

**Health Impacts of the California Healthy Families,  
Healthy Workplaces Act of 2008:  
A Report on Ongoing Research**

**April 20, 2009**



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### **SUGGESTED CITATION**

Bhatia R, Cook WC, Farhang L, Heller J. Health Impacts of the California Healthy Families, Healthy Workplaces Act of 2008: A Report on Ongoing Research. Oakland, California: Human Impact Partners and San Francisco Department of Public Health. April, 2009.

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## **I. Overview**

In the spring and summer of 2008, the San Francisco Department of Public Health (SFDPH) and Human Impact Partners (HIP) conducted a comprehensive health impact assessment (HIA) on the *Healthy Families, Healthy Workplaces Act of 2008* (AB 2716) to inform policy-makers on the relationship of paid sick days to individual- and community-level health. AB 2716 proposed to allow all California workers to accrue paid sick days. The HIA synthesized evidence from diverse sources and included original analysis but found a number of important data gaps in the evidence base for this policy.

A similar bill that would also require paid sick days for California workers—AB 1000—was introduced in March 2009. In response to outstanding research questions, HIP and SFDPH have continued to conduct additional qualitative and quantitative research. This report on our ongoing health research provides further evidence on the potential positive impacts of paid sick days on the health of California populations and communities. The evidence in this report is based on three new sources of data:

### **1) Summary of Communicable Disease Outbreaks in California.**

This summary describes the impact of ill workers on communicable disease outbreaks in California. Specifically, it assesses reported foodborne disease outbreaks from 2003 to 2007 in workers employed in sensitive occupations. We used reported communicable disease outbreak investigation records provided by the California Department of Public Health to identify cases where outbreaks involved either employee food handling practices or worker illness as contributing causes. Our findings illustrate that foodborne disease outbreaks commonly involve actively working ill individuals.

### **2) Summary of Home Care Worker Focus Group.**

This summary describes working conditions and the need for paid sick days among home care workers in California—specifically, In-Home Supportive Services (IHSS) providers. Funded by a combination of federal, state, and county funds, the IHSS program provides eligible providers with health, dental, and vision insurance but not paid sick leave afforded by most public-sector employees. The findings of our focus group demonstrate that paid sick days may help improve mental and physical health of IHSS providers, provide benefits for their sick clients, and reduce turnover of IHSS providers and thus stabilize and reduce costs of elder care.

### **3) Summary of National Healthy Interview Survey Analysis**

We report on an analysis of paid sick days and health care utilization using the National Health Interview Survey (NHIS). We report statistics on the distribution of paid sick days in the population, the relationship of paid sick days to various demographic and health factors, and the relationship of paid sick days to outpatient care use in the past year. Our analysis confirms that there are significant disparities in paid sick days access by various demographic factors including age, education and income. Furthermore, our analysis indicates that having paid sick days is associated with utilization of outpatient medical care.

Below we provide more detailed findings for each these areas of research.

## **II. Communicable Disease Outbreaks in California**

### **Introduction and Methods**

Community communicable disease transmission commonly occurs in workplace settings and may involve sick workers at work. Foodborne disease outbreaks, in particular, have been traced to food handling workers with active communicable diseases. These outbreaks occur despite laws and regulation requiring ill workers to be excluded from foodhandling.

In 2009, the research team requested foodborne disease outbreak investigation data from the California Department of Public Health (CDPH). CDPH subsequently provided data reported by local and county health officials through the Centers for Disease Control's Electronic Foodborne Outbreak Disease Report System (eFORS) during a 5-year period from 2003 to 2007. The database includes reports on single county outbreaks, multi-county outbreaks, as well as multi-state outbreaks, all with exposure in California.

### **Findings**

Based on available, reported data, there were 883 foodborne disease outbreaks for 2003– 2007 in California, with 16,075 related cases of illness. The vast majority of these outbreaks (90%) and cases (93%) occurred in institutional and workplace settings including schools, day care settings, restaurants, workplace cafeterias, grocery stores, hospitals, and jails. In these settings, workers with a communicable disease have a significant potential to contribute to a communicable disease outbreak if they work when ill.

Of the 792 outbreaks occurring in the specific settings listed above, for 8% of outbreaks (n = 67) and 13% of cases (n = 1,955), food-handling by an infected person or carrier of a pathogen was identified as a contributing cause. Norovirus was the most commonly implicated illness in these outbreaks (n = 55) and cases (n = 1,459).

