

# **A Health Impact Assessment of the Healthy Families Act of 2009**

**Massachusetts Addendum – A Health Impact Assessment of An Act  
Establishing Paid Sick Days; SB 688; HB 1815**

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## **BACKGROUND**

On June 11, 2009 researchers at Human Impact Partners and the San Francisco Department of Public Health released a Health Impact Assessment of the Healthy Families Act of 2009. The act is proposed federal legislation that would guarantee that workers have the right to earn paid sick days. The HIA report included a literature review on the links between health outcomes and paid sick days, national existing conditions data relevant to the policy (e.g., demographics of who currently does not earn paid sick days, communicable disease outbreaks, avoidable hospitalizations), and information from focus groups conducted with workers who do not earn paid sick days. The report also predicts the magnitude and direction of several health outcomes that would be likely to result if the act became law. The full report can be found at: [http://www.humanimpact.org/PSD/NationalPaidSickDaysHIA\\_report.pdf](http://www.humanimpact.org/PSD/NationalPaidSickDaysHIA_report.pdf).

In this addendum to the national report, we provide Massachusetts specific existing conditions data relevant to paid sick days legislation being considered at the state level. The literature review, data, and predictions in the national report are all relevant to the proposed Massachusetts legislation. The data provided in this addendum supplement the national data in an effort to support the specific context in Massachusetts.

## **I. INTRODUCTION**

In 2006, the commonwealth of Massachusetts became the first state to provide nearly universal health care by requiring all residents to obtain health coverage by July 1, 2007. Individuals who could afford private insurance would be penalized on their state income taxes if they did not purchase it; government subsidies to private insurance plans would allow more of the working poor to buy insurance and expand the number of children who were eligible for free coverage; and businesses with more than 10 workers that did not provide insurance would be assessed a fee of up to \$295 per employee per year. The overall uninsured rate for Massachusetts decreased to 2.6% and the number of people without coverage was 167,000 in 2008 (MDHCFP 2009). However, the cost of the program has been much greater than anticipated and cost containment is being investigated.

In this appendix, we consider the health impacts of a paid sick days bill currently pending in the Massachusetts state legislature; An Act Establishing Paid Sick Days SB 688 and HB 1815. Given virtually universal health care coverage in Massachusetts, in addition to our analysis of the general impacts of paid sick days on health, we focus on the health impacts of paid sick days among working adults with health insurance. While paid sick days may help all workers access health care, the benefits of paid sick days may be primarily experienced by those who already have health insurance as health insurance is a fundamentally enabling factor in accessing health care. Working adults who have insurance still need time off without loss of income to seek medical attention for themselves, recover from illness, or provide care for their family members who are ill. By allowing working adults with health insurance to take such time off, paid sick days may be an important factor that further facilitates their access to care and may be a health care cost containment strategy. For those without health insurance, paid sick days may enable taking leave, but would not aid in the receipt of health care services (Ward et al. 2008).

Over 40% of the Massachusetts workforce would be directly affected by the legislation being considered. Approximately 693,000 workers in the state currently have no paid leave at all and approximately 1,404,000 private-sector workers in the state lack paid sick days specifically. (Lovell 2009).

This appendix is composed of six sections. In section II, we summarize data regarding avoidable hospitalizations and emergency room visits in Massachusetts. In section III, we present original findings regarding utilization of health care services based on our analysis of National Health Interview Survey (NHIS) data. The impact of paid sick days on communicable disease transmission – both foodborne illness and influenza – is presented in section IV. In section V, the effect of paid sick days on school-age dependents is discussed briefly. Results of focus group discussions in Massachusetts are described in section VI and section VII presents results from an informal survey of workers regarding paid sick days. We summarize our findings in section VIII of this report.

## II. AVOIDABLE HOSPITALIZATIONS AND EMERGENCY ROOM VISITS

In Section 4.5 of our national HIA report on the potential health effects of paid sick days, we describe how the lack of paid sick days may create a barrier to the utilization of primary and preventive care, and could therefore also increase the utilization of more expensive therapeutic and hospital care. Many hospital admissions for common chronic diseases such as asthma, hypertension, and diabetes are preventable with timely and effective outpatient and primary care (Parker 2005).

Although Massachusetts implemented nearly universal health care in 2007, data from the Boston Public Health Commission (BPHC 2009) shows that ER visits have not changed significantly in the city between 2005 and 2008. In 2005, there were 156,848 ER visits by adults aged 18 to 64. The numbers of ER visits in 2006, 2007 and 2008 by 18 to 64 year olds were 159,818, 149,083, and 164,044, respectively. ER visits by 18 to 64 year olds in Boston for either diabetes or hypertension – preventable ER visits – also stayed fairly consistent through this period (753 in 2005, 729 in 2006, 711 in 2007 and 832 in 2008). Dr. JudyAnn Bigby, the state’s Secretary of Health and Human Services, noted that people’s ability to take time off from work with pay impacts their usage of primary care and, therefore, visits to the ER (Lazar 2008).

*“I only go to the doctor in an emergency. That’s the only time I can go to a doctor.” – Focus Group participant without paid sick days*

Below we provide data regarding avoidable hospitalizations and emergency room visits in Massachusetts and the costs of those visits in order to describe the magnitude of the problem. Even a small percentage reduction in these avoidable events as a result of a paid sick days policy could lead to a large number of hospitalizations and ER visits being avoided and substantial cost savings.

The Massachusetts Division of Health Care Finance and Policy studied preventable hospitalizations and emergency room visits during Fiscal Years 2002 and 2003 in Massachusetts (MDHCFP 2005). In their report, they point out that “Having health insurance does not equate to access to, or appropriate use of, high quality health care.” In 2002 and 2003, there were a total of 224,306 preventable hospitalizations (14.4% of total hospitalizations) and 631,061 preventable ER visits (14.4% of total ER visits). These numbers translate to 17.54 preventable hospitalizations per 1000 people in the state and 49.35 preventable ER visits per 1000 people. Table 1 details the rates for specific conditions. A different report by the state, that uses different definitions and data sources, calculates that over 21% of all outpatient ER visits in the 2005 fiscal year were categorized as non-emergent; an additional 26% were emergent but could have been treated in a primary care setting or avoided with better primary care (MDHCFP 2007), suggesting that 47% of all ER visits would have been prevented with better access to primary care.

*“As a result of the benefit, I can get an appointment at the doctor sooner. For example, if I call out sick during the day, then I can go to an appointment between 9-5 pm. However, if I was to work and schedule an appointment after 5 pm, then it is almost impossible to obtain an appointment. My alternative option is to go to the emergency room and wait for a treatment that could be resolved at a regular clinic.” – Focus Group participant with paid sick days*

In a 2008 survey, 14% of adults in

Massachusetts said that they used an emergency room at least once in the past year for conditions they believed could have been treated by their doctors (Lazar 2008). Lower income respondents – those that frequently do not have paid sick days – were about twice as likely to have done so than higher income respondents, according to the survey.

