A Health Impact Assessment of the California Healthy Families, Healthy Workplaces Act of 2008

July 30, 2008

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ACKNOWLEDGEMENTS

We would like to thank the numerous workers and health professionals who made themselves available for focus groups and interviews for this report. We also thank the following individuals for support throughout the process: Dr. Vicky Lovell with the Institute for Women's Policy Research for sharing her insight and data; Laura Trupin with the UCSF Institute for Health Policy Studies for invaluable assistance regarding the California Work and Health Survey; Young Workers United and Mujeres Unidas y Activas staff for help in recruiting workers for the focus groups; Sandra Huang and Diane Portnoy with the San Francisco Department of Public Health for their support in coordinating interviews with disease control investigators; Phil Sparks and Nancy Bennett with Communications Consortium Media Center, Brenda Munoz and Vibhuti Mehra with the Labor Project for Working Families, Andrea Buffa with the UC Labor Center, Alan Jenkins with Opportunity Agenda, Kate Karpilow with the California Center for Research on Women and Families, and Bob Prentice with the Bay Area Regional Health Inequities Initiative for communications and media support; and, Beth Altshuler and Felice Le with SFDPH and Celia Harris and Won Kim Cook with HIP for general HIA support. Finally, we thank the Unitarian Universalist Veatch Program at Shelter Rock for providing partial funding for this health impact assessment.

SUGGESTED CITATION

Bhatia R, Farhang L, Heller J, Capozza K, Melendez J, Gilhuly K, Firestein N. A Health Impact Assessment of the California Healthy Families, Healthy Workplaces Act of 2008. Oakland, California: Human Impact Partners and San Francisco Department of Public Health. July 2008.

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1 Introduction

Factors associated with labor and employment, including income, safety of working conditions, and benefits such as paid sick days are potent determinants of health and contribute to health disparities, particularly those related to individual socio-economic status (Marmot and Wilkinson 2006; Yen and Syme 1999). Understanding the health impacts of employment conditions is necessary for sound workplace policy and may help reduce longstanding health disparities associated with employment class.

Internationally, 137 countries mandate paid annual leave and 121 countries guarantee two weeks of leave or more. Regarding paid sick leave specifically, 145 countries require employers to provide paid sick days or leave for short- or long-term illnesses, and 127 countries provide a week of paid sick leave or more annually (Heymann et al. 2007b). In contrast, however, with the exception of the City and County of San Francisco, there is no right to paid sick days in the United States. Such benefits, where available in the U.S., are provided voluntarily by employers.

The ability to earn paid sick days and utilize these benefits when ill or when a family member needs care confers substantial benefits to health (Heymann 2007a). At the individual level, paid sick days can help people recover from illness and use preventative health care services. Employment characteristics related to health, such as wages, family and sick leave policies, and health, dental and eye care benefits are correlated with each other, and therefore workers that lack paid sick days are likely to experience a greater vulnerability to adverse health outcomes and thus have a greater need for chronic and acute health care. Access to paid sick days can allow workers to more easily provide essential care for family members and dependents, thereby potentially preventing a worsening of illness and use of expensive hospital care, and avoiding the need for paid caregivers. At the community level, paid sick days allow workers and students to stay home when ill and could help prevent transmission of infectious disease in schools and workplaces.

In the spring and summer of 2008, Human Impact Partners (HIP) and researchers at the San Francisco Department of Public Health (SFDPH) conducted a health impact assessment (HIA) of the Healthy Families, Healthy Workplaces Act of 2008 that aimed to document the relationship of paid sick days to individual and community level health. This HIA mobilizes and synthesizes evidence from diverse sources to make a judgment of the future health impacts of this California paid sick days statute. Evidence utilized in this HIA includes existing statistics regarding employment and health conditions as well as new qualitative and quantitative research conducted specifically for this assessment. Section two of this report provides background for the HIA including a summary of the proposed legislation and a description of the HIA process, describes multiple conceptual pathways in which paid sick days affects health, and reviews the methods used to complete this HIA. Section three summarizes the evidence related to the conceptual pathways. Section four provides an assessment of the magnitude, direction and certainty of potential impacts of the proposed Healthy Families, Healthy Workplaces Act on health.

2 Background

2.1 HEALTH IMPACT ASSESSMENT OVERVIEW

The World Health Organization defines Health Impact Assessment (HIA) as "a combination of procedures, methods, and tools by which a policy or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population" (WHO 1999). Increasingly, countries are using Health Impact Assessment to prevent disease and illness, improve the health of their populations, and reduce avoidable and significant economic costs of health care services.

STEPS IN THE HIA PROCESS

1. ***Screening*** involves determining the need and value of a HIA.
2. ***Scoping*** involves determining which health impacts to evaluate, the methods for analysis, and the workplan for completing the assessment.
3. ***Assessment*** of impacts involves using existing data, expertise, and experience along with qualitative and quantitative research methods to judge the magnitude and direction of potential health impacts.
4. ***Communication*** of the results of the HIA involves synthesizing the assessment and communicating the results. This can take many forms including written reports, comment letters, and public testimony.
5. ***Monitoring*** describes the process of tracking the effects of the HIA on health determinants and health status.

Simply put, HIA aims to make the health impacts of social decisions more explicit. To do this, HIA uses diverse methods and tools and engages health experts, decision-makers and diverse stakeholders to identify and characterize health effects resulting from a policy decision or proposal and its alternatives (Quigley 2006). HIA draws upon diverse sources of knowledge including lay and professional expertise and experience. HIA also offers recommendations for decision-makers for alternatives or improvements to policy decisions that enhance positive health impacts and eliminate, reduce, or mitigate negative health impacts. HIA is concerned with harmful effects but also with the ways in which pubic policy can be used to promote and improve a population's health. HIA is also explicitly concerned with vulnerable populations and includes an analysis of a proposal's impacts on health inequalities.

There is no single best approach to HIA. Each HIA process should reflect the needs of its particular context. An HIA is most often carried out prospectively, before a decision is made to enact a policy proposal. A typical HIA involves five stages: screening, scoping, assessment, communication, and monitoring.

2.2 PAID SICK DAYS BENEFITS IN THE UNITED STATES

United States

In the United States, only 52% of employees receive paid sick day benefits (Hartmann 2007). Table 1, which describes the availability of paid sick days by occupation in the United States, illustrates that paid sick days benefits vary substantially by occupation. For example, only 15% of workers in the food preparation and services occupation have paid sick days—the lowest rate among major groups of occupations (Hartmann 2007). In contrast, workers in "white-collar" occupations have far higher rates of paid sick day coverage (e.g., 84% in legal, 83% in management, and 81% in computer and math occupations).

The Family Medical Leave Act (FMLA), which applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees, provides employees with up to 12 weeks of job-protected unpaid leave per year for the birth of a newborn child, to care for an immediate family member, or to take leave for a serious health condition (DOL 2008). However, the FMLA does not create a basic right to paid sick days, and workers taking family or medical level must bear the economic impact of their leave.

TABLE 1. WORKER ELIGIBILITY FOR PAID SICK DAYS IN THE UNITED STATES AMONG PRIVATE SECTOR EMPLOYERS BY OCCUPATION

Occupation	% of workers with paid sick days
Food preparation and services	15
Construction and extraction	18
Protective services	22
Personal care and service	37
Transportation and material moving	41
Production	41
Sales	46
Building services, grounds cleaning, and maintenance	53
Installation, maintenance, and repair services	58
Arts, entertainment, sports	62
Education and training	62
Health care support	65
Office and administrative support	68
Health care practice and technical	71
Life, physical, and social sciences	75
Community and social services	77
Business and financial	78
Architecture and engineering	81
Computer and math	81
Management	83
Legal	84
All	52%

Source: Table adapted from Institute for Women's Policy Research analysis of the March 2006 National Compensation Survey, the November 2005 through October 2006 Current Employment Statistics, and the November 2005 through October 2006 Job Openings and Labor Turnover Survey (Hartmann 2007).

California

A slightly greater percentage of California employees have paid sick days than employees nationally. According to an analysis by Lovell (2008), 5.4 million Californians lack paid sick days (39% of working Californians). The proportion of employees in California in major industrial categories that have access to paid sick days is presented in table 2. In California, proportions of workers with paid sick leave were highest among those in information (89%), management (84%), and finance and insurance (83%). Only a minority of workers in construction (22%), administrative and waste services (28%), and accommodation and food service (30%) industries had paid sick leave.

TABLE 2. ESTIMATED CALIFORNIA WORKERS WITH AND WITHOUT PAID SICK DAYS

Industry	Percent of workers with paid sick leave, Pacific region [1]	Percent of workers WITHOUT paid sick leave, Pacific region	Employment in California 2007[2]	Number of California workers without paid sick days
Mining	48%	52%	24,518	12,674
Utilities	58%	42%	57,062	24,167
Construction	22%	78%	896,245	702,720
Manufacturing	65%	35%	1,463,970	513,430
Wholesale trade	66%	34%	696,006	237,662
Retail trade	49%	51%	1,639,988	831,857
Transportation and warehousing	73%	27%	423,423	114,863
Information	89%	11%	450,680	50,986
Finance and insurance	83%	17%	588,365	100,545
Real estate and rental	67%	33%	274,969	90,505
Professional and technical services	68%	32%	968,907	307,971
Management	84%	16%	194,557	30,506
Administrative and waste services	28%	72%	963,327	695,758
Educational services	68%	32%	237,468	74,940
Health care and social assistance	78%	22%	1,306,069	284,396
Art, entertainment, and recreation	35%	65%	235,907	154,174
Accommodation and food service	30%	70%	1,222,963	856,233
Other service	60%	40%	674,990	270,472
Total				5,353,859

[1] Source: Data provided by Dr. Vickie Lovell based on Institute for Women's Policy Research analysis of the March 2006 National Compensation Survey, adjusted for job tenure eligibility using the annual average of the 2007 JOLTS. Figure for local government is from Lovell (2004), No Time To Be Sick.

[2] Source: Data provided by Dr. Vickie Lovell from Quarterly Census of Employment and Wages. 3rd and 4th Quarter of 2006 and 1st and 2nd Quarter of 2007. Downloaded from www.labormarketinfo.edd.ca. Excludes federal, state, and San Francisco workers, who already have paid sick days.

Within the state of California, only the City and County of San Francisco requires all employers to provide paid sick days benefits to employees. State policies that provide support while experiencing illness include State Disability Insurance (SDI) and Paid Family Leave, both funded through employee payroll deductions. The SDI program provides short-term benefits to eligible workers who suffer a loss of wages when they are unable to work due to a non work-related illness or injury, or due to pregnancy or childbirth. The Paid Family Leave program was established for workers who suffer a loss of wages when they need to take time off from work to care for a seriously ill child, spouse, parent, registered domestic partner, or to bond with a new minor child. Paid Family Leave provides a maximum of six weeks of partial pay to workers who qualify.

Limitations of SDI and Paid Family Leave are that they only pay a partial replacement of wages earned before taking leave and benefits are provided only after the eighth day of leave (EDD 2008). To receive SDI, a worker must be under the care and treatment of a licensed doctor or accredited religious practitioner during the first eight days of their disability and a doctor must complete the medical certification of disability. Limitations for Paid Family Leave specifically are that unless complications arise, the common cold, influenza, earaches, and upset stomach are conditions that do not meet the definition of a serious health condition for purposes of Paid Family Leave insurance benefits (EDD 2008).

A number of U.S. state and local jurisdictions are now considering laws to require employers to provide paid sick days benefits to all employees. The California state legislature is currently considering AB 2716, the Healthy Families, Healthy Workplaces Act of 2008. AB 2716 allows workers to earn paid sick days that can be used to recover from illness, care for a sick family member, or recover from domestic violence or sexual assault. If signed into law, AB 2716 would make California the first state in the nation to ensure paid sick days for all workers.

2.3 CALIFORNIA PAID SICK DAYS LEGISLATION – AB 2716, HEALTHY FAMILIES, HEALTHY WORKPLACES ACT OF 2008

The subject of this HIA is AB 2716, the Healthy Families, Healthy Workplaces Act of 2008, introduced by Assembly member Fiona Ma in February 2008. At the time of this HIA, AB 2716 had passed out of the California State Assembly is now being considered by the California State Senate. If passed by the Senate, the bill will require the approval of the Governor to become law. As currently drafted, the bill entitles an employee who works in California for seven or more days in a calendar year to accrue paid sick time at a rate of no less than one hour of paid sick time for every 30 hours worked up to a maximum of 9 days per year. After 90 days of employment, an employee would be entitled to use accrued sick time for diagnosis, care, or treatment of health conditions of the employee or an employee's family member, or for leave related to domestic violence or sexual assault. An employer would be required to meet posting and record-keeping requirements and would be prohibited from discriminating or retaliating against an employee who requests paid sick time. The bill would not apply to employees covered by a collective bargaining agreement that provides for paid sick leave. The California Department of Industrial Relations would administer and enforce these requirements.

2.4 THE DECISION TO CONDUCT AN HIA ON PAID SICK DAYS LEGISLATION

Screening, the first step in health impact assessment, involves establishing the value and feasibility of an HIA for a particular decision-making context. In general, screening informs the decision to conduct an HIA by answering three related questions.

1. Is the proposal associated with potentially significant health impacts that would otherwise be unconsidered or undervalued by decision-makers?

2. Is it feasible to conduct a relevant and timely analysis of the health impacts of the proposal?

3. Are the proposal and its decision-making process potentially open and receptive to the findings and recommendations of a health impact analysis?

Potentially Significant Health Impacts

The Healthy Families, Healthy Workplaces Act of 2008 has a significant potential to affect the health of Californians. Currently, 5.4 million working Californians have zero paid sick days (PSD) (Lovell 2008). Guaranteeing paid sick days for all workers in the state could substantially reduce adverse health impacts associated with the lack of this benefit. For example, paid sick days could help enable primary and preventative care for a worker or dependent family members. Workers with paid sick days could be more likely to seek early diagnosis of illnesses and less likely to continue to work while ill, reducing the potential for transmitting contagion in workplaces such as restaurants and child care centers.

With access to paid sick days, workers could be more likely to comply with public health recommendations for community transmitted infections such as influenza, helping to reduce the burden of this and other important communicable diseases. Finally, a *paid* sick day benefit could limit the loss of income for workers who need to take sick days to care for themselves and their family members.

Guaranteed access to paid sick days is also a strategy to address health disparities associated with income and class. Currently, workers with higher wages are likely to disproportionately benefit from paid sick days while lower-wage workers, including many in the food service, health care support, and retail industries, do not have the ability to accrue paid sick days. Lower wage workers often experience health disparities related both to access of health care services and to environmental and social determinants of health. This law could create a new standard for paid sick day benefits, thus reducing a potential source of health disparities.

Feasibility and Timeliness

A limited HIA is feasible within the timeline of the decision-making process for the bill (the current legislative session). Even without significant funding for the HIA effort, it is possible to mobilize evidence from existing sources with limited research capacity and resources. A small amount of external funding allows qualitative research including focus groups and simple surveys using convenience samples. Additional resources for an HIA on paid sick days would enable quantitative analyses using available health research datasets.

Receptiveness of Decision-Making Process

An HIA could help document the breadth, magnitude, and certainty of potential health benefits associated with policies such as paid sick days. Specifically, an HIA on PSD could: (1) highlight, using state and national databases, the burden of preventable illnesses potentially affected by paid sick days; (2) describe pathways between PSD benefits and physical and mental health outcomes; (3) mobilize evidence for or against these pathways through literature review, data analysis, surveys and focus groups; and (4) make an overall judgment about the magnitude and direction of health impacts along with an assessment of uncertainties. Conducting an HIA on PSD

legislation in California could also help inform other state and national paid sick day policy efforts by providing both data and a model for an assessment.

It appears that the decision-making process is open to the information produced through an HIA. There is no apparent majority of legislators opposed to the bill and the Governor of California has not signaled intent to veto the measure. The HIA could help inform legislators of the bill's costs and benefits to the State of California and would provide information complementary to more traditional analysis of fiscal and economic outcomes. An HIA of the proposed law could also be used to educate public and private interest groups on the health benefits of paid sick days and inform deliberations on the bill in public and private forums. Advocates could use the findings to build awareness regarding health-related issues among their bases, the general population, and elected officials, and thereby build support for the legislation. Overall, the HIA could foster an inclusive, transparent, and fully informed policy-making process that will help motivate health-promoting and prevention-oriented public policy.

2.5 POTENTIAL HEALTH IMPACTS RESULTING FROM PAID SICK DAYS REQUIREMENTS

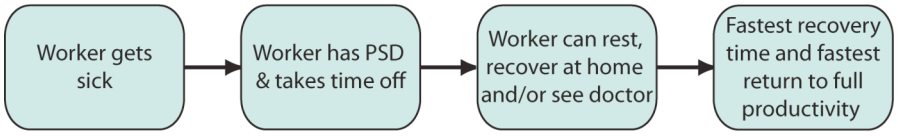
Scoping, the second step of HIA, involves creating a work plan and timeline for conducting an HIA that includes prioritizing research questions and identifying research methods and participants' roles. Based on a preliminary review of health research on paid sick days and comments made in public testimony, the HIA team hypothesized potential pathways between paid sick days and health outcomes. Those hypothetical scenarios are described in the figures and narrative below. Each scenario describes potential health outcomes associated with a worker or his/her dependents becoming ill, combined with whether or not the worker has paid sick days. Based upon the scenarios, the HIA team selected a set of research questions that focus evaluation of the potential pathways.

Scenarios A and B outline health outcomes associated with an ill worker taking time off from work, whether or not he/she has paid sick days. In Scenario A, the worker with paid sick days who takes time off can rest, recover and/or see a doctor, and thereby is able to recover from the illness as quickly as possible. Thus, significant health impacts associated with not having paid sick days and/or not taking time off are avoided.

