# PUBLIC HEALTH IMPACTS OF THE HEALTHY FAMILIES ACT

**Testimony of**

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I am Rajiv Bhatia, and I currently serve as the Director of Occupational and Environmental Health for the San Francisco Department of Public Health. I earned a Medical Doctorate from Stanford University and a Masters Degree in Public Health from the University of California at Berkeley, and I have practiced medicine and environmental health since 1992. I am an Assistant Clinical Professor of Medicine at the University of California at San Francisco, and I teach a graduate course in health impact assessment of public policy at the University of California at Berkeley. I also serve as the scientific director for the non-profit group Human Impact Partners.

I deeply appreciate the committee's interest in the public health impacts of the Health Families Act. I have been involved in conducting research on the health impacts of paid sick day policies since 2006 and have co-authored comprehensive health impact assessments of the paid sick day legislation currently being considered in the California legislature as well as the legislation currently being considered today by the House of Representative (Bhatia 2008; HIP 2009). In conducting research for these health impact assessments, I and others have critically reviewed available published health research literature on paid sick days, analyzed data from State and National health surveys, reviewed disease statistics for communicable diseases and food borne disease outbreaks, conducted focus groups and surveys with workers, and interviewed and surveyed public health officials responsible for communicable disease control. I have also been involved in the implementation of San Francisco's Paid Sick Days Law through outreach and training to San Francisco businesses. I have provided evidence and analysis on the health impacts of paid sick day legislation to stakeholder groups, and I have testified previously on paid sick day legislation both at local and state hearings and on a prior version of the bill in the US Senate.

Almost all available data and evidence I have reviewed is consistent with the premise that a requirement for paid sick days would protect the health of all Americans. The evidence provides substantial support for the following six conclusions:

- Workers that have greater need for sick leave, such as those with families, are less likely to have paid sick days.
- Workers with paid sick days are more likely to take time off work when they become ill.
- A substantial burden of food borne disease outbreaks are connected to food service workers working with a communicable illness despite laws that should exclude sick workers from work.

- Effective strategies for influenza prevention require compliance with recommendations that keep workers and students at home when sick; paid sick day legislation would enable compliance with these strategies.
- Workers with paid sick day are more likely to care for their sick children and ensure their regular contact with medical providers.
- Workers with paid sick days are more likely to access timely medical care.

***Access to paid sick days in relation to need***

Almost 60 million workers – 48% of the workforce – in the country currently do not have the ability to earn and use paid sick days when ill or when a family member needs care (Lovell 2006). Moreover, the availability of paid sick days varies among subpopulations with less availability of paid sick day benefits among those populations with a greater need for medical and dependent care.

Over 70% of workers in the highest income quartile receive paid sick days compared to about 20% of those in the lowest income quartile (Hartmann 2007). Disparities in access to paid sick days by income are important because lower income confers greater vulnerability to illness and disease, both through the experience of absolute and relative poverty and through exposure to adverse neighborhood and workplace conditions.

Disparities in access to paid sick days also correlate with disparities in access to health insurance. Based on data from the 2007 National Health Interview Survey (NHIS), those who had paid sick days were more likely to have health insurance coverage, compared to those without paid sick days (95.3% vs. 68.0%) (HIP 2009).

Furthermore, those who have access to paid sick day also have better health status. Analysis of 2007 NHIS data revealed that a higher proportion of working adults who rated their health as excellent, very good, or good had paid sick days compared to those who viewed their health as fair or poor (61.2% vs. 48.3%) (HIP 2009).

Mothers with children with relatively poor health are also less likely to have access to paid sick days. Heymann and others (1996) found that 40% of mothers whose children had asthma and 36% of mothers whose children had chronic conditions lacked sick leave during a five-year period. Similarly, Heymann and Earl (1999) found that mothers of children with chronic conditions are more likely to lack sick leave. Clemens–Cope (2007) found that, among children in low-income working families, 30% of children in fair/poor health lived in families that had access to paid sick leave for the entire year compared to 37% of children in good, very good or excellent health.

***Sick Leave among workers with and without paid sick days***

A number of studies have demonstrated that workers without paid sick days are less likely to take sick leave when ill. One recent survey of U.S. workers found that among employed adults aged 19-64, 42% without paid sick days did not miss work because of illness in contrast to 28% of workers with paid sick day benefits. The relationship was even stronger after adjusting for chronic health problems, disabilities, age and wages; employed adults without paid sick days were only half as likely to take time off for illness (Davis 2005).

