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THE MODERATOR ROLE OF ORGANIZATIONAL SUPPORT IN THE RELATIONSHIP BETWEEN JOB STRESS AND PRESENTEEISM AMONG HEALTHCARE WORKERS

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Abstract

The phenomenon of presenteeism among healthcare workers, which is vital in terms of its direct intervention in human life, emerges as a critical but often overlooked factor that affects both the well-being of employees and the quality of patient care. Determining the factors that trigger and prevent presenteeism, which occurs as a result of employees' mental disconnection from work as a result of going to work despite being sick, is very important for public health. Based on this point, the moderator role of perceived organizational support in the effect of job stress on presenteeism was investigated in this study. The study included 396 healthcare professionals working in hospitals in Istanbul. According to the findings of the study, perceived job stress increases presenteeism, while perceived organizational support decreases it. In addition, the moderating role of perceived organizational support was determined in the effect of perceived job stress on presenteeism. Accordingly, organizational support decreases the effect of perceived job stress on presenteeism. Within the framework of the research findings, it is important for the Ministry of Health and health organizations to collaboratively implement comprehensive strategies that not only alleviate job stress but also robustly develop organizational support structures, thereby significantly reducing presenteeism and promoting a healthier, more resilient health workforce.

Keywords: Job stress, organizational support, presenteeism, health workers.

1. Introduction

The health sector is a critical component of societal well-being and development, and plays an important role in maintaining the health and productivity of populations around the world. It relies heavily on its human capital, particularly health workers, who are at the center of delivering quality health services. The performance and well-being of health workers is inextricably linked to the quality of patient care, making it important to develop strategies to ensure their retention and optimal working conditions. With the increasing complexity and demands of healthcare, as in all other service sectors, the importance of a robust and efficient healthcare workforce is becoming ever more evident. The sector's dependence on skilled workers underscores the need to maintain a healthy and skilled workforce that can meet the complexity of contemporary healthcare challenges.

In this context, presenteeism, which is the phenomenon of employees being present at work but not fully performing, emerges as an important concern, especially in the health sector where risks are high (Homrich et al., 2020). This behavior, while seemingly harmless, can have profound effects on both employee health and the safety and quality of patient care (Kustler et al., 2021). The consequences of presenteeism are far-reaching, going beyond individual health to affect organizational productivity and overall healthcare costs (Lui et al., 2018). Given the critical role of human capital in healthcare, it is vital to understand and mitigate the determinants of presenteeism.

Addressing these issues is key to maintaining an effective, efficient and healthy workforce, which is essential for the delivery of quality healthcare services.

One of the main determinants of presenteeism in the healthcare sector is job stress experienced by employees (Yang et al., 2017). The healthcare environment is inherently stressful, characterized by long working hours, emotional labor, and high-stakes decisions. This stress is exacerbated by factors such as staff shortages, administrative workload, and the emotional toll of patient care (Atasoy & Yorgun, 2013). The high prevalence of job stress among healthcare workers requires closer examination of its impact, especially in relation to presenteeism (Yang et al., 2018). Understanding the causes and consequences of job stress is critical for developing effective strategies to mitigate its effects on healthcare workers and thus the quality of healthcare services.

Another important factor affecting presenteeism is the level of organizational support perceived by healthcare workers (Şahan & Yıldız, 2020). Organizational support includes various elements such as the availability of resources, effective management practices, and a supportive workplace culture (Altai, 2021). While adequate organizational support can act as a buffer against the negative effects of job stress (Serinikli, 2019), the absence of such support can intensify stress and contribute to increased absenteeism. Therefore, it is important to understand the role and impact of organizational support. High organizational support will not only help address the immediate challenges of presenteeism, but also contribute to the development of a more supportive and conducive working environment for healthcare workers.

In the light of this information, the aim of this study is to investigate the moderating role of organizational support in the relationship between job stress and presenteeism among healthcare workers.

2. Literature Review And Hypothesis Development

2.1. Presenteeism

Presenteeism, which is derived from the English word “presence” meaning being present, being ready and appearance (Yeşiltaş & Ayaz, 2019), emerged with the industrial revolution when physical presence at work was very important (Johns, 2010). Presenteeism, which is predominantly seen in employees who undertake large workloads and responsibilities, refers to the situation where employees come to work despite being sick, experience various physical and psychological problems as a result, and mentally disconnect from work despite being physically present (Lowe, 2002). Until the early 80s, the concept was used synonymously with the concept of absenteeism, which is defined as sick employees not going to work, and then it was differentiated into those who go to work despite being sick and those who are mentally absent from work despite being physically present at work (Yeşiltaş & Ayaz, 2019). While Cooper and Lu (2018) defined presenteeism as “going to work while sick”, Aronsson et al. (2000) defined it as “working while sick to the detriment of health and productivity”, emphasizing the impact of the concept on productivity. Schultz and Edington (2007), on the other hand, approach the concept from a health perspective and define it as “loss of workplace productivity due to health problems or emotional distress”. Miraglia and Johns (2016) expand this definition and consider it as “the behavior of continuing to work despite being ill, which is considered as an opposite behavior to absenteeism”. Integrating these views, presenteeism can be defined as employees continuing to work despite health-related or emotional difficulties, potentially hindering their productivity and well-being.