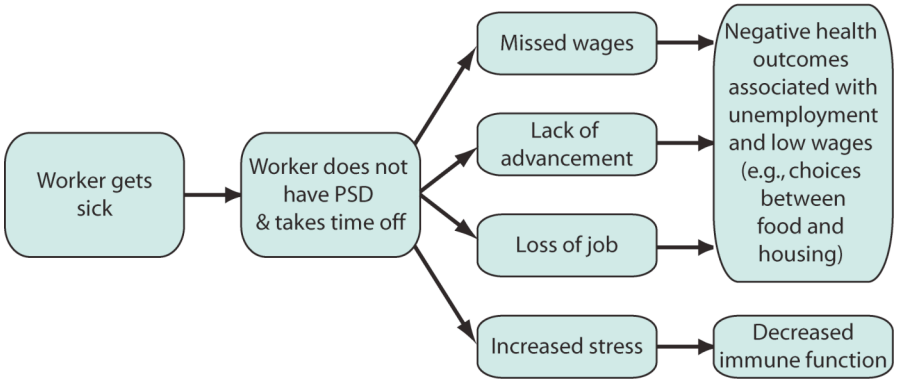
In Scenario B, the ill worker takes time off, but, because of the lack of paid sick days, may suffer health outcomes associated with missing work. As a result of taking time off, a worker will miss wages and may suffer from short-term or long-term employer retaliation in the form of job loss or lack of advancement (e.g., salary increases and/or promotions) at work. These have potential health impacts that include the negative health outcomes commonly associated with unemployment and low-wage work. Unemployment is associated with reduced life expectancy, hypertension, depression, and suicide (Jin et al. 1995; McKee-Ryan et al. 2005; Voss et al. 2004). Lack of income with which to pay for nutritious food can result in hunger (Sandel et al. 1999), for example, while lack of income with which to pay for adequate housing can lead to adverse health outcomes associated with homelessness (e.g., depression) (Zima et al. 1994), et al. 2004), overcrowding (e.g., increased spread of infectious disease) (Antunes et al. 2001; Bhatia 2004), and/or living in sub-standard housing (e.g., exposure to lead and asbestos). Furthermore, a

worker may suffer from increased stress, for example, as a result of worrying about the consequences of taking the time off. Increased stress has been shown to lead to decreased immune function (McEwen 2006).

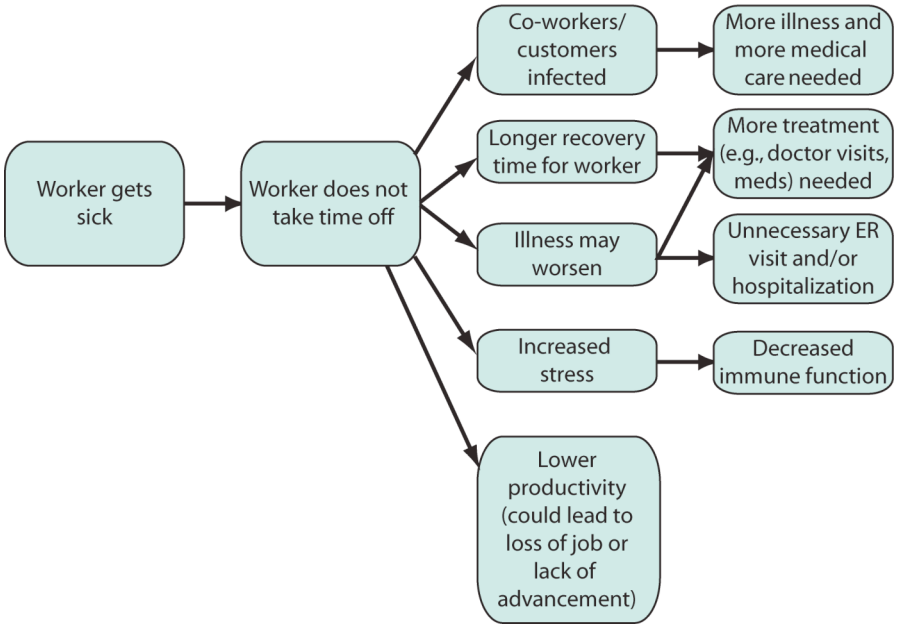
Scenario A: Sick worker with PSD takes time off



Scenario B: Sick worker without PSD takes time off



Scenario C: Sick worker does not take time off

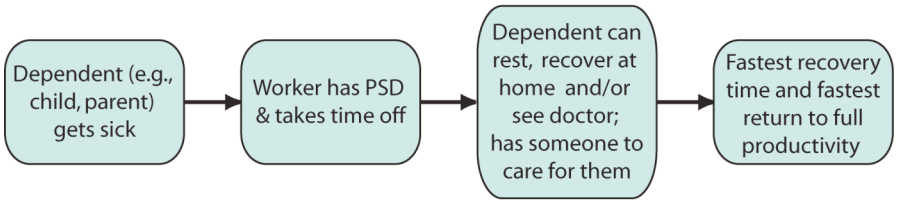


In Scenario C, the worker does not take time off and, instead, goes to work sick. At the community level, if the illness is one that is communicable through casual contact and the worker is infectious, this leads to a hazard for co-workers and/or customers (e.g., diners at a restaurant) with whom the worker interacts. There are several possible health-related outcomes at the individual level. The worker may take longer to recover or the disease can become more severe, which can necessitate more significant treatment (e.g., increased number of visits to a doctor or increased medication) and/or hospitalization or visits to an emergency room. The worker may also face increased stress levels and/or, as a result of lower productivity, may face job loss or lack of advancement (see Scenario B for some of the associated health consequences).

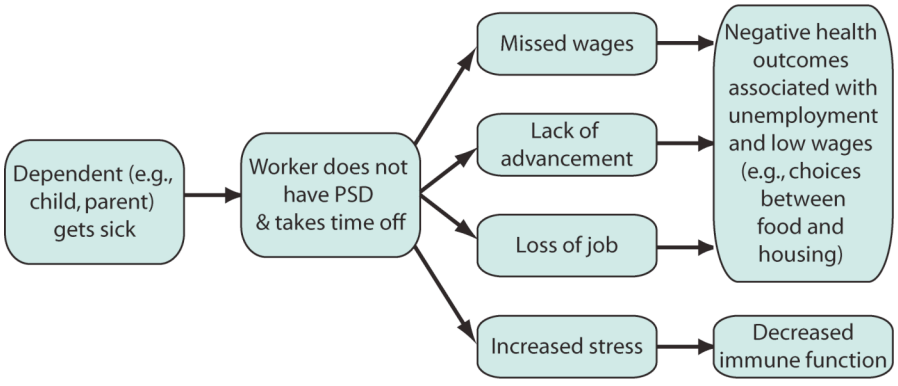
Scenarios D, E and F parallel Scenarios A, B, and C, but reflect a dependent of the worker (e.g., a child or parent) getting sick. As in Scenario A, in Scenario D potential negative health outcomes are avoided as a result of the worker using paid sick days to take time off to care for the dependent.

In Scenario E, the dependent gets sick and the worker takes time off despite not having paid sick days. The consequences for the worker (and his/her family) are the same as those in Scenario B (see above).

Scenario D: Sick dependent, worker with PSD takes time off



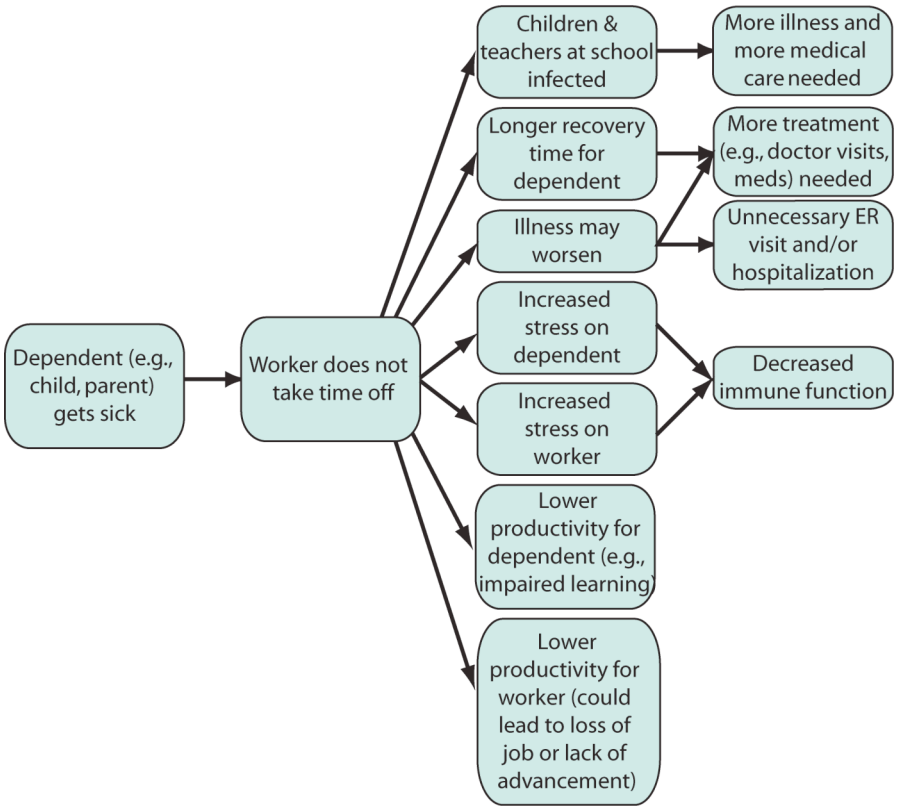
Scenario E: Sick dependent, worker without PSD takes time off



In Scenario F, the worker does not take time off to care for the sick dependent. In this case, the dependent may be forced to take care of him or herself or may, in the case of a sick child, may be sent to child care or school sick. At the community level, the people with whom the dependent interacts (e.g., other children or teachers) may contract an illness if it is infectious. At the individual level, there are consequences both for the dependent and for the worker. Similarly to the consequences for the worker in Scenario C (see above), the dependent may face longer

recovery times or his/her disease may become more severe. The dependent may also face increased stress levels and his/her productivity (e.g., performance at school) may decrease. Additionally, the worker may face increased stress as a result of not being able to care for his/her dependent and also may be less productive (e.g., as a result of having to arrange for care). The health consequences of these are also described above.

Scenario F: Sick dependent, worker does not take time off



2.6 RESEARCH QUESTIONS AND METHODS

The pathways described above suggest that a legal requirement for paid sick days could have diverse impacts on health of employees and their dependents. Generally, employment policy such as paid sick days has not been the subject of public health research. Still, it is possible to mobilize evidence for a health impact assessment both through existing published literature and through original research. To focus this evaluation, this health impact assessment selected the following six questions:

1. What is the availability of paid sick days in relationship to need and health status?

2. Is the availability of paid sick days associated with taking sick days to recover from illness or care for a dependent?

3. What is the effect of paid sick days on recovery from illness, primary care utilization and preventable hospitalizations for workers with and without paid sick days?

4. What is the effect of paid sick days on recovery from illness, primary care utilization and preventable hospitalizations among dependents of workers with and without paid sick days?

5. What are the effects of paid sick days on communicable disease transmission in workplaces and other community settings?

6. What are the effects of paid sick days on wage loss, risk of job loss and employer retaliation?

This HIA employed mixed research methods to assess these six research questions. Methods included developing logic frameworks, reviewing existing secondary data sources and empirical literature, conducting focus groups and surveys among workers in California, and interviewing health experts. The table below briefly describes each method. The HIA provides a synthesis of the key findings from the research in the assessment section below. Appendices I – IV provide detailed methods and findings for original research conducted as part of the HIA.

HIA RESEARCH AND ASSESSMENT METHODS
Review of peer-reviewed and available empirical research studies relevant to the relationship between paid sick days and health including those focusing on the following outcomes: physical and mental health outcomes, health care utilization, communicable disease transmission, care of family members, and employment retention.
Summary of statistics on the availability of PSDs and utilization of sick leave in relationship to health status and need.
Summary of statistics on the burden of illness in California that could potentially be modified by paid sick days legislation including the prevalence of communicable diseases and preventable hospitalizations.
Analysis of the relationship between paid sick days and health in a selection of non-self-employed workers in the California Work and Health Survey. Detailed methods and findings in appendix I.
Convenience survey of workers in California to assess use and importance of PSDs in facilitating health access, care of dependents, and wellness. Detailed methods and findings in appendix II.
Focus groups with California workers without paid sick days to understand the consequences of having or not having PSD benefits. Detailed methods and findings in appendix III.
Interviews with public health officials responsible for communicable disease control. Detailed interview methods and findings in appendix IV.
Solicited expert opinions on the relationship of PSD and health care utilization.

3 Assessment of the Health Impacts of Paid Sick Days—A Synthesis of the Findings

For each of the research questions listed in section 2.6 above, we evaluated the question using available empirical research as well as additional qualitative and quantitative research that we conducted specifically for this health impact assessment. This section provides a summary of that evidence for each question. Importantly, this section is organized to build a foundation for research questions related to more indirect effects of paid sick days. For example, some of the more indirect impacts (subsections 3.3 – 3.5) are dependent on the availability and utilization of paid sick days as discussed in subsections 3.1 and 3.2. In contrast to subsections 3.1 – 3.5, which examine health impacts, subsection 3.6 examines the economic consequences on workers of the utilization of paid sick days, including effects on income and employment, which has additional indirect health impacts.

3.1 AVAILABILITY OF PAID SICK DAYS IN RELATIONSHIP TO SOCIAL VULNERABILITY, HEALTH STATUS, AND RESPONSIBILITY FOR DEPENDENTS

The need to utilize paid sick days depends on health status and the presence or absence of dependents along with their health status.

Notably, studies looking at data for specific vulnerable populations show disparities in access to paid sick days by economic or demographic status. Table 3 illustrates striking disparities in paid sick days between low-wage and high-wage workers: 72% of high-wage workers (highest quartile) receive paid sick days compared to 21% of low-wage workers (lowest quartile) (Hartmann 2007). Disparities in access to paid sick days by income are important because lower income is associated with vulnerability to illness and disease, health-adverse occupational and environmental exposures, and limited ability to buffer a loss of income.

TABLE 3. WORKER ELIGIBILITY FOR EMPLOYER-PROVIDED PAID SICK DAYS IN THE PRIVATE SECTOR BY WAGE AND WORK SCHEDULE CHARACTERISTICS

Wage Level	**% of workers with employer-provided PSD**
Fourth quartile (bottom)	21
Third quartile	54
Second quartile	62
First quartile (top)	72
Work Schedule	
Full-time	62
Part-time	20
Full-year	53
Part-year	26
Full-year, full-time	63
Not full-year, full-time	21

Source: Table adapted from Institute for Women's Policy Research analysis of the March 2006 National Compensation Survey, the November 2005 through October 2006 Current Employment Statistics, and the November 2005 through October 2006 Job Openings and Labor Turnover Survey (Hartmann 2007).

Employed workers in households with children are among those with the greatest need for paid sick days due to responsibilities for the care of children and requirements excluding sick children from schools and child care settings. Furthermore, legally, parents cannot leave young dependent children under 12 years alone.

Today, 70% of mothers with children under 18 are in the workforce (BLS 2006). In 2005, with most

parents actively in the workforce, about 61% of children ages 0–6 (12 million children) received some form of child care on a regular basis from persons other than their parents (Childstats.gov 2008). The need for non-parental child care varies by household income. Children in families with incomes at least twice the poverty level are more likely than children in families with incomes below the poverty level to have non-parental child care (68% versus 51%, respectively).

Sick children with contagious diseases are asked to stay home from child care as they have been illustrated to contribute to the higher rate of observed infections in day care centers. The Centers for Disease Control and Prevention recommends that child care providers encourage parents of sick children to keep their child home and away from the child care setting until the child has been without fever for 24 hours, to prevent spreading illness to others (CDC 2008b). The American Academy of Paediatrics has published explicit exclusion guidelines for sick children identifying 28 specific symptoms and diseases that warrant temporary exclusion of children, and most child care facilities enforce policies that sick children with infectious diseases stay home from school (Copland et al. 2006).

Absenteeism of children from day care centers due to sickness is significant (Dahl et al. 1991; Mottonen and Uhari 1992), and translates into a need for parental absenteeism from work. In one study of children in a prepaid health plan in Memphis, illness in a child accounted for 40% of parental absenteeism from work. Among study subjects, parents of children in day care centers lost about half a day a month from work due to child illness (Bell et al. 1989).

Based on a nationally representative sample, Heymann and colleagues (1996) found that over 50% of poor and non-poor families had an illness burden greater than one week (table 4). Additionally, the study found that while one-third of families had a family illness burden of two or more weeks per year (both poor and non-poor), two-thirds of employed mothers lacked sick days at least some of the time that they worked. In the same study, 49% of employed mothers in non-poor families had access to greater than six days per year of paid sick days annually, only 19% employed mothers of poor families had such access (table 5). In a later study, Heymann and Earl (1999) similarly found that 36% of mothers who returned to work from welfare lacked paid sick days for the entire time they worked over a five-year period.

TABLE 4. ANNUAL NUMBER OF CHILDREN'S SICK DAYS DURING THE WORK WEEK

	0—1 week	**1—2 weeks**	**2—3 weeks**	**> 3 weeks**
Poor	47%	16%	10%	27%
Non-poor	44%	21%	12%	23%

Source: Table adapted from Heymann et al. (1996). Parental availability for the care of sick children. *Pediatrics*. 98:226-30.

There are demands on families for dependent care related to dependent adults as well as children. The National Study of the Changing Workforce found that between 25% and 35% of working Americans are currently providing care for someone over 65 (Bond et al. 2002). Additionally, two in seven families report having at least one family member with disabilities (Wang 2005).

Some research has assessed the availability of paid sick days by health status. According to data analyzed by Heymann and others (1996), 40% of mothers whose children had asthma and 36% of mothers whose children had chronic conditions lacked sick leave during a five-year period (table 6). In other words, the very children who need to access care more routinely have mothers with less sick time to support that need.

TABLE 5. NUMBER OF PAID SICK DAYS AVAILABLE TO WORKING MOTHERS

	0—5 days	**≥ 6 days**
Poor	82%	19%
Non-poor	51%	49%

Source: Table adapted from Heymann et al. (1996). Parental availability for the care of sick children. *Pediatrics*. 98:226-30.

Similarly, Heymann and Earl (1999) found that mothers of children with chronic conditions are more likely to lack sick leave and less likely to receive other paid leave or flexibility. Clemens–Cope (2007) found that among children in low-income working families, 30% of children in fair/poor health had access to paid sick leave for the entire year while 37% of children in good, very good or excellent health had access to this need.

Using the California Work and Health Survey (CWHS) data (see appendix I for detailed methods and findings) we conducted an analysis of the relationship between paid sick days and a number of health outcomes. According to table 7, there appears to be a relationship between overall self-rated health and availability of paid sick days in California workers. For example, among California workers in excellent/very good/good health, 24% had no paid sick days, while 31% had up to one week of paid sick days, and 46% had more than one week of paid sick days. In contrast, among those who viewed their health as fair or poor, 45% had no paid sick days while 31% had more than one week of paid sick days.

