Job dissatisfaction and the older worker: baseline findings from the Health and Employment After Fifty study

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ABSTRACT
Objectives Demographic changes are requiring people to work longer. Labour force participation might be promoted by tackling sources of job dissatisfaction. We aimed to describe the epidemiology of job dissatisfaction in older British workers, to explore which perceptions of work contribute most importantly, and to assess possible impacts on health.

Methods Participants aged 50–64 years were recruited from 24 English general practices. At baseline, those currently in work (N=5437) reported on their demographic and employment circumstances, overall job satisfaction, perceptions of their work that might contribute to dissatisfaction, and their general health, mood and well-being. Associations of job dissatisfaction with risk factors and potential health outcomes were assessed cross-sectionally by logistic regression, and the potential contributions of different negative perceptions to overall dissatisfaction were summarised by population attributable fractions (PAFs).

Results Job dissatisfaction was more common among men, below age 60 years, those living in London and the South East, in the more educated and in those working for larger employers. The main contributors to job dissatisfaction among employees were feeling unappreciated and/or lacking a sense of achievement (PAF 55–56%), while in the self-employed, job insecurity was the leading contributor (PAF 79%). Job dissatisfaction was associated with all of the adverse health outcomes examined (ORs of 3–5), as were most of the negative perceptions of work that contributed to overall dissatisfaction.

Conclusions Employment policies aimed at improving job satisfaction in older workers may benefit from focusing particularly on relationships in the workplace, fairness, job security and instilling a sense of achievement.

INTRODUCTION
The proportion of older people in developed countries is steadily growing, such that by 2060, 30% of the European population will be aged over 65 years. Currently, however, many workers from OECD (Organisation for Economic Co-operation and Development) countries leave the labour market before the normal pension age1 and the so-called ‘total dependency ratio’ (that of those not working to those in the labour force) is rising.2 In response, governments have implemented policies to encourage workers to retire later, including delayed payment of state pensions and reduced pension incentives (to make early retirement less attractive), and legislation against age and disability discrimination (to make employment more flexible and accommodating).3

Retention of older workers in the labour market might also be promoted by measures aimed at improving their job satisfaction. Job dissatisfaction has previously been linked with labour turnover,4–6 intentions to retire early7–11 and sickness absence.12–14 However, reports to date have typically focused on selected occupations,13–16 rather than representative samples of the general population, and there has been little emphasis on the
older worker. \textsuperscript{10} \textsuperscript{11} As such, the epidemiology of job dissatisfaction in later working life remains ill defined.

A notable area of uncertainty is the relative importance of different negative perceptions of work that might contribute to job dissatisfaction, and whether this varies across subgroups of the population. Job dissatisfaction is a complex phenomenon with many potential determinants, of which some are personal and some relate to the work environment (e.g., dissatisfaction with pay or working hours, job insecurity, and problematic relationships with colleagues). However, the most important occupational drivers of dissatisfaction could vary importantly between subgroups defined by age, sex or employment circumstances.

Furthermore, while the link between job dissatisfaction and poorer psychological health is well recognised and much studied, \textsuperscript{13} it remains unclear whether some aspects of dissatisfaction are more important than others in influencing workers’ health.

This report has three aims relating to these gaps in evidence: (1) to describe the epidemiology of job dissatisfaction in British workers at older ages; (2) to explore the contributions of different negative perceptions of work to overall job dissatisfaction, and whether their relative importance varies across subgroups of the working population; and (3) to determine whether these aspects of dissatisfaction differ in their associations with measures of health.

\section*{METHODS}

For our analysis we used baseline data from the Health and Employment After Fifty (HEAF) study, which follows a large population-based cohort of older adults resident in England. The study’s design and methods of data collection have been reported in detail elsewhere. \textsuperscript{18} In brief, questionnaires were mailed to 39,359 adults born between 1948 and 1962 (target age band at recruitment 50–64 years) from 24 English general practices contributing data to a primary care research database, the Clinical Practice Research Datalink (CPRD). The practices were drawn from every region of England and all deciles of social deprivation, \textsuperscript{18} and all that agreed to support the study became foci of recruitment. Forms were sent to all people in the target age range who were registered with these practices after excluding those with terminal illness or recent bereavement, or who had de-registered between sampling and mailing (2.3\% of the enumeration list). In all, 8,134 participants completed an initial questionnaire during 2013–2014, and are now being followed up annually, initially for a 5-year period, through further questionnaires and record linkage. Ethical approval was obtained from the National Health Service (NHS) Research Ethics Committee North West-Liverpool East.