These avoidable events come at great financial cost. In 2007 in Massachusetts, the average charge for an asthma-related hospitalization was \$9665 and for an asthma-related ER visit was \$1,104. Table 2 shows average charges for hospitalizations and ER visits for the conditions for which hospitalizations and ER visits are often considered avoidable.

TABLE 1. PREVENTABLE HOSPITALIZATION ADMISSION RATES AND EMERGENCY ROOM VISITS PER 1,000 PERSONS IN MASSACHUSETTS (2002 & 2003)		
Condition	Preventable Hospitalizations	Preventable ER Visits
Bacterial pneumonia	3.70	2.53
Congestive heart failure	3.43	0.45
Chronic obstructive pulmonary disease	1.99	1.08
Dehydration	1.66	1.53
Kidney/urinary infection	1.47	4.92
Asthma	1.36	6.10
Cellulitis	1.16	6.00
Diabetes	0.93	1.40
Convulsions	0.60	2.25
Gastroenteritis	0.33	3.37
All other conditions	0.90	19.73
Total preventable events	17.54	49.35
Total events	121.59	342.13

Source: Massachusetts Division of Health Care Finance and Policy (MDHCFP) 2005. Preventable Hospitalizations in Massachusetts: Update for FY02 and FY03. Commonwealth of Massachusetts May.

TABLE 2. CHARGES FOR HOSPITALIZATIONS AND EMERGENCY ROOM VISITS IN MASSACHUSETTS (2007)		
Condition	Hospitalization Charges	ER Charges
Bacterial pneumonia	\$14,237	\$1,475
Congestive heart failure	\$21,069	\$2,211
Chronic obstructive pulmonary disease	\$13,378	\$1,068
Dehydration	\$9,098	\$1,788
Kidney/urinary infection	\$11,700	\$1,398
Asthma	\$9,665	\$1,104
Cellulitis	\$10,673	\$891
Diabetes	\$13,412	\$1,343
Convulsions	\$13,065	\$1,437
Gastroenteritis	\$10,168	\$1,463

Source: Massachusetts Department of Public Health. (2009).

### **III. EFFECT OF PAID SICK DAYS ON HEALTH CARE SERVICES UTILIZATION BY THOSE WITH HEALTH INSURANCE: AN ANALYSIS OF 2007 NHIS DATA**

In investigating the effects of paid sick days on accessing health care services, we focus on three outcomes: 1) *medical visits* with health care practitioners by working adults; 2) *emergency room use* among working adults; and 3) *delayed medical care for family*. In doing so, our goal is to elucidate whether paid sick days help increase access to timely and adequate health care for working adults who have health insurance and their family members.

Past research has consistently demonstrated that health insurance coverage increases health services utilization and improves health. The insured have been found to receive more ambulatory and preventive care (e.g., Buchmueller et al. 2005; Weissman and Epstein 1993), to have better care for chronic conditions and fewer unmet health needs (e.g., Hoffman and Paradise 2008; IOM 2002), and to be less severely ill when diagnosed with diseases and have better health outcomes and lower mortality rates (e.g., Hadley 2003). Other factors that may also affect the access to health care, especially by those who have health insurance, have received less attention. Aside from social determinants known to affect health access and behaviors—such as race, income, and education—other factors identified as potential predictors of health care access are those that concern the health care system, such as a regular place for care (e.g., Shi and Stevens 2005; Sambamoorthi and McAlpine 2003) and cost of care (e.g., Sabatino et al. 2006; Callahan and Cooper 2006). Little research has been reported on the enabling factors that are *outside* the health care system but related to one's life in an important manner (such as those related to one's job) which may also affect access to timely and adequate health care use. In examining whether paid sick days serves as such a facilitating factor, our analysis results presented in this appendix shed some light in this little explored area.

While also an indicator of health care services use, emergency room (ER) visits may have a different implication altogether from that of primary care use. Research has found that many visits to emergency rooms are for conditions that are not life threatening or otherwise do not require immediate medical attention (Cunningham and May 2003; McCraig 1994). As described in section II, there are many avoidable emergency room visits in Massachusetts. To the extent that ER visits are associated with conditions that are non-emergent or treatable in primary care settings, a large number of ER use visits may be an indication of limited accessibility to timely primary care (Billings et al. 2000). Therefore, an inverse association between paid sick days and ER use may imply increased access to timely health care that paid sick days may help facilitate to prevent avoidable and more costly hospital use.

#### ***1. Methods***

##### *Sample and Measures*

A detailed description of the methodology, including the sample and measures used in analyzing the NHIS data, is provided in Appendix I of our national health impact assessment report on the potential health effects of paid sick days, A Health Impact Assessment of the Healthy Families Act of 2009. To access the report, please visit: [www.humanimpact.org/PSD](http://www.humanimpact.org/PSD).

In brief, given the virtually universal health insurance coverage provided in Massachusetts, we generated a sample from the NHIS data that reflects the profile of working adults in Massachusetts—i.e., working adults in the U.S. with health insurance. We thus included 10,217 working adults who had health insurance coverage in the analyses reported in this appendix.

All three outcomes—medical visits and emergency room use among working adults, and delayed medical care for family (that was needed but not received)—were binary variables indicating whether visits to medical practitioners or emergency rooms were made in the past 12 months. Other variables used in this analysis were age, gender, race/ethnicity, educational attainment, household income, self-rated health status, and chronic health conditions. (See the national HIA for an extensive description of how these variables were constructed.) In addition, we included another potential factor which recent research has found to be an important factor related to health services use—a binary variable indicating whether the working adult had a regular place for care when they were sick.

#### *Analysis*

We conducted a multivariate logistic regression analysis for each of these three outcomes. Availability of paid sick days was the predictor of interest in these analyses. As was the case in the national HIA, other factors identified in the literature that might confound or modify the effects of paid sick days were also included in the multivariate models.

In the ER visits model, we included age, gender, race/ethnicity, household income, educational attainment, self-rated health status, chronic health conditions, and having a regular place for care when sick, in addition to paid sick days. In the medical visits model, we included the same variables, with the exception of a regular place for care when sick, which we excluded. This is because while other covariates were implied predictors of medical visits, a regular place of care does not have a clear temporal relationship with medical visits (that is to say, more medical visits may create a regular place of care) and thus could not be treated as a potential predictor. In the delayed family care model, we included as covariates mainly social determinants of health—e.g., gender, age, race/ethnicity, educational attainment, and household income level of the working adults. We thus excluded self-reported health status, chronic health conditions, and a regular place for care when sick, which we deemed may be important factors for one's own use of health services but may not necessarily have bearings on family members' health care use.