TABLE 6. AMOUNT OF TIME EMPLOYED MOTHERS HAVE ACCESS TO PAID SICK LEAVE OVER A 5-YEAR PERIOD IN RELATION TO CHILDREN'S CHRONIC HEALTH CONDITION

	Had sick leave *none* of the time they worked	**Had sick leave less than half the time they worked**	**Had sick leave more than half the time they worked**	**Had sick leave all of the time they worked**
Children with no chronic conditions	28%	21%	17%	34%
Children with a chronic condition	36%	20%	13%	31%
Children with asthma	40%	19%	10	31%

Source: Table adapted from Heymann et al. (1996). Parental availability for the care of sick children. *Pediatrics*. 98:226-30.

TABLE 7. PAID SICK DAYS AND SELF-RATED HEALTH STATUS

	No paid sick days		**Up to 1 week of paid sick days**		**More than 1 week of paid sick days**		**Total**	
	N	%	N	%	N	%	N	%
Excellent/Very Good/Good	186	24%	240	31%	358	46%	784	100%
Fair/Poor	47	45%	25	24%	32	31%	104	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

Self-rated health is widely affected by social determinants affecting both health status and income. However, research examining paid sick days in relation to illness vulnerability or the need for medical or dependent care clearly demonstrates that the availability of paid sick days is lower for populations with greater need for medical and dependent care.

3.2 EFFECT OF PAID SICK DAYS ON THE UTILIZATION OF SICK LEAVE

Many of the hypothesized health effects of paid sick days on health are mediated through the utilization of sick days to care for oneself or a dependent. Taking sick days in turn has potential effects on health status (e.g., recovery from illness), on health care utilization behaviors, including seeking and obtaining diagnosis and treatment for illness, and on the transmission of communicable disease in the workplace and larger community. This section explores how access to paid sick days affects a worker's use of sick days. The impacts of this utilization are salient to each of the pathways evaluated in the subsequent sections.

Utilization of Sick Leave among Workers With and Without Paid Sick Days

Limited evidence is available to evaluate the relationship between access to paid sick days and taking time off due to illness. One recent survey of U.S. workers found that 42% of employed adults aged 19-64 without paid sick days did not miss days because of illness in contrast to 28% of workers with paid sick day benefits (Davis 2005). Adjusting for chronic health problems, disabilities, age and wages, the relationship was even stronger with employed adults without paid sick days only half as likely to take time off for illness.

Lovell (2008) estimated utilization of sick paid days for California workers using data from the 2006 National Health Interview Survey (NHIS). Among workers with employer-provided paid sick days who used no more than nine days of paid sick days (five days for small businesses), the average use of paid sick days for a worker's own illness was 1.8 days per year. Similar workers without paid sick day benefits used only 1.4 days per year. As an average for all workers, this is a significant difference. Interestingly, disaggregated NHIS data for California (table 8) illustrates that the relationship between paid sick days and the utilization of sick days appears to vary by industry. Overall, workers with paid sick leave tended to miss more work-days due to illness and injury than do those without, with the exception of those in mining, utilities, information, health and social assistance, accommodation and food services, and other service. Given their low average hourly wages, workers in accommodation/food service and health care/social assistance are likely to suffer particularly from the financial impact of wage loss due to missing work days without paid sick leave.

As part of this HIA, we conducted a short survey using a small convenience sample of California workers (N=91) to ask questions about the paid sick days benefits and utilization of paid sick days (see appendix II for detailed methods and findings). While we did not distribute the survey with the intent of gathering a statistically representative sample and making comparisons to other studies, our results parallel those from other studies. Most workers (69%) worked for firms with greater than 10 employees. Almost half of the workers responding to the survey (47%) did not have any paid sick days benefits and only 28% of respondents had more than nine paid sick days available per year.

TABLE 8. NUMBER OF WORK-DAYS MISSED DUE TO ILLNESS AND INJURY AND AVERAGE HOURLY WAGE BY INDUSTRY

Industry	Workers with paid sick days	Workers without paid sick days	All workers	Average hourly wage
Mining	2.02	3.9	2.5	$32.00
Utilities	3.36	8.02	3.83	$26.45
Construction	4.44	3.36	3.69	$18.75
Manufacturing	6.02	3.53	5.02	$19.20
Wholesale trade	2.75	1.06	2.29	$18.13
Retail trade	3.70	3.12	3.64	$13.43
Transportation and warehousing	5.56	2.96	4.57	$15.88
Information	2.28	5.69	2.97	$25.10
Finance and insurance	3.72	2.29	3.45	$20.63
Real estate and rental	2.85	2.63	2.72	$16.50
Professional and technical services	2.45	1.30	2.13	$24.62
Management	3.40	0.10	2.81	$19.06
Administration and waste services	4.48	3.90	4.11	$12.81
Educational services	3.41	2.70	3.25	$20.51
Health care and social assistance	4.24	4.85	4.37	$17.71
Art, entertainment, and recreation	3.13	2.26	2.66	$14.43
Accommodation and food service	2.45	4.12	3.72	$10.00
Other service	3.31	3.74	3.51	$11.73

Source: Data provided by Dr. Vickie Lovell based on Institute for Women's Policy Research analysis of the 2006 National Health Interview Survey and the 2005-7 ASEC files of the Current Population Survey.

In our survey, 64% of respondents described having gone to work sick at least once, because of a lack of sufficient paid sick days. The survey identified a number of barriers to being absent from work due to illness. When respondents were asked what happened when they called in sick, most (57%) responded that calling in sick resulted in a loss of wages; 22% responded that calling in sick results in the loss of a job; 22% responded that calling in sick results in the loss of good shifts; and 32% responded that calling in sick results in retaliation from a supervisor or boss. Finally, 63% of survey respondents reported that calling in sick was stressful.

"I have to go to work, or I end up broke. Because I have….the rent, the rent has to be paid, the phone, money for the kids. No, I could be dying, but I have to work, I have to work."
- Focus Group Participant

We also conducted focus groups to gather qualitative information on workers' experiences accessing paid sick day benefits and the effect of having (or not having) such a benefit on their health and the health of their families (see appendix III for detailed methods and findings). Of the thirteen individuals participating in the two focus groups, none had access to paid sick days. Most focus group participants acknowledged that they and their co-workers had indeed taken sick time off in the absence of the benefit; however, doing so often resulted in real and/or perceived consequences. For example, participants described that taking sick days resulted in the threat of being fired, loss of wages, being reprimanded or written up, and receiving decreased work hours or bad shifts.

One focus group participant who worked in the restaurant industry described how employers expected that workers find someone to cover their shift if they needed to call in sick. Given examples of co-workers being fired for calling in sick, one worker felt that they had no choice but to go to work sick. She elaborated the reason for this by saying, "we're so expendable…we're service [workers]." She went on to describe how such workplace norms, in combination with close working conditions, led to habitually passing illness around to one another, decreased productivity among workers, and significantly longer recovery times. She stated, "The staff of the restaurant is pretty big. People have kids. People get sick all the time. There's someone always sick out…..It gets passed from one person to the next. People cover each others' shifts and try to help each other out when necessary but there isn't such thing as sick leave." In the most extreme situation of a penalty being levied, one participant described being laid off after taking time off to take her daughter to the doctor. Another described seeing a co-worker, "someone who worked there for two years," getting fired because she didn't show up for a shift.

Compounding these issues, participants also expressed guilt for abandoning co-workers, and some perceived being seen by their employer as "irresponsible." Collectively, participants' responses suggested that such experiences with taking sick days contributed to an overall pressure to go to work while they or their family members were sick.

Care for Dependents among Workers With and Without Paid Sick Days

Taking care of sick children is a routine need for parents. Young children in particular need parents to be with them when they are sick, to take them in for medical care, and to administer medicine. Similarly, adult children have responsibilities for their parents when they age or suffer from illness or diseases. As discussed above in table 4, Heymann and colleagues (1996) found that 56% of non-poor families and 53% of poor families had an annual illness burden of a week or more with 23% and 27% respectively having an illness burden of over three weeks.

Thus, direct care for sick children and labor to meet a child's or family's other needs are activities that compete for the time of parents and other caregivers. Adults need to meet a child's demands for nutrition, shelter, and other material needs. When a child is not well, parents might reasonably view staying home to care for a child as jeopardizing their ability to earn income to pay for essential health services, food or housing. Higher income, replacement income for time off, or another capacity to meet the needs for basic material consumption would intuitively enable direct care for an ill dependent.

Limited evidence has evaluated the influences on parents' decisions to care for sick children. Heymann and colleagues (1999b) analyzed data in the Baltimore Parenthood Study to assess what factors affected parents' decisions to care for sick children. Of the working parents in the sample, 42% cared for their own sick children while the remainder left sick children in the care of others. Half of the parents who cared for their own sick children reported that paid leave enabled them to take leave from work. Overall, the study found that parents who had either paid sick or vacation leave were 5.2 times as likely to care for their children when they were sick.

Clemens-Cope and others (2007) analyzed determinants of taking sick leave among the families of a sample of 10,790 children in low-income families (less than 200% of the federal poverty level) using data from the Medical Expenditure Panel Survey. In the sample, only 36% of the children in working families had access to paid sick days for the entire year (49% had access to paid sick leave for at least part of the year). Prevalence of access to paid sick days was higher for children in families with two full-time employees relative to those with one full-time employee (66% vs 53%). In families with paid sick days, employees were much more likely to miss work to care for family members (44% vs 26%).

Responses to our survey provide further corroborating data on this question. Over half (62%) of respondents had children under the age of 18. Forty-four percent of survey respondents acknowledged sending kids to school sick because of the lack of paid sick days. Furthermore, 38% of respondents were responsible for the care of a non-child family member (e.g., parents). In total, 54% of participants acknowledged that there were times when they could not care for dependents because of the lack of paid sick days.

One powerful story shared by a focus group participant was about a former co-worker who suffered from mental illness and whose partner had AIDS. The participant and her co-worker worked in a small restaurant with only five staff, and did not receive paid sick days, though they could call in sick if they needed to. The participant described situations in which the co-worker would have an acute mental health crisis at work, but could not afford to go home because she needed the money to buy medicines for her partner. She stated, "She would be having an episode at work…and I'm serving with her in a small restaurant….there's nothing to be done because if the one other girl that works there couldn't work for her…she would have to come and work because she needed to money…you're clearly sick but you have to be here."

3.3 EFFECT OF PAID SICK DAYS ON RECOVERY FROM ILLNESS, PRIMARY CARE UTILIZATION, AND PREVENTABLE HOSPITALIZATIONS

Intuitively, taking leave from work when ill enables recovery from illness. Taking time to rest to recuperate when sick encourages a speedier recovery and may prevent minor health conditions from progressing into more serious illnesses that require longer absences from work and more costly medical treatment. There is, however, limited empirical research on this common-sense proposition. The following section explores the available evidence linking paid sick days and medical outcomes.

Recovery from Illness

While there is a large empirical evidence base on the causes and management of sick leave absence, there is very little research on the effects of taking sick leave on an individual's health status. Some evidence on this subject comes from studies on "presenteeism" (Goetzel 2004), or going to work and working while ill.

Based on data from Sweden, Aronsson and colleagues (2000) explored the hypothesis that certain occupations would be more susceptible to presenteeism because, for example, the services they provided on the job were less replaceable. Analysis of sick leave data showed that

workers employed in health care, education, and food services had higher rates of sickness presenteeism. The same analysis showed that workers with higher rates of presenteeism also had higher rates of common somatic symptoms, including fatigue, back pain, and sleep disturbances (Aronsson et al. 2000). Another analysis of the subject found that among employees with poor self-rated health, the incidence of coronary events among those who took no sick leave during a three-year follow-up was double that of employees who took a moderate amount of sick leave (hazard ratio = 1.97; confidence interval = 1.02-3.83) (Kivmaki 2005).

Studies of presenteeism provide some indirect evidence about the potential consequences of the lack of access to paid sick days. Notably, the fact of presenteeism in countries with a guaranteed right to paid sick leave also suggests that guaranteeing access to paid sick leave may not remove all barriers to taking time off of work for medical needs. Other factors may be the overall economic climate (risk of unemployment) and the nature and culture of the workforce (Aronsson et al. 2000).

"Just power through… don't get fixed."
- Focus Group Participant

Participants in our focus groups described how prior illnesses were exacerbated because they went to work sick, and were unable to take the adequate amount of time necessary to get well. One participant described how she went to work with the flu and did not get the rest she needed to overcome the illness. As a result, she continued to be ill for two months with symptoms from the flu. Participants agreed there was a sense to "just power through…don't get fixed." Another participant described going to work while recovering from dental surgery. While the dentist had recommended taking two days off to recover, not getting paid for the time off meant that taking time off was not an option for her. Another described going to work with the flu and being feverish while at work. While her employer noticed she was sick, "she never told me to go home and rest, until I finally made the decision not to go to work--but she didn't pay me for that day."

Furthermore, lack of paid sick days was described by focus group participants as contributing to a culture of not taking care of oneself when injured at work. For example, one focus group participant discussed how she made a deep cut in her finger that bled profusely while at work. Rather than encourage her to seek immediate medical attention, co-workers provided ideas on how to treat the injury on the spot so she could return to work. There was a strong workplace culture that supported taking care of each other, but "nobody said go to the hospital now….or go home." This sentiment was echoed by another participant who described working with glass doing custom framing, and everyone having cut-up hands but that "No one ever really like went home….Because there's also a culture…don't want to seem like you're complaining." Another participant continued to say, "If they felt they could handle it [an injury]…there's pressure of not wanting to look bad to your employer."

Primary Care Utilization

Being able to pay for health care or having health insurance is only one determinant of health care utilization. Timely primary and preventative care is also dependent on the types of services available, transportation access, and the ability to take time off from work to access health care services (Billings et al. 1996). Given that employed individuals without paid sick days appear to

be less likely to take time off work when ill (Davis 2005), lack of access to paid sick days could also be a barrier to the utilization of primary and preventive care.

Limited empirical evidence examines the relationship between availability of paid sick days and primary care utilization. Lovell's (2008) analysis of 2006 NHIS data estimated that California workers with paid sick leave visit the doctor 3.3 times per year, but the study did not report a corresponding figure for workers without paid sick days.

In one study using the Medical Expenditure Panel Survey, Kneipp (2002) analyzed the relationship between employment factors and reported difficulty obtaining health care in a sample of single mothers. Among a subgroup of mothers who were employed full-time, the analysis did not find that paid sick leave had an independent and statistically significant effect (odds ratio=0.339, confidence interval= 0.84-1.359). However, one limitation of the study was its small sample size (N=100), which limited its power.

In a related study, Gleason (2002) surveyed 77 employed low-income rural residents in North Central Florida to assess the importance of job flexibility on ability to access primary care services. While the study is small and not a representative sample, 60% of the participants reported difficulty in leaving work during the day to access non-emergency health services. Qualitatively, the reasons for difficulty in leaving work when ill included the absence of paid sick time, the loss of pay, the lack of help at work, and the lack of permission from one's supervisors. In some analytic models, both job flexibility and paid sick leave predicted less difficulty in leaving work when sick.

In our analysis of CWHS data, we found that when asked about the length of time since a respondent last had a routine check-up, respondents who had no sick leave were less likely to have had a recent routine check-up than those with sick leave. For example, table 9 illustrates that among those without paid sick days, 26% visited the doctor for a routine check-up three or more years ago, while only 16% of those with paid sick days visited the doctor for a routine check-up three or more years ago. In contrast, 81% of those with paid sick days had received a routine check-up within the past two years, while only 69% of those without paid sick days had received a routine check-up within the past two years.

Self-rated health is a common survey measure predictive of morbidity and mortality. When we stratify the above results by self-rated health, the differences in recent routine check-ups among those with and without paid sick days are greater for those who view themselves in good health versus those who view themselves in poor health. For example, table 10 illustrates that among respondents who consider themselves in excellent/ very good/good health and who have paid sick days were more likely to have a routine check-up in

TABLE 9. PAID SICK DAYS AND LAST ROUTINE CHECK-UP

	No paid sick days		**Some paid sick days**	
	N	%	N	%
Within the past 2 years	151	69%	525	81%
3 or more years ago	58	26%	105	16%
Never	10	5%	17	3%
Total	219	100%	647	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

the past two years than those without paid sick days (82% and 68%, respectively). For those in fair/poor health, the difference between those without paid sick days and those with paid sick days with respect to routine check-up in the past two years is about the same (74% and 78%, respectively).

The association between paid sick days and visiting a doctor in the past year are similarly sensitive to health status. Table 11 illustrates that among respondents who consider themselves in excellent/very good/good health, those with paid sick days are more likely to have visited the doctor in the past year than those without paid sick days (80% and 67%, respectively). For those in fair/poor health, the difference between those without paid sick days and those with paid sick days with respect to visiting the doctor in the past year is about the same (77% and 81%, respectively).

TABLE 10. SELF-RATED HEALTH STATUS, PAID SICK DAYS AND LAST ROUTINE CHECK-UP

	Excellent/Very Good/Good Health				**Fair/Poor Health**			
	No paid sick days		**Some paid sick days**		**No paid sick days**		**Some paid sick days**	
Last routine check-up	N	%	N	%	N	%	N	%
Within the past 2 years	119	68%	482	82%	32	74%	43	75%
3 or more years ago	51	29%	93	16%	7	16%	12	21%
Never	6	3%	15	3%	4	9%	2	4%
Total	176	100%	590	100%	43	100%	57	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

TABLE 11. SELF-RATED HEALTH STATUS, VISITED THE DOCTOR IN THE PAST YEAR, AND ACCESS TO PAID SICK DAYS

	Excellent/Very Good/Good Health				**Fair/Poor Health**			
	No paid sick days		**Some paid sick days**		**No paid sick days**		**Some paid sick days**	
Visited the doctor in the past year	N	%	N	%	N	%	N	%
No	61	33%	117	20%	11	23%	11	19%
Yes	125	67%	479	80%	36	77%	46	81%
Total	186	100%	596	100%	47	100%	57	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

These data suggest that paid sick days are associated with the frequency of doctor visits (e.g., routine and non-routine visits) for those who rate their health good to excellent, but not for those who rate their health as fair to poor. This suggests that access to paid sick days may affect routine and preventative care more than non-routine care (e.g., emergency care).