In an additional 189 reported outbreaks and 3890 related cases during this time period, bare-or glove-handed food contact was identified as a contributing cause of the outbreak. In total, 32% of all outbreaks and 39% of all cases occurring in an institutional setting had contributing causes involving a food handler/worker/preparer.

Additional information obtained by the research team based on a survey of local health officers also provides support for the significance of ill food service workers as a cause of disease outbreaks. In one large urban California county, 17 of 155 confirmed outbreaks in a five-year period (2003–2007) could be traced back to an ill food service worker. In another moderate-sized county, 5 of 8 confirmed foodborne outbreaks involving 165 cases involved an infected food handler. In one case, an employee with confirmed norovirus illness was implicated in a single outbreak at a restaurant that infected 80 people.

### **Conclusions**

A substantial burden of avoidable communicable disease is associated with foodborne disease outbreaks related to ill working food service workers. Paid sick days may facilitate accountability to workplace exclusion policies that are in place designed to prevent such outbreaks.

## II. Home Care Worker Focus Group Summary

### Introduction and Methods

Most home care workers in California are paid through In-Home Supportive Services (IHSS). IHSS provides personal care and domestic services to persons who are aged 65 or older, blind or disabled, who might be placed in an out-of-home care facility but who can live safely in their own homes with those services (CDDS 2008). Many recipients of formal home care services are low-income elderly individuals or disabled people of working age (Howes 2005). Home care providers in California are mainly middle-aged women of low-incomes. One representative study found that 53% of IHSS providers lived in households with average incomes of less than \$24,000; the majority of IHSS providers were people of color and foreign-born, with Latinas, Chinese, Russians, and Armenians being the largest ethnic groups (Howes 2008).

Available literature suggests that those needing long-term care prefer to receive it in a community or home setting. While literature suggests that employment benefits support retention in the IHSS provider population, there is little research on the impacts of IHSS employment benefits and health of IHSS providers.

To explore the potential impact of paid sick days on the health of IHSS providers, we conducted a focus group with eight providers and three care recipients living in Riverside and Orange Counties in April 2009. The goal was to gather qualitative data on home health care provider experiences with paid sick day benefits and the effect of not having such a benefit on their health. Though all participants were female, the group was racially diverse and included three Caucasian, one African American, one Latina, one Native American, and two Asian American providers; and a Native American and two Caucasian clients. Seven of the eight providers provided care for their family members and one of them for an unrelated client whom she described as “a long-time friend.” All of them lived with their IHSS clients, providing care around the clock.

Below we report focus group findings on participant perceptions of paid sick days, experiences delaying medical care and potential benefits of paid sick days to their health.

### Findings

*Value of Paid Sick Days to IHSS workers* There was an overwhelming consensus among all the focus group participants that IHSS providers needed paid sick days. Several participants considered paid sick days to be, “Very important!” Most of the focus group participants described the “physical pain,” “stress,” and “mental exhaustion” they experienced from working as IHSS providers that came from “lifting” their clients to bathe, help dress or otherwise assist them and from having to provide care around the clock with little rest. They described how paid sick days could be used to see doctors or to recuperate from their own illnesses or simply get “respite” from physically demanding work. Leaving their clients unattended is not an option for IHSS providers and several suggested they would have to “pay someone to come in while recuperating” or “when going out,” essentially giving up their wages from IHSS work.

Notably, some providers reported occasionally enlisting family members and friends to fill in for them. Some paid younger family members, if available, a small amount of money for their hours. However, most participants agreed that they simply could not “count on family” or that “blood

family is the hardest one” to enlist because “they don’t want to deal with it,” “they have their own lives,” or “not everybody has a close-knit family.”

*Delayed Medical Care* Some participants reported that the lack of access to paid time off resulted in delayed seeking medical care for their own health problems. One provider reported having neglected to have a surgery to remove a uterine tumor for two years because she would need to take a month to recuperate after the surgery. As a result, the tumor had grown from the size of about 6 centimeters when it was first diagnosed to 8.9 centimeters at the time of the focus group.

*Perceived Benefits for Clients* Providers and clients who participated in the focus group agreed that paid sick days would also benefit the clients, because “the caregiver will be more focused, more fresh,” “they won’t make mistakes or be irritable,” or “their frustration level would be lower.” According to one provider, “Patients themselves pick up the tension and frustration and they act on it. The client needs a break from the caregiver too.” Notably, no IHSS providers mentioned the prevention of communicable disease transmission as a benefit to paid sick days; conceivably, this is because many IHSS providers are living in the same households as those they provide care for.