Among other things, the baseline questionnaire covered: demographic characteristics; employment status; for those in paid work, its nature and their feelings about working conditions; and self-reported health.

Demographic characteristics relevant to the current analysis were: sex and age; highest educational qualification (school only, vocational training certificate, university or higher professional degree); household composition; and the location of the participant’s general practice, which was used to classify them by an area-based measure of deprivation, the English Index of Multiple Deprivation 2010. \textsuperscript{19}

Items on the nature of work concerned: the size of an employer’s workforce (these were combined with employment status to create a variable with three levels, self-employed, employed and working for a small employer (<500 staff), employed and working for a large employer (≥500 staff)); tenure with the same employer (<1, 1 to 5, >5 years); type of contract (permanent vs temporary/renewable) and type of salary (fixed vs paid by output); hours worked per week (≤20, 20 to 40, >40); shift working (often vs sometimes/rarely/never); entitlement to paid holiday; and whether or not a second paid job was held.

Overall job dissatisfaction was assessed from the question: ‘How satisfied have you been with your job as a whole, taking everything into consideration?’ Response categories of ‘very satisfied’ and ‘satisfied/fairly satisfied’ were combined, as were ‘dissatisfied’ and ‘very dissatisfied’, to generate a binary variable ‘dissatisfied versus not’.

The questions on feelings about work were designed to ascertain various negative perceptions that might contribute to overall job dissatisfaction: satisfaction with pay and with working hours (scored as for overall dissatisfaction); whether there was choice in the job (often, sometimes, rarely/never) or support from colleagues or managers (often, sometimes, rarely/never); and whether the respondent felt appreciated at work by others (often, sometimes, rarely/never), had a work colleague who was very difficult to get on with (yes vs no), had been criticised unfairly at work (often, sometimes, rarely/never), or felt insecure in employment, overall and in the event of illness (very secure/secure vs rather insecure/very insecure). Before any associations with other variables were explored, answers to these questions were reclassified to create a set of binary variables.

Finally, three self-reported measures of health were assessed: self-rated health (SRH), determined with a single question \textsuperscript{20} and dichotomised (as fair/poor vs at least good); depressive symptoms, assessed by the Centre for Epidemiologic Studies Depression scale (CES-D) with participants scoring ≥16 considered ‘depressed’ \textsuperscript{21}; and well-being (measured using the Warwick-Edinburgh Mental Well-being Scale (WEMWBS), with participants in the lowest quintile of scores classified as having ‘poor’ well-being (score <32). \textsuperscript{22}

Analysis was restricted to respondents in paid work who completed the question on overall job satisfaction. In evaluating the epidemiology of job dissatisfaction at older ages, its associations with demographic factors and employment conditions were estimated using logistic regression, with results expressed as ORs with 95\% CIs. Risk estimates were initially adjusted for age and sex, and then derived from mutually adjusted models.

In exploring negative perceptions of work that might drive job dissatisfaction, we first summarised their pairwise associations by crude ORs, and then after combining those with high ORs and which appeared to measure closely related attributes (e.g., job insecurity in illness vs job insecurity in health), we analysed associations with overall job dissatisfaction (again the dependent variable). As well as ORs, we computed the population attributable fractions (PAFs) for each perception, indicating the proportion of cases (people dissatisfied with their job) that might be eliminated if no one experienced that perception (ie, if all people had the same risk of dissatisfaction as in the reference category). We used the formula PAF=p×(RR−1)/RR, where p represented the proportion of cases exposed to that risk factor and RR the OR obtained through a logistic regression model adjusted for age and sex. PAFs were derived for the population as a whole, and also within strata defined separately by sex, age band, level of educational attainment and employment status.