In our focus groups, participants did not identify the specific value of access to paid sick days when asked about primary care utilization. When asked whether lack of sick days meant that participants did not seek out routine preventative care, a participant responded that, "well that's

TABLE 12. PREVENTABLE HOSPITALIZATION ADMISSION RATES PER 100,000 CALIFORNIA RESIDENTS

Ambulatory Care Sensitive Condition	Rate
Diabetes short-term complications/uncontrolled	60.6
Diabetes long-term complications	112.4
Lower extremity amputation among diabetes patients	34.1
Pediatric asthma	134.2
Pediatric gastroenteritis	61.4
Low birth weight (per 1,000 births)	49.2
Adult asthma	97.7
Chronic obstructive pulmonary disease	185.3
Bacterial pneumonia	306.8
Hypertension	30.3
Congestive heart failure	408.0
Angina without procedure	47.0
Dehydration	100.5
Urinary tract infection	130.4

Source: Table adapted from Parker JP et al. (2005) Office of Statewide Health Planning and Development.

more because you couldn't afford to….if you weren't insured at your job…you couldn't really afford going and paying the whole coverage." This illustrated that a sick day benefit may not be the dominant barrier in access to health care. Without the ability to access routine and affordable health care – sick days provided an opportunity for respite when ill, but they did not necessarily address preventative care and treatment needs. One participant summed up the relationship by saying that sick days and health insurance "go hand-in-hand."

Preventable Hospitalizations

The State of California considers many of the admissions to our hospitals for chronic diseases such as asthma, hypertension, and diabetes entirely preventable with timely and effective outpatient and primary care (Parker et al. 2005). Table 12 provides detailed rates and counts of these hospitalizations based on data from the California Department of Health Services. Every year, tens of thousands of hospitalizations occur in California that would be prevented with appropriate and timely primary care (Parker et al. 2005).

Because the lack of paid sick days may create a barrier to the utilization of primary and preventive care, it could increase the utilization of more expensive therapeutic and hospital care. For example, early treatment of a flare-up of asthma in a doctor's office or clinic can prevent deterioration to the point where hospital care is required. There is currently no available empirical evidence that examines the relationship between availability of paid sick days and preventable hospitalizations.

However, our CWHS analysis highlights that many people with chronic health conditions that can lead to preventable hospitalizations do not have paid sick days. For example, table 13 illustrates:

- Among workers with diabetes, 41% do not have access to paid sick days.
- Among workers with heart disease, 38% do not have access to paid sick days.
- Among workers with chronic lung disease, 31% do not have access to paid sick days.
- Among workers with asthma, 29% do not have access to paid sick days.

- Among workers with high blood pressure/hypertension, 24% do not have access to paid sick days.

TABLE 13. PAID SICK DAYS AND PRESENCE OF CHRONIC HEALTH CONDITIONS

	No paid sick days		Some paid sick days		Total	
	N	%	N	%	N	%
High blood pressure/hypertension	34	24%	107	76%	141	100%
Heart disease	14	38%	23	62%	37	100%
Diabetes	15	41%	22	59%	37	100%
Asthma	25	29%	60	71%	85	100%
Chronic lung disease	8	31%	18	69%	26	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

Our analysis suggests that workers with poorer health status or chronic conditions have less access to paid sick days. In every category of chronic illness (e.g., high blood pressure/hypertension, heart disease, diabetes, asthma, and chronic lung disease), a large proportion of workers do not have access to paid sick days. While the relationship is not causal, it does suggest that workers with greater medical care needs have an additional barrier to getting care for their conditions.

3.4 EFFECT OF PAID SICK DAYS ON RECOVERY FROM ILLNESS, PRIMARY CARE UTILIZATION, AND PREVENTABLE HOSPITALIZATIONS FOR DEPENDENTS OF WORKERS

Almost every hospitalization for asthma is preventable with timely primary care. Nationally, there are almost 200,000 hospitalizations for childhood asthma each year. A single hospitalization in California costs over $13,000.

The burden of illness potentially preventable through policies that support needed care for dependents is substantial. For example, California has a hospitalization rate for pediatric asthma of 134 hospitalizations per 100,000 (OSHPD 2006). Early treatment of a flare-up of asthma in a doctor's office or clinic can prevent deterioration to the point where hospital care is required. In California, a single hospitalization for asthma costs over $13,000 (CDHS 2008). Studies of hospitalized children have shown that sick children have shorter recovery periods, better vital signs, and fewer symptoms when their parents share in their care (Palmer 1993). The presence of parents has also been found to shorten children's hospital stays by 31% (Taylor and O'Connor 1989).

"There were several occasions when my children were small, and I was a divorced single mom, that I sent them to school sick. This was because I used up my sick-days. Almost all of my sick-days were used for my children, so I went to work sick several times. As I had a lot of contact with the public as social worker, I probably spread illness."
- Survey Respondent

In section 3.2.2, we explored the relationship between having a paid sick day benefit and taking leave to care for dependents. In this section, we explore the consequences of care-giving for health and well-being of dependents, including children and elders. Children left home alone may be unable to see physicians for diagnoses, needed medications, or

emergency help if their conditions worsen. For dependents who are ill with chronic or acute illnesses, access to caregivers can be a matter of life and death.

In one of the only available studies evaluating the relationship between maternal employment conditions and children's medical visits, Pimoff and Hamilton (1995) modeled the effect of employment and socio-demographic factors on preventative and illness-related ambulatory care visits in a sample of 4,169 children aged 0-15 using the national Medical Expenditure Panel Survey. Overall, based on the data, working mothers had fewer sick child visits than non-working mothers. The authors found that a 10% increase in "sick visit price" visit time multiplied by post-tax wages reduced the number of visits for sick children by 2.3%. Mothers who could use sick leave for doctor visits had 27% more sick-child visits than those without this benefit.

Even for ill adults, receiving care from another can benefit health. Elderly individuals live longer when they have higher levels of social support from friends and family members (Seeman 2000; Berkman 1995). Other studies have consistently found that receiving material or emotional support from family members leads to a faster and fuller recovery from conditions such as heart attacks and strokes (Gorkin et al. 1993; Tsouna-Hadjis et al. 2000).

3.5 EFFECT OF PAID SICK DAYS ON COMMUNICABLE DISEASE TRANSMISSION IN COMMUNITY SETTINGS

It is both common sense and established science that going to work or school with an infectious disease can mean transmitting it to others. Many common infectious diseases are transmitted in workplaces, schools, and other public venues through casual contact. These diseases include influenza or "the flu," viral gastroenteritis or the "stomach flu," viral meningitis, and the common cold. For each of these common diseases, ensuring that a sick worker can stay out of their workplace and that sick children can stay home from school helps keep infections from spreading. Intuitively, if working adults are able to stay home when they are sick, they are also less likely to spread their illness to those they work with. Collectively, the burden of infectious illnesses transmitted through casual contact in community settings is significant.

Some worksites have a greater importance as sites of communicable disease transmission because workers have greater direct contact with the public (e.g., health care and child care providers, teachers), prepare food consumed by the public (e.g., food service workers), or work with populations who are susceptible to infection (e.g., health care workers). For occupations such as health care workers, child care providers, and food service workers, it is critical and even legally required to keep sick workers out of the workplace.

Influenza

Each year in the United States, 5% to 20% of the population gets the seasonal influenza (the flu), more than 200,000 people are hospitalized from flu complications, and about 36,000 people die from flu (CDC 2008b). The emergence of a highly infectious novel influenza strain as a pandemic is likely to result in 68% of the population being affected and 34% suffering a clinical infection, translating into 100 million sick individuals in the United States (Ferguson 2006).

Transmisison of influeza occurs through the generation of aerosol droplets by infectious individuals as well as through contact with infectious individuals. It is estimated that 30% of the transmission of influenza occurs in homes, 37% occurs in schools and workplaces, and 33% in other general community settings (Ferguson 2006).

The U.S. Centers for Disease Control and Prevention (CDC 2008a) provides the very common sense recommendation to people with influenza: "stay home from work, school, and errands when you are sick."

Both pharmacological strategies (e.g., vaccines, prophylaxis) and non-pharmacological strategies (e.g., quarantine, isolation, school closure) exist to prevent the spread of influeza. According to researchers who have studied the effectiveness of strategies to limit transmission of influenza using mathmatical models, a combination of strategies is necessary to control influenza (Halloran 2008).

The hazard of a new strain of the influenza virus will depend on factors such as its infectivity and the percentage of infected individuals with clinical symptoms. However, strategies to minimize social contacts between people can be highly effective in controlling the spread of influenza. Such strategies include having a sick person remain at home when symptomatic, quarantine of an infected individual and his or her family members for a specified period, isolation of infected individuals, closing schools, closing workplaces, and limiting travel. The U.S. Department of Health and Human Services now recommends "liberal leave" policies to help control pandemic flu (USDHHS 2007).

The effect of community strategies to control the spread of influenza depends ultimately on compliance. In general, strategies that restrict movement to a greater degree are much less feasible. Most social distancing strategies require people to take leave from work for periods of time when they or their family members are potentially infectious.

Table 14 summarizes the modeled effects of certain social distancing measures on cumulative attack rates of pandemic influenza. Glass (2006) estimated that from a moderately infectious pandemic strain (R_0=1.6) requiring that all sick persons stay at home when symptomatic could result in a 22% reduction of the cumulative attack rate in a hypothetical U.S. small town. Ferguson estimated that a policy of household quarantine would result in a 15% reduction in the cumulative attack rate for infected individuals and household members with a somewhat more infectious strain of influenza (R_0=1.7) and a 50% compliance with the policy. Wu (2006) estimated a 34% reduction in the cumulative attack rate for voluntary household quarantine using a model of pandemic influenza with R_0=1.8 in a population similar to Hong Kong. Finally, Germann (2006) found that local social distancing measures reduced the cumulative incidence rate of a moderately infectious (R_0=1.6) pandemic influenza strain by 24%.

All of these pandemic modeling studies are consistent in predicting a reduction in the cumulative incidence of clinical infections with modest measures to reduce contacts among individuals, but estimates vary between models and scenarios (Halloran 2008). Collectively, these studies modeling influenza transmission and control strategies provide direct support of workplace leave as an influenza prevention strategy (Halloran 2008).

TABLE 14. MODELED EFFECTS OF CERTAIN SOCIAL DISTANCING MEASURES ON CUMULATIVE ATTACK RATES OF PANDEMIC INFLUENZA

Study	Intervention measure	Context	Reproductive number (R_0)[1]	Prevalence of compliance	Baseline cumulative attack rate (cases per 100 people)	Intervention cumulative attack rate (cases per 100 people)	Percent reduction in cumulative attack rate
Ferguson (2006)	Quarantine of household contacts of symptomatic individual	U.S. population	1.7	50%	27.0	23.0	15%
Glass (2006)	Symptomatic people stay home	Small town of 10,000 people	1.6	90%	50.2	39.3	22%
Wu (2006)	Quarantine of household contacts of symptomatic individual	Hong Kong	1.8	50%	74.0	49.0	34%
Germann (2006)	Voluntary social distancing measures	U.S. population	1.6	N/A	32.6	25.1	24%

[1] Reproductive number (R_0) = Mean number of secondary cases a typical single infected case will cause in a population with no immunity to the disease and in the absence of intervention.

The modeling studies also provide indirect evidence supporting the role of paid sick days in community prevention of influenza. While there has been no effort to model or study the effect of employer-provided paid sick leave benefits on influenza reduction, conceptually, having paid sick days enables and increases the likelihood of compliance with both voluntary and mandatory social distancing strategies, including the home isolation of sick individuals and related household members. Access to paid sick days would also affect the feasibility of other social distancing strategies, particularly for families with children. School closure is an effective strategy in several modeling scenarios, as transmission among school-aged children is an important driver of influenza transmission. Closing schools, either for short or long periods of time, will require adults who are not sick to stay home to supervise their children. Families with young children may be as a less wealthy group than average workers, and thus may have a greater need for employer support during periods of workplace leave.

While it is not possible to estimate the magnitude of the change in compliance that is specifically attributable to paid sick days using available data or existing research, even if the effect was small, because of the large burden of disease associated with influenza, the overall magnitude of the health benefit of paid sick days could be substantial. An indirect benefit of effective compliance with social distancing strategies would include not only a reduction of morbidity and mortality but also a reduction of hospital and health care costs and less dependence on pharmacological strategies to control seasonal epidemics and pandemics.

Transmission of Foodborne Disease in Restaurants

Foodborne diseases cause approximately 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States each year (Mead et al. 1999). More than half of all U.S. reported foodborne illness outbreaks occurs in restaurants (Jones and Angulo 2006). Table 15 provides the number of foodborne disease outbreaks and the number of foodborne disease outbreak-related cases in California between 2002 and 2007. As indicated, the number of cases has remained relatively constant over the past several years.

TABLE 15. FOODBORNE DISEASE OUTBREAKS AND RELATED CASES IN CALIFORNIA

Report year*	Foodborne disease outbreaks	Foodborne disease outbreak-related cases
2002	216	3492
2003	178	2649
2004	176	2644
2005	150	3241
2006	196	3009
2007	180	2646

*Report year may not necessarily the year of onset. Please consider 2007 data provisional.

Source: California Department of Health Services/Surveillance & Statistics Section.

The California Retail Food Code (2007) requires local health officers to restrict a food service worker from a food facility if the employee is diagnosed with an infectious agent, symptomatic, and still considered infectious. In reality, public health officials rely on workers to recognize the illness and their employers to self-enforce requirements that protect the public. Unfortunately, 70% of California workers in the accommodation and food service industry do not have access to paid sick days (Lovell 2008). This means that that many food service workers have barriers to accessing treatment and diagnosis for infectious diseases and have disincentives to taking time off when ill.

Delay in diagnosis creates public health risks. A worker may recognize a symptom but may not associate it with a foodborne illness. A food worker may not want to take unpaid time to obtain a diagnosis or may defer care until the symptom worsens, potentially infecting co-workers and patrons in the meantime.

The impact of food worker-related disease outbreaks can be significant. In 2005, an ill worker without paid sick day benefits at a sandwich shop in Kent County, Michigan was responsible for the illness in over 100 customers (MMWR 2006). In 2006, a restaurant-worker without paid sick day benefits infected over 350 customers (MMWR 2007) with norovirus at a restaurant in Lansing, Michigan.

Guzewich and Ross (1999) reviewed published scientific literature for reports of foodborne disease believed to have resulted from contamination of food by food workers, finding 81 published outbreaks involving 14,712 infected persons. Eighty-nine percent (72) of the outbreaks occurred at food service establishments, such as restaurants, cafeterias and catered

functions. Hepatitis A and Norwalk-like viruses accounted for 60% (49) of outbreaks. Ninety-three percent of these outbreaks involved food workers who were ill either prior to or at the time of the outbreak.

With regards to specific etiologic agents, norovirus is responsible for 50% of all foodborne illnesses in the U.S (Widdowson 2005). Between 48% and 93% of all norovirus outbreaks may be linked to ill food service workers (Guzewich 1999).

Contamination of food by an infected food worker is the most common mode of transmission of hepatitis A in foodborne disease outbreaks (Guzewich 1999). A review of foodborne hepatitis A outbreaks in the United States found that in many cases the infected food handler either did not seek medical care or delayed getting medical care (Fiore 2004).

One participant in our focus groups described how workplace conditions in the restaurant industry could exacerbate illness among workers. She described how employers expected that workers find someone to cover their shift if they needed to call in sick. Given examples of co-workers being fired for calling in sick, one worker felt that they had no choice but to go to work sick. She elaborated the reason for this by saying, "we're so expendable…we're service [workers]." She went on to describe how such work place norms, in combination with close working conditions, led to habitually passing illness around to one another, decreased productivity among workers, and significantly longer recovery times. She stated, "The staff of the restaurant is pretty big. People have kids. People get sick all the time. There's someone always sick out….It's gets passed from one person to the next."

Transmission of Infectious Disease in Health Care Facilities

Between 2002 and 2004, California had 480 reported outbreaks of viral gastroenteritis. Half of the outbreaks occurred in long-term care facilities and 40% were in skilled nursing facilities (nursing homes). Nursing home outbreaks accounted for 6,500 patient illnesses, 120 hospitalizations, and 29 deaths (CDPH 2008).

Recently, nursing homes have experienced a large number of norovirus outbreaks. For example, according to the CDC, 23% of all norovirus outbreaks occur in nursing homes (CDC 2006). In California, 100-200 norovirus outbreaks occur in nursing homes each year (CDPH 2006). The vast majority of patients will recover from norovirus illness within a few days, but an estimated 10% experience more serious symptoms, including acute dehydration that ultimately requires hospitalization (Calderon-Margalit et al. 2005). In addition, approximately 2% of those afflicted face the risk of death (Calderon-Margalit et al. 2005).

Nursing home-based respiratory and gastrointestinal disease outbreaks involve residents and staff. Analogous to legal requirements for food service workers, California State guidelines for illness prevention suggest that ill staff with viral gastroenteritis should be symptom-free for 24 hours before returning to work (CDPH 2008). However, as a significant proportion (27%) of nursing home workers do not have paid sick day benefits (Lovell 2008), these workers may be more likely to come to work sick, thus putting patients and coworkers at risk of contracting illness.

A study of New York State nursing homes conducted in 1993 found that risk of respiratory and gastrointestinal infectious disease outbreaks was significantly less for nursing homes with paid sick leave policies (adjusted relative risk = 0.38, 95% confidence interval 0.15-0.99) (Li et al. 1996). Capozza et al. (2008) estimated the number of norovirus outbreaks in California nursing homes potentially avoided though a universal paid sick day policy. The analysis assumed the effect of this workplace policy found in the analysis of Li and others (1996) would be similar to the effect in California nursing homes. The analysis also assumed that the prevalence of paid sick day benefits among nursing homes would be the same as the prevalence of the benefit among for nursing home workers nationally (73%) and that nursing home workers would utilize this benefit to take leave from work when ill with norovirus. Using these assumptions, Capozza et al. estimated that between 30 and 45 fewer nursing homes would experience norovirus outbreaks annually under a policy of paid sick days. Additionally, Capozza et al. estimated that the reduction in nursing home outbreaks would result in between 939-1407 fewer resident cases of norovirus and between 667-999 fewer employee cases of norovirus.

Transmission of Infectious Disease in Child Care Facilities

Children placed in child care have an increased risk for respiratory and gastrointestinal communicable diseases, particularly in the first two years of care (Wald et al. 1991; NICHHD 2001). As discussed above, both common childhood illness and sick-child exclusion policies that are in place in schools and child care facilities create a substantial burden on work leave for parents.