In our analysis of the 2007 NHIS data, among workers who missed no more than nine work days due to sickness (i.e., those who did not have a prolonged illness), the average number of missed work days in the past 12 months was higher for workers with paid sick days than for those without (1.39 days per year vs. 0.92 days per year) (HIP 2009). Others have found a similar difference for California workers using data from the 2006 NHIS (1.8 days per year, versus 1.4 days per year) (Lovell 2008). These findings suggest that substantial numbers of ill workers without paid sick days are going to work when sick. In fact, in one survey on paid sick days, the majority (64%) of respondents reported having gone to work sick at least once because of a lack of sufficient paid sick days (Bhatia 2008).

Workers who take sick time off without the benefit of a paid sick leave policy may face real and perceived consequences of their choices, such as being reprimanded, the loss of wages, good shifts, or even a job. Surveys and focus groups with workers without paid sick days also have identified factors that may discourage workers from taking sick leave. For example, in one focus group, a participant described going to work with the flu and being feverish while at work (HIP 2009). While her employer recognized her illness, she was not instructed to go home. According to a recent poll (Smith 2008), one in six workers reported that they or a family member had been fired, suspended, punished, or threatened by an employer due to needing time off for illness. Collectively, these factors suggest that paid sick day policies could support a workplace culture that is more likely to accept and accommodate employee absence for illness.

***Working when sick and the spread of communicable disease***

Many common infectious diseases are transmitted in workplaces, schools, and other public institutions through simple casual contact. These diseases include influenza, food borne diseases such as salmonella and norvirus, and the common cold. For these common infections, keeping a

sick worker out of their workplace and sick children out of school will help stop infections from spreading.

***Influenza*** Each year in the United States, 5% to 20% of the population gets the flu; more than 200,000 people are hospitalized from flu complications; and, about 36,000 people die from flu (CDC 2008). Transmission of influenza occurs through the generation of aerosol droplets by infectious individuals and through contact with infectious individuals. An estimated 30% of influenza transmission occurs in homes, 37% in schools and workplaces, and 33% in other community settings (Ferguson 2006).

Substantial attention and public health planning is focused on the prevention of worldwide pandemics due to a novel strain of influenza. Research has shown that the emergence of a highly infectious novel influenza strain as a pandemic could result in 68% of the population being affected and 34% suffering a clinical infection, potentially translating into 100 million sick individuals in the United States (Ferguson 2006). According to researchers who have studied prevention strategies to limit transmission of influenza, a combination of effective strategies including pharmacological strategies (e.g., vaccines, prophylaxis) and non-pharmacological strategies (e.g., quarantine, isolation, school closure) are necessary to effective control an influenza pandemic (Halloran 2008).

Strategies to minimize social contacts between people can be highly effective in controlling the spread of influenza but require people to take leave from work when they or their family members are potentially infectious (USDHHS 20007). Pandemic infectious disease modeling studies are consistent in predicting a reduction in the cumulative incidence of clinical infections with modest measures to reduce contacts among individuals, but estimates vary between models and scenarios (Halloran 2008). Glass (2006) estimated that from a moderately infectious pandemic strain requiring that all sick persons stay at home when symptomatic could result in a 22% reduction of the cumulative attack rate in a hypothetical U.S. small town. Ferguson (2006) estimated that 50% compliance with policy of household quarantine would result in a 15% reduction in the cumulative attack rate for infected individuals and household members with a somewhat more infectious strain of influenza in the United States.

The U.S. Centers for Disease Control and Prevention explicitly advises people with influenza: "*stay home from work and school when you are sick*" (CDC 2008). The modeling studies, combined with understanding that having paid sick days enables taking leave from work, provide a strong rationale for access to paid sick day as a strategy both for community prevention of seasonal

influenza and for the management of an influenza pandemic. Legislation requiring universal paid sick day policies would enable and increase compliance with both voluntary and mandatory social distancing strategies, including the home isolation of sick individuals and related household members and school closure

***Foodborne Disease Outbreaks*** Some workplaces are priority sites for prevention of communicable disease transmission because workers have direct and regular contact with the public. Restaurants and other places where workers prepare food consumed by the public are particularly important because of their role in the transmission of food borne diseases.