## **Conclusions**

The lack of paid time off appears to limit access to needed health care and prevent recuperation from illness in this group of IHSS providers. The results suggests that paid sick days may help IHSS providers improve their health by allowing them to receive timely medical care and by reducing the stress related to IHSS work. It may also improve elder care and reduce the cost of elder care by reducing care turnover rates and allowing caregivers the opportunity to address their own needs and thereby be more attentive to the needs of their clients. It is notable that providers and clients did not discuss communicable disease transmission and prevention. This is likely because all the IHSS workers in this group appear to live with clients. This is an important finding and suggests that, while benefits for workers are significant, benefits for community health may be limited.

## IV. NHIS Analysis and Findings

### Introduction and Methods

For an employed person, lack of access to paid sick days may be an important barrier in accessing primary care; however, there is limited research exploring this relationship. To explore the relationship between population characteristics, paid sick days, and health care utilization, we analyzed data from the 2007 National Health Interview Survey (NHIS), a cross-sectional household interview survey conducted annually by the Centers for Disease Control and Prevention (CDC) to monitor the health of the U.S. population.

Our analysis used data from 12,432 NHIS adult respondents who had met the following inclusion criteria: 1) were employed for pay at a job or business in the previous week (excluding those who were self-employed) and 2) were aged 24 to 64. We constructed several new variables to simplify response categories for demographic characteristics. We constructed a composite variable for “medical visit in past year” to reflect any visit to a medical doctor, obstetrics/gynecological specialist, nurse practitioner, physicians’ assistant, midwife or specialist doctor in the past year. To evaluate potential confounding, we conducted analysis of paid sick days and medical visits stratified by several demographic, health insurance access, and health care status variables. All analysis incorporates weights to account for sampling probabilities and to ensure that results were generalizable to the national population. STATA version 10 was used for all analysis.

Below we report preliminary findings on: 1) distribution of paid sick days in the population, 2) access to paid sick days relative to demographic characteristics, health insurance, and health status indicators, and 3) the relationship of paid sick days and health care provider contact in the past year.

### Findings

***Prevalence of Access to Paid Sick Days*** Table 1 illustrates the proportion of the population receiving paid sick days. In total, 60.3% of the population receives paid sick days while 39.7% do not.

Table 2 describes paid sick days by demographic, health insurance and health status characteristics. There are notable disparities in the access to paid sick days by age, education and income status. With the exception of marital status and all chronic health conditions, all results reported below are statistically significant at  $p < .01$ .

***Gender and Age*** Men (58%) were less likely to have access to paid sick days than women (63%) and while the mean age of those without paid sick days was slightly lower than for those with paid sick days, those in the youngest age group (age 24-34) had less access than older working adults.

***Race / Ethnicity*** Hispanic workers (46.%) were the least likely to have paid sick days as compared to about 62% among non-Hispanic whites and blacks. The proportion of workers with paid sick days was higher for Asians (67.4%) than for any other racial group.

***Marital Status*** Widowed respondents (54.5%) were less likely to have paid sick days than those who were married or lived with partners, divorced or separated, or had never been married, but these differences were not statistically significant.

***Education and Income*** The proportion of workers without paid sick days was highest among those who did not graduate from high school (66.8%), and lower as educational achievement increased. For example, 48.7% of those graduating from high school/receiving a GED diploma, 38.7% with some college, 26.2% with a college degree and 24.4% with an advanced degree did not receive paid sick days. Correspondingly, a similar pattern was evident by income with 61% of those earning less than \$34,999 not receiving paid sick days as compared to 40.8% of those earning \$35,000 - \$74,999, 29.3% earning between \$75,000 - \$99,000, and 26.9% of those earning over \$100,000.

***Health Insurance Benefits*** Those who did not have any health insurance were less likely to have access to paid sick days (81.6%); conversely, 68.1% of those with health insurance received paid sick days. Among those who received employer-sponsored health insurance, the proportion receiving paid sick days was even higher – 77.5% of those receiving employer-provided health insurance also received paid sick days.

***Health Status and Chronic Health Conditions*** With respect to health status, 61.2% of respondents with excellent, very good, or good self-reported health were likely to have paid sick days while only 48.3% of those with fair or poor health did. Similar proportions of the population with chronic conditions including asthma, diabetes, coronary heart disease, chronic bronchitis and hypertension did not have access to paid sick days (ranging between 35-40%). Overall, 40% of the population with any one of these conditions did not have access to paid sick days.