The importance of presenteeism for organizations lies in its impact on productivity, employee well-being, and overall organizational health (Johns, 2010). Presenteeism often results in sub-optimal work output and can impose

costs on organizations that even exceed the costs of absenteeism (Goetzel et al., 2004). Its occurrence is often attributed to organizational cultures that implicitly reward physical presence, job insecurity and high job demands (Johns, 2011). In healthcare organizations, the problem becomes more pronounced due to the critical nature of healthcare services and the ethical implications of working while ill (Yıldız et al., 2015). In such settings, reluctance to take sick leave is often due to a sense of responsibility and the difficulty of finding a replacement (Aronsson et al., 2000). Moreover, healthcare workers faced with presenteeism may increase the potential for medical errors by jeopardizing the quality of patient care (Miraglia & Johns, 2016). This phenomenon has been observed globally with studies highlighting its prevalence and impact in the healthcare sector in various countries (Cooper & Lu, 2018). However, the presence of non-functioning healthcare workers can also negatively impact team dynamics and morale, further undermining the quality of care provided (Lohaus & Habermann, 2019). Therefore, addressing presenteeism in healthcare organizations is not only a matter of improving employee health and well-being, but also an important step towards ensuring high standards of patient care and safety.

Organizational consequences of presenteeism include reduced overall productivity, increased errors, and compromised workplace safety (Johns, 2010). In healthcare organizations, these consequences are exacerbated by the direct impact on patient care and the potential for the spread of infections (Aronsson et al., 2000; Yıldız et al., 2015; Miraglia and Johns, 2016). Prolonged presenteeism can also lead to longer-term health problems among employees, which can exacerbate absenteeism and healthcare costs for the organization (Schultz & Edington, 2007). Furthermore, a culture of presenteeism can affect the overall morale and mental health of healthcare workers, perpetuating the cycle of poor health and low productivity (Miraglia & Johns, 2016). The need for policies that address presenteeism, especially in healthcare settings, is critical to ensure both employee well-being and organizational effectiveness (Yang et al., 2017; Lui et al., 2018).

2.2. Job Stress

The etymology of the concept of work stress, often referred to as ‘occupational stress’, is based on the Latin word ‘strictus’ meaning tight or narrow, which later evolved into the English word ‘stress’ meaning difficulty or distress. Historically, the study of work stress began in the early 20th century with Walter Cannon’s pioneering theories on ‘fight or flight’ responses and Hans Selye’s ‘General Adaptation Syndrome’, which paved the way for the understanding of physiological responses to stress (Cannon, 1914; Selye, 1950). The concept of stress is the physical and emotional response of an individual to potentially threatening situations in the environment (Selye, 1976). Selye’s work laid the foundation for subsequent theories in the organizational context, including the job demands and job resources model (Bakker & Demerouti, 2007) and the effort-reward imbalance model (Siegrist, 1996). These theoretical frameworks have contributed to the understanding of job stress as a multifaceted phenomenon. Lazarus and Folkman (1984) define job stress as a condition resulting from the interaction between individuals and their work environment, leading to psychological and physiological reactions. The International Labor Organization (1986) defines job stress as “harmful physical and emotional reactions that occur when the requirements of the job do not match the employee’s abilities, resources or needs”. Cox and Griffiths (2005) defined it as “the process that occurs when job demands of various types and combinations exceed the coping capacity and ability of the individual”. Job stress refers to a situation in which pressure that leads to deterioration in the mental and physical performance of the employee occurs as a result of interaction with work-related factors (Beehr & Newman, 1978). Within the framework of these definitions, job stress can be generally defined as a

multifaceted reaction resulting from the imbalance between job demands and the individual's coping capacity, which is influenced by both organizational factors and personal perceptions.

The formation of job stress is multifactorial and includes factors such as workload, role ambiguity, role conflict, lack of support and job insecurity (Kurt, 2010; Tuna & Baykal, 2013; Sheraz et al., 2014). The importance of understanding and managing job stress is crucial for organizations as it significantly affects employee well-being, productivity and organizational effectiveness (Visser et al., 2003; İştar, 2012; Jackson & Frame, 2018). In healthcare organizations, these stress factors increase with factors such as emotional labor, shift and long working hours, exposure to patient trauma and bureaucratic organizational structure (McVicar, 2003; Özcan et al., 2014). Healthcare workers often face unique stressors such as dealing with life-and-death situations that can lead to burnout, compassion fatigue, and reduced quality of patient care (Lindsay et al., 2008; Chirico, 2016; Muhamad Robat et al., 2021). The high-risk environment of healthcare, often coupled with understaffed and resource-constrained settings, exacerbates stress levels among healthcare workers (Aiken et al., 2002). Moreover, organizational factors such as leadership style, team dynamics, and institutional support play an important role in reducing stress in these settings (Laschinger et al., 2001).