Non-compliance with sick-child exclusion policies at child care facilities is a potential avoidable cause of communicable disease transmission in these settings. Conceptually, paid sick days could enable parental compliance with these policies. As discussed above, findings from the survey conducted for this HIA suggested that over half of survey participants acknowledged that there were times when they could not care for dependents because of the lack of paid sick days. Furthermore, the interview with communicable disease control investigators highlighted that enforcement of restrictions is most difficult in the child care arena given that there are a large number of child care settings and they are not all licensed. Similarly, investigators felt that the process for keeping ill children home from child care is less regulated than restrictions for workers in sensitive occupations such as food service and health care.

However, we found no other published research to support an effect of paid sick days on parental compliance. Research discussed above suggests that the availability of paid sick days makes it more likely that a parent will care for his or her own sick child (Heymann et al.1999b). Similarly, Clemans-Cope et al. (2007) found that in families with employer-provided paid sick leave, employees were more likely to miss work to care for family members (44% vs 26%). Overall, it is not possible to infer from this limited research that the absence of paid sick days predicts non-compliance with child exclusion policies.

INTERVIEW WITH SFDPH COMMUNICABLE DISEASE CONTROL AND PREVENTION PROGRAM DISEASE CONTROL INVESTIGATORS AND HEALTH WORKERS

As part of this health impact assessment, a group interview was conducted with a number of disease control investigators and health workers employed by the San Francisco Department of Public Health's Communicable Disease Control and Prevention (CDCP) Program. The purpose of the interview was to gather qualitative information about investigators' work dealing with communicable diseases, particularly among workers in sensitive occupations, and the role paid sick days might play in supporting their work.

The CDCP program is responsible for the control and prevention of communicable diseases in San Francisco by tracking reports of over 80 reportable diseases and conditions, investigating cases and contacts, and recommending public health actions to control the spread of disease. According to California State law, if a person becomes infected with a certain type of communicable disease, and they work in a "sensitive occupation", they must be placed on an official work restriction. Diseases with official restrictions include amebiasis, salmonella infections, shigella infections and typhoid fever. Sensitive occupations include food handling, health care (if involved in direct care), and child care. Restrictions for patients in sensitive occupations with other diseases not listed separately in the regulations or during outbreaks are at the discretion of the Health Officer. For example, CDCP also restricts ill workers with E. Coli O157/H7, shiga toxin producing E. coli and hepatitis A.

If a patient is a worker in a "sensitive occupation or situation", then he/she is instructed in writing, via a "restriction letter," either not to report to work or to refrain from engaging in certain work duties (depending on the illness and the patient's occupation) until he/she receives clearance from SFDPH to resume normal activities. The idea behind this law is that workers should refrain from engaging in work activities in order to limit the risk of disease transmission to others.

Reasons for Treatment-Seeking Behaviors

In the interview, investigators pointed out that while in some situations they may ask patients what led them to seek treatment, the question is not standard and data on treatment-seeking behaviors is not routinely collected. However, investigators shared impressions of why people choose to seek treatment when they become ill. One investigator replied, "I think sometimes it's gotten so bad that they finally decide to go to the hospital." They may also notice that people around them, such as their family, their coworkers, or people who have dined with them at a restaurant, have become ill. Other investigators agreed, adding that most of the time, patients do not seek treatment until they have been sick for several days. One investigator added that patients who have health insurance tend to go to the hospital sooner than those who do not. The investigator also reported situations where patients put off seeking treatment because they did not have paid sick days; for example, he recalled one patient who suffered from diarrhea for two weeks before seeking treatment.

Reactions to Having a Work Restriction

When asked how patients react to being placed on a work restriction, investigators responded that the reactions vary widely between people. One investigator commented that health care workers tend to react well because they understand the ramifications of continuing to work. Food handlers can be a little "more difficult." Parents sometimes get upset when they are instructed to keep their children home from child care or school, because they have to take time off from work to stay home with their children.

One investigator commented that patients' reactions often depend on the benefits they have at their jobs. People often are very concerned about the loss of income they will experience from the work restriction. The investigators reported patients saying, "I can't afford this" or crying on the phone. Another investigator commented that some patients are "totally cooperative—amazingly so," given the difficulties imposed on them by the restriction.

Adherence to Work Restrictions and Barriers to Adherence

The investigators reported that because of improved enforcement procedures over the last few years, most patients comply with work restrictions, whether "willingly or not." They reported, for example, that when they contact a supervisor to check on adherence, it is "really unusual for the patient to be there." They commented that when patients and supervisors receive phone calls from SFDPH, that sometimes "sends an alarm" to them that the matter should be taken seriously. One investigator stated that business owners' concerns about liability and their reputation also encourage adherence. Since supervisors are notified of work restrictions in writing, they know that "there are ramifications to people not complying."

The investigators agreed that enforcement of restrictions is most difficult in the child care arena given that there are a large number of child care settings and they are not all licensed. Similarly, they felt the process for keeping ill children home from child care is less regulated than restrictions for workers in sensitive occupations (e.g., food handling, health care and child care.). When asked specifically about access to paid sick days and adherence to work restrictions, the investigators reported that they had encountered situations where lack of sick days was a barrier to adherence. One investigator commented that this often happens when parents need to take time off to stay home with their children.

Access to Paid Sick Days

The investigators were asked if they believed there was a relationship between access to paid sick days and patients' recovery time, preventable hospitalizations, disease transmission, adherence to work restrictions, or other aspects of their work.

The investigators answered that while it can be difficult to draw definitive conclusions, they generally believed having access to paid sick days could help. An investigator commented that they have had patients tell them, "I can't afford to miss work." Another investigator pointed out that having access to paid sick days would also benefit patients who do cooperate; as of now, these patients "are being punished for cooperating, at some level" because are not getting paid while they adhere to the work restriction. The investigator gave an example of one worker who cooperated, but was in such dire financial straits that the investigator searched for some administrative avenue through which the patient could receive funds while he was not able to work. Another investigator added that since most patients are cleared to return to work within eight days, they do not miss enough days to qualify for State Disability Insurance.

See appendix IV for more detailed interview methods and findings.

3.6 EFFECT OF PAID SICK DAYS ON WAGE LOSS, RISK OF JOB LOSS AND EMPLOYER RETALIATION

As reasoned from the evidence above, the absence of paid sick days can be expected to have important economic impacts on workers as well as employers. Workers without *paid* sick days experience wage loss when they take time off to care for themselves and their family members. In addition, some workers may also place themselves at risk of job loss if sickness absence is not approved by their employers (Heymann 2000). Furthermore, having the ability to earn and utilize paid sick days may enable some with chronic or frequent illnesses to remain employed. Each of these economic impacts would be expected to have important indirect effects on health outcomes.

Wage Loss

Income is one of the strongest and most consistent predictors of poor health and disease in public health research literature (Yen and Syme 1999). The magnitude of income's effect on health is significant. For example, people with average family incomes of $15,000 to $20,000 were three times as likely to die prematurely as those with family incomes greater than $70,000 (Sorlie et al. 1995). The strong relationship between income and health is not limited to a single illness or disease. People with lower incomes have higher risks than people with higher incomes for giving birth to low birth weight babies, for suffering injuries or violence, for getting most cancers, and for getting chronic conditions (Yen et al. 1999).

An adequate and stable income allows an individual or household to access critical material needs for health including food, shelter, clothing and transport. According to the U.S. Department of Agriculture, in 1999, 31 million people (including 12 million children) were either uncertain of having or unable to acquire adequate food to meet basic needs at some time during the previous year because there was not enough money for food. Nationally, those with incomes in the bottom fifth of the income distribution and who pay 50% of their incomes for housing have an average of $417 to cover all non-housing monthly expenses (JCHS 2003). Furthermore, income is essential for heating and cooling homes and transport to jobs or schools.

> *"I have to go to work, or I end up broke. Because I have….the rent, the rent has to be paid, the phone, money for the kids. No, I could be dying, but I have to work, I have to work."*
> *- Focus Group Participant*

This means even a small loss of income on a monthly basis may lead to trade-offs between housing, food, and health care services. One focus group participant stated that if "I only work three shifts this week and if I'm like too sick and I can't make my $150 that I need… I'm totally not paying rent and I definitely can't buy groceries…a lot of times there's no choice but to keep working. I never call in sick. And I've been working in restaurants for seven years." This sentiment was echoed by others as well. "We don't have that privilege--not even to get sick… I know if I don't work, because of the two or three days I'm not feeling well, I won't be able to cover my rent and my bills. That's the way it is."

A recent survey of American cities found that low-paying jobs and high housing costs are the most frequently cited reasons for hunger (Sandel et al. 1999). For those with lower income,

short-term financial instability also creates risks of displacement, homelessness, or risk of living in crowded or substandard conditions with moisture or mold, poor ventilation, cockroaches, rodents, asbestos or lead, or homes that may be structurally unsafe (SFDPH 2004). Because people will often work extra hours or second jobs to meet financial obligations, overwork may generate psychosocial stress, compromise personal or family relationships, and result in punitive or low-effort strategies to resolve conflict with children (Dunn 2002).

The California Budget Project has estimated the amount of income families and single individuals need to earn to achieve a modest standard of living (CBP 2007). The CBP basic family budget includes housing, food, child care, transportation, health care costs, and other essentials. The minimum wage required for meeting basic needs in California ranges from $13.62 to $28.72, depending on the number of adults and number of working adults in the household. Housing costs and child care expenses are strong determinants of these budgets.

"I can say I'm not going to work, but the money isn't just going to fly into my wallet, and that's the problem."
- Focus Group Participant

Given that workers without paid sick leave are disproportionately low-wage occupations (Hartmann 2007), they would be at the greatest risk of income loss due to sickness, family illness, or maternity leave. According to Lovell (2008), 5.4 million Californians currently do not have access to paid sick days. The average hourly wage of workers without paid sick days is $15.70, substantially lower that the median wage for California workers ($17.42).

To provide a sense of how much a week's worth of lost wages translates into, table 16 compares the loss of income due to a five-day sickness absence for California workers making the minimum wage ($8.00) to workers making the median wage ($17.42). While the relative loss is the same, for workers making minimum wage, the absolute impact is far stronger given the limited amount of "wiggle room" in the budgets of low-income families.

TABLE 16. IMPACT OF A FIVE CONSECUTIVE DAY SICKNESS ABSENCE ON MONTHLY INCOME

	Wage	**Annual / Monthly income (at 2,080 hours per year)**	**Loss of income due to a five-day sickness absence**
California minimum wage (2008)	$8.00	$16,640 / $1,386	$320
California median wage (2006)	$17.42	$36,235 / $3,019	$696

Source: Calculations based on CA minimum wage and median wage based on the California Budget Project (2007).

In our analysis of CWHS data, workers with no paid sick days are more likely to say they found it somewhat difficult/difficult/extremely difficult to live on their total household income (52%) than workers with some paid sick days (45%). Conversely, workers with some paid sick days are more likely to find it not at all difficult to live on their total household income (55%) in contrast to workers with no paid sick days (48%) (table 17). These data provide evidence that a high proportion of overall workers find that it is difficult to live on their total household income. This implies that the loss of a day's wages due to calling in sick could present a significant hardship affecting material needs (e.g., housing, food) necessary for health.

TABLE 17. PAID SICK DAYS AND DIFFICULTY LIVING ON TOTAL HOUSEHOLD INCOME				
	No paid sick days		**Some paid sick days**	
	N	%	N	%
Not at all difficult	112	48%	361	55%
Somewhat difficult/Difficult/Extremely difficult	120	52%	290	45%
Total	232	100%	651	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

In the survey we conducted, 57% of respondents stated that they lost wages if they called in sick. For participants in our focus groups, loss of wages for calling in sick was felt to be a stressful experience. One participant stated that missing a shift meant added stress due to the loss of income. She described the pressure to pick up extra shifts to make up the lost pay. However, "doing a double shift at a restaurant" meant working fourteen hours straight, and being "incapacitated for a day." If the participant couldn't pick up that extra shift, she described making up the lost pay by adjusting her eating habits: "Then you find yourself eating more cheaply…maybe not taking the time to nourish yourself the way you should because you're really strained on money. I go on the mac and cheese diet or the ramen noodle diet. You go into survival mode…because it's about making the money that you need at the end of the month."

> *"Then you find yourself eating more cheaply… maybe not taking the time to nourish yourself the way you should because you're really strained on money. I go on the mac and cheese diet or the ramen noodle diet. You go into survival mode…because it's about making the money that you need at the end of the month."*
> *- Focus Group Participant*

Lost wages also had the impact of creating tension with others. In particular, several focus group participants discussed how loss of wages affected their relationships with their husbands, primarily because they were unable to contribute to family wages, or because their wage input was less than usual. One participant said, "And if we stop working and aren't earning, how are we going to contribute the other half that's our share?" Several participants identified domestic violence as resulting from such tension.

Risk of Job Loss and Employer Retaliation

Health problems can translate into unemployment through several mechanisms. Earle and Heymann (2002) found that a health problem led to a 53% increase in job loss among low-wage mothers and having a child with health problems led to a 36% increase in job loss even after taking into account the mother's years of education, her skills, and the local environment in which she was looking for work.

Chronic unemployment is associated with a number of adverse health outcomes, including shortened life expectancy and higher rates of cardiovascular disease, hypertension, depression and suicide (Jin et al. 1995; McKee-Ryan et al. 2005; Voss et al. 2004). Precarious or unstable employment also has adverse impacts on physical and mental health (Ferrie et al. 2005).

Based on some research, paid sick days and other forms of paid leave also appear to encourage a return to work after a serious illness, preventing unemployment. For example, one study found that nurses with paid sick days were 2.6 times more likely to return to work after a heart attack or angina (Earle et al. 2006).

> *"I know it's good for me to stay home like another day or two…but just knowing like you really would be looked down upon by management. They would use that against you."*
> *- Focus Group Participant*

The above finding suggests that *paid* sick days may be a component of workplace culture that is more likely to accept and accommodate employee absence for illness. According to focus group participants, employer retaliation for calling in sick was closely tied to the threat of job loss. In the most extreme situation of a penalty being levied, one participant described being laid off after taking time off to take her daughter to the doctor. Another described seeing a co-worker, "someone who worked there for two years," as getting fired because she didn't show up for a shift.

Others described consequences in terms of the type of work they were asked to do or the number of work hours they were assigned after calling in sick. One woman who did domestic work talked about how, after taking time off, when she returned to work, there were more difficult tasks she was asked to complete. Another woman who returned to work after a birth found that the number of work hours she was assigned was reduced to less than before the birth. She said, "It's not fair. It's not fair. They should respect a person, because it's not a bad thing to take off to have a baby and go back to work."

In both these instances, participants perceived such treatment to be a "punishment" for taking time off. A worker who did manual jobs talked about another form of penalty – a "three strikes" rule – at one job, where calling in sick could count as a strike in performance evaluations. He stated, "Calling in sick too often could cause some strikes against you, which would look bad during an upcoming review" which also meant that "[workers] would bring their illness into the work environment. Because instead of being at home they didn't want to like jeopardize their job..."

Related to the threat of job loss was the role that social pressure and guilt played as obstacles for workers to call in sick, or to take enough time to get well. One participant discussed how she was made to feel guilty by her employer for taking time off while her children were sick. She quoted her employer as saying, "When you want, you can go, and I'll never get a person who has children again, because the ones with children are really problematic, because they have to leave work to take care of their children." Another participant said, "it's hard to claim it [sick days]….because sometimes you're grateful to have work, and sometimes, as my fellow worker said, you end up working harder for fear of losing the little bit you've got." Participants also agreed that often, "After being home sick for a day, people feel like they need to work extra hard the next day."

4 Assessment of the Magnitude, Direction, and Certainty of Health Impacts

This section provides conclusions about the magnitude, direction and certainty of health impacts predicted from the Healthy Families, Healthy Workplaces Act of 2008 based on the evidence summarized above. A summary of these conclusions is outlined in table 18 below.

These conclusions are based on the available evidence on the research questions. Overall, while paid sick days are conceptually and logically linked to a number of health and health care outcomes, our HIA was constrained by limited peer-reviewed and empirical research available on paid sick days and health. This limited research on paid sick days is consistent with the limited focus of public health research on workplace and employment policy.

Regardless of this limitation, almost all available evidence was generally consistent with the hypothesis that paid sick days protect and enable worker health, worker care for sick dependents, and the reduction of communicable disease transmission in community settings. Overall, research examining paid sick days benefits in relation to illness vulnerability or the need for medical or dependent care clearly demonstrates that the availability of paid sick days is lower for populations with greater need for medical and dependent care. The most specific and suggestive research arose from the study of community mitigation strategies for pandemic flu. Importantly, no published research suggested that paid sick days would harm health of workers or in workplaces.

Focus groups conducted for this HIA, while limited and not necessarily representative of California's working population, provided strong and consistent support of the conceptual pathways and hypothesized effects. Similarly, our analysis of the California Work and Health Survey provided clear support of various hypothesized effects.

Based on all of the evidence, the following impacts appear to be most certain:

- A requirement for paid sick days will result in more workers taking needed leave from work to care for an illness. Quantitative research, including peer-reviewed analysis of national and state datasets, and qualitative focus group findings provide evidence consistent with this impact.

- A requirement for paid sick days will result in more workers taking needed leave from work to care for ill children and dependents. Quantitative peer-reviewed research and qualitative focus group findings provides evidence consistent with this impact.

- A requirement for paid sick days will facilitate compliance with public health guidance for seasonal influenza and community mitigation strategies for pandemic flu. This conclusion is supported by quantitative modeling of community mitigation strategies for pandemic flu, authoritative public health guidance on influenza prevention and the effects, described above, on workers taking leave from work to care for their illness or for dependents.

