985-1987, job satisfaction was positively associated with general health. When age, origin, education and social class were held constant, job satisfaction had a significant independent relationship with general health status; the other four job attitude items, however, were not significantly related to health (Table 4). The strength of the association between job satisfaction and general health was similar to that observed in 1985-1987: job satisfaction accounted for 1.8% of the variance in general health, or 33.1% of the total explained variance. The adjusted mean difference between the health scores of satisfied and less satisfied workers was 0.22 points, a similar difference to that observed in 1985-1987. Of the other variables in these analyses, education was the only one with a significant independent association with health.

When all five of the attitude questions were simultaneously included in the analysis as well as age, origin, education and social class, job satisfaction was the only one of the five that was significantly associated with health ($P = 0.028$). Controlling for all other variables, it accounted for 1.5% of the variance, or 13.8% of the total explained variance. The total explained variance (4.5%) was the same as when the other four questions were not included in the analysis.

Longitudinal Analysis

Workers who expressed satisfaction with their work in 1975-1976 were slightly more likely to be still working in 1985-1987 (OR = 1.3). This tendency was not, however, statistically significant, in the sample as a

whole (using the crude data or controlling for age) or in any specific age group. Among those who stopped working, there was no association between satisfaction in 1975-1976 and the stated reason for not working in 1985-1987.

Among men who continued to work, changes in job satisfaction were frequent—34% switched categories. The agreement between the ratings of satisfaction on the two occasions was poor ($\kappa^{33} = 0.18$), although it was significantly greater than zero ($P = 0.0053$).

Associations between the job attitudes expressed in 1975-1976 and health status in 1985-1987 were explored in a series of analyses of covariance, in which age and other possible confounders were controlled. These analyses revealed no significant relationships whatever between job satisfaction or any of the other four job attitude items measured in 1975-1976 and health status (general, physical or emotional) in 1985-1987. Separate analyses were done in men who continued to work in 1985-1987, in men who gave up working, and in the total sample. The variables controlled in the analyses included education, social class, nature of work (white- or blue-collar) and reported prospects of advancement. Analyses were conducted both controlling and not controlling for health status in 1975-1976, which explained 9-12% of the variance of general health in 1985-1987, 6-8% of the variance of physical health, and 8% of the variance of emotional health.

As a typical illustration of these negative results, in the total sample the general health score in 1985-1987 was higher by only 0.03 points ($P = 0.7$) in men who had expressed satisfaction in 1975-1976 than in those

TABLE 4 Relationships of job attitudes to general health, 1975-1976: analyses of covariance, controlling for age, region of birth, education and social class

	Satisfied	Prospects	Interesting	Oversimple	Prefer other
<i>P</i>	0.007	0.11	0.25	0.70	0.61
Coefficient ^a	0.22	0.15	0.10	0.03	0.03
% of variance ^b	1.8	0.8	0.3	0.04	0.1
% of explained variance	33.1	27.6	8.9	1.4	1.5
Total explained variance (%)	4.5	2.7	3.0	2.6	2.6

The basic data set comprised 398 men; 50 self-employed men were not asked the question about work prospects; the numbers of subjects with missing values in respective analyses were 6 (satisfaction), 12 (prospects), 7 (interest), 8 (oversimple) and 16 (prefer other job).

^a Difference between health scores of satisfied and less satisfied workers, adjusted for effects connected with all other variables in the model.

^b Partial r^2 .

who had not, controlling for age, type of work (white- or blue-collar) and general health status in 1975-1976.

There was a slight tendency for men who said they were healthy in 1975-1976 to be satisfied with their work in 1985-1987, but this was not statistically significant. The relevant OR was 1.6 with age controlled ($P = 0.15$) and 1.3 when work satisfaction in 1975-1976 was also held constant ($P = 0.43$).

The longitudinal analysis revealed a single significant association between work satisfaction and health: as shown in Table 5, the small group of men who expressed dissatisfaction both in 1975-1976 and in 1985-1987 (group D) tended to be less healthy in 1985-1987 than those who expressed satisfaction at both times (group A) or at only one time (groups B and C). This analysis was confined to men aged 50-69 in 1985-1987, since none of the men in group D were older than 69. Controlling for age, and using a modified Bonferroni procedure^{34,35} to compensate for the performance of multiple comparisons, the differences between group D and groups A and C were statistically significant, and the difference between D and B bordered on significance.