Given that NHIS samples are nationally representative, the results of our analysis can be generalized to all working adults living in the United States. To further ensure that the results of multivariate analyses are not confounded by region, we ran two sets of logistic regression analyses—i.e., a set of bivariate logistic regressions, each including paid sick days and an outcome, and another set of logistic regressions additionally including in each of these models three dummy variables for region (one for the Midwest, one for the South, and one for the West, with Northeast as baseline). We then compared the regression coefficients of paid sick days for each outcome between the two analyses to evaluate if the inclusion of the dummy variables for region significantly changed them. All of the coefficients of paid sick days changed little for any of the three outcomes when the region variables were included. Therefore, we determined that it was not necessary to include the region variables in our multivariate models. This means that the results of the multivariate analyses presented below are not confounded by region and thus



generalizable to working adults in all regions of the United States. These results are therefore relevant to those in the Northeast.

## 2. Results

The proportions of working adults who had paid sick days in the United States and the Northeast are compared in Table 3. Overall, the proportion of working adults who had paid sick days was higher (64.4%) in the Northeast than in the U.S. (60.3%). As a result, the proportion of working adults in almost every demographic or health category with paid sick days was higher in the Northeast than in the country. Some categories of workers – Hispanics, non-Hispanic blacks, people who were widowed, divorced or never married, those who did not graduate from high school, and those with chronic bronchitis or hypertension – had even higher access to paid sick days than would be expected given the higher levels of paid sick days generally. Other groups – Asians, higher income workers, those who graduated college or had an advanced degree, those without health insurance, and those with asthma – had less access than would be expected.

Although the average age of working adults who had paid sick days in the Northeast was similar to the U.S. average (42.6 vs. 42.5), a slightly higher proportion of working adults aged 50 or younger had paid sick days in the Northeast than that of older workers, whereas the opposite was the case nationally. As was the case in the U.S., a lower proportion of Hispanics had paid sick days than those of all the other races in the Northeast. Interestingly, the proportion of blacks who had paid sick days was higher than any other races in the Northeast. As was the case in the U.S., the proportions of working adults with paid sick days were higher among those with better educations and with higher incomes. Also as was the case nationally, those who reported better health status were likely to have paid sick days. Both in the U.S. and in the Northeast, working adults with health insurance were much more likely to have paid sick days than those who did not have health insurance. There was no consistent pattern between having chronic health conditions and access to paid sick days, which was also the case nationally.

TABLE 3. PROPORTIONS OF WORKING ADULTS WHO HAD PAID SICK DAYS BY POPULATION CHARACTERISTICS, U.S. & NORTHEAST		
	U.S.	Northeast
	60.3%	64.4%
<b>Gender (%)</b>		
Male	57.9%	61.5%
Female	63.1%	67.7%
<b>Age: Mean (95% CI)</b>	42.6 (42.2-42.8)	42.5 ( 42.2-42.8)
<b>Age Group (%)</b>		
50 or younger	59.8%	64.5%
Older than 50	61.7%	64.2%
<b>Race/Ethnicity (%)</b>		
Hispanic	46.8%	52.9%
Non-Hispanic White	62.4%	65.1%
Non-Hispanic Black	62.3%	72.1%

Asian	67.4%	66.0%
Other	49.4%	63.1%
<b>Marital Status (%)</b>		
Married/Partnered	60.4%	62.8%
Widowed	54.4%	62.6%
Divorced or Separated	60.2%	69.9%
Never Married	60.4%	66.9%
<b>Educational Achievement (%)</b>		
Did not graduate HS	33.2%	45.8%
HS graduate/GED	51.3%	53.5%
Some college	61.3%	66.7%
College graduate	73.8%	73.9%
Advanced degree	75.6%	75.0%
<b>Household Income (%)</b>		
\$0 - \$34,999	39.0%	42.6%
\$35,000 - \$74,999	59.2%	60.9%
\$75,000 - \$99,000	70.7%	69.1%
\$100,000 and over	73.1%	73.8%
<b>Any Health Insurance (%)</b>		
Yes	68.1%	69.9%
No	18.4%	17.1%
<b>Self Rated Health Status (%)</b>		
Excellent / Good	61.2%	64.9%
Fair / Poor	48.3%	52.8%
<b>Asthma (%)</b>		
Yes	60.0%	58.9%
No	60.4%	65.1%
<b>Diabetes (%)</b>		
Yes	61.1%	65.9%
No	60.3%	64.4%
<b>Coronary Heart Disease (%)</b>		
Yes	65.4%	67.2%
No	60.3%	64.4%
<b>Chronic Bronchitis (%)</b>		
Yes	56.6%	65.5%
No	60.4%	64.4%
<b>Hypertension (%)</b>		
Yes	60.2%	66.0%
No	60.4%	64.1%
<b>Any of Above 5 Chronic Conditions (%)</b>		
Yes	60.3%	63.3%
No	60.4%	64.9%

*Medical Visits*

TABLE 4. RESULTS OF MULTIVARIATE ANALYSIS: PREDICTORS OF MEDICAL VISITS FOR WORKING ADULTS WITH HEALTH INSURANCE COVERAGE			
Predictors	Odds Ratio	95% CI	p-value
Paid sick days	1.123	0.983-1.284	p > 0.05
Male	0.321	0.284-0.363	p < .001
Age over 50	1.372	1.181-1.593	p < .001
Hispanic	0.685	0.563-0.833	p < .001
Black	0.997	0.822-1.209	p > 0.05
Asian	0.594	0.456-0.775	p < .001
College education	1.364	1.189-1.565	p < .001
High household income (\$75,000 or higher)	1.669	1.443-1.928	p < .001
Self-rated health status	0.480	0.350-0.657	p < .001
Chronic condition	2.365	2.063-2.712	p < .001

As Table 4 shows, gender, age, being Hispanic and Asian (compared to whites), college education, household income, and having a chronic condition were significant predictors of medical visits for working adults with health insurance coverage. That is to say, among those who had health insurance: males (OR=0.321) were far less likely than females to have had at least one medical visit in the past 12 months; those who were older than 50 (OR=1.372) were more likely to have medical visits than those who were younger; Hispanics (0.685) and Asians (0.594) were less likely to have medical visits than whites; those who had received college degrees or more advanced education (OR=1.364) were more likely to have medical visits than those who did not; those who had annual household incomes of \$75,000 or higher (OR=1.669) were more likely to have medical visits than those who had earned less. Not surprisingly, those with poor health indicated by self-rated health status (OR=0.480) and the presence of chronic conditions (OR=2.365) were more likely to have visited medical practitioners. However, paid sick days was not significantly associated with medical visits, suggesting that among those who had insurance, paid sick days did not further increase primary care service utilization.