Finally, with overall job dissatisfaction and negative perceptions of work treated as independent variables, we used logistic regression to assess associations with fair or poor SRH, depressive symptoms (CES-D score ≥16) and poor well-being score (WEMWBS score lowest quintile). In this analysis, ORs were
RESULTS

From 8134 responders to the baseline questionnaire, we excluded 2625 who were not in paid work, and a further 72 who did not provide usable information about job satisfaction. This left a total of 2649 men and 2788 women who were included in the analysis. Within this sample, the prevalence of job dissatisfaction overall was 6.7%, while that of negative perceptions of work that might contribute to job dissatisfaction ranged from 2.3% for often being criticised unfairly to 44.4% for job insecurity in illness.

Table 1 summarises the associations of overall job dissatisfaction with various demographic and personal risk factors. After adjustment for other variables, overall dissatisfaction was less common in women than men (OR 0.76, 95% CI 0.61 to 0.94), and at older ages (OR 0.59, 95% CI 0.44 to 0.79 for age 60–64 vs 50–54 years). There were also geographical differences, the highest rates of dissatisfaction being reported in London and the South East (OR 1.54, 95% CI 1.01 to 2.34) and least common among participants working for large employers (OR 12.9, 95% CI 10.2 to 16.2), and although only 13.7% of participants made this complaint, the PAF was 53.6% (95% CI 47.9% to 58.7%). An even higher PAF (56.1%) was estimated for job insecurity, which was less strongly associated with overall dissatisfaction (OR 4.0, 95% CI 3.1 to 5.1), but more prevalent for job insecurity in illness (OR 12.9, 95% CI 10.2 to 16.2). There were also geographical differences, the highest rates of dissatisfaction being reported in London and the South East (OR vs North East and North West 1.68, 95% CI 1.08 to 2.59) and in the East (OR 1.42, 95% CI 1.01 to 2.00). In addition, there was a higher prevalence of job dissatisfaction in participants who were more educated (ORs 1.25 to 1.31), and in those who lived alone (OR 1.63, 95% CI 1.28 to 2.08).

Table 2 shows associations of overall job dissatisfaction with various aspects of employment. Dissatisfaction was most common among participants working for large employers (OR 2.25, 95% CI 1.32 to 3.81 vs self-employed), and was less frequent in those who worked for ≤20 h/week or had a longer tenure of current employment. There was also a weak positive association with shift work (OR 1.37, 95% CI 1.04 to 1.82).

All of the negative perceptions were mutually associated (see online supplementary table S1), ORs for pairwise associations being particularly high for: rarely/never having a feeling of achievement and rarely/never feeling appreciated (15.9); having difficult colleague(s) and often being criticised unfairly (9.8); and perceived job insecurity in illness and when well (8.4). It seemed likely that in these cases, the two perceptions reflected the same problem. Therefore, in subsequent analyses, new variables were created, defined by the presence of either or both perceptions (eg, either rarely/never having a feeling of achievement or rarely/never feeling appreciated or both).

Table 3 shows how overall job dissatisfaction related to different negative perceptions of work. The strongest association was with rarely/never feeling appreciated or a sense of achievement (OR 12.9, 95% CI 10.2 to 16.2), and although only 13.7% of participants made this complaint, the PAF was 53.6% (95% CI 47.9% to 58.7%). An even higher PAF (56.1%) was estimated for job insecurity, which was less strongly associated with overall dissatisfaction (OR 4.0, 95% CI 3.1 to 5.1), but more prevalent (47.8% of participants). Least important were lack of choice in activities (OR 2.7, PAF 24.4%) and lack of support when in difficulty at work (OR 3.8, PAF 23.2%).