***Paid Sick Days and Outpatient Care*** Table 3 describes the relationship between paid sick days and outpatient care. Overall, the availability of paid sick days was significantly higher among those who had medical visits in the past year. Among those with paid sick days, 76.9% saw a medical practitioner in the past year while for those without paid sick days, 63.8% saw a medical practitioner in the past year. Based on logistic regression, those with paid sick days were almost twice as likely to have had contact with a medical provider (OR 1.88; CI: 1.70 - 2.09).

Importantly, the relationship between medical visits and paid sick days remained consistent when stratified by demographic, social and economic subgroups defined by gender, marital status, race/ethnicity, education or income. The relationship between paid sick days and outpatient care also did not appear to be confounded by health status. For both those with poor and good self-rated health and those with and without chronic diseases, paid sick days was associated with medical visits in the past year. Finally, paid sick days also predicted medical visits for those with and without health insurance.

## **Conclusions**

Overall, these preliminary results suggest that paid sick days appear to facilitate access to outpatient medical care. Paid sick days may be an important and avoidable barrier to primary care access both for those with chronic disease and those in good health.

Yes	60.3%
No	39.7%

<b>Table 2. Paid Sick Days by Population Characteristics</b>	<b>Have Paid Sick Days</b>	<b>Don't Have Paid Sick Days</b>	<b>P-value</b>
<b>DEMOGRAPHICS</b>			
<b>Gender (%)</b>			
Male	57.9%	42.0%	*
Female	63.1%	36.9%	
<b>Age</b>			
Mean age	42.5	41.9	*
<b>Age Group (%)</b>			
24-34	57.2%	42.9%	*
35-44	61.1%	38.9%	
45-54	62.2%	37.8%	
55-64	61.5%	38.5%	
<b>Race (%)</b>			
Hispanic	46.8%	53.3%	*
Non-Hispanic White	62.4%	37.6%	
Non-Hispanic Black	62.3%	37.7%	
Asian	67.4%	32.6%	
Other	49.4%	50.7%	
<b>Marital Status (%)</b>			
Married/Partnered	60.4%	39.6%	
Widowed	54.4%	45.6%	
Divorced or Separated	60.2%	39.8%	
Never Married	60.4%	39.6%	
<b>Educational Achievement (%)</b>			
Did not graduate HS	33.2%	66.8%	*
HS graduate/GED	51.3%	48.7%	
Some college	61.3%	38.7%	
College graduate	73.8%	26.2%	
Advanced degree	75.6%	24.4%	
<b>Household Income (%)</b>			
\$0 - \$34,999	39.0%	61.0%	*
\$35,000 - \$74,999	59.2%	40.8%	

\$75,000 - \$99,000	70.7%	29.3%	
\$100,000 and over	73.1%	26.9%	
<b>EMPLOYMENT BENEFITS</b>			
<b>Have Any Health Insurance (%)</b>			
Yes	68.1%	31.9%	*
No	18.4%	81.6%	
<b>Have Employer Provided Insurance (%)</b>			
Yes	77.5%	22.6%	*
No	16.6%	83.4%	
<b>HEALTH STATUS</b>			
<b>Self Rated Health Status (%)</b>			
Excellent / Good	61.2%	38.8%	*
Fair / Poor	48.3%	51.7%	
<b>Asthma (%)</b>			
Yes	60.0%	40.0%	
No	60.4%	39.6%	
<b>Diabetes (%)</b>			
Yes	61.1%	38.9%	
No	60.3%	39.7%	
<b>Coronary Heart Disease (%)</b>			
Yes	65.4%	34.6%	
No	60.3%	39.7%	
<b>Chronic Bronchitis (%)</b>			
Yes	56.6%	43.4%	
No	60.4%	39.6%	
<b>Hypertension (%)</b>			
Yes	60.2%	39.9%	
No	60.4%	39.6%	
<b>Have Any of Above 5 Chronic Conditions (%)</b>			
Yes	60.3%	39.7%	
No	60.4%	39.7%	
* Relationships are statistically significant at $p < .01$			

<b>Table 3. Paid Sick Days and Outpatient Care</b>	Have paid sick days (%)	Don't have paid sick days (%)
Medical contact in the past year	76.9%	63.8%
No medical contact in the past year	23.1%	36.2%
OR 1.88; CI: 1.70 - 2.09		

## **V. Conclusions**

Populations without access to paid sick days in the United States tend to have characteristics making them more vulnerable to adverse health outcomes; for example, almost four-fifths of the lowest paid workers do not have paid sick days in the United States and those without paid sick days tend to have less access to other employee benefits such as health insurance. Providing paid sick days to these workers could help advance health equity by allowing them to take paid time off to recover from illness or to take care of their family members who are ill, without risking wages. Furthermore, workers with paid sick days are in occupations that amplify the hazard of their transmitting communicable disease transmission in community settings.