This result stands in contrast to our findings regarding all working adults (i.e., those with and without health insurance), reported in the national paid sick days HIA, where we found that paid sick days were significant in predicting medical visits. The current finding suggests that inconsistent with what we implicitly hypothesized, paid sick days are not likely to significantly increase the odds of having medical visits for working adults who have health insurance. This may be because given that the majority (68%) of working adults who had health insurance also had paid sick days—in contrast to a much smaller proportion (18%) of those with paid sick days among those who did not have health insurance—a smaller variability in medical visits is explained by paid sick days when only those who have health insurance are subset. This may also be due to the ambiguity inherent in the construct we used to capture medical visits, which we address in the discussion section below.

TABLE 5. RESULTS OF MULTIVARIATE ANALYSIS: PREDICTORS OF EMERGENCY ROOM VISITS FOR WORKING ADULTS WITH HEALTH INSURANCE COVERAGE			
Predictors	Odds Ratio	95% CI	p-value
Paid sick days	0.871	0.760-0.999	p < 0.05
Male	0.830	0.733-0.939	p < .01
Age over 50	0.737	0.634-0.857	p < .001
Hispanic	0.882	0.709-1.097	p > 0.05
Black	1.269	1.058-1.523	p < 0.05
Asian	0.532	0.368-0.771	p < .01
College education	1.019	0.876-1.186	p > 0.05
High household income (\$75,000 or higher )	0.839	0.724-0.972	p < 0.05
Self-rated health status	0.410	0.324-0.517	p < .001
Chronic condition	1.557	1.367-1.775	p < .001
Regular place for medical care	1.246	0.951-1.632	p > 0.05

Results of our multivariate analysis with emergency room visits as the outcome are presented in Table 5. Notably, access to paid sick days is a significant protective factor from emergency room visits. Other significant predictors of emergency room visits are: gender (with males being less likely to have visited emergency rooms in the past 12 months; OR=0.830), age (with those older than 50 being less likely to have visited emergency rooms than those who are younger; OR =0.737), being black and Asian (with the former being more likely to have visited emergency rooms than whites and with the latter being less likely to), having high household income (with those who earned household income of \$75,000 or higher being less likely to visit emergency rooms; OR=0.839), self-rated health status (with those who rated their health as good, very good, and excellent being much less likely to have visited emergency rooms than those with poorer health; OR=0.410), and chronic conditions (with those who have at least one of the five common chronic conditions were more likely to have visited emergency rooms; OR=1.557). Educational level was not significantly associated with emergency room visits. Interestingly, having a regular place for care was not significantly associated with emergency room visits.

TABLE 6. RESULTS OF MULTIVARIATE ANALYSIS: PREDICTORS OF DELAYED MEDICAL CARE FOR FAMILY OF WORKING ADULTS WITH HEALTH INSURANCE COVERAGE			
Predictors	Odds Ratio	95% CI	p-value
Paid sick days	0.723	0.607-0.862	p < .001
Male	0.871	0.751-1.011	p > 0.05
Age over 50	0.858	0.720-1.023	p > 0.05
Hispanic	0.838	0.656-1.071	p > 0.05
Black	0.593	0.469-0.748	p < 0.05
Asian	0.402	0.258-0.626	p < .01
College education	1.061	0.888-1.269	p > 0.05
High household income (\$75,000 or higher )	0.466	0.381-0.569	p < 0.05

As findings presented in Table 6 indicate, paid sick days was a significant predictor of delayed medical care for family members, with those who had paid sick days less likely to have family members whose needed medical care were delayed or not received (OR=0.723). Blacks (OR=0.593) and Asians (0.402) were less likely than whites to have family members whose medical care were delayed or not received. Those with household incomes of \$75,000 or higher were less likely to have family members with delayed or no medical care (OR=0.466). However, educational level was not significantly associated with delayed family care. Gender, age, and being Hispanic were unrelated to delayed family care.

The finding that having paid sick days is associated with less delayed medical care for family members is consistent with its association with fewer ER visits.

### ***3. Discussion***

In our multivariate analyses, we found that while access to paid sick days was not a significant predictor of *medical visits* for working adults with health insurance, it was a significant protective factor from *ER visits* and from *delayed family care* for working adults with health insurance.

The insignificant association between medical visits and paid sick days may stem from the ambiguity inherent in the construct, *medical visits*. That is to say, while *medical visits* with practitioners may constitute an important indicator of health care access, it may also suggest the health conditions of those who have them (i.e. those who are sick may simply be more likely to see medical practitioners), which may particularly be the case for working adults with health insurance for whom the largest barrier to access to health care has been removed. NHIS did not collect data on the circumstances under which medical visits were made and thus does not allow us to tease out the effects of paid sick days on reducing other barriers working adults might face in accessing primary care, which may have greater policy implications with regard to paid sick days.

Our findings regarding emergency room visits and delayed care clearly demonstrate the benefits of paid sick days for families of working adults. Although little research has reported on the benefits of paid sick days on the family's health or health care access, there have been studies that reported on the benefits of paid family leave. For example, Chung and colleagues (2007) found that parents with paid leave benefits had 2.8 times greater odds than other parents of taking time off work for their children, which implies that the former are less likely than the latter to have needed medical care delayed for their families. A more recent study (Schuster et al. 2009) also found positive health effects of paid leave on children with special health care needs, both physical and emotional, and on their working parents. Our findings are in line with these findings, pointing to the importance of family- and worker-friendly social policy—such as paid sick days bills—in promoting health of workers and their families.

Also important is our finding that the reduced use of emergency rooms is significantly associated with the provision of paid sick days. The extensive use of emergency rooms for non-urgent conditions has been a major concern. Among others, ER visit charges are much higher than visits to office-based practitioners (Baker and Baker 1994), reflecting more intensive use of staff and equipment and higher price markups for inpatient care (Carey 1994). Shifting much of the non-urgent care provided in hospital ERs to other outpatient settings could result in substantial

cost savings to the health care system (Cunningham et al. 1995). Our findings suggest that paid sick days may contribute to it.

A typical scenario involving ER use for non-urgent care may conjure up images of persons without health insurance who use hospital ERs as their regular source of primary care (Baker et al 1994), at times for non-urgent, non-emergent conditions. While it may very well be the case that uninsured patients use the ER due to the lack of primary care access (Newton et al. 2008), research has also found that uninsured individuals are no more likely to have ER visits than insured individuals (Weber et al. 2005; Irvin et al. 2003). In a way, reducing healthcare costs through reduced avoidable hospital use may be more critical for a system that provides universal health coverage than one that does not and thus limit access to health care. A healthcare system with universal coverage is invaluable, but the high costs of Massachusetts' health care system that may undermine the gains of the system have been also noted (e.g., Sack 2009). Reducing health care costs by reducing ER visits may thus be imperative to maintain a healthy and viable healthcare system that provides universal coverage long term. Our findings suggest that paid sick days may be one approach to helping the state of MA achieve its goal of reducing high healthcare costs associated with ER visits.