Table 4 compares the possible contributions of different negative perceptions of work to overall job dissatisfaction in various subgroups of the study sample. There were no major differences between men and women, but at older ages, concerns about

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**Table 1** Demographic and personal risk factors for job dissatisfaction

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Number</th>
<th>Number of cases</th>
<th>Associations with overall job dissatisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>*OR (95% CI) tOR (95% CI)</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>2649</td>
<td>199</td>
<td>Reference</td>
</tr>
<tr>
<td>Female</td>
<td>2788</td>
<td>169</td>
<td>0.79 (0.64 to 0.98) 0.76 (0.61 to 0.94)</td>
</tr>
<tr>
<td>Age (years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50–54</td>
<td>1843</td>
<td>140</td>
<td>Reference</td>
</tr>
<tr>
<td>55–59</td>
<td>2051</td>
<td>154</td>
<td>0.99 (0.78 to 1.25) 0.97 (0.76 to 1.24)</td>
</tr>
<tr>
<td>60–64</td>
<td>1543</td>
<td>74</td>
<td>0.61 (0.46 to 0.82) 0.59 (0.44 to 0.79)</td>
</tr>
<tr>
<td>Area of GP practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East and North West</td>
<td>1221</td>
<td>71</td>
<td>Reference</td>
</tr>
<tr>
<td>West Midlands</td>
<td>745</td>
<td>52</td>
<td>1.22 (0.84 to 1.76) 1.21 (0.83 to 1.77)</td>
</tr>
<tr>
<td>East</td>
<td>1245</td>
<td>95</td>
<td>1.34 (0.98 to 1.85) 1.42 (1.01 to 2.00)</td>
</tr>
<tr>
<td>South Central and West</td>
<td>1809</td>
<td>114</td>
<td>1.09 (0.80 to 1.48) 1.14 (0.82 to 1.59)</td>
</tr>
<tr>
<td>London and South East</td>
<td>417</td>
<td>36</td>
<td>1.54 (1.01 to 2.34) 1.68 (1.08 to 2.59)</td>
</tr>
<tr>
<td>Deprivation (thirds)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best</td>
<td>1157</td>
<td>75</td>
<td>Reference</td>
</tr>
<tr>
<td>Intermediate</td>
<td>1666</td>
<td>116</td>
<td>1.05 (0.79 to 1.38) 1.16 (0.83 to 1.62)</td>
</tr>
<tr>
<td>Worst</td>
<td>2614</td>
<td>177</td>
<td>1.08 (0.80 to 1.46) 1.12 (0.83 to 1.51)</td>
</tr>
<tr>
<td>Educational level</td>
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<td></td>
<td></td>
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<tr>
<td>School only</td>
<td>1844</td>
<td>108</td>
<td>Reference</td>
</tr>
<tr>
<td>Vocational training certificate</td>
<td>1749</td>
<td>127</td>
<td>1.22 (0.94 to 1.60) 1.31 (1.00 to 1.72)</td>
</tr>
<tr>
<td>University degree or higher</td>
<td>1844</td>
<td>133</td>
<td>1.21 (0.93 to 1.57) 1.25 (0.95 to 1.63)</td>
</tr>
<tr>
<td>Professional degree or higher</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living alone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4271</td>
<td>263</td>
<td>Reference</td>
</tr>
<tr>
<td>Yes</td>
<td>1091</td>
<td>100</td>
<td>1.60 (1.26 to 2.04) 1.63 (1.28 to 2.08)</td>
</tr>
</tbody>
</table>

*Adjusted only for sex and age.

†Mutually adjusted risk estimates derived from a single logistic regression.

GP, general practitioner.
working hours seemed to be less of a problem than in younger participants (PAF 24.6% at age 60–64 years vs 40.8% at age 50–54 years). In comparison with those whose education had not progressed beyond school, overall dissatisfaction among participants with a university degree or higher professional qualification appeared less likely to be driven by concerns about pay, lack of appreciation or a feeling of achievement, or lack of choice in occupational activities. Dissatisfaction among the self-employed appeared to be driven mainly by concerns about working hours and pay.