The organizational consequences of job stress range from decreased job performance and satisfaction to increased absenteeism and turnover (Milner et al., 2018; Kavosi et al., 2018). These consequences not only affect individual employees but also have a significant financial impact on organizations (Jamal, 2005). In healthcare organizations, the repercussions of job stress extend to patient care, where stressed healthcare workers are more likely to make mistakes, show less empathy, and provide lower quality care (Ruotsalainen et al., 2014). Furthermore, high levels of stress can contribute to a negative work environment, further perpetuating the cycle of stress and dissatisfaction among healthcare workers (Dyrbye et al., 2007). This link between employee stress and patient outcomes underscores the critical importance of addressing work stress in healthcare settings.

One of the important outcomes of job stress is presenteeism (Yang et al., 2017). Presenteeism is often the result of high job demands and the necessity to be present at work despite stress or illness (Johns, 2010). Aronsson et al. (2000) established a relationship between high levels of stress and increased presenteeism in healthcare settings. Research suggests that stressed healthcare workers are more likely to exhibit presenteeism, which negatively impacts their health and potentially leads to suboptimal patient care (Yang et al., 2017; Yang et al., 2018; Yang et al., 2020; Deng et al., 2022). Studies by McKevitt et al. (1997) and Hemp (2004) show that presenteeism fueled by job stress not only reduces the quality of healthcare delivery, but also imposes a significant economic burden on healthcare systems. Accordingly, the first hypothesis of the study was developed as follows:

H_1: Job stress increases presenteeism in healthcare workers.

2.3. Organizational Support

The concept of organizational support has its roots in social exchange theory and the concept of reciprocity in workplace relationships. The term "organizational support" was first used to describe the extent to which an organization values the contributions of its employees and cares about their well-being (Rhoades & Eisenberger, 2002). The historical development of this concept is intertwined with theories of organizational behavior and psychology, especially the work of Eisenberger et al. (1986) who introduced the theory of perceived organizational support. Eisenberger et al. (1986) explained organizational support as a situation in which organizational values take into account the well-being of employees and increase their happiness. This concept was further elaborated

by Rhoades and Eisenberger (2002) who emphasized the importance of positive treatment by the employer beyond the contract. Shore and Wayne (1993) defined organizational support as the level of help and support that an organization provides to its employees. Moorman (1991) saw it as an organization's readiness to reward increased employee commitment and loyalty with job security and career development opportunities. Synthesizing these perspectives, organizational support can be defined as a multidimensional construct that encompasses employees' perceptions of how much their organization values their contributions and cares about their well-being, influenced by both tangible rewards and emotional support.

Shore and Shore (1995) emphasize the importance of fair treatment and trust in the development of perceived organizational support. This is particularly true in healthcare settings where trust between healthcare workers and management is vital for effective collaboration and patient care (Laschinger et al., 2001). The role of supervisor support as an antecedent of organizational support was emphasized by Eisenberger et al. (2002). As noted by Rhoades and Eisenberger (2002), organizational rewards and job conditions are also critical antecedents of perceived organizational support. In healthcare settings, the adequacy of resources, wages and working conditions directly affect healthcare workers' perceptions of organizational support (Aiken et al., 2001).

The organizational consequences of organizational support are wide-ranging. High levels of perceived organizational support are linked to increased job satisfaction, organizational commitment and reduced turnover intentions (Allen et al., 2003; Rhoades et al., 2001). In health organizations, this will manifest as better patient care and reduced staff shortages. The effects of this are even more important in health organizations. Organizational support in healthcare organizations can improve both employee well-being and patient care quality by reducing job stress and burnout (Leiter & Maslach, 2009; Afşar et al., 2021; Özbezek et al., 2021). In addition, organizational support in these environments can improve team cohesion and collaboration necessary for effective patient care (West et al., 2006; Ho et al., 2021). A supportive organizational climate in healthcare organizations contributes to the well-being of both employees and patients by acting as a buffer against the high demands of healthcare work (Laschinger et al., 2001).

It is clear that in parallel with providing organizational support to employees, working conditions will improve and the employee will take time off work in case of any illness and will not exhibit presenteeism (Cote et al., 2021). Especially in the health sector, where employee actions directly affect human health, presenteeism decreases with organizational support and thus the negative effects of presenteeism are eliminated (Şahan & Yıldız, 2020). This is because perceived organizational support can alleviate job stress and reduce the need for presenteeism by encouraging coping mechanisms (Yang et al., 2019). Other research results in the literature have revealed that organizational support has a negative effect on presenteeism (Huang et al., 2021; Şahin & Aydın, 2021; Wu et al., 2023). Accordingly, the second hypothesis of the study was developed as follows:

H_2: Organizational support reduces presenteeism in healthcare workers.