Since this finding suggests the possibility that these men were particularly unhealthy in 1985-1987 because of their repeated or continuous work dissatisfaction between 1975-1976 and 1985-1987, it is of interest to compare their health with that of the other groups in 1975-1976 and 1969-1971. As Table 5 shows, at these earlier times the differences between the rates were less marked and not significant. The OR expressing the high prevalence of poor health in the men in group D, compared with the combined other groups (controlling for age) was 3.1 in 1985-1987, 1.9 in 1975-1976, and 1.6 in 1969-1971.

DISCUSSION

The positive association observed between overall job satisfaction and the health of middle-aged and elderly workers in the analysis of the 1975-1976 data, when age, origin, education, social class and other factors were held constant, replicates the result of the similar cross-sectional analysis in 1985-1987, and thus constitutes confirmatory evidence that the association is a real one in the community studied.

The relationship between job satisfaction and current health status appears to be a fairly strong one—the OR in favour of poor general health was 2.8 times as high in dissatisfied workers as in very satisfied ones (Table 2).

Two sets of findings render it unlikely that the association is an artefact attributable to a proneness to report both dissatisfaction and ill-health, as a result of shared-methods bias³⁶ or negative affectivity.³⁷ Firstly, in 1985-1987 the association with general health remained significant when emotional or physical health was added to the variables held constant in the analysis, as did the association with emotional health when general or physical health was added to the control variables.¹³ Assuming that these added measures are adequate proxies for any underlying tendency to over- or under-complain, the persistence of the associations with satisfaction means that these cannot be wholly attributable to such a tendency. The association between satisfaction and physical health, which became non-significant when general health was controlled, may be an artefact; the decrease in its strength may, however, be at least partly an effect of overcontrolling, since the inclusion of a correlated health measure in the multivariate model must lead to underestimation of associations with the dependent

TABLE 5 Relationship between work satisfaction in 1975-1976 and 1985-1987 and general health in 1985-1987, 1975-1976 and 1969-1971; 210 men aged 50-69 years in 1985-1987

Group	Satisfied		No.	Poor general health: age-standardized rate per 100 men		
	1975-1976	1985-1987		1985-1987	1975-1976	1969-1971
A	Yes	Yes	113	18***	16*	25*
B	Yes	No	24	25**	21*	33*
C	No	Yes	46	13***	33*	39*
D	No	No	27	41	33	41

This analysis embraces all men who were included in both surveys, were working on both occasions, and were aged 50-69 years in 1985-1987, excluding 12 who were self-employed.

Significance tests: comparisons with group D, controlling for age by Mantel-Haenszel procedure, with P values adjusted by Holm's modification of the Bonferroni procedure^{34,35} on the basis that four groups permit six inter-group comparisons.

*** $P < 0.05$; ** $P = 0.058$; * $P > 0.25$.

health measure. Secondly, in 1975–1976 the significant relationship of health to overall job satisfaction was not consistently paralleled by similar associations with negative attitudes concerning specific occupational features, such as uninteresting or oversimple work, as might have been expected had the responses been expressions of an underlying tendency to over- or under-complain.¹³

The latter finding also supports the conclusion that the association between job satisfaction and health reflects the impact of overall satisfaction (or its determinants) on health, rather than vice versa. If reported job dissatisfaction was merely a non-specific expression of poor health, it might be expected that dissatisfaction with specific job features would be similarly associated with poor health.

The particularly poor health status in 1985–1987 of the small group of men who had expressed job dissatisfaction both in 1975–1976 and 1985–1987 points to the possibility that repeated or continuous dissatisfaction, or its determinants, may have an especially marked impact on health. The fact that the relatively high prevalence of ill health in these men was less marked in 1975–1976 and 1969–1971 than in 1985–1987 supports this causal explanation, although other interpretations are possible.