Table 2  Associations of job dissatisfaction with aspects of employment

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Number</th>
<th>Number of cases</th>
<th>*OR (95% CI)</th>
<th>tOR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>884</td>
<td>30</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Small employer (&lt;500 staff)</td>
<td>2543</td>
<td>153</td>
<td>1.89 (1.27 to 2.83)</td>
<td>1.38 (0.82 to 2.33)</td>
</tr>
<tr>
<td>Large employer (≥500 staff)</td>
<td>1984</td>
<td>181</td>
<td>2.90 (1.95 to 4.31)</td>
<td>2.25 (1.32 to 3.81)</td>
</tr>
<tr>
<td>Time worked same employer (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;1</td>
<td>336</td>
<td>34</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>1 to 5</td>
<td>965</td>
<td>77</td>
<td>0.77 (0.51 to 1.18)</td>
<td>0.86 (0.54 to 1.35)</td>
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<tr>
<td>&gt;5 years</td>
<td>4071</td>
<td>255</td>
<td>0.60 (0.41 to 0.88)</td>
<td>0.56 (0.37 to 0.84)</td>
</tr>
<tr>
<td>Type of contract</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent</td>
<td>4314</td>
<td>315</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Temporary/renewable</td>
<td>320</td>
<td>22</td>
<td>0.96 (0.61 to 1.51)</td>
<td>Reference</td>
</tr>
<tr>
<td>Not applicable (self-employed)</td>
<td>775</td>
<td>29</td>
<td>0.48 (0.33 to 0.72)</td>
<td>Reference</td>
</tr>
<tr>
<td>Salary</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fixed</td>
<td>4502</td>
<td>324</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Paid by output</td>
<td>885</td>
<td>40</td>
<td>0.60 (0.43 to 0.85)</td>
<td>1.03 (0.65 to 1.63)</td>
</tr>
<tr>
<td>Hours worked per week</td>
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<tr>
<td>≤20</td>
<td>804</td>
<td>34</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>&gt;20 to 40</td>
<td>3218</td>
<td>230</td>
<td>1.59 (1.09 to 2.32)</td>
<td>1.68 (1.09 to 2.59)</td>
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<td>&gt;40</td>
<td>1380</td>
<td>104</td>
<td>1.57 (1.03 to 2.39)</td>
<td>1.75 (1.09 to 2.82)</td>
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<tr>
<td>Fixed time of starting work</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some or no work days</td>
<td>1329</td>
<td>61</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Most or all work days</td>
<td>4091</td>
<td>306</td>
<td>1.73 (1.30 to 2.30)</td>
<td>1.39 (1.02 to 1.91)</td>
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<tr>
<td>Shift work</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes/rarely/never</td>
<td>4543</td>
<td>288</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Often</td>
<td>843</td>
<td>76</td>
<td>1.43 (1.10 to 1.87)</td>
<td>1.37 (1.04 to 1.82)</td>
</tr>
<tr>
<td>Holidays</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some entitlement</td>
<td>5254</td>
<td>356</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>No entitlement</td>
<td>20</td>
<td>2</td>
<td>1.57 (0.36 to 6.83)</td>
<td>1.14 (0.15 to 8.86)</td>
</tr>
<tr>
<td>Have a second paid job</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>4612</td>
<td>317</td>
<td>Reference</td>
<td>Reference</td>
</tr>
<tr>
<td>Yes</td>
<td>418</td>
<td>27</td>
<td>0.95 (0.63 to 1.43)</td>
<td>1.00 (0.65 to 1.53)</td>
</tr>
</tbody>
</table>

Table 3  Contributions of negative perceptions of work to overall job dissatisfaction

<table>
<thead>
<tr>
<th>Perception</th>
<th>Number (% reporting perception Among all participants (n=5437)</th>
<th>Association with overall job dissatisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissatisfied with working hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissatisfied with pay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely/never feel appreciated and/or sense of achievement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely/never support when in difficulty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rarely/never have choice in activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or more colleagues difficult and/or often criticised unfairly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Job insecure in illness and/or when well</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*ORs (with 95% CIs) adjusted for age and sex. Separate models were constructed for each negative perception.  
†Population attributable fractions (% with 95% CIs).  
PAF, population attributable fraction.
Table 5 summarises the relationship of overall job dissatisfaction and contributing negative perceptions to three health outcomes—fair/poor SRH, depression (CES-D score ≥16) and poor well-being (lowest quintile of WEMWBS score). Overall job dissatisfaction was associated with each of the health outcomes, the ORs (3.16, 5.26 and 5.52, respectively) being higher than for any of the individual perceptions. Among the perceptions, lack of support at work appeared to have little effect (ORs 0.94 to 1.22), whereas the three health outcomes were each significantly associated with difficulty with colleagues/feeling unfairly criticised and job insecurity, while all but well-being were significantly associated with dissatisfaction about pay. Not feeling appreciated or a sense of achievement was also associated with all three measures of health, and particularly with poor well-being (OR 3.18, 95% CI 2.25 to 4.49). Dissatisfaction with working hours related to depression and poor well-being but not to SRH, whereas lack of choice in occupational activities showed no relationship to poor well-being but was weakly associated with fair/poor SRH and depression.