On the other hand, organizational support is expected to act as a buffer in the effect of job stress on presenteeism and mitigate the effect of job stress on presenteeism. On the axis of the psychological contract between the employee and the organization, when employees perceive their organizations as supportive, they will feel valued and understood, and this perception will act as a psychological buffer against the negative effects of job stress (Arunachalam, 2021; Duran et al., 2021). High levels of perceived support will contribute to better stress management, lower levels of perceived job tension and a healthier work-life balance (Thakur & Kumar, 2015;

Labrague et al., 2018), which indirectly reduces the tendency towards presenteeism. Thus, organizational support will act as a moderator not only by alleviating direct stressors but also by reshaping the employee's response to stress, reducing the likelihood of presenteeism despite the high-stress nature of their work. Accordingly, the third hypothesis of the study was developed as follows:

H_3: Organizational support plays a moderator role in the effect of job stress on presenteeism in healthcare workers.

The research model to be tested within the framework of the developed hypotheses is presented in Figure 1:

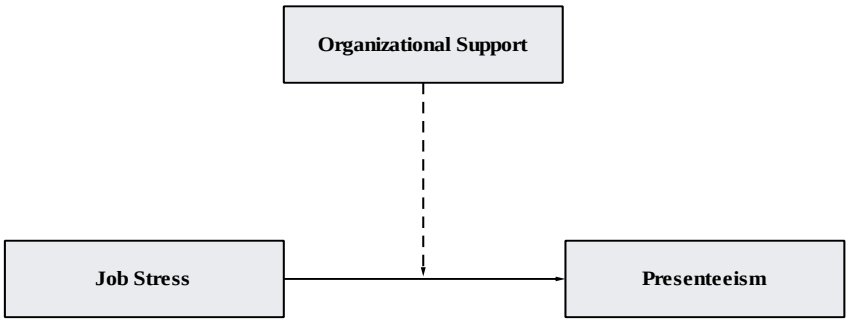

Figure 1. Research Model

3. Methodology

3.1. Sampling

The population of the study consists of healthcare professionals working in hospitals throughout Istanbul. Cochran (1977) sampling calculation was used in determining the minimum sample number to be reached due to the inability to determine the number of the population (Bartlett, Kotrlik, & Higgins, 2001). The minimum sample number to be reached was determined as 385 in the calculation made for 5% significance level. Accordingly, links to the online questionnaire form were sent to 1000 participants selected by simple random sampling technique. 42.7% of 427 participants returned the questionnaire. However, since the responses of 31 participants were determined to be unsuitable for analysis, the research sample consisted of 396 participants. The characteristics of the sample are presented in Table 1.

Table 1. Demographic Characteristics of the Sample

		f ($\bar{X}$±sd)	**%** (Min-Max)
Gender	Make	152	38.4
	Female	244	61.6
Age (yars)		(32.677±8.188)	(20-62)
Marital Status	Single	268	67.7
	Married	183	46.2
Education	High School	35	8.8
	Associate degree	67	16.9
	Bachelor's degree	227	57.3
	Postgraduate	67	16.9
Income	Low	192	48.5
	Moderate	153	38.6
	High	51	12.9
Hospital Type	Public	268	67.7
	Private	128	32.3
Hospital Experience (years)		(5.184±3.407)	(1-12)
Sector Experience (years)		(7.831±6.962)	(1-30)

According to the information in Table 1, the majority of the participants were female with 61.6% and the average age was calculated as 32.677±8.188. While the majority of the participants were single with 67.7%, the majority of them were bachelor's degree graduates with 57.3%. The majority of the participants (48.5%) think that their income is less than their expenses. While the majority of the participants (67.7%) work in public hospitals, the average hospital experience is 5,184±3,407 years and sector experience is 7,831±6,962 years.

3.2. Data Collection

The questionnaire form prepared for the collection of research data consists of four main sections. These sections are Demographic Information Form, General Job Stress Scale, Perceived Organizational Support Scale and Stanford Presenteeism Scale and the characteristics of the scales are given below.

Demographic Information Form: The form prepared by the researcher includes 8 items. With these items, information on gender, age, marital status, education level, income level, type of hospital, hospital experience and sector experience were obtained.

General Job Stress Scale: The scale was developed by De Bruin (2006) and adapted into Turkish by Teleş (2021). Consisting of 9 items, the scale is a 5-point Likert-type scale and responses are scored from 1-Never to 5-Always. An increase in the total score obtained from the scale indicates an increase in job stress. In the adaptation study conducted by Teleş (2021), Cronbach's Alpha value for the reliability of the scale was calculated as 0.91.

Perceived Organizational Support Scale: It was developed by Eisenberger, et al. (1986) and shortened by Eisenberger, et al. (1997). Turkish adaptation of the shortened version was conducted by Turunç and Çelik (2010). Consisting of 8 items, the scale is a 5-point Likert-type scale and responses are scored on a scale of 1 - Strongly disagree to 5 - Strongly agree. The higher the total score obtained from the scale, the higher the perceived organizational support. In the adaptation study conducted by Turunç and Çelik (2010), Cronbach's Alpha value for the reliability of the scale was calculated as 0.88.