This report of ongoing research on the health impacts of paid sick days confirms that workers with characteristics making them vulnerable to poor health tend to have less access to paid sick days. Because of the dependence and needs of their clients, home health providers appear to have unique health consequences from the lack of access to paid time off. Workers without paid sick days tend to have less contact with medical professionals, indicating that sick days may be an important barrier to preventive or primary care. A substantial burden of foodborne communicable disease outbreaks can be traced back to ill workers working with communicable diseases - a social burden that might be lessened with access to paid sick days.

Overall, these research findings continue to demonstrate that paid sick days can support individual and community health through several mechanisms and illustrate the particular benefits of paid sick days for workers in vulnerable social groups.

## **Appendix 1. Paid Sick Days and Home Care Workers: Focus Group Findings**

### **Introduction and Methods**

This narrative summarizes the findings of a focus group conducted by Human Impact Partners and the San Francisco Department of Public Health as part of a research project assessing the impacts of paid sick days on health. The purpose of this focus groups was to gather qualitative information on In-Home Supportive Services (IHSS) provider 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. To contextualize our findings, we also reviewed related literature and report relevant findings in this narrative.

The focus group was conducted in April 2009 in Riverside County, California. Eight IHSS providers and three care recipients living in Riverside and Orange County participated in our focus group. Though all female, the focus group was racially diverse including: three Caucasian, one African American, one Latina, one Native American, and two Asian American providers; and a Native American and two Caucasian clients. Seven of the eight providers provided care for their family members and only one of them for an unrelated client who was “a long-time friend.”

The focus group was conducted in and transcribed into English. Participation in the group 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.

### **Background: In-Home Supportive Services (IHSS) Program in California**

Most home care workers in California are paid through In-Home Supportive Services (IHSS). IHSS provides personal care and domestic services to persons who are aged 65 or older, blind or disabled who might be placed in an out-of-home care facility but who can live safely in their own homes with those services (CDDS 2008). Many consumers of formal homecare services are low-income elderly individuals or disabled people of working age (Howes 2005).

IHSS services are provided primarily through an “independent provider” model consisting of three elements: 1) consumers directly hire and supervise the workers who care for them; 2) county social service workers determine eligibility for services; and 3) the state IHSS issues the paychecks (Delp and Quan 2002). Consumers in the California IHSS program are allowed to hire friends and family members directly and avoid going through agencies where hourly rates are as much as twice as much as the cost of consumer-directed home care (Howes 2008). IHSS is administered by county agencies and funded by a combination of federal, state, and county funds. Currently, federal Medicaid funding pays for about 50% of the costs, the state covers 65% of the balance and counties cover the remainder (information obtained from personal communication with Public Authority for IHSS in Alameda County).

In January 2009, 432,869 Californians received 37,511,615 hours of in-home supportive services at a total cost of \$398.6 million; on average, each care recipient thus received 86.7 hours of services at a cost of \$920.76 per person (CDSS 2009). Currently, there are over 370,000 IHSS providers in California (CAPA 2009).

Home care workers in California are mainly middle-aged women of low-incomes. In a 2005 representative sample obtained using the state administrative database for the IHSS program, 53% of IHSS providers lived in households with average incomes of less than \$24,000; the majority of IHSS providers were people of color and foreign-born, with Latinas, Chinese, Russians, and Armenians being the largest ethnic groups (Howes 2008).

Many IHSS workers are family caregivers. Studies show differing proportions of family caregivers ranging from 20% in Los Angeles (RTZ 2005) to 40% statewide (CDSS 2001) to 70% in urban California counties (Howes 2004).

Wages and the availability of benefits vary across counties in California. As of June 2008, hourly wages range from \$8 in rural counties such as Colusa and Siskiyou to \$12.35 in Santa Clara County. Eligible workers have access to health insurance in 41 California counties, dental insurance in 30, and vision coverage in 20 (UDWA 2008). The eligibility criteria for benefits, mainly concerning hours worked, vary.