NHIS did not provide data that would allow us to elucidate how this might occur. Perhaps it is the fast recovery from illness paid sick days may facilitate. Or it may be the reduced level of stress experienced by working adults with paid sick days, knowing that they are able to take time off when they or their family members are sick, which lead to their better health. Or perhaps it is the increased access to primary care paid sick days allow, which the limited data of NHIS may not capture. The extent to which ER visits can be reduced may depend on improving the delivery and accessibility of outpatient care, the latter of which may be improved upon by the provision of paid sick days. Future research could examine the mechanisms by which paid sick time or family leave improve health and reduce costly emergent care.

#### **IV. EFFECT OF PAID SICK DAYS ON COMMUNICABLE DISEASE TRANSMISSION IN COMMUNITY SETTINGS**

##### *Foodborne Illness*

In section 4.7 of our national HIA report on the potential health effects of paid sick days, we discussed how paid sick days may help reduce the transmission of communicable disease, such as influenza, foodborne diseases, and other infectious diseases in healthcare and childcare facilities, restaurants, and other institutional and community settings. In this section, we focus on how paid sick days may help reduce the transmission of foodborne diseases in Massachusetts, using data provided by the Center for Disease Control and Prevention (CDC).

During the five-year period of 2003-2007, 55 outbreaks and 1,929 outbreak-related diseases in Massachusetts were reported to the CDC. The majority of those cases—35 foodborne outbreaks and 1,182 outbreak-related illnesses—involved food prepared in institutional or workplace settings including schools, day care centers, nursing homes, restaurants or delis, workplace cafeterias, grocery stores, hospitals, and/or jails. The contributing factors of the vast majority (about 80%) of the community-based outbreaks and outbreak-related cases are unknown. However, ‘food handling by an infected person or carrier of pathogens was implicated in at least 3 of 7 outbreaks with confirmed contributing factors; ‘bare-handed contact with food by handler/worker/preparer’ was listed as a contributing factor of two outbreaks with known contributing factors. Although it was unknown whether the workers were infected when preparing the food in the latter cases, many of foodborne diseases in Massachusetts may have been prevented if the sick workers had been able to stay home with pay when sick.

Between 2003 and 2008, there were 19 gastrointestinal illness outbreaks in food service establishments in Boston and 15 such outbreaks in long term care facilities in Boston (BPHC 2009). According to the Institute for Women’s Policy Research, 37 nursing homes in Massachusetts reported norovirus outbreaks each year (Lovell 2009).

Most confirmed etiologies of outbreak-related foodborne disease cases in Massachusetts included salmonella, norovirus, escherichia coli, and hepatitis A. It has been documented that many of foodborne outbreaks caused by these pathogens in the United States may be linked to ill food service workers. Between 48% and 93% of all outbreaks involving norovirus—which is responsible for 50% of all foodborne illnesses in the U.S (Widdowson 2005)—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 also found that in many cases the infected food handler either did not seek medical care or delayed getting medical care (Fiore 2004). At least 60 taxi drivers at Logan Airport are believed to have been infected by a food worker with Hepatitis A in 2004 (Allison 2007).

Coinciding with the 1999 Federal Food Code, Massachusetts State Sanitary Code 105 CMR 590.00 requires that an employee diagnosed with an infectious agent transmissible through food should be excluded from a food establishment and that an employee suffering from a symptom

that may have been caused by such an agent should be restricted from working with exposed food, clean equipment, utensils, linens, and unwrapped single-service and single-use articles in a food establishment. Such symptoms include diarrhea, vomiting, jaundice, fever, sore throat with fever, and any cuts or open wounds on exposed skin (MADPH 2000).

Public health officials rely on workers to recognize the illness and their employers to self-enforce requirements that protect the public. Unfortunately, however, 85% of workers in the food service industry do not have access to paid sick days (Lovell 2008). This means that many food service workers face barriers in accessing treatment and diagnosis for infectious diseases and have disincentives to taking time off when ill. Such delay in diagnosis and treatment carries 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. Paid sick days that allow sick employees to rest at home or to seek medical attention with no wage loss may very well facilitate precautionary measures to promote public health.

*“Lack of sick days can cause my work place to look like a disease center. If one person gets sick, then everyone will have the equal opportunity to become sick. It can be an ugly scene.” – Focus Group participant without paid sick days*

### *Influenza*

In section 4.7 of our national HIA report on the potential health effects of paid sick days, we discussed the impact of paid sick days on seasonal and pandemic influenza. Some of our findings include:

- 37% of seasonal influenza transmission occurs in schools and workplaces, and 33% in other community settings (Ferguson 2006);
- A sick worker who is in the workplace while contagious is likely to infect 1.8 of every 10 co-workers (Lovell 2005);
- Staying at home when infected may reduce the number of people impacted by pandemic influenza by 15%–34% (Ferguson 2006; Germann 2006; Glass 2006; Wu 2006);
- Between 4 and 5 out of every 10 people said that they would lose pay and have money problems if asked to stay home for 7 to 10 days during a pandemic; 25% of people said they would have “serious financial problems” as a result (Blendon 2006; Blendon 2009);
- Compliance with social distancing measures during pandemic flu could increase by 29% among workers currently without paid sick days, if they were given the benefit.

*“I work at a nursing home. You would think they would want us to get a flu shot but they won’t pay half day to do that.” – Focus Group participant without paid sick days*



Fourteen influenza outbreaks were reported between 2003 and 2008 at long term care facilities in Boston (BPHC 2009). During the Spring 2009 flu season in Boston, health providers in low-income communities were seeing higher numbers of Influenza A - H1N1 cases. Rates in minority communities were very high as well: African Americans are about 25% of Boston's population, but were 37% of the cases; Hispanics are 14% of the population, but were 33% of the cases. Minorities were twice as likely to be hospitalized for swine flu. According to Dr. Anita Barry of the Boston Public Health Commission, this is at least in part due to a lack of being able to take time off from work to care for sick children: "For some parents in lower-wage jobs, if they don't show up at work, they don't get paid, and people may already be on the economic margins. So parents were desperate to get some of these children back in school." (Knox 2009)

*"For some parents in lower-wage jobs, if they don't show up at work, they don't get paid, and people may already be on the economic margins. So parents were desperate to get some of these children back in school." Dr. Anita Barry of the Boston Public Health Commission on why the number of cases of Influenza A – H1N1 was higher in low-income neighborhoods in Boston and among minorities.*

## V. PAID SICK DAYS AND CARE FOR SCHOOL-AGE DEPENDENTS

During the 2007-2008 school year, the average number of annual absences from school for children in Massachusetts was 9.2 days (MDESE 2008). Specific reasons for absences are not recorded by schools and this figure most likely includes a variety of reasons for absences, including illness. As revealed in our focus groups (see below), parents without paid sick days that can be used to care for dependents struggle to care for their children when they miss school or must send their children to school sick.