TABLE 18. ASSESSMENT OF HIA HEALTH OUTCOMES, JUDGMENT OF THE MAGNITUDE OF IMPACT, AND THE QUALITY OF THE EVIDENCE

Health Outcome	Judgment of Magnitude of Impact[1]	Quality of Evidence
Impacts on Worker or Dependent Health		
Taking leave for medical need	▲▲▲	Consistent but limited quantitative evidence; supportive qualitative research
Taking leave to care for ill dependents	▲▲▲	Consistent but limited quantitative evidence; supportive qualitative research
Appropriate and timely utilization of primary care	▲	Limited supportive evidence
Avoidable hospitalization	-	Insufficient evidence
Impacts on Community Transmission of Communicable Diseases		
Seasonal or pandemic influenza	▲▲▲	Consistent and adequate indirect quantitative research; established authoritative public health guidance
Foodborne disease in restaurants	▲▲	Consistent sufficient quantitative research; established authoritative public health guidance
Gastrointestinal infections in health care facility disease transmission	▲▲	Consistent limited research; established authoritative public health guidance
Communicable diseases in child care facilities	▲	Inadequate empirical evidence; established authoritative public health guidance
Worker Economic Impacts		
Loss of income	▲▲▲	Sufficient Evidence
Job loss	▲	Consistent but limited qualitative evidence

[1] This column provides a scale of significance ranging from 0 – 3, where 0 = no impact and 3 = a significant impact. An effect is considered significant if it would affect a large number of people in California and have the potential to create a serious adverse or potentially life threatening health outcome.

- A requirement for paid sick days would reduce the hazard of worker-related foodborne disease transmission in restaurants. Empirical research on foodborne disease outbreaks, public health laws on the exclusion of sick workers from sensitive situations (e.g., child care, health care and food service), and qualitative interviews with disease control professionals provide evidence consistent with this impact.

- A requirement for paid sick days would reduce the hazard of worker-related gastrointestinal disease transmission in long-term care facilities for the elderly. This conclusion is supported by limited empirical research on employer sick leave policies and disease outbreaks in nursing homes, authoritative public health guidance on the exclusion of sick workers from long-term care facilities, and the effects, concluded above, on workers taking leave to care for their illness or for dependents.

- A requirement for paid sick days would mitigate income loss and the threat of job loss for low-income workers during periods of illness or care for dependents. The prevention of income loss would be of a magnitude significant enough to prevent food or housing insecurity.

The following effects are plausible but less well-supported by available evidence:

- A requirement for paid sick days could increase the utilization of outpatient medical care for acute illnesses.

- A requirement for paid sick days supports infection control policies, limiting the transmission of communicable diseases in child care facilities and schools.

- A requirement for paid sick days could prevent job loss resulting from the lack of available sick leave and from the utilization of sick leave.

5 Conclusion

While doctors and public health agencies either advise or require workers and school children to stay at home when ill, for U.S. workers without paid sick days, illness in their household means having to make an extremely difficult choice. Should they take unpaid time off from work, or should they go to work sick or send their children to school sick? For low-income workers, not going to work for even a few days may mean not having enough money to pay the rent, keep children in child care, or buy groceries. Some workers may also be insecure in their jobs, not knowing whether an absence from work may translate into the loss of a job or some kind of employer retaliation. This inconsistency between public heath guidance and workplace policy creates a potent barrier for workers to follow common-sense advice from their doctors and public health agencies.

This health impact assessment has examined evidence on the potential health impacts of a mandatory requirement for paid sick days as proposed by the California Healthy Families, Healthy Workplaces Act of 2008. While limited published, peer-reviewed research has focused specifically on the health impacts of paid leave for sickness, sufficient evidence exists to support the conclusion that the law would have significant positive public health impacts. The guaranteed availability of paid sick days would increase workers' use of sick time to care for medical conditions and to care for sick dependents. A guarantee of paid sick days would reduce the hazard of communicable disease transmission in community settings including restaurants and long-term care facilities, with potential for reductions in infectious disease outbreaks. Paid sick days would have a particularly significant benefit in enabling established community mitigation strategies for pandemic flu. Finally, a guarantee of paid sick days would prevent potential hunger and loss of housing among low-income workers by mitigating wage loss during periods of illness.

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Appendix I: California Work and Health Survey – Research Methods and Findings

INTRODUCTION

This narrative summarizes the methods and findings from an analysis of the California Work and Health Survey (CWHS). The analysis was conducted by Lili Farhang and Rajiv Bhatia at the San Francisco Department of Public Health as part of a larger health impact assessment (HIA) of paid sick days benefit legislation in California.

The purpose of this analysis was to assess the relationship between paid sick days and health. Using CWHS data, we examined the following questions:

- What is the prevalence of the paid sick days (PSD) in the CWHS sample?
- Are there differences between those who have/don't have PSD and self-rated health status?
- Are there differences between those who have/don't have PSD and last reported routine check-up?
- Are there differences between those who have/don't have PSD and last medical visit?
- Are there differences between those who have/don't have PSD and the presence of chronic disease?
- Are there differences between those who have/don't have PSD and the extent to which they report difficulty living on household income?

METHODS

The California Work and Health Survey (CWHS) is a telephone-based, longitudinal survey of California adults, designed by faculty and staff of the Work and Health Program at the University of California, San Francisco, with input from researchers and practitioners in the fields of health and economics. The survey includes extensive coverage of employment status, recent job loss, working conditions and environment, and of physical and mental health status. Interviews are conducted in English and Spanish. Three annual interviews have been completed – 1998, 1999, and 2000. CWHS data are available for use by the general public, with the understanding that they will be used solely for research purposes. Extensive documentation of CWHS survey methods can be located at:
http://ucdata.berkeley.edu:7101/new_web/FTP/ftpreadmecwhs.html.

Cross-sectional data from the 2000 survey were used for this analysis. Per the recommendation of CWHS researchers, a proportional weight for each respondent was included in all analyses. The weight was calculated by CWHS researchers in an effort to have the sample of respondents

align as closely as possible to the known characteristics of the California population and to account for oversampling. This analysis reports all results using the proportional weight

There were 2,168 total respondents to the 2000 CWHS survey. Given our interest in assessing access to paid sick days benefits, this analysis was limited to respondents who 1) currently had a job, 2) those who worked for someone else (i.e., not self-employed), and 3) those who provided information on whether they received paid sick days at their job. Based on these criteria, 888 respondents were eligible for this analysis.

Currently having a job was determined through a series of survey questions assessing what the respondent was doing for most of the last week in terms of work (e.g., working, not at work but had a job, looking for work, keeping house, going to school, retired, etc.), whether the respondent was paid for work, and reasons for respondent work absence. Responses were combined into a composite variable created by CWHS researchers and provided in the dataset. Working for someone else/being self-employed was asked as a separate interview question.

The following CWHS survey variables were used in this analysis:

- Access to paid sick days was determined through the CWHS survey question, "On this (main) job, how many days of sick leave are you allowed each year, without losing pay? (SICKLV00). Respondents could state the number of paid sick days they received, could state that they had no set number of paid sick days, or could state that they don't know.

  In this analysis, responses was coded into two separate paid sick days variables: 1) a dichotomous variable to reflect whether a respondent received any paid sick days and 2) a categorical variable to reflect the amount of paid sick days each respondent received in weeks.

  Those reporting "don't know" were excluded from this analysis. Forty-seven respondents stated that they had "no set number" of paid sick days. For this analysis, we assumed that respondents who could not state the number of paid sick days they received were likely workers who received a larger number of paid sick days. As such, we categorized these respondents as having "some sick days" when paid sick days were examined at as a dichotomous variable, and as having "more than one week" of paid sick days when paid sick days were examined as a categorical variable.

- Self-rated health (HEALTH00) in the CWHS dataset was asked as "In general, would you say your health is excellent, very good, good, fair or poor." In this analysis, these five self-rated health categories were recoded into two groups of self-rated health: excellent/very good/good health and fair/poor health.

- Last routine check-up (CHEKUP00) was asked as "About how long has it been since you last visited a doctor for a routine check-up?" Responses were provided in the following categories: within the past year, 1-2 years ago, 3-4 years ago, 5 or more years ago, and never. For this analysis, these categories were recoded into the following: within the past two years, 3 or more years ago and never.

- Visited the doctor in the past year (MEDVIS00) was determined through the question "During the past 12 months how many times have you seen or talked to a medical doctor about your health, including emergency room or clinic visits?" Responses were presented in the CWHS dataset as a continuous variable and recoded in this analysis into a dichotomous variable reflecting any visit to the doctor in the past year.

- The CWHS survey included a question on whether respondents found it difficult living on their household income (SUFINC00) – "How difficult is it for you to live on your total household income right now – not at all difficult, somewhat difficult, difficult, very difficult, or extremely difficult." In this analysis, the preceding scale was recoded into three categories: not at all difficult, somewhat difficult and difficult/very difficult/extremely difficult.

- Finally, the CWHS asked respondents whether they had a series of specific chronic health conditions. The following chronic health conditions were assessed as dichotomous variables in this analysis: high blood pressure or hypertension (HBP00), heart disease (HEART00), diabetes (DIABET00), asthma (ASTHMA00), and chronic lung disease (LUNG00).

FINDINGS

Of the 888 workers who provided information regarding whether they received paid sick days, 26% reported they received no paid sick days, 30% reported receiving up to one week of paid sick days, and 44% reported having more than one week of paid sick days.

Table 2 suggests a clear relationship between overall self-rated health and how many paid sick days a worker has. For example, among people in excellent/very good/good health, 24% had no paid sick days, while 31% had up to one week of paid sick days, and 46% had more than one week of paid sick days. In contrast, among those who viewed their health as fair or poor, 45% had no paid sick days while 31% had more than one week of paid sick days.

TABLE 1. AMOUNT OF PAID SICK DAYS AMONG WORKERS RESPONDING TO THE CALIFORNIA WORK AND HEALTH SURVEY

	N	%
No paid sick days	233	26%
Up to 1 week of paid sick days	266	30%
More than 1 week of paid sick days	389	44%
Total	888	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

When asked about the length of time since a respondent had their last routine health check-up (table 3), respondents who had no paid sick days were less likely to have had a recent routine check-up than those with paid sick days. For example, table 3 illustrates that among those without paid sick days, 26% visited the doctor for a routine check-up three or more years ago, while only 16% of those with paid sick days visited the doctor for a routine check-up three or more years ago. In contrast, 81% of those with paid sick days had received a routine check-up within the past two years, while only 69% of those without paid sick days had received a routine check-up within the past two years.

TABLE 2. PAID SICK DAYS AND SELF-RATED HEALTH STATUS

	No paid sick days		**Up to 1 week of paid sick days**		**More than 1 week of paid sick days**		**Total**	
	N	%	N	%	N	%	N	%
Excellent/Very Good/Good	186	24%	240	31%	358	46%	784	100%
Fair/Poor	47	45%	25	24%	32	31%	104	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

When we stratify the above results by self-rated health, the differences in recent routine check-ups among those with and without paid sick days are greater for those who view themselves in good health versus those who view themselves in poor health. For example, table 4 illustrates that among respondents who consider themselves in excellent/very good/good health and with paid sick days were more likely to have a routine check-up in the past two years than those without paid sick days (82% and 68%, respectively). For those in fair/poor health, the difference between those without paid sick days and those with paid sick days with respect to routine check-up in the past two years is about the same (74% and 78%, respectively).

TABLE 3. PAID SICK DAYS AND LAST ROUTINE CHECK-UP

	No paid sick days		**Some paid sick days**	
	N	%	N	%
Within the past 2 years	151	69%	525	81%
3 or more years ago	58	26%	105	16%
Never	10	5%	17	3%
Total	219	100%	647	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

TABLE 4. SELF-RATED HEALTH STATUS, PAID SICK DAYS AND LAST ROUTINE CHECK-UP

	Excellent/Very Good/Good Health				**Fair/Poor Health**			
	No paid sick days		**Some paid sick days**		**No paid sick days**		**Some paid sick days**	
Last routine check-up	N	%	N	%	N	%	N	%
Within the past 2 years	119	68%	482	82%	32	74%	43	75%
3 or more years ago	51	29%	93	16%	7	16%	12	21%
Never	6	3%	15	3%	4	9%	2	4%
Total	176	100%	590	100%	43	100%	57	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

The association between paid sick days and visiting a doctor in the past year is similarly sensitive to health status. Table 5 illustrates that among respondents who consider themselves in excellent/very good/good health those with paid sick days are more likely to have visited the doctor in the past year than those without paid sick days (80% and 67%, respectively). For those in fair/poor health, the difference between those without paid sick days and those with paid sick days with respect to visiting the doctor in the past year is about the same (77% and 81%, respectively).

TABLE 5. SELF-RATED HEALTH, VISITED THE DOCTOR IN THE PAST YEAR, AND ACCESS TO PAID SICK DAYS

	Excellent/Very Good/Good Health				**Fair/Poor Health**			
	No paid sick days		**Some paid sick days**		**No paid sick days**		**Some paid sick days**	
Visited the doctor in the past year	N	%	N	%	N	%	N	%
No	61	33%	117	20%	11	23%	11	19%
Yes	125	67%	479	80%	36	77%	46	81%
Total	186	100%	596	100%	47	100%	57	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

Our analysis highlights that many people with chronic health conditions that can lead to preventable hospitalizations do not have paid sick days. For example, table 13 illustrates:

- Among workers with diabetes, 41% do not have access to paid sick days
- Among workers with heart disease, 38% do not have access to paid sick days
- Among workers with chronic lung disease, 31% do not have access to paid sick days
- Among workers with asthma, 29% do not have access to paid sick days
- Among workers with high blood pressure/hypertension, 24% do not have access to paid sick days.

TABLE 6. PAID SICK DAYS AND PRESENCE OF CHRONIC HEALTH CONDITIONS

	No paid sick days		**Some paid sick days**		**Total**	
	N	%	N	%	N	%
High blood pressure/hypertension	34	24%	107	76%	141	100%
Heart disease	14	38%	23	62%	37	100%
Diabetes	15	41%	22	59%	37	100%
Asthma	25	29%	60	71%	85	100%
Chronic lung disease	8	31%	18	69%	26	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

TABLE 7. PAID SICK DAYS AND DIFFICULTY LIVING ON TOTAL HOUSEHOLD INCOME

	No paid sick days		**Some paid sick days**	
	N	%	N	%
Not at all difficult	112	48%	361	55%
Somewhat difficult/Difficult/Extremely difficult	120	52%	290	45%
Total	232	100%	651	100%

Source: Analysis based on the California Work and Health Survey data, 2000. See appendix I for detailed methods and findings.

Finally, table 7 illustrates that workers with no paid sick days are more likely to say they found it somewhat difficult/difficult/extremely difficult to live on their total household income (52%) than workers with some paid sick days (45%). Conversely, workers with some paid sick days are more likely to find it not at all difficult to live on their total household income (55%) in contrast to workers with no paid sick days (48%).

CONCLUSION

These findings support associations between those without access to paid sick days and a number of health-related issues: specifically, self-rated health status, preventative and non-routine health care visits, prevalence of chronic health conditions, and difficulty living on household income.

First, our analysis suggests that workers with poorer health status or chronic conditions have less access to paid sick days. In every category of chronic illness (e.g., high blood pressure/hypertension, heart disease, diabetes, asthma, and chronic lung disease), a large proportion of workers do not have access to paid sick days. While the relationship is not causal, it does suggest that workers with greater medical care needs have an additional barrier to get care for their conditions.

Second, the data suggest that paid sick days are associated with the frequency of doctors visits (e.g., routine and non-routine visits), for those who rate their health good to excellent but not for those who rate their health as fair to poor. This suggests that access to paid sick days may affect routine and preventative care more than non-routine care (e.g., emergency care)

Third, the data provide evidence that a high proportion of overall workers find that it is difficult to live on their total household income. This implies that the loss of a day's wages due to calling in sick can present a hardship affecting material needs (e.g., housing, food) necessary for health.

Appendix II: Paid Sick Days Survey – Methods and Findings

INTRODUCTION

At the present time many professional and semiprofessional workers in industries such as health care, information technology, and communication receive paid sick day (PSD) benefits. However this benefit is often not extended to minimum wage workers employed in the restaurant, retail and health support industries. State legislation is being currently considered to extend paid sick day benefits to workers in California. Human Impact Partners (HIP) and researchers at the San Francisco Department of Public Health (SFDPH) are conducting a health impact assessment to better understand the impact of paid sick days on health with the goal of supporting more holistic accounting of paid sick days impacts. This narrative summarizes the results of a brief survey administered to workers regarding paid sick days and their health.

METHODS

A non-experimental design was used to measure the characteristics of the population affected by the lack of PSD benefits. To gather information regarding paid sick days benefits among workers, HIP and the SFDPH researchers developed a short survey and asked the Labor Project for Working Families (LPWF)[1] to distribute the survey to partner organizations with a member base that might be willing to complete the survey. The survey instrument was a simple two-page double-sided handout, and was later converted into a web-based survey using Survey Monkey. One organization who distributed the survey translated it into Spanish to be able to include responses from Spanish- speaking members.

The survey was primarily developed to qualitatively describe the experiences of individuals with and without paid sick days. This survey draws on a convenience sample that was willing to complete the survey. The survey as not administered randomly, but completed by partner organizations of LPWF, who have a vested interest in the legislation. Additionally, only two organizations sent back responses. We don't know how many other organizations chose not to respond. As a result, it is important to note that these findings should not be generalized to the general population. Surveys were completed between May 19 and June 26, 2008.

RESULTS

Over a period of three months, two organizations, Parent Voices[2] and National Association of Working Women (9to5)[3], sent back a total of 75 completed hard copy surveys. At the end of the

[1] Since 1992, the Labor Project for Working Families (LPWF) has been partnering with unions, union members, community based organizations and other activists to promote better work and family policies and programs, including paid family leave, child care, elder care and flexible work schedules. (Accessed June 17, 2008 at http://www.workingfamilies.org/about/about.html)

[2] Parent Voices is a project of the California Child Care Resource and Referral Network (the Network). This chapter organization works throughout California to improve access to childcare for all families in their communities, in California, and in the United States. Parent Voices combines leadership development, advocacy, and community organizing in order to increase funding and improve quality and access to childcare. We do this through trainings, regular meetings, special events, media, and participation in the political process. Parents are an integral part of planning and executing in this organization. (Accessed June 17, 2008 at www.parentvoices.org/contact.htm)

third month, 16 additional responses came via the Survey Monkey version, which was distributed via LPWF.

Table 1. Access to paid sick day benefits among paid sick days survey respondents.

Response	# of participants	% of participants
Yes	35	43.2
No	38	46.9
I don't know	8	9.9
*Table	81	100

*Ten survey participants skipped question related to paid sick days benefits.

In total, 91 individuals completed the survey. Seventy-six of the participants were female and thirteen were male. Respondents ranged in age from 16 to 69. Twenty surveys were completed in Spanish. Respondent educational backgrounds ranged from non-high school graduates (n=16) to post-graduate school (n=17). Eight respondents completed high school, 3 completed vocational school, 2 completed vocational and some college, 19 completed some college, and 21 had a college degree.