Apart from this, the longitudinal analysis demonstrated no clear-cut associations between job satisfaction in 1975–1976 and health status in 1985–1987, or vice versa, and thus throws no light on the temporal relationship between the variables. Taken at their face value, the findings bear out the influence of job satisfaction or its determinants on current health, although the effect is no longer manifest 10 years later.

A number of studies have linked job satisfaction with health, but its importance needs clarification.³⁸ A review of over three dozen studies that used job satisfaction as an index of job-related strain showed that under 10% of the variance in life satisfaction could be attributed to job satisfaction.³⁹ In a study of Swedish workers, however, job factors predicted health and behaviour better than family factors.⁴⁰ Fletcher concluded from a literature review that psychological stressors at work probably have a major impact on the life expectancy of the worker, as well as considerable spill-over on those outside the work environment.⁵ In the Duke Longitudinal Study of Aging, where 'work' included 'any useful activity such as housework, gardening, etc.' work satisfaction was the strongest predictor of longevity.^{41–43}

A study of US university workers suggested that job dissatisfaction led to physical symptoms and that these

had a (weaker) reciprocal effect on satisfaction.⁴⁴ The hypothesis that satisfaction affects health (rather than vice versa) was confirmed in a 2-year follow-up of air traffic controllers, where marked dissatisfaction with management was found to predict high rates of injuries and acute illnesses.⁴⁵ Associations between job dissatisfaction and mental health have been shown in data entry clerks,⁴⁶ interpreters,⁴⁷ and office workers.⁴⁸ Reviewing the literature, Kasl noted that associations between job dissatisfaction and mental health are usually weak.⁴⁹ At least two studies have reported discrepant findings: among air traffic controllers, those who were dissatisfied had a lower risk of developing hypertension;⁵⁰ and among Danish bus drivers, men who reported a high degree of job satisfaction had an increased risk of ischemic heart disease.⁵¹

The results of this study point to the importance, for middle-aged and elderly workers, of being happily occupied, and underline the need for preventing and managing work-related psychological strain.

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בריאות ושביעות רצון בעבודה בקרב מבוגרים וקשישים

יוסף אברמסון • חיים גופין • ג'ק חביב
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סדרת תדפיסים



בריאות ושביעות רצון בעבודה בקרוב מבוגרים וקשישים

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| 1 | המחלקה לרפואה חברתית, האוניברסיטה העברית-הדסה, ביה"ס לבריאות הציבור ולרפואה קהילתית והסתדרות מדיצינית הדסה |
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תקציר

קיימות עדויות לכך שגורמים תעסוקתיים היוצרים לחץ פסיכולוגי על העובד עלולים להשפיע על בריאותו הפיזית והנפשית. אולם, הממצאים מן המחקרים השונים אינם זהים. המחברים עושים שימוש בשביעות רצון בעבודה כמדד גלובאלי שימושי של לחץ פסיכולוגי בעבודה. הקשרים בין עבודה לבין בריאות כללית, פיזית ונפשית נמדדו, בעזרת שאלון, בקרב עובדים גילאי חמישים ומעלה במסגרת מחקר לונגיטודינלי על בריאות קהילתית שנערך בירושלים.

נמצאו קשרים חיוביים בין שביעות רצון בעבודה לבין בריאות, הן בשנים 1976-1975 והן בשנים 1985-1987, כאשר הגיל, המוצא, החינוך, המין וגורמים נוספים הוחזקו קבוע. הסיכוי היחסי לכך שהבריאות הכללית תהיה לקויה היה גבוה פי 2.8 אצל עובדים שלא היו שבעי רצון מאשר אצל אלה שהיו שבעי רצון ביותר. מניתוחים רב-משתניים עולה, כי לא ניתן לייחס קשרים אלה לנטייה מוגברת לדווח על אי-שביעות רצון ועל בריאות לקויה. העובדים שהביעו אי-שביעות רצון הן ב-1975-1976 והן ב-1985-1987 סבלו מבריאות לקויה במיוחד בשנים 1985-1987.

הממצאים מצביעים על כך שלשביעות רצון בעבודה או למקבעיה יש השפעה על הבריאות. עולה מהם שאי-שביעות רצון נמשכת עלולה להיות מזיקה במיוחד לבריאות העובד.