Stanford Presenteeism Scale: The scale was developed by Koopman et al. (2002) and adapted into Turkish by Baysal et al. (2014). Consisting of 6 items, the scale is a 5-point Likert-type scale and the responses are scored on a scale from 1 - Strongly disagree to 5 - Strongly agree. An increase in the total score obtained from the scale indicates an increase in presenteeism. In the adaptation study conducted by Baysal et al. (2014), Cronbach's alpha value for the reliability of the scale was calculated as 0.89.

3.3. Data Analysis

The research data were analyzed by partial least squares method using Smart PLS 4. Analyses were conducted in two stages: Measurement/internal and structural/external models. The measurement model was evaluated by examining indicator reliability, internal consistency reliability, convergent validity and discriminant validity. In addition, descriptive statistics were presented for the obtained factor structures. In the structural model, the research hypotheses were tested. In this step, the 5000 bootstrapping procedure was used on the full model to generate the t values corresponding to the path coefficient values. Model fit was evaluated according to the Standardized Root Mean Square Residual (SRMR) and Normed Fit Index (NFI) values, which indicate good model fit. The findings were evaluated at 95% confidence interval and 5% significance level.

4. Findings

4.1. Measurement Model Assessment

The most frequently used methods for evaluating the measurement model are reliability and validity analyses. While indicator and internal consistency reliabilities are evaluated in reliability analyses, convergent and discriminant validity are checked in validity analyses (Henseler et al., 2016). In the light of this information, reliability analyses were conducted first. In this step, factor loadings, composite reliability (CR), Cronbach's alpha and rho_A values were analyzed (Ringle et al., 2012). These values greater than 0.70 indicate that the measurement

model is reliable (Hair et al., 2021). As presented in Table 2, reliability was achieved for the 3-factor measurement model.

Following the reliability analyses, in the first step of the validity analyses, the average variance extracted (AVE) value was examined to test convergent validity. Convergent validity is ensured if the AVE value is greater than 0.50 in all constructs and the CR value is higher than AVE in all constructs (Henseler et al., 2016). As shown in Table 2, the AVE value is greater than 0.50 in all constructs and all AVE values are greater than CR. These results show that convergent validity is achieved.

Table 1. Measurement Model Results

Factor	Item	Factor Loading	p	Cronbach Alpha	rho_A	CR	AVE	VIF
Job Stress (AIS)	AIS1	0.807	0.000	0.900	0.906	0.918	0.557	2.772
	AIS2	0.761	0.000					3.098
	AIS3	0.785	0.000					2.549
	AIS4	0.733	0.000					3.124
	AIS5	0.762	0.000					3.327
	AIS6	0.725	0.000					2.084
	AIS7	0.738	0.000					2.245
	AIS8	0.719	0.000					2.184
	AIS9	0.775	0.000					1.719
Organizational Support (AOD)	AOD1	0.749	0.000	0.905	0.920	0.922	0.598	1.860
	AOD2	0.789	0.000					2.339
	AOD3	0.767	0.000					2.900
	AOD4	0.796	0.000					3.461
	AOD5	0.784	0.000					2.779
	AOD6	0.742	0.000					2.171
	AOD7	0.817	0.000					2.896
	AOD8	0.738	0.000					2.341
Presenteeism (PRE)	PRE1	0.841	0.000	0.882	0.894	0.910	0.627	2.371
	PRE2	0.792	0.000					2.213
	PRE3	0.803	0.000					2.570

	PRE4	0.798	0.000					2.736
	PRE5	0.753	0.000					2.141
	PRE6	0.759	0.000					1.868

In the discriminant validity test phase, the cross-loading matrix, Fornell-Larcker criterion and Heterotrait-Monotrait ratio (HTMT) criteria proposed by Leguina (2015) were used. First of all, cross-loading matrices of the factors were created and presented in Table 3. In the cross-loading matrix, if the factor value on which the items are loaded is higher than the cross-loading values, it indicates that discriminant validity is achieved. In Table 3, the loading values of the items on the factor to which they belong are marked in bold and this table shows that the criterion is met.

Table 2. Cross Loadings

	AIS	AOD	PRE
AIS1	**0.807**	-0.254	0.344
AIS2	**0.761**	-0.187	0.251
AIS3	**0.785**	-0.227	0.385
AIS4	**0.733**	-0.302	0.394
AIS5	**0.762**	-0.291	0.337
AIS6	**0.725**	-0.236	0.286
AIS7	**0.738**	-0.189	0.393
AIS8	**0.719**	-0.228	0.352
AIS9	**0.775**	-0.256	0.316
AOD1	-0.336	**0.749**	-0.234
AOD2	-0.282	**0.789**	-0.180
AOD3	-0.182	**0.767**	-0.169
AOD4	-0.136	**0.796**	-0.145
AOD5	-0.193	**0.784**	-0.216
AOD6	-0.284	**0.742**	-0.147
AOD7	-0.285	**0.817**	-0.256
AOD8	-0.248	**0.738**	-0.144
PRE1	0.325	-0.200	**0.841**

PRE2	0.335	-0.298	**0.792**
PRE3	0.314	-0.120	**0.803**
PRE4	0.357	-0.167	**0.798**
PRE5	0.281	-0.198	**0.753**
PRE6	0.308	-0.201	**0.759**

As the second step in discriminant validity, the criterion that the square root of AVE, as proposed by Fornell and Larcker (1981), should be higher than the correlations of all factors in the model with each other was checked. The analysis outputs presented in Table 4 show that the Fornell and Larcker (1981) criterion is met.