The data collected from the 91 responses yielded relevant information about the work characteristics such as types of jobs and hours worked, and benefits received through employers. Summary statistics of participant responses are presented in the following pages, and fill-in responses follow those. Please note that fill-in responses in Spanish were translated into English.

Table 2. Types of jobs held by paid sick days survey respondents

Types of jobs	# of participants	% of participants
Administrative	18	22
Non-Profit	17	21
Food Packing	8	10
Care Giver	7	9
Education	7	9
Service Provider	7	9
Technology	6	7
N/A	3	4
Farming	2	2
Construction	1	1
Financial	1	1
Human Services	1	1
Meat processing	1	1
Student	1	1
Unemployed	1	1
*Total	81	100

*Ten survey participants skipped question related to type of job held

Included in this appendix are a summary of participant responses to the survey and three tables highlighting findings with respect to 1) access to paid sick days benefits among survey respondents, 2) types of jobs held by survey respondents, and 3) an age distribution of survey respondents.

Table 3. Age distribution of paid sick days survey respondents

Age distribution	# of participants	% of participants
15-19	1	1
20-29	22	26
30-39	23	27
40-49	20	23
50-59	10	11
60-69	11	13
*Total	87	100

*Four people did not respond to this question

[3] National Association of Working Women (9to5) is a national, grassroots membership organization that strengthens women's ability to work for economic justice. In California we are involved in the fight against job discrimination and harassment and for equal pay, paid sick days, and immigrant rights. (Accessed June 17, 2008 at http://9to5califonia.org)

SURVEY RESPONSES

1. What type of place do you work in now (your main source of income)?

	Response Percent	Response Count
Self-employed	14.1%	11
Fewer than 10 employees	16.7%	13
10-50 employees	15.4%	12
50-100 employees	10.3%	8
More than 100 employees	**43.6%**	**34**
Other (please specify)		15
answered question		**78**
skipped question		**13**

2. What is your job at your main place of employment?

	Response Count
	81
answered question	**81**
skipped question	**10**

3. What industry do you work in?

	Response Percent	Response Count
Restaurant	2.2%	1
Retail	0.0%	0
Office work	**46.7%**	**21**
Healthcare	11.1%	5
Other	40.0%	18
Other (please specify)		68
answered question		**45**
skipped question		**46**

4. Do you work more than one job?

	Response Percent	Response Count
Yes	18.2%	16
No	80.7%	71
Other	1.1%	1
Other (please specify)		4
answered question		88
skipped question		3

5. How many hours a week do you work at your main job?

	Response Count
	86
answered question	86
skipped question	5

6. Do you have paid sick days benefits?

	Response Percent	Response Count
Yes	43.2%	35
No	46.9%	38
I don't know	9.9%	8
answered question		81
skipped question		10

7. How many paid sick days off can you take a year?

	Response Percent	Response Count
0	47.0%	39
1-5	7.2%	6
6-8	4.8%	4
9+	27.7%	23
I don't know	13.3%	11
Other (please specify)		10
answered question		83
skipped question		8

8. Have you ever gone to work because you don't have paid sick days off (or enough paid sick days)?

	Response Percent	Response Count
Yes	64.4%	56
No	35.6%	31
answered question		87
skipped question		4

9. Do any of the following happen if you call in sick?

	Yes	No	I don't know	Response Count
Loss of wages	**57.3% (43)**	40.0% (30)	2.7% (2)	75
Loss of job	22.4% (15)	**65.7% (44)**	11.9% (8)	67
Lose good shifts	21.5% (14)	**73.8% (48)**	4.6% (3)	65
Stress	**66.7% (48)**	30.6% (22)	2.8% (2)	72
Retaliation	32.3% (21)	**60.0% (39)**	7.7% (5)	65
Threats of losing wages/jobs	35.2% (25)	**60.6% (43)**	4.2% (3)	71
answered question				82
skipped question				9

10. Do you have children under the age of 18?

	Response Percent	Response Count
Yes	61.8%	55
No	38.2%	34
answered question		89
skipped question		2

11. Have you ever sent your kids to school sick because you do not have paid sick days?

	Response Percent	Response Count
Yes	43.8%	32
No	56.2%	41
Other (please specify)		15
answered question		73
skipped question		18

12. Are you responsible for other family member's care (older parents, disabled)?

	Response Percent	Response Count
Yes	37.9%	33
No	62.1%	54
answered question		87
skipped question		4

13. Have there been times when you couldn't care for children, older parents, or others who are dependent on you because you didn't have paid sick days?

	Response Percent	Response Count
Yes	53.6%	45
No	46.4%	39
Other (please specify)		6
answered question		84
skipped question		7

14. What is your age?

	Response Count
	87
answered question	87
skipped question	4

15. What is the highest level of education you've attained?

	Response Percent	Response Count
1st - 12 grade	18.6%	16
High school graduate	9.3%	8
Vocational School	3.5%	3
Vocational School & Some College	2.3%	2
Some college (including associate's degree and junior college)	22.1%	19
College graduate (bachelor's)	**24.4%**	21
Post graduate school	19.8%	17
answered question		86
skipped question		5

16. Gender

	Response Percent	Response Count
Male	14.6%	13
Female	**85.4%**	76
Other (please specify)		0
answered question		89
skipped question		2

17. Marital status

	Response Percent	Response Count
Married	**41.9%**	36
Unmarried with partner	19.8%	17
Single	38.4%	33
answered question		86
skipped question		5

18. Ethnicity

	Response Percent	Response Count
White	**47.1%**	41
Black/African American	5.7%	5
Spanish speaking/Latino	40.2%	35
Asian	6.9%	6
American Indian/Alaskan Native	1.1%	1
Native Hawaiian/other Pacific Islander	2.3%	2
Other (please specify)		4
answered question		87
skipped question		4

19. Do you have a story about sick days you would like to share with us? If so, please either write it in the space below or include your contact info so we can call you in the space below.

	Response Count
	38
answered question	38
skipped question	53

SELECTED RESPONSES TO SURVEY QUESTION 19

Do you have a story about sick days you would like to share with us? If so, please either write it in the space below or include your contact info so we can call you in the space below.

1. Although I have sick days, I could not use them for family members - my two daughters. So I would call my boss and try to "sound sick" to get the day off paid, even though my child was the one who was sick. It was embarrassing.

2. "I was sick and I could not afford soup, Gatorade. Effects your children/family in some ways."

3. In part time jobs I would get 3 weeks for sick days and vacation days, so more sick days less vacation days. If sick plus vacation is more than 3 weeks then loose pay.

4. Difficulty getting adequate maternity leave in my first year in a new school district. Having to take 2 weeks as on leave without pay. Inadequate pay during time out on maternity leave overall.

5. I have spent many years earlier on where I went to work sick because I couldn't afford not to work. It was really miserable for everyone involved, my coworkers, my customers, and myself.

6. Many times I had to call my father who lived 45 minutes away to pick up my sick boys so that I could go to work.

7. There were several occasions when my children were small, and I was a divorced single mom, that I sent them to school sick. This was because I used up my sick-days. Almost all of my sick-days were used for my children, so I went to work sick several times. As I had a lot of contact with the public as social worker, I probably spread illness.

8. I would like to get "paid sick days" so I can stay home without the fear of being fired.

9. They pay not too much attention when you are sick where I work. If I am sick and don't work, in addition to lose money I could lose my job.

10. I have gone to work many times sick because I had to support my family. I could not afford to take a day off.

11. In many jobs, especially, in restaurant jobs vacation time and paid sick days are not offered. When restaurant workers get sick they don't get pay. And if they cannot work for three days they get no pay for those days. If for some reason they are not fully recovered after three days the doctor release them but with some work restrictions. In this situation, because they have some job restrictions some employers prefer to send them home without pay and save money this way.

12. When I am sick it is very difficult for me. Because if I don't work I would not get pay for the sick days and then my check would come short which means that I would not have enough money for the days I did not work. For that reason when I get sick sometimes I had to work in that condition because I know that when I get pay my check will came up short.

13. Fortunate for me, my company is very flexible and family oriented. When my sick time runs out I am allowed to make up time on weekends.

20. If you want us to contact you please provide your contact information. Thanks

	Response Percent	Response Count
Name:	100.0%	5
Address:	60.0%	3
City/Town:	60.0%	3
State:	60.0%	3
Phone Number:	80.0%	4
answered question		5
skipped question		86

21. Do you work in California?

	Response Percent	Response Count
Yes	91.3%	21
No	8.7%	2
answered question		23
skipped question		68

Appendix III: Paid Sick Days Focus Groups – Methods and Findings

INTRODUCTION

This narrative summarizes the findings of two focus groups conducted by the San Francisco Department of Public Health and Human Impact Partners ("staff") as part of a larger health impact assessment (HIA) of paid sick day benefit legislation in California. The purpose of these focus groups was to gather qualitative information on workers' experiences accessing paid sick day benefits and the effect of having (or not having) such a benefit on their health and the health of their families.

Staff conducted the first focus group on April 25, 2008, with members of the community-based organization, Mujeres Unidas y Activas (MUA).[4] A second group was held on June 4, 2008 with members of the community-based organization, Young Workers United (YWU).[5] Both MUA and YWU were sought out for participation as both organizations have a membership base of low-wage workers in occupations that must interact with the public and/or with sensitive populations. For example, MUA members provide child-care and home-care services and YWU members mostly work in the restaurant industry.

Given the limited availability of data of how access to paid sick days affects health, findings from these focus groups help to fill some of these data gaps. And while these findings may not be representative of all workers, the results provide powerful perspectives often overlooked in a discourse dominated by economic cost-benefit analysis.

METHODS

Upon initial contact from SFDPH researchers and an explanation of the HIA purpose, both MUA and YWU agreed to recruit members to participate in a focus group.

MUA staff recruited participants from a general membership meeting and ten women chose to participate in the 90-minute session. All participants were Latina. The MUA focus group was conducted in Spanish and simultaneously transcribed and translated into English. Participants worked in a range of areas, including domestic work, child/day care and patient care; eight were employed either half- or part-time, and two participants were employed full-time. YWU staff also recruited participants from a general membership meeting, with one woman and two men participating in the one-hour session. The YWU focus group was conducted in and transcribed

[4] Mujeres Unidas y Activas is a grassroots organization of Latina immigrant women with a dual mission of personal transformation and community power. Creating an environment of understanding and confidentiality, MUA empowers and educates members through mutual support and training to be leaders in their own lives and in the community. Working with diverse allies, MUA promotes unity and civic-political participation to achieve social justice. (Accessed June 2, 2008 at http://www.mujeresunidas.net/)

[5] Young Workers United is a multi-racial and bilingual membership organization dedicated to improving the quality of jobs for young and immigrant workers and raising standards in the low-wage service sector, particularly restaurants, in San Francisco through organizing workers and students, grass-roots advocacy, leadership development, and public education. (Accessed June 2, 2008 at http://www.youngworkersunited.org/)

into English. Two participants worked in the service sector (e.g., restaurant, manual labor) and another worked at an educational institution. All participants were employed half- or part-time. While participants in the MUA group reflected a wide age distribution from young to old, some with spouses and child dependents, YWU workers were all young workers with no child dependents.

Participation in both groups was completely voluntary, and participants were told that names and identifying information would be kept confidential. Each participant received a $20 Safeway gift card as compensation. Focus group moderators asked for permission to audiotape and take notes at the outset of the meeting in an effort to obtain an accurate description of the discussion.

FINDINGS

In November 2006, San Francisco voters passed a local ordinance requiring all employers to provide paid sick leave to each employee who performs work in San Francisco.[6] The Paid Sick Leave Ordinance took effect in February 2007. While the Ordinance has been in effect for over a year, the thirteen focus group participants, all of whom worked in San Francisco, stated that they were not receiving paid sick leave.[7] Consequently, participants could not speak to the experience of having sick day benefits at their current jobs or to how access to a paid sick day benefit has affected their health. Accordingly, this narrative is primarily based on workers who do not have access to the benefit and how that lack of access affects their health.

> *"People get sick all the time. There's someone always sick out…..It gets passed from one person to the next."*

Overall Group Sentiment

While participants in the focus group did not receive *paid* sick days benefits, most participants acknowledged that they and their co-workers had indeed taken sick time off in the absence of the benefit. Doing so was often not without real and/or perceived consequence, however. Overall, participants described the ways that workers were penalized for taking sick days – for example, there was the threat of being fired, loss of wages, being reprimanded or written up, and receiving decreased work hours or bad shifts. Compounding these penalties was guilt that participants felt for abandoning co-workers and being seen by their employer as "irresponsible." Collectively, participants agreed that such experiences and sentiments contributed to an overall pressure to go to work while they or their family members were sick.

[6] Under the SF ordinance, for every 30 hours worked, an employee accrues one hour of paid sick leave. For employees of employers for which fewer than 10 persons work for compensation during a given week, there is a cap of 40 hours (5 days) of accrued paid sick leave. For employees of other employers, there is a cap of 72 hours (9 days) of accrued paid sick leave. The accrued paid sick leave caps are for a given point in time. They are not annual caps. Accrued paid sick leave does not expire; it carries over from year-to-year. There is no cap on how much paid sick leave an employee may use in a year. Paid sick leave can be used when the employee is ill or injured or for the purpose of receiving medical care, treatment, or diagnosis; and to aid or care for a family member or designated person when that person is ill, injured, or receiving medical care, treatment, or diagnosis. For more information, visit: http://www.sfgov.org/site/olse_index.asp?id=49389

[7] This reality reflects generally a lack of enforcement that will not be discussed extensively in this narrative. Note that a number of public agencies, including the Office of Labor Standards Enforcement, are currently working to improve enforcement of the ordinance. For more information, please visit: http://www.sfgov.org/site/olse_index.asp

> *"I have to go to work, or I end up broke. Because I have….the rent, the rent has to be paid, the phone, money for the kids. No, I could be dying, but I have to work, I have to work."*

One participant who worked in the restaurant industry described how employers expected that workers find someone to cover their shift if they needed to call in sick. Given examples of co-workers being fired for calling in sick, one worker felt that they had no choice but to go to work sick. She elaborated the reason for this by saying, "we're so expendable…we're service [workers]." She went on to describe how such work place norms, in combination with close working conditions, led to habitually passing illness around to one another, decreased productivity among workers, and significantly longer recovery times. She stated, "The staff of the restaurant is pretty big. People have kids. People get sick all the time. There's someone always sick out…..It's gets passed from one person to the next. People cover each others' shifts and try to help each other out when necessary but there isn't such thing as sick leave." In the most extreme situation of a penalty being levied, one participant described being laid off after taking time off to take her daughter to the doctor. Another described seeing a co-worker, "someone who worked there for two years," as getting fired because she didn't show up for a shift.

Economic Impact and Stress

Loss of wages for calling in sick was felt by many as a significant impact given life needs. One participant stated that if, "I only work three shifts this week and if I'm like too sick and I can't make my $150 that I need…. I'm totally not paying rent and I definitely can't buy groceries…a lot of times there's no choice but to keep working. I never call in sick. And I've been working in restaurants for seven years." The sentiment was echoed by others as well. "We don't have that privilege--not even to get sick….. I know if I don't work, because of the two or three days I'm not feeling well, I won't be able to cover my rent and my bills. That's the way it is." One powerful story shared by a participant was about a former co-worker who suffered from mental illness and whose partner had AIDS. They worked in a small restaurant with only five staff, and did not receive paid sick days, though they could call in sick if they needed to. The participant described situations in which the co-worker would have an acute mental health crisis at work, but could not afford to go home because she needed the money to buy medicines for her partner. She stated, "She would be having an episode at work…and I'm serving with her in a small restaurant….there's nothing to be done because if the one other girl that works there couldn't work for her…she would have to come and work because she needed to money…you're clearly sick but you have to be here."

> *"Then you find yourself eating more cheaply…maybe not taking the time to nourish yourself the way you should because you're really strained on money. I go on the mac and cheese diet or the ramen noodle diet. You go into survival mode…because it's about making the money that you need at the end of the month."*

The participant continued that, for herself, missing a shift meant added stress due to the loss of income. She described the pressure to pick up extra shifts to make up the lost pay. However, "doing a double shift at a restaurant" meant working fourteen hours straight, and being "incapacitated for a day." If the participant couldn't pick up that extra shift, she described making up the lost pay by adjusting her eating habits, "Then you find yourself eating more cheaply…maybe not taking the time to nourish yourself the way you should because you're really strained on money. I go on the mac and cheese diet or the

ramen noodle diet. You go into survival mode…because it's about making the money that you need at the end of the month."

"I can say I'm not going to work, but the money isn't just going to fly into my wallet, and that's the problem."

Lost wages also had the impact of creating tension with others. In particular, several focus group participants discussed how job loss and loss of wages affected their relationships with their husbands, primarily because they were unable to contribute to family wages, or because their wage input was less than usual. One participant said, "And if we stop working and aren't earning, how are we going to contribute the other half that's our share?" Several participants identified domestic violence as resulting from such tension.

Participants felt strongly that a benefit that protected their wages if they called in sick would help to alleviate much of this fear and stress – as they would not be forced to choose between their income and their health.

Employer Retaliation

"Something that happens to us all the time--accidents. Because when we're taking care of patients, we hurt our backs, our arms, also when we're taking care of children, our backs. We have to climb up to high places when we're cleaning. Accidents happen. And as my fellow worker here was saying, they lay you off or they fire you, but they never give you a sick day."

Another theme that emerged throughout the discussions was that going back to work after taking sick time off sometimes had consequences in terms of the type of work participants were asked to do or the number of work hours they were assigned. For example, a woman who did domestic work talked about how, after taking time off, when she returned to work, there were more difficult tasks she was asked to complete. Another woman who returned to work after a birth found that the number of work hours she was assigned was reduced to less than before the birth. She said, "It's not fair. It's not fair. They should respect a person, because it's not a bad thing to take off to have a baby and go back to work." In both these instances, participants perceived such treatment to be a "punishment" for taking time off. A worker who did manual jobs talked about another form of penalty – a "three strikes" rule – at one job, where calling in sick could count as a strike in performance evaluations. He stated "Calling in sick too often could cause some strikes against you, which would look bad during an upcoming review" which also meant that "[workers] would bring their illness into the work environment. Because instead of being at home they didn't want to like jeopardize their job..."

Illness, Injury and Recovery

"just power through …don't get fixed."