**DISCUSSION**

Within our study sample, the main perceptions of work driving job dissatisfaction among employees were lack of appreciation and/or a feeling of achievement, and difficulty with colleagues at work and/or feeling unfairly criticised, whereas in the self-employed they were job insecurity and dissatisfaction with pay. Overall job dissatisfaction was more common in men than women, below age 60 years, in London and the South East, and in those working for large employers. It was also associated with longer education and living alone. Most potential drivers of job dissatisfaction contributed to overall associations with worse SRH, depression and poor well-being, but lack of support and choice in work had relatively little impact.

Potential strengths and limitations have to be considered when interpreting these findings. A notable strength was the large, geographically dispersed, population-based sampling strategy. Almost everyone in Britain registers with a general practice for healthcare free at the point of delivery, so the patient lists of general practices provide a comprehensive and representative sampling frame. The response rate at baseline was relatively low but respondents tended to be somewhat older, more affluent and more often female than non-responders, although the sample’s profile approximated reasonably to national statistics for this age band.18 The prevalence of overall job dissatisfaction could have been underestimated or overestimated if those dissatisfied with their work were less or more likely to participate. However, associations of job dissatisfaction with the variables of interest (demographic and workplace factors, its occupational components, and the report’s health outcomes) would only be biased if they differed importantly between responders and non-responders. We have no reason to expect this. Moreover, questions on job dissatisfaction and its potential drivers formed only a small part of a larger question set (in all 91 questions and up to 154 responses), and are unlikely therefore to have influenced decisions to participate in the research.

A further strength stemming from population sampling was the opportunity (assuming causal relationships) to estimate PAFs for negative perceptions contributing to job dissatisfaction, overall and within strata with differing characteristics. To our knowledge, such information has never previously been available. New insights are offered into the relative importance of different potential drivers at a population level and within important subgroups.

### Table 4

<table>
<thead>
<tr>
<th>Population group</th>
<th>Age (years)</th>
<th>Male</th>
<th>Female</th>
<th>Age (years)</th>
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The figures presented are population attributable fractions per cent with 95% CIs in brackets.

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Set against these strengths, it should be noted that our analysis was based on the baseline phase of the HEAF study and cross-sectional in nature, imposing limits on interpretation. Thus, for example, while poor quality of relationships at work and lack of fulfilment are credible sources of job dissatisfaction, we cannot exclude the possibility that dissatisfaction at work may have sourced some people’s working relationships with others. Likewise, while job dissatisfaction may well lead to poorer self-assessed health, circumstances can be imagined in which poor health could erode satisfaction with one’s own work performance and lead to overall job dissatisfaction. Survivorship effects are also evident in this cross-sectional analysis: for example, the inverse relationship between dissatisfaction and job tenure probably reflects a propensity of people to remain longer in a job that appeals to them.

A further potential limitation stems from the challenge inherent in measuring a complex multifaceted phenomenon. Different approaches have been taken to assessment of job dissatisfaction across studies. Some investigations have used elaborate scales containing many questions. By contrast, we did not consider all the many facets that have been proposed.24 25 In particular, we did not consider ‘intrinsic’ determinants of dissatisfaction, such as negative affectivity and other aspects of personality, although several theoretical models have been developed that are based on such attributes.26 Collecting the extra detail was not feasible given the broad aims of the HEAF study, but conounding by personality differences between groups is unlikely to have importantly influenced findings in our area of primary interest.