Table 3. Fornell-Larcker Criteria

	AIS	AOD	PRE
AIS	0.746		
AOD	-0.322	0.773	
PRE	0.523	-0.252	0.792

Notes: Bolded diagonal values indicate the square root of AVE.

In the last step of discriminant validity, HTMT was evaluated. Discriminant validity is achieved when the HTMT value is less than 0.90 in the intersections between factors (Henseler et al., 2015). According to the analysis outputs presented in Table 5, HTMT values for all factors are less than 0.90 and these results show that discriminant validity is achieved according to HTMT.

Table 4. Heterotrait-Monotrait Ratio

	AIS	AOD	PRE
AIS			
AOD	0.351		
PRE	0.562	0.267	

When all the analyses conducted to evaluate the measurement model are considered together, the results confirm the reliability of the model as well as its convergent and discriminant validity. Descriptive statistics of the confirmed factor structure are presented in Table 6.

Table 5. Descriptive Statistics

	$\bar{X}$±sd	Range	Skewness	Kurtosis
AIS	4.163±0.486	2.56-5.00	0.745	0.684
AOD	2.280±0.550	1.00-4.00	-0.119	0.893
PRE	3.892±0.487	1.50-5.00	-0.250	0.619

According to Tabachnick et al. (2013), in order to ensure a normal distribution of the data, Skewness and Kurtosis values should remain within the range of ±1.50 and the research variables show a normal distribution accordingly. Skewness and Kurtosis values, as well as the mean and standard deviation values of the scales are shown in Table 6. After testing the measurement model, the next step was to evaluate the structural model to test the research hypotheses.

4.2. Structural Model Assessment

In the partial least squares method, Root Mean Square Residual (SRMR), Normed Fit Index (NFI), R^2 and Stone-Geisser Q^2 values are used to ensure model fit (Hair et al., 2021). According to Henseler et al. (2014), SRMR values less than 0.08 indicate good fit. However, according to Lohmöller (1989), an NFI value greater than 0.80 indicates good fit. As seen in Table 7, the SRMR value of the structural model is 0.049<0.080 and the NFI value is 0.853>0.80, and these values indicate a good fit. On the other hand, Chin (1998) suggested that the R2 value should be at least 0.10 to ensure a satisfactory model fit. Accordingly, the R^2 value for the endogenous variable PRE is calculated as 0.336, which exceeds the recommended threshold score. In addition, the Stone-Geisser Q^2 calculation resulted in a value of 0.169, which is greater than zero, indicating that the structural model has a satisfactory predictive power (Henseler et al., 2009). As a result, the values in Table 7 indicate a good structural model fit.

Table 6. Determination Coefficients (R^2 ve Q^2) ve Model Fit (SRMR ve NFI)

Endogenous Latent Factors	**R^2**	**Q^2**
PRE	0.336	0.169
Model Uyumu	**SRMR**	**NFI**
	0.049	0.853

In testing the structural model, a 5000 resampling procedure was used on the model to generate the values of the path coefficient for both linear and indirect relationships and to determine the corresponding t-values (Hair et al., 2021). In the current study, a total of 3 hypotheses, 2 linear effects and 1 indirect effect, were tested. The test results are presented in Table 8 and Figure 2.

Table 7. Structural Model Results

	Hypothesis	β	sd	t	p	Confidence Interval (BC)		Result
						LL	UL	
H_1	AIS → PRE	0.385	0.027	20.187	0.000	0.632	0.770	Accepted
H_2	AOD → PRE	-0.207	0.038	4.120	0.000	-0.228	-0.079	Accepted
H_3	AIS X AOD → PRE	0.184	0.032	3.068	0.002	0.035	0.141	Accepted