### **Findings: IHSS Providers and Paid Sick Days**

#### *IHSS Working Conditions*

Most of the focus group participants discussed the “physical and mental exhaustion” they experience from working as IHSS providers. All of the providers in the group, including one who cared for an unrelated client, lived with their clients, providing care around the clock. The most prominent difficulties they raised were a lack of control over their own lives and “having no set schedule.” One person cared for a son with uncontrollable seizures and most of the other providers cared for their parents who had dementia, some with other health conditions such as coronary or cardiovascular heart diseases. Most of these clients thus could not be left alone without risking potentially life-threatening consequences. One provider mentioned how her client “can put herself into a coma” and “crushed her head against hard tiles” when unattended.

The corollary of this on the provider is the “lack of sleep” and having to make arrangements for the most mundane tasks outside their homes because “you don’t have time to go to the bank, to the store, or to the post-office, which are three main critical things.” Still another described how her father with dementia and a heart problem could fall anytime and she mostly stayed awake at night watching him. For providers with more than one client—for example, those who provide care for both of the parents—the burden is even greater. One such provider put it simply, “I have given up my life.”

Focus group participants reported having to respond any emergency involving their clients that may arise, losing more control over their own schedule. One provider recounts: “Last night, my mom had a tooth ache and her mouth was killing her and we all went to the dentist. But the place was jam-packed. Now I have to go back tomorrow. So you have to fit your schedule to these emergency situations.”

Focus group participants reported on the physical and emotional abuse they took from their clients. A provider described how her father, one of her IHSS clients, “often whacked” her “with a cane,” and “threw a dinner plate” at her when she served dinner ten minutes after he demanded it. She also described the chronic back pain she developed after having to repeatedly lift her father with

dementia whenever he fell. Another provider said, “I developed a hernia lifting my mom repeatedly.” Her IHSS client—her mother—admitted to throwing at her daughter “canes, walkers, or any other objects” she could get her hands on. A previous IHSS provider, this client mentioned that after all the verbal abuse she had taken from her own mother (who had been her client until she passed away), which had left her “in tears all the time,” she may “look normal to everybody but had big mental issues.”

Providers experience a high level of stress. One provider said that she lost a lot of weight because she did not have appetite, another related to gaining 60 pounds. Still another mentioned how her doctor said that everything she was going through was “stress-related” and she “needed help.” Another agreed that her doctor said the same thing, but added, “What could you do? Walk out? You can’t.” It does not help that they were “home-bound all the time” and they did not “get time to exercise or to see the outside world,” “go out and have a little social life,” or “have someone to talk to so you can unload.”

#### *IHSS Workers and their Perceptions of Paid Sick Days*

There was an overwhelming consensus among all the focus group participants that IHSS providers needed paid sick days. Asked how important having access to paid sick days was to them, several participants shouted, “Very important!” They described how paid sick days could be used to see doctors or to recuperate from their own illnesses when they become sick. Additionally, since leaving their clients unattended is not an option, they usually had to “pay someone to come in while recuperating” or “when going out,” essentially giving up their wages from IHSS work. What makes it more difficult for IHSS providers to take time off is that the hours they report do not have a bearing on actual hours worked because they must allocate their hours evenly across all seven days a week on their time sheets. Therefore, IHSS providers, most of whom are paid part-time, cannot take time off without wage loss. To take some paid time off, because of all the invasive “questioning and humiliation the social worker will put you through,” they would have to “jump through loops to get it,” which is very “demeaning” and “kills your self-esteem and dignity.

Some providers reported occasionally enlisting family members and friends to fill in for them. Some paid younger family members, if available, a small amount of money for their hours. However, most participants agreed that they simply could not “count on family” or that “blood family is the hardest one” to enlist because “they don’t want to deal with it,” “they have their own lives,” or “not everybody has a close-knit family.” In addition, as a provider said, “not everyone has their family living in the area.”