There is a high prevalence of asthma among children in the state, and asthma is likely the cause of many school absences. For example, approximately 10.5% of children ages 0 to 17 had asthma in 2007 (BRFSS 2007). Rates are higher for school-age children (11.6% for 5 to 11 year olds; 13.1% for 12 to 17 year olds) and vary by race/ethnicity (11.4% for non-whites vs. 10.2% for whites; 14.7% for Hispanics vs 10.1% for non-Hispanics) and family income (16.4% for children in families earning less than \$75K vs. 6.4% in families earning \$75K or more) (BRFSS 2007). In the 2007-2008 school year in Massachusetts, the most common physical/developmental condition reported to school nurses was asthma (105.8 per 1,000 enrolled students) and asthma medications were the most frequent medicine disbursed by school nurses (33.4 prescriptions per 1,000 enrolled students) (MDPH 2009). Asthma-related avoidable hospitalization and emergency room use data and costs are given above, in section II and illustrate that better management of asthma would improve health and save money.

Nation-wide, 40% of mothers of children with asthma do not have paid sick days (Heymann 1996).

*"I have small children at home and I can't tell them, 'Sorry, you can't get sick today because I can't take care of you.' Sometimes you send them to school, knowing they don't feel well because you can't stay home to care for them. But the school calls you, 'Come and pick them up.'"* – Focus Group participant without paid sick days

## VI. PAID SICK DAYS FOCUS GROUPS – METHODS AND FINDINGS

### *Introduction*

This narrative summarizes the findings of eight focus groups conducted in Massachusetts on paid sick days. Three focus groups were organized by Greater Boston Legal Services (GBLS) and conducted by researchers from the Center for Social Policy of the McCormack Graduate School of Policy Studies at the University of Massachusetts Boston (Center for Social Policy). The remaining five focus groups were conducted as part of the city of Boston's Ambassador Program. 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.

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*

The five focus groups conducted through Boston's Ambassador Program took place in May and June of 2009. The focus groups were organized by ethnic group, including participants from:

- Cape Verde (9 participants)
- China (6 participants)
- Haiti (10 participants)
- Vietnam (10 participants)
- Cuba, Dominican Republic, El Salvador, Honduras, Peru, and Puerto Rico (10 participants)

Each of these focus groups was conducted by an ambassador from the Ambassadors Program from the ethnic group of the participants and was conducted in the language of the participants or in a mix of English and the language of the participants. Notes were taken by the facilitator with permission of the participants and were provided to Human Impact Partners staff for analysis.

The ambassadors, who are well known in their community, recruited the participants. Participants worked either part-time or full-time in a variety of industries including, health care, landscaping, security, food service, retail, banking and manufacturing. A majority of participants received paid sick day benefits.

The first focus group conducted by the Center for Social Policy researchers took place on September 10, 2009 in Boston. The second and third were conducted on September 16, 2009 in Lawrence and in New Bedford. The focus group in Boston had three participants recruited through an ad posted by GBLS on Craigslist. Only one of these participants received paid sick days, and he only received the benefit at one of his two jobs. The Lawrence focus group was conducted in Spanish and had eight participants, all of whom worked in a factory and did not receive paid sick days. The New Bedford focus group had eight participants as well. All

participants in the New Bedford focus group were members of SEIU Local 1199, were personal care attendants, and did not receive paid sick days in that capacity.

These Center for Social Policy focus groups were approximately 90 minutes in length. The focus groups were recorded, with permission of the participants, and later transcribed, with simultaneous translation/transcription for the focus group conducted in Spanish. Transcriptions were made available to Human Impact Partners staff for analysis.

Participation in all groups was completely voluntary, and participants were told that names and identifying information would be kept confidential. Each participant in the Center for Social Policy focus groups received \$15 and light snacks as compensation, while participants in the Ambassadors focus groups received \$45 and dinner.

### *Findings*

During these discussions, participants raised a variety of issues related to paid sick days and taking paid or unpaid time off from work. Issue areas can be divided into the following topics:

- recovery from illness, access to healthcare and delayed healthcare;
- ability to care for dependents;
- infecting co-workers/customers and co-worker/customer dissatisfaction with interacting with sick workers;
- the economic consequences of taking unpaid time off and related stress;
- decreased productivity at work;
- employer retaliation;
- overall feelings of not having basic rights as workers.

There was a clear overall sentiment by all participants that having paid sick days would improve their lives in multiple ways. While many issues related to other labor laws and benefits, such as worker's compensation and health insurance, arose as barriers to workers being able to care for themselves and family members and as rights that should be enforced, paid sick days were independently considered an important benefit that could be put in place. A very limited number of participants commented on their employer being small and potentially having a harder time providing paid sick days, but the overall feeling was that the benefit of such a policy greatly outweighed the costs to employers regardless of size.

#### *Recovery from Illness, Access to Healthcare, and Delayed Healthcare*

Many participants felt that being able to use a paid sick day to stay home and rest when sick would speed their recovery. One person said, for example, "If I take the day off to rest and care for myself then I will most likely recover faster."

Many participants that did not have paid sick days, and therefore decided to go to work when sick, felt that they recovered from illness more slowly and/or that their illnesses became more severe as a result:

- "A month ago we had a shortage of staff, I was sick and could not even speak, I went to work so sick, and it got so bad, I was out for the next three days."

- “I had the flu and I did not let it heal and I got more sick and even more sick as I had to go to my job. Again, it took me so long to get over that illness. I will never work in a place that gives no time off for being sick!”

Participants without paid sick days reported that it was hard for them to make an appointment with a doctor when they or their dependents were sick:

- “[It’s] hard to make appointments. I have to try and do that when I don’t work.”
- “I only go to the doctor in an emergency. That’s the only time I can go to a doctor.”
- “I don’t usually have a problem for myself, but I had a problem when I had to take my child to the doctor. The pediatricians have certain times when they can see the child; that’s when I have problems.”

One participant commented on his inability to get preventative care, even when it would benefit his customers and employer: “I work at a nursing home. You would think they would want us to get a flu shot but they won’t pay half day to do that.”

Conversely, participants with paid sick days reported that it was easier for them to see a doctor when necessary, both when sick and for preventative care:

- “As a result of the benefit, I can get an appointment at the doctor sooner. For example, if I call out sick during the day, then I can go to an appointment between 9-5 pm. However, if I was to work and schedule an appointment after 5 pm, then it is almost impossible to obtain an appointment. My alternative option is to go to the emergency room and wait for a treatment that could be resolved at a regular clinic.”
- “I caught a cold from my son and we were both sick. So I was out for a week. Missing a week of work, if I didn’t have sick time, that’s, like, no check. So it really benefited me. I was able to take him to the doctors and go to my appointment too.”
- “I took a sick day for a flu shot; sick days should be used for preventative measures.”

Several participants reported ignoring advice from a doctor because they felt that they needed to work. One participant reported, “I have a lump in my arm, you see it’s like a ball and it’s because of excessive work. The doctor said, ‘You have inflammation in both arms because of work.’ She said, ‘You have to take some time off.’ But I can’t. I will have to work until the day I die.”