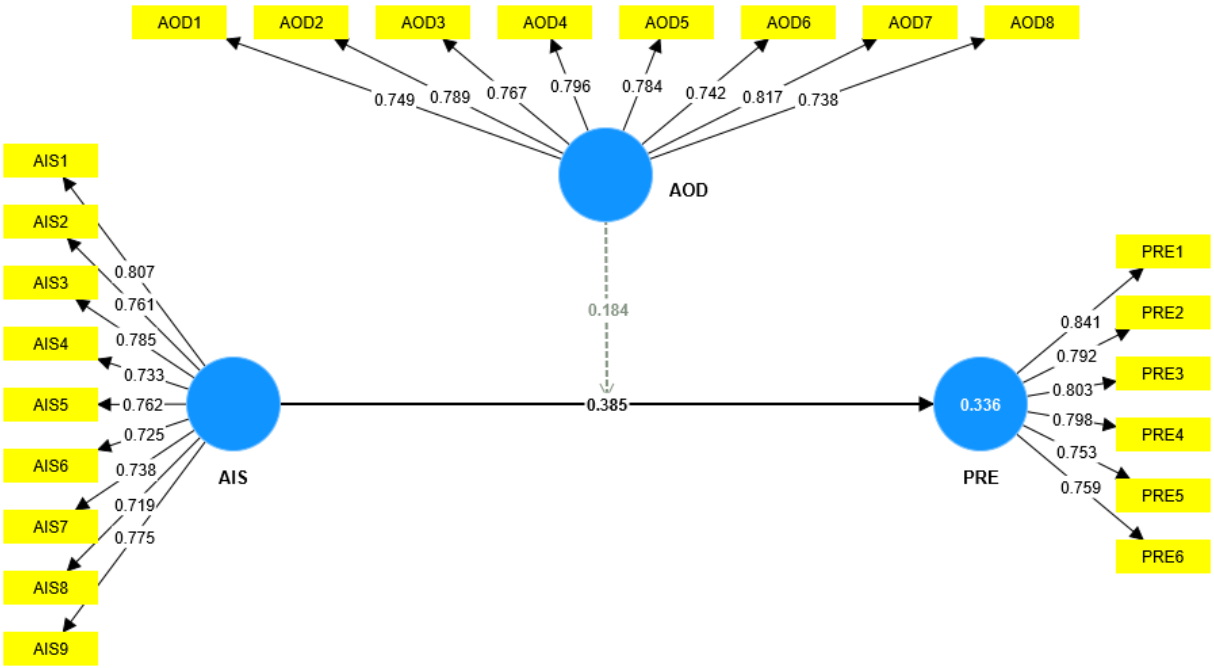

Figure 1. Structural Measurement Model

According to the direct effect results in Table 7 and Figure 2, perceived job stress has a positive and significant effect on presenteeism (AIS→PRE, β=0.385, t=20.187 and p=0.000). However, perceived organizational support has a negative and significant effect on presenteeism (AOD→PRE, β=-0.207, t=4.120 and p=0.000). According to these direct effect results, hypotheses H_1 and H_2 are accepted.

According to the indirect effect test results, perceived organizational support has a moderating role in the effect of perceived job stress on presenteeism (AIS X AOD → PRE, β=0.184, t=3.068 and p=0.001). Accordingly, the positive effect of perceived job stress on presenteeism decreases when perceived organizational support is included in the model as a moderator. Within the framework of this finding, hypothesis H_3 is accepted. The graph regarding the moderating role is given in Figure 3.

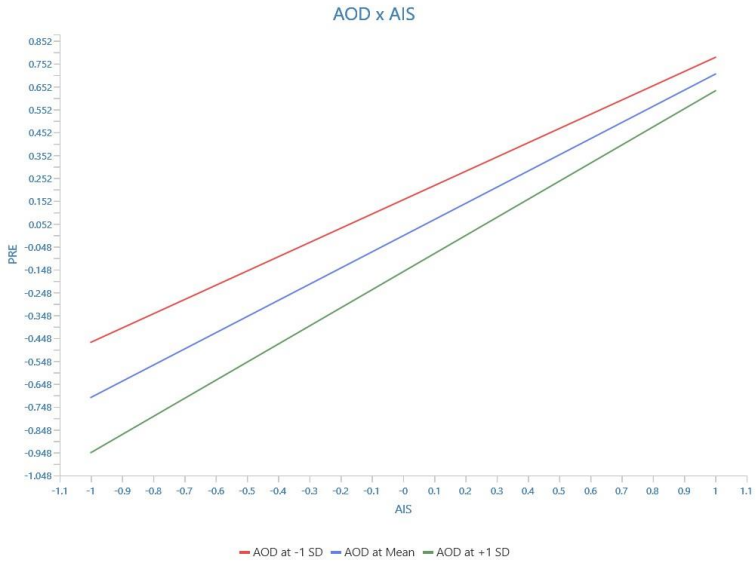

Figure 2. Moderator Role Graph

5. Discussion And Conclusion

According to the findings of the study, perceived job stress increases presenteeism in healthcare workers. Presenteeism, which is the phenomenon of employees continuing to work despite illness, injury, or other conditions that require absenteeism, is particularly salient in the healthcare industry, a field characterized by inherently demanding physical and emotional challenges (Homrich et al., 2020; Kustler et al., 2021). This finding on healthcare workers suggests that a multifaceted mechanism is at work where stress is not only an isolated psychological experience, but a mix of systemic, organizational, and individual pressures contribute to a culture of continuance. When examining the mechanism by which job stress affects presenteeism in healthcare workers, it is crucial to consider the unique pressures that healthcare workers face. These include the relentless demand for high performance in vital situations, a pervasive sense of responsibility for patient welfare, and the often inflexible nature of healthcare systems, which offers limited space for rest time or personal recovery (Aronsson et al., 2000; Johns, 2011; Yıldız et al., 2015; Miraglia and Johns, 2016). High levels of stress can exacerbate health problems or contribute to burnout (Dyrbye et al., 2007; Milner et al., 2018; Kavosi et al., 2018), which paradoxically can lead to increased presenteeism as employees strive to meet external expectations or internalized professional standards despite deteriorating health. This cycle points to a systemic problem in healthcare settings where the prioritization of continuous service delivery can unintentionally undermine the well-being of the individuals responsible for providing care. Aronsson et al. (2000) found a relationship between high levels of stress and increased presenteeism in healthcare settings. Other research findings in the literature have also revealed that stressed healthcare workers are more likely to exhibit presenteeism (Yang et al., 2017; Yang et al., 2018; Yang et al., 2020; Deng et al., 2022). In the light of this information, it can be said that the current research finding is parallel to the literature.