#### *Delayed Medical Care*

Without social support they could rely on, some participants reported that they delayed seeking medical care for their own health problems. One provider reported having a uterine tumor for two years. She was not able to get surgery to remove it because her doctor, who had been urging her to do so, had also advised that she would need a month to recuperate after the surgery, which she felt that she did not have without having anyone taking over the care for her parents. As a result, the tumor had grown from the size of about 6 centimeters when it was first diagnosed to 8.9 centimeters at the time of the focus group. She simply said, “I do need paid sick days.” Another provider related to the episode of having to undergo a surgery to remove a cyst on her neck of “the size of a golf ball,” scars from which she showed to the group. She said that since there was nobody else to take care of her parents, she was forced to take them to the hospital, drive them back after the surgery, and then cook dinner for them and clean them. The wound from the surgery did not heal properly

because “You’re sweaty, you’re lifting them, bathing them, cleaning them.” The same provider stated that she had recently been going through tests for breast cancer, and even with the stress of dealing with the possibility of having a potentially life-threatening illness, she could not tell her parents about the tests because “that’s going to worry my dad more and give him another stroke, and kill him, maybe.” Without a replacement to care for her parents, she would have to delay getting tests because otherwise she would have to go to the hospital with her parents and they might wonder, “Why do you keep going to your doctor?”

#### *Benefits for Clients*

Providers and clients who participated in the focus group agreed that paid sick days would also benefit the clients, because “the caregiver will be more focused, more fresh,” “they won’t make mistakes or be irritable,” or “their frustration level would be lower.” According to a provider, “Patients themselves pick up the tension and frustration and they act on it. The client needs a break from the caregiver too.”

#### *Related Literature*

It has been found that home care may offer benefits to care recipients by allowing them to remain in their homes and to maintain independence, and to take an active role in their care (Sheldon and Bender 1994). Research findings indicate that most consumers prefer to receive long-term care in a home-care setting (Howes 2008) and that recipients of IHSS of all ages in California would like to be more involved in directing their care (Benjamin and Matthias 2001).

Available data indicate that home care is a more cost-effective service than hospital- or facility-based care. For example, in 2003, average Medicare charges for home care per visit were \$105, a fraction of \$499 of Medicare charges per day for skilled nursing facility care or \$3,838 of Medicare charges per day for hospital care (NAHCH 2004). Likewise, Medicaid Home and Community Based Services expenditures per person served (\$9,103) was much lower than Medicaid nursing facility expenditures per person served (\$25,833) in California in 2005 (AARP 2009). A meta-analysis found a small to moderate positive impact of home care in reducing hospital days, ranging from 2.5 to 6 days (Hughes et al. 1997), suggesting an additional way in which home care can reduce high-cost hospital care.

Although most of our focus group participants were family providers, nonfamily providers experience similar difficulties. High turnover rates among IHSS providers in California--ranging from 23% for family providers and 35% for nonfamily providers (Howes 2004) to close to 40% (RTZ 2005; Doty et al. 1999), are testament to this. High worker turnover and worker shortages negatively impact the consumer through unmet need for personal assistance services, which may lead to pain and discomfort, mobility restriction, going hungry, running out of food, getting burned, unintentional weight loss, dehydration, falls, staying in bed most of the time, soiled self, skin problems, and even death (Harrington 2004).

The number of people in need of long-term care, especially in the community setting, is expected to double in the next 50 years to 27 million. Because the increase in the number of women between the ages of 25 and 54 who provide most long-term care is not likely to keep up with the increase in the population over 65, the current widespread shortage is expected to greatly worsen by 2050 (Stone and Weiner 2001). Without a reliable workforce to deliver quality care, homecare services may fail and the burden may fall on expensive residential care facilities and on families (Howes 2005).

There is evidence that the provision of benefits and increased wages may help retain IHSS providers, family and non-family providers alike, because wages and benefits they receive impact their attachment to the job. A San Francisco study found that the annual retention rate of new providers rose from 39 percent to 74 percent following significant wage and benefit increases and that both health and dental insurance have a large effect on retention rates (Howes 2005). Similarly, a Los Angeles study found that IHSS providers of all demographic subgroups who received benefits were more likely to remain in the workforce after 24 months than those who did not (RTZ 2005). Paid sick days benefit, added to the currently available benefit, may help retain IHSS providers.

Therefore, if provided, paid sick days would help IHSS providers improve their health by allowing them to receive timely medical care and by reducing the stress related to addressing their healthcare needs. It would also improve elder care and reduce the cost of elder care by: 1) reducing care turnover rates and thereby stabilizing and enhancing home care; 2) keeping elders in more health-promoting home care settings and out of nursing homes; and 3) allowing care-givers the opportunity to address their own needs and thereby be more attentive to the needs of their clients.

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