*“[The doctor] said, ‘You have to take some time off.’ But I can’t. I will have to work until the day I die.”  
–Focus Group participant without paid sick days*

Several workers also said that they postponed necessary medical care because they did not have paid sick days. For example, one person said, “I was supposed to have surgery for a cyst on my arm. I postponed it.”

None of the participants stated that they had ever been hospitalized for an illness that could have been avoided if they could have called in sick.

#### *Ability to Care for Dependents*

Many participants who did not have paid sick days and had children reported difficulty taking time off to care for them when they were sick. This led to children being sent to school sick and to additional stress on the parent:

- “I have small children at home and I can’t tell them, ‘Sorry, you can’t get sick today because I can’t take care of you.’ Sometimes you send them to school, knowing they don’t feel well because you can’t stay home to care for them. But the school calls you, ‘Come and pick them up.’”
- “If your kids are sick and you have to go to work, it’s extremely stressful. Sometimes you don’t want to go but you have to go.”

This was especially true for parents of children with disabilities. One participant told a story about a co-worker: “She has four children and they all have disabilities; two have mental disabilities and the other two have physical ones. She calls out [sick] a lot and they give her a lot of problems... She has received many warnings, a lot of problems. Not sure how she deals with it. Well I know why she deals with it, because she has to.”

Several participants felt that they were better parents and that their kids were happier when they had paid sick days. One participant noted, “Well I can tell you my kids are much happier. When I’m sick and I have to work, I am an awful mom. But when I am healthy, I feel as though I am a better mom.”

Participants also noted that they had trouble taking care of aging parents when they could not take paid time off of work.

#### *Infecting Co-workers/ Customers and Co-worker/ Customer Dissatisfaction with Interacting with Sick Workers*

There was a clear awareness and feeling of discomfort by many that they were putting their co-workers and customers at risk of getting sick by coming to work when ill, but many felt that they had no choice but to do so:

- “I come into work if I’m sick, unless I really can’t come in. I know that I put my co-workers at risk if I’m sick, but I need to make that choice.”
- “I felt very uncomfortable. I was putting others at risk... If I had coughed in someone’s face, they would have gotten something. If you are sick, you are sick.”

Others talked of “cross-contamination” in the work place. Still others discussed the extent of the problem:

- “I have noted that when people don’t have paid sick days, what that does is create a cycle.”
- “Lack of sick days can cause my work place to look like a disease center. If one person gets sick, then everyone will have the equal opportunity to become sick. It can be an ugly scene.”

Food workers were especially attuned to the issue, but still felt like they needed to work:

- “I’m around food...I don’t want to put anyone at risk, especially old people. If they catch a cold, it could...affect them even worse.”
- “I used to work at a restaurant as a hostess. Even though I was a hostess and I didn’t work directly with the food, I still had to walk through the kitchen and by people’s tables...You can put it in the food and pass it along to everyone very easily.”

Because of the risk of spreading illness in the workplace, several participants were aware that their co-workers and customers were unhappy when they came to work sick. They also felt isolated and/or alienated as a result of coming to work sick. One person discussed their co-workers, saying, “People aren't happy around you because they don't want you to come to work spreading disease.” Others focused on their customers:

- “Since I work in the market, the customers will definitely not want a sick person processing their groceries. This may scare away all the potential customers. Eventually, the store can go out of business.”
- “I have to work with clients everyday. If I am sick, then they don’t want me to service their manicures and pedicures.”

*“If a person is really sick and they can’t come to work, you can’t pay your bills. This affects someone emotionally in addition to their physical illness. This causes more stress, it’s been proven, and stress causes other sickness. Like depression.”*  
– Focus Group participant without paid sick days

#### *Economic Consequences of Taking Unpaid Time Off and Related Stress*

Loss of wages for calling in sick was felt by many as a significant impact, given life needs. Many discussed the stress related to not having enough income to make ends meet, and the relation of that stress to illness. There was a clear sentiment of having to choose between one’s health and having enough money. Examples of participants’ stories include:

- “Unfortunately, I don’t have the luxury of having sick time. If I’m sick I have a choice. I can stay home and lose out on a lot of money, miss a payday. Or I can drag myself into work. And I usually drag myself into work when I’m sick.”
- “Even though I am sick I had to go to work, I have bills!! They don't give me a hard time to take off, but I need the money! So I just had to go. I support a son. It was so stressful. If I don't go to work, I'll stay on probation.”
- “If a person is really sick and they can’t come to work, you can’t pay your bills. This affects someone emotionally in addition to their physical illness. This causes more stress, it’s been proven, and stress causes other sickness. Like depression.”
- “Our monthly budget gets thrown off forever....This causes more tension, more stress, and then more sickness.”

Conversely, a participant with paid sick days said, “For sure I must say the stress factor is relieved a bit. There are so many things people stress over, but when you can get relief from one, it makes life better.”

### *Decreased Productivity at Work*

Several participants noted that they are not as productive at work when they are sick and that this loss of productivity harms the employer:

*“When a person is sick, they can’t work in their total capacity. They are at 60% or 40 or 50%. But if we had sick days, it would benefit both us and the company. Not only do we not get someone else sick, but we work better.”*  
– Focus Group participant without paid sick days

- “If employees are sick, then our ability to output work will slow down. It is their loss because our production rate is decreased when we are sick while pay rate remains the same. Employers are paying the same amount with less productivity.”
- “If you want to have better workers, then let them rest when you are sick. Better performance, take better care of your clients.”
- “When a person is sick, they can’t work in their total capacity. They are at 60% or 40 or 50%. But if we had sick days, it would benefit both us and the company. Not only do we not get someone else sick, but we work better.”

*“For sick time, you would get penalized. My manager says, ‘Only if you call in dead.’”* – Focus Group participant without paid sick days

### *Employer Retaliation*

A large number of participants without paid sick days discussed ways in which they were penalized by their employers for taking time off when sick. Some talked about it generally: “For sick time, you would get penalized. My manager says, ‘Only if you call in dead.’”

Many others discussed “point systems” or “warnings.” For example, one participant’s husband had sick time but would be given a ‘point’ for taking the time, but would also be given a ‘point’ for coming to work sick. When ‘points’ accrued to a certain amount, he would be written up or given warnings. Another person said, “I mean the doctor is telling you not to go to work, but they [management] don’t allow it. They don’t permit it. We still get warnings with a doctor’s note.” These warnings accumulate and lead to other consequences for the worker: “People get fired not because of their error, but because of the accumulation of warnings.”

Some workers reported losing good shifts or seniority as a result of taking time off when sick. One person said that she was forced to work weekends after she called in sick. Another noted, “If you are out a lot, you lose seniority. If you have a good position and you’re out, you end up losing that position. You go on the ‘spare’ list. You still have your job, but you don’t get as much work or as good work. You go straight to the bottom.”