According to the second finding of the study, the perception of organizational support reduces presenteeism in healthcare professionals. The negative effect of perceived organizational support on presenteeism sheds light on a complex interaction in which the support provided by an organization acts as a buffer against the obligation to work while ill, challenging the often unyielding nature of healthcare work culture, and thus the important role that organizational dynamics play in shaping employee behavior and well-being in healthcare. It is clear that in parallel with providing organizational support to employees, working conditions will improve and the employee will take time off work in case of illness and will not exhibit presenteeism (Cote et al., 2021). This support can come in various forms, such as comprehensive health benefits, mental health resources, flexible scheduling, and a culture that truly encourages rest and recovery. By incorporating these elements into the organizational fabric, health workers can perceive a more empathetic and understanding work environment and alleviate the pressure to continue working when their health is compromised. This is because perceived organizational support can alleviate job stress and reduce the need for presenteeism by encouraging coping mechanisms (Yang et al., 2019). Research results in the literature support the current research finding by revealing that organizational support has a negative effect on presenteeism (Huang et al., 2021; Şahin & Aydın, 2021; Wu et al., 2023).

According to the last finding of the study, organizational support perception has a moderating role in the effect of job stress on presenteeism. Accordingly, the positive effect of perceived job stress on presenteeism decreases with the inclusion of perceived organizational support in the model as a moderator. This finding indicates that the presence of supportive organizational structures and practices can significantly change the way healthcare workers respond to stress and potentially reduce the tendency to presenteeism. An examination of this moderating mechanism reveals that organizational support is a critical counterbalance to the stressors inherent in health professions. Generally, the high workload, emotional demands, and stress arising from the critical nature of healthcare tasks naturally predispose employees to continue working even if they are sick as a way of coping with these pressures (Yang et al., 2020; Deng et al., 2022). However, when employees perceive their organizations as supportive through tangible resources, emotional support, appreciation, or policies that prioritize employee well-being, a psychological safety net can be created for the resulting stress that leads to presenteeism (Arunachalam, 2021; Duran et al., 2021). This safety net is likely to reassure employees that their health and well-being are valued and that taking time off to recover will not lead to negative professional or personal consequences. However, the finding also suggests that supportive organizational practices and policies may change the way stress is experienced and processed by health workers, thereby influencing their decision-making processes related to presenteeism. High levels of perceived support would contribute to better stress management, lower levels of perceived job strain, and a healthier work-life balance (Thakur & Kumar, 2015; Labrague et al., 2018), which would indirectly reduce the propensity for presenteeism.

Based on the findings of the study, it is recommended that healthcare workers should actively participate in strategies to reduce job stress and increase their perceptions of organizational support. Healthcare workers who are aware of the impact of perceived job stress on presenteeism should seek and use stress management resources such as mindfulness practices, counseling and peer support groups. In addition, health workers should actively

communicate their needs and challenges to their employers and encourage a two-way dialog that can lead to a more supportive work environment. By being proactive in managing stress and advocating for their wellbeing, health workers can contribute to a healthier workplace dynamic, ultimately benefiting their personal health and the quality of care they provide. Healthcare organizations have the greatest role to play in this regard and are recommended to implement comprehensive support systems that address both the physical and psychological well-being of employees. Health organizations can take steps such as providing access to mental health resources, employing sufficient staff to reduce workload, and creating a culture that truly supports taking time off for health reasons. On the other hand, the development of policies by the Ministry of Health that encourage and support health organizations to implement stress management and organizational support programs will play an important role in reducing presenteeism.

The study was limited to 396 healthcare professionals working in hospitals in Istanbul. In future research, it is recommended to take samples from different cities and make comparisons between cities. This may increase the generalizability and applicability of the findings to different healthcare settings. In addition, repeating the research model with employees from different sectors may help to identify potential antecedents of presenteeism in terms of different organizational structures. On the other hand, considering the limitation of obtaining data through questionnaires, it is suggested that qualitative research methods such as in-depth interviews or focus group discussions should be integrated in addition to questionnaire research in future studies; thus, it is thought that richer insights will be obtained regarding the subjective experiences of healthcare professionals regarding job stress, presenteeism and perceived organizational support. In addition to the variables included in the research model, it is suggested to add demographic characteristics and other organizational and individual factors in future studies.

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