None of the participants stated that they had ever been hospitalized for an illness that could have been avoided if they had could have called in sick. However, participants did describe the exacerbation of an illness because they went to work sick, and were unable to take the adequate amount of time necessary to get well. One participant described how she went to work with the flu and did not get the rest she needed to overcome the illness. As a result, she continued to be ill for two months with symptoms from the flu. Participants agreed there was a sense to "just power through…don't get fixed." Another participant described going to work

> *"A lot of guys at work cut themselves really badly, or burn themselves. A lot of guys get burns on their arms…and they will just wrap it up and be at work the next day…"*

while recovering from dental surgery. While the dentist had recommended taking two days off to recover, not getting paid for the time off meant that taking time off was not an option for her. Another described going to work with the flu and being feverish while at work. While her employer noticed she was sick, "she never told me to go home and rest, until I finally made the decision not to go to work--but she didn't pay me for that day." Work conditions exacerbated recovery as well. One participant described how their place of work was "poorly insulated especially during the winter season in San Francisco...people's immune systems would be weaker because of cold," and this, she believed, only prolonged illness when workers came to work sick.

Even workers injured on the job were not given the latitude to take the time to recover. For example, one participant discussed how she had fallen on the job and hurt her knee, which required an operation on her meniscus. She was unable to take enough time for the surgery to heal and as a result, developed cysts at the site of her operation, which then required additional surgery. After that, she heard that "my boss didn't want me on light duty," meaning that they would not adjust her work to accommodate her recovery process – to date, she had not been called back into work. Another participant discussed how she made a deep cut in her finger that bled profusely while at work. Rather than encourage her to seek immediate medical attention, co-workers provided ideas on how to treat the injury on the spot so she could return to work. There was a strong culture of taking care of each other, but "nobody said go to the hospital now….or go home." This sentiment was echoed by another participant who described working with glass doing custom framing, and everyone having cut up hands but that "No one ever really like went home….Because there's also a culture…don't want to seem like you're complaining."[8] Another participant continued to say, "If they felt they could handle it [an injury]…there's pressure of not wanting to look bad to your employer."

> *"After being home sick for a day, people feel like they need to work extra hard the next day."*

Social Pressures and Guilt

> *"I know it's good for me to stay home like another day or two…but just knowing like you really would be looked down upon by management. They would use that against you."*

Finally, a major theme discussed by participants was the role that social pressure and guilt played as obstacles for workers to call in sick, or to take enough time to get well. One participant discussed how she was made to feel guilty by her employer for taking time off while her children were sick. She quoted her employer as saying, "When you want, you can go, and I'll never get a person who has children again, because the ones with children are really problematic, because they have to leave work to take care of their

[8] Notably, the Coalition for Domestic Workers Rights conducted a survey of 247 domestic workers in San Francisco. The responses from these workers about occupational health and survey illustrated that 63% of the domestic workers surveyed believed their jobs were dangerous; however, only 26% of participants reported receiving protective equipment to prevent occupational exposure or injuries. Of all the domestic workers surveyed, only 14% had received occupational health training. Source: Kappagoda M, Bhatia R, Farhang L, Sargent M. Tales of a City's Workers: A Profile of Jobs and Health in San Francisco. San Francisco Department of Public Health, Program on Health, Equity and Sustainability, June 2007. Available at: www.sfdph.org/phes.

children." Another participant said, "it's hard to claim it [sick days]….because sometimes you're grateful to have work, and sometimes, as my fellow worker said, you end up working harder for fear of losing the little bit you've got." Participants also agreed that often, "After being home sick for a day, people feel like they need to work extra hard the next day."

The restaurant industry was also described as particularly susceptible to pressure to be as productive as possible. For example, a participant described that retribution from co-workers was not uncommon if they perceived you as lagging on the job. For example, "they'll f**k up your orders. And they'll make it a little hard for you if you abuse them, they'll abuse you back in a way." The sentiment was also expressed as, "[you] don't want people to dislike you at your job." In contrast, another participant described how the pressure to not call in sick was rooted in the need to be perceived as "responsible." He described a story in which "one of the women I work with, she has kids and really bad allergies but she runs the whole office. She won't take off because she doesn't want to look like she's leaving [because] she has so many responsibilities." Regarding getting the flu, one participant talked about having the flu and "feeling like I should probably stay home…I know it's good for me to stay home like another day or two…but just knowing like you really would be looked down upon by management. They would use that against you."

Other Work-Related Conditions

Absence of sick days was not the only work-related condition that participants discussed. Among participants in the MUA group, there was a clear sense that they were being taken advantage of by their employers. As examples of such exploitation, participants pointed to the lack of health, sick days and vacation benefits; the piling on of work that was not agreed to; a lack of consistency in their work schedule and expected time commitment; and, continuous threats of being fired. Importantly, however, participants did not accept their work environments as normal or healthy. Participants routinely used the language of fairness, rights, and dignity in reflections of how they were treated, and how they should be treated.

> *"Is taking a day for your self really an abuse of the system?"*

> *"So I think that if I've been working for a person for two years I have the right to pay, a salary, if I get sick. Even if it's just one day, I have a right. Also [there are] the demands they make of us. We work harder and they don't pay us more, not what they should pay us."*

Interestingly, whereas participants acknowledged that some workers might take advantage of a sick days benefit, everyone agreed that that was not sufficient reason to deny the benefit to all workers. Furthermore, one participant stated, "Is taking a day for your self really an abuse of the system?" Another noted that employers routinely took advantage of the system as well. One story that elicited strong reaction from participants related to a San Francisco-based employer who, when the sick days benefit went into effect, rescinded a policy of giving five vacation days to workers and converting those into the sick days benefit. The participant said, "They took away all of our vacation and just gave us sick days." He described the employer's action further by saying, "The company had figured out this way…. this cool law had just passed [sick days benefit]…but we're going to like flip it and just take away everyone's vacation because there's no vacation law…that caused a lot of despair…..this

company had used a passing of a law that was good and had manipulated it and manipulated us with it."

In the situations described in the focus groups, it was clear that many factors, aside from having the paid sick days benefit, also compounded the difficulty of calling in sick. For example, participants discussed the role that language and immigration status played in this fear of job loss and calling in sick – as one participant stated "undocumented workers would never risk calling in sick." This sentiment in particular highlights the complex set of issues that workers must navigate before deciding when to take a sick day. When asked whether lack of sick days meant that participants did not seek out routine preventative care, a participant responded that, "well that's more because you couldn't afford to….if you weren't insured at your job…you couldn't really afford going and paying the whole coverage." This illustrated how a sick day benefit only went so far. Without the ability to access routine and affordable health care – sick days provided an opportunity for respite when ill, but not necessarily addressed preventative care and treatment needs. One participant summed up the relationship by saying, sick days and health insurance "go hand-in-hand."

CONCLUSION

Collectively, the stories and experiences of participants illustrated that the absence of paid sick days affected the health of participants via a number of different pathways. Fear of job loss and lost wages were categorically the most pervasive reasons that participants did not feel they could call in sick. Participants expressed that other forms of retaliation and penalization for taking sick time off was also common (e.g., receiving less working hours, being reprimanded, receiving a "strike"). As a result, participants shared experiences about going to work while ill, about elevated stress levels, and about family conflict. Participants described an inability to recover from illness (even when illness was job-related), or to support dependents in their recovery. Members of the YWU group described how they believed their work environment made them particularly susceptible to illness because of close working quarters, an overall atmosphere of "toughing it out," and pressure to not abandon co-workers.

While participants were working in San Francisco and had not yet received their sick day benefit, they had a number of ideas on how to advance the topic and educate workers about their rights. These included: requiring employers to list sick time on pay stubs, running an educational campaign on public transit, employers developing back-up plans in the event that workers called in sick, and requiring employers to discuss employee benefits with all new hires. One participant strongly noted, "The laws are there. The enforcement is always lacking. There needs to be some kind of employer accountability." Additionally, for the law to be effective, employer retaliation must be discouraged.

Research has identified many economic benefits to providing paid sick leave benefits to workers. Cost-benefit analyses reveal that, although employers must bear the initial financial burden of providing sick leave, the financial benefits outweigh the burden. Paid sick days benefits would increase productivity by reducing worker absenteeism, reduce costs of employee turnover and increase employers' ability to recruit and retain employees. What these focus groups also highlight is that lack of sick day benefits means that workers go to work while ill, take longer to

recover and have significant fears of job loss and stress related to lost wages. They also unequivocally illustrate that in many ways, workplace norms and policies have a strong influence on whether employees feel they can take a sick day.

Focus group participants clearly understood the paid sick days issue as a health-related issue, both through the direct impacts on health (e.g., longer recovery times, lack of full recovery) and through indirect impacts (e.g., loss of job or wages leading to hunger or loss of housing, domestic violence). Importantly, they also saw the policy as a human rights issue, a question of fairness, and a policy that would afford them basic dignity.

Appendix IV: Communicable Disease Control and Prevention Interview – Methods and Summary

INTRODUCTION

This narrative summarizes the findings of an interview of a group of disease control investigators and health workers ("investigators") from the Communicable Disease Control and Prevention (CDCP) program of the San Francisco Department of Public Health (SFDPH). The interview was conducted by SFDPH staff as part of a larger health impact assessment (HIA) of paid sick day legislation in California. The purpose of the interview was to gather qualitative information about investigators' work dealing with communicable diseases, particularly among workers in sensitive occupations, and the role paid sick days might play in supporting their work.

METHODS

Upon initial contact from SFDPH staff and an explanation of the HIA purpose, CDCP supervisors agreed to convene a group interview with their investigators. Two supervisors and three staff investigators participated in the 50-minute session. Participation in the interview was completely voluntary, and participants were told that names and identifying information would be kept confidential. Two staff took notes of the discussion on computers. The interview was conducted on June 25, 2008.

FINDINGS

Overview of the Work Restriction Process

The CDCP program is responsible for the control and prevention of communicable diseases in San Francisco by tracking reports of over 80 reportable diseases and conditions, investigating cases and contacts, and recommending public health actions to control the spread of disease. The CDCP program does not investigate cases of sexually transmitted diseases, tuberculosis, or HIV/AIDS, as these diseases are handled by other programs within SFDPH. CDCP investigators are informed of new cases of reportable diseases by laboratories, physicians, or persons who have contracted a disease ("patient"); reports are made telephone, fax, or letter.

According to California State law, if a person becomes infected with a certain type of communicable disease, and they work in a "sensitive occupation", they must be placed on an official work restriction. Diseases with official restrictions include amebiasis, salmonella infections, shigella infections and typhoid fever. Sensitive occupations include food handling, health care (if involved in direct care), and child care. Restrictions for patients in sensitive occupations with other diseases not listed separately in the regulations or during outbreaks are at the discretion of the Health Officer. For example, CDCP also restricts ill workers with E. Coli O157/H7, shiga toxin producing E. coli and hepatitis A.

If a patient is a worker in a "sensitive occupation or situation", then he/she is instructed in writing, via a "restriction letter," either not to report to work or to refrain from engaging in

certain work duties (depending on the illness and the patient's occupation) until he/she receives clearance from SFDPH to resume normal activities. The idea being that workers should refrain from engaging in work activities to limit the risk of disease transmission to others. SFDPH investigators also contact the patient's supervisor and inform him/her of the patient's work restriction. In an attempt to maintain the confidentiality of a patient's health status, investigators may avoid naming the specific disease the patients are infected with, if doing so does not increase the health threat and is not necessary in order to recommend interventions.

If the patient works in food service, a SFDPH environmental health inspector visits the patient's workplace to make sure the patient is adhering to the work restriction. In the case of health care workers, the investigators coordinate with the Infection Control Department of the health care facility. The patient and the patient's supervisor receive written notice when the patient has been cleared to resume his/her normal activities. Depending on the illness, "close contacts" to the patient (e.g., household members) may also be instructed not to report to work until cleared. If the patient is a child who attends child care or school, the child's parents are instructed not to send the child to child care or school until they receive clearance from SFDPH.

Reasons for Treatment-Seeking Behaviors

Investigators pointed out that while in some situations they may ask patients what led them to seek treatment, the question is not standard and data on treatment-seeking behaviors is not routinely collected.

However, here are their impressions of why people choose to seek treatment when they become ill. One investigator replied, "I think sometimes it's gotten so bad that they finally decide to go to the hospital." They may also notice that people around them, such as their family, their coworkers, or people who have dined with them at a restaurant, have become ill. Other investigators agreed, adding that most of the time, patients do not seek treatment until they have been sick for several days. One investigator added that patients who have health insurance tend to go to the hospital sooner than those who do not. The investigator also reported situations where patients put off seeking treatment because they did not have paid sick days; for example, he recalled one patient who suffered from diarrhea for two weeks before seeking treatment.

Another investigator commented that in the case of some parasitic infections, patients may not seek treatment because their symptoms diminish after a short while, leading them to think incorrectly that they no longer have an illness. Investigators also discussed the role that age may play in treatment-seeking behaviors. For example, parents tend to seek treatment for their young children sooner than they would for themselves, and elderly patients tend to seek treatment sooner than others.

Reactions to Having a Work Restriction

When asked how patients react to being placed on a work restriction, investigators responded that the reactions vary widely between people. One investigator commented that health care workers tend to react well because they understand the ramifications of continuing to work. Food handlers can be a little "more difficult." Parents sometimes get upset when they are

instructed to keep their children home from child care or school, because they have to take time off from work to stay home with their children.

One investigator commented that patients' reactions often depend on the benefits they have at their jobs. People often are very concerned about the loss of income they will experience from the work restriction. The investigators reported patients' saying, "I can't afford this" or crying on the phone. Another investigator commented that some patients are "totally cooperative—amazingly so," given the difficulties imposed on them by the restriction.

The investigators reported that supervisors are generally cooperative, since they do not want disease transmission to occur in their facilities. They are sometimes concerned if the patient is a "key" employee, such as a chef at a restaurant. Some supervisors have been very supportive, providing alternative duties or otherwise easing patients' concerns. An investigator commented, however, that in general, the consequences of the work restriction on the patient are "generally not [the supervisors'] concern."

Adherence to Work Restrictions and Barriers to Adherence

The investigators reported that because of improved enforcement procedures over the last few years, most patients comply with work restrictions, whether "willingly or not." They reported, for example, that when they contact a supervisor to check on adherence, it is "really unusual for the patient to be there." They commented that when patients and supervisors receive phone calls from SFDPH, that sometimes "sends an alarm" to them that the matter should be taken seriously. One investigator stated that business owners' concerns about liability and their reputation also encourage adherence. Since supervisors are notified of work restrictions in writing, they know that "there are ramifications to people not complying."

The investigators agreed that enforcement of restrictions is most difficult in the child care arena given that there are a large number of child care settings and they are not all licensed. Similarly, they felt the process for keeping ill children home from child care is less well regulated than restrictions for workers in sensitive occupations. They cited examples where parents who did not feel they could take time off from work to care for their children brought the children to other day care centers when they were instructed to keep the children home. Overall, the investigators' impression was that in the case of child care, procedures for avoiding transmission are not always "being followed properly."

The investigators also reported that immigration status is "a huge" barrier to cooperation with work restrictions. Patients' concerns can make them wary of providing personal information to investigators. Furthermore, employers may also be more likely to fire workers who are undocumented immigrants when they are placed on work restrictions. One investigator recalled an employer who said, "They were illegal. I don't want them working here." The investigators agreed that the provision of mandatory paid sick days may not help this problem.

The investigators also commented that another barrier is patients' concerns about confidentiality. Patients worry that their diagnosis will be divulged to other people, or that their confidentiality will otherwise be compromised.

When asked specifically about access to paid sick days and adherence to work restrictions, the investigators reported that they had encountered situations where lack of time off was a barrier to adherence. One investigator commented that this often happens when parents need to take time off to stay home with their children. Another investigator commented that in some cases patients have contracted the disease while they were on vacation, so when they return and are given a work restriction, they have already used up their time off.

Collectively, the investigators reported that they rarely see illnesses being transmitted through workplaces because of lack of adherence to a work restriction. They commented that this is partly because it is very difficult to verify the source of disease transmission. For example, they gave an example of a parasite that infected multiple people in a restaurant. Although the source of transmission could have been a worker in the restaurant, the disease could also have been transmitted through food items themselves. Similarly, the investigators reported situations where multiple children in the same day care center became ill with the same disease, but the source could not be verified.

Access to Paid Sick Days

The investigators were asked if they believed there was a relationship between access to paid sick days and patients' recovery time, preventable hospitalizations, disease transmission, adherence to work restrictions, or other aspects of their work.

The investigators answered that while it can be difficult to draw definitive conclusions, they generally believed having access to paid sick days could help. An investigator commented that they have had patients tell them, "I can't afford to miss work." Another investigator pointed out that having access to paid sick days would also benefit patients who do cooperate; as of now, these patients "are being punished for cooperating, at some level" because are not getting paid while they adhere to the work restriction. The investigator gave an example of one worker who cooperated, but was in such dire financial straits that the investigator searched for some administrative avenue through which the patient could receive funds while he was not able to work. Another investigator added that since most patients are cleared to return to work within eight days, they do not miss enough days to qualify for State disability insurance.

The investigators pointed out, however, that they lack quantitative data of a link between access to paid sick days and workplace disease transmission. An investigator commented that in order to establish this link, data would be needed that described patients' behavior only while they are infectious, which may not directly correspond to when they feel ill. Another investigator commented that there have been cases of transmission between family members, and that access to sick days would not necessarily prevent such cases.

CONCLUSION

Research has identified many economic benefits to providing paid sick day benefits to workers. Cost-benefit analyses reveal that, although employers must bear the initial financial burden of providing paid sick days, the financial benefits outweigh the burden. Paid sick days benefits

increase productivity by reducing worker absenteeism, reduce costs of employee turnover and increase employers' ability to recruit and retain employees.

The investigators' responses and stories illustrated several ways that the absence of paid sick days could affect the health of the workers they come into contact with in their work, as well as the health of the general population. Patients sometimes put off seeking medical help, therefore increasing health risks to themselves and the people around them, because they cannot afford the loss of income from missing work. The prospect of lost income and stigma concerns leads some workers to attempt to circumvent the work restriction system, such as by refusing to provide information about their occupations or places of work, or by moving ill children from one child care center to another. Access to paid sick days would alleviate the need for such practices, which undermine disease control and prevention efforts. Providing paid sick days to workers could also ensure that those who do cooperate with the work restriction process are not "being punished for cooperating" by losing much-needed income.