Several people reported stories of job loss related to taking time off when sick:

- “I used to work in a glass factory. I woke up lightheaded, called in sick. Felt dizzy and lightheaded. I was fired.”
- “I actually lost a job when I was a PCA [Personal Care Assistant]. The person I was taking care of, it was unacceptable to them that I could be sick, when they felt that they were more important.”



- “One of my friends, she has two kids and is single. She lost her job. When her kids got sick, she would have to stay home with them. It didn’t happen that often, but it did happen. She got fired. I think it was because she stayed out when her kids were sick.”

As a result of such penalties for taking time off when sick, participants felt pressure from their employers to report to work no matter what. One person stated simply, “You kind of get a little intimidated to call in sick.”

#### *Overall Feelings of Not Having Basic Rights as Workers*

Among many participants, there was a clear sense that they were being taken advantage of by their employers. Several people reported this as ‘injustice’ or a lack of fairness. For example, one worker said, “This isn’t fair. We shouldn’t have to work under this pressure. This just produces more sickness, more stress. And then more sickness.”

Others were more extreme in their descriptions. One person said, “We are practically slaves.” Another said, “Employers are using us. They feel that they don’t need us and that they can find people to fill the jobs easy. So they don’t provide any benefits. People are scared to lose their jobs so they just don’t say anything.”

*“This isn’t fair. We shouldn’t have to work under this pressure. This just produces more sickness, more stress. And then more sickness.”*  
– Focus group participant without paid sick days

#### *Focus Group Conclusion*

Collectively, the stories and experiences of participants illustrate 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 “warnings” or “points” or being assigned to less desirable jobs or shifts). As a result, participants shared experiences about going to work while ill and about elevated stress levels.

There was a recognition that going to work sick or sending sick children to school led to the infection of others. Food workers were particularly attuned to the issue. Others that interacted with customers regularly also expressed concern for their clients, but also for the loss of business that may result if customers do not return as a result of sick workers. People were concerned with getting co-workers sick as well, and described the “cycle” of passing illnesses between co-workers. Given the recent emergence of several potential pandemic influenza strains (e.g., ‘avian flu’ and ‘swine flu’), these concerns are well founded.

Participants without paid sick days described an inability to recover from illness or to support dependents in their recovery. They described delaying necessary medical care. They told stories about having trouble scheduling appointments for themselves, for children and for older parents, both when ill and for preventative care. Participants clearly felt that their health and well-being suffered as a result of this.

Conversely, participants who had paid sick days discussed being able to make doctor's appointments when sick and obtaining preventative care. They discussed being able to rest and recover fully from illness. They also talked about how having the benefit made them better parents and allowed them to care for sick dependents. And, importantly, they described how having paid sick days removed a potential source of stress from their lives.

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. Participants in the focus groups recognized and discussed these issues based on personal experience.

Focus group participants clearly understood the paid sick days issue as a health-related issue through the direct impacts on health (e.g., longer recovery times, lack of full recovery), indirect impacts (e.g., loss of wages, loss of job, stress) and public health impacts (e.g., infection of co-workers or customers). Importantly, they also saw the policy as a human rights issue and a question of justice.

## VII. INFORMAL PAID SICK DAYS SURVEY – METHODS AND FINDINGS

### *Introduction*

This narrative summarizes the results of a brief survey administered to workers regarding paid sick days and their health.

### *Methods*

To gather information regarding paid sick days benefits among workers, we used a survey originally developed by Human Impact Partners and the San Francisco Department of Public Health and asked Greater Boston Legal Services (GBLS) 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 available in both English and Spanish. A copy of the English survey is available in the appendix to our California Paid Sick Days HIA (see [www.humanimpact.org/PSD](http://www.humanimpact.org/PSD)). 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 was not administered randomly, but completed by partner organizations of GBLS, who have a vested interest in the legislation. As a result, it is important to note that these findings should not be generalized to the general population. Surveys were completed during the summer of 2009.

### *Results*

A total of 101 individuals completed the survey. Of those, 71 respondents (70%) did not have paid sick days, 27 had paid sick days and 3 did not respond to the question.

Among respondents who did not have paid sick days, 58 (82%) reported having gone to work sick at some point in their lives. As a result of calling in sick, among respondents who lacked paid sick days:

- 58 (82%) reported having lost wages;
- 16 (23%) reported having lost a job;
- 33 (46%) reported losing good shifts;
- 49 (69%) reported stress;
- 20 (28%) reported retaliation; and
- 31 (44%) reported threats of losing wages or jobs.

*“My son had a growth on his rib cage, which, the emergency room wanted us to go straight to Children’s Hospital. I couldn’t find coverage for my shift so I didn’t go to work, got written up and lost shifts for a few weeks.” – survey participant*

Of the 25 participants who lacked paid sick days and had children under the age of 18, 17 (68%) reported having sent their children to school sick as a result of not having paid sick days. Of the 27 participants who lacked paid sick days and were responsible for other family members’ care, 21 (78%) reported that there were times when they could not care for their dependents because they did not have paid sick days.

## VIII. SUMMARY OF MAJOR FINDINGS

Major findings from this research include:

- There are a very large number of costly and preventable hospitalizations and emergency room visits in Massachusetts each year. There is no evidence that the number of these events is declining as a result of implementation of nearly universal health care in the state.
- 57% of the lowest paid workers in the Northeast do not have paid sick days.
- Among workers with health insurance in the U.S., those without paid sick days were 15% more likely to use the emergency room and almost 40% more likely to delay necessary medical care relative to those with paid sick days.
- Between 2003 and 2007, Massachusetts health agencies reported 55 foodborne disease outbreaks and 1,929 related cases of illness to the Centers for Disease Control and Prevention. Between 2003 and 2008, there were 19 gastrointestinal illness outbreaks in food service establishments in Boston and 15 such outbreaks in long term care facilities in Boston.
- Pandemic influenza in Massachusetts, which could be reduced through social distancing measures including paid sick days, is impacting low-income populations who have less access to paid sick days.
- Long term care facilities in Boston experienced 14 influenza outbreaks and 15 gastrointestinal disease outbreaks between 2003 and 2008. Statewide, there are 37 norovirus outbreaks in long term care facilities annually.
- Children in the state missed 9.2 days of school on average in the 2007-2008 school year. School children have high rates of asthma and, nationally, 40% of mothers of children with asthma do not have access to paid sick days. Access to paid sick days would help working parents care for their children.
- Focus group participants raised concerns regarding access to paid sick days and:
  - recovery from illness, access to healthcare and delayed healthcare;
  - ability to care for dependents;
  - infecting co-workers/customers and co-worker/customer dissatisfaction with interacting with sick workers;
  - the economic consequences of taking unpaid time off and related stress;
  - decreased productivity at work;
  - employer retaliation;
  - overall feelings of not having basic rights as workers.

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