In focusing on risk factors in the workplace that might be avoidable, we included some facets that have been little studied previously but appeared of interest a priori. Thus, for example, existing literature on the impact of perceived lack of recognition15 16 and cohesiveness of working relationships25 is fairly small.

Relationships of job dissatisfaction to younger age and male sex are well established by other research and in agreement with our own findings. Others’ findings also accord with ours on several less frequently studied demographic and occupational associations, such as shorter job tenure,28 longer working hours,27 29 30 working in large establishments29 30 and higher educational attainment,29 30 relationships we have been able to confirm specifically in a sample of older workers. The greater propensity towards job dissatisfaction of Londoners and those living in the South East of England is a novel discovery, however. Among the possible drivers we considered, our findings on autonomy and decision latitude,15 31 working relationships,27 feeling undervalued with lack of recognition,15 16 and job insecurity29 32 are similar to those in a relatively small number of other reports, although supplemented here by quantification of effects at the population level. They are also compatible with some reports based on effort–reward imbalance and job dissatisfaction, such as that by de Jonge et al,33 which defined occupational rewards in terms of satisfaction with pay, social support and job security.

Associations between job dissatisfaction and psychological ill health are well recognised. Thus, in a meta-analysis of 485 mainly cross-sectional studies, Faragher et al17 found clear-cut correlations between job dissatisfaction and anxiety, depression and poorer general mental health. However, the impact on self-reported health of the different negative perceptions that drive job dissatisfaction has been unclear, and table 5 provides useful new information.

Studies in older workers (in the age bands of the HEAF study) have been uncommon to date and their focus has differed from that presented here. However, in the Survey of Health, Aging and Retirement in Europe (SHARE), a large cohort of 50–64-year olds from 10 European countries, overall job dissatisfaction was assessed using a very similar question to our own and a similar estimate of prevalence was derived.10 In the same survey, in keeping with our findings, job satisfaction was greater among women, with advancing age, in those who felt there was recognition for the job and in those perceiving their job to be secure34; poor job quality (defined in part to include job dissatisfaction) was strongly associated with poor SRH and depression.35

Our data suggest that feeling unappreciated, lacking a sense of achievement at work, perceptions about having critical colleagues, being dealt with unfairly and job insecurity, and concerns about pay may be important population drivers of overall job dissatisfaction, albeit with variation between subgroups. As such,
they represent potential targets for interventions based on improved employment policies.

The impetus for employers to intervene is likely to be driven by costs and benefits, one consideration being the likely effect of job dissatisfaction on labour force participation. Workers from the SHARE study who were dissatisfied with their job were more likely to express retirement intentions and twice as likely actually to retire 2 years later. Job dissatisfaction was the strongest predictor of early retirement, suggesting that the impact could be material. Findings in mixed-age workforces are less clear-cut, however, with some reports indicating increased labour turnover but others indicating only a small effect. Further research is required in older workers, since their employment outcomes may differ from those in other age bands. Moreover, while dissatisfied younger workers may seek alternative employment, dissatisfied older workers may be less permanently to the workforce.

Participants of the HEAF study are being followed up annually with linkage to the CPRD, and this prospective phase should provide much needed additional data on how job dissatisfaction influences future employment, how changes in work circumstances affect job dissatisfaction and health over time, and whether job dissatisfaction has long-term effects on health, including doctor-recorded as well as self-reported health outcomes.

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Contributors

KTP and DC identified the study questions and designed the study and its measuring instruments. KTP supervised data collection, and with SD and DC, planned the analyses. SD conducted the analyses, wrote the first draft of the paper and shared with KTP in reviewing the existing literature. KW-B, ECH, CL, AAS, CRG, ME, TVS and CC contributed to the study’s design, content, measuring instruments and plan of execution. Additionally, ECH and CL led in data collection, cleaning and preparation, and the enlistment of participating general practices. All authors read and approved the final manuscript.

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Competing interests

None declared.

Patient consent

Obtained.

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NHS Research Ethics Committee North West-Liverpool East.

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REFERENCES