Foodborne diseases cause approximately 76 million illnesses, 325,000 hospitalizations, and 5,000 deaths in the United States each year (Mead 1999). Outbreaks refer to two more cases of a food borne illness linked to a common food source. More than half of all U.S.-reported foodborne illness outbreaks are associated with restaurants (Jones 2006).

Food safety codes typically require the exclusion of a food service worker from a restaurant if the employee is diagnosed with an infectious agent, symptomatic, and still considered infectious. Public health officials rely on workers to recognize the illness and their employers to self-enforce requirements that protect the public. In reality, expecting voluntary compliance is not realistic. A worker may recognize a symptom but may not associate it with a food borne illness requiring work exclusion. Also, 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 along with clear workplace policies for their use could enable appropriate leave for food service workers; however, 85% of workers in the food service industry do not have access to paid sick days (Lovell 2008).

Unfortunately, in the current workplace environment, sick food service workers are commonly the source of restaurant food borne disease outbreaks. Guzewich and Ross (1999) reviewed published scientific literature for reports of food borne disease believed to have resulted from contamination of food by workers, finding 81 published outbreaks involving 14,712 infected persons. Eighty-nine percent (n=72) of the outbreaks occurred at food service establishments, such as restaurants, cafeterias and catered functions. Hepatitis A and Norwalk-like viruses accounted for 60% (n=49) of outbreaks. Ninety-three percent of these outbreaks involved food workers who were ill either prior to or at the time of the outbreak.

According to data from Centers for Disease Control's Electronic Foodborne Outbreak Disease Report System (eFORS), there were 5754 foodborne disease outbreaks between 2003 and 2007 nationally, with 121,948 related cases of illness (HIP 2009). The majority of these outbreaks (71%) and cases (61%) occurred in institutional and workplace settings including schools, day care settings, restaurants or delis, 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 4,079 outbreaks occurring in the specific settings listed above, for 14% of outbreaks (n=586) and 24% of cases (n=18,030), food handling by an infected person or carrier of a pathogen was identified as a contributing cause.

A survey of local health officers in California that I conducted this year also provides similar findings on significance of ill food service workers as a cause of disease outbreaks. For example, in San Francisco and Los Angeles counties, about 11-12% of outbreaks involve an ill food service worker working.

The public health impact of a single disease outbreak with food borne disease can be significant. For example, in 2006, a restaurant-worker without paid sick day benefits infected over 350 customers (MMWR 2007) with norovirus at a restaurant in Lansing, Michigan. In 2007 in Santa Cruz, a dishwasher working at a hotel was implicated as the likely source of a norovirus outbreak affecting 134 people through a resort hotel.

***Outbreaks in Health Care Facilities*** Nursing homes are another important setting for infectious disease outbreaks and outbreaks may be traced back to both residents and staff. For example, according to the CDC, 23% of all norovirus outbreaks occur in nursing homes (CDC 2006). In one year in California, nursing home outbreaks accounted for 6,500 patient illnesses, 120 hospitalizations, and 29 deaths (CDPH 2008). The vast majority of patients will recover from norovirus illness within a few days, but an estimated 10% experience more serious symptoms, including acute dehydration that ultimately requires hospitalization (Calderon-Margalit 2005).

Paid sick days may play an important role in nursing home-based disease outbreaks. About a quarter of nursing home workers nationally do not have paid sick day benefits. These workers may be more likely to come to work sick, thus putting patients and co-workers at risk of contracting illness. While this question has received only limited attention, one study of New York State nursing homes conducted in 1993 found that risk of respiratory and gastrointestinal infectious disease outbreaks was significantly less for nursing homes with paid sick leave policies (Li 1996).

***Parental Care and Health Care in Dependents***

Employed workers in households with children are among those with the greatest need for paid sick days due to responsibilities for the care of children. Furthermore, the American Academy of Pediatrics recommends excluding sick children from schools and childcare settings for a number of specific conditions and symptoms (Copeland 2006). In 2006, 70% of mothers with children under 18 were in the workforce (BLS 2006).

Unfortunately, care for sick children competes for the time and labor of parents and other caregivers. When a child is not well, parents might reasonably view staying home to care for a child as jeopardizing their ability to earn income to pay for essential health services, food, or housing.

For dependents, including children and elders, having access to an adult caregiver can be a matter of life and death. Children left home alone may be unable to see physicians for diagnoses, receive needed medications, or emergency help if their conditions worsen. The presence of parents has also been found to shorten children's hospital stays by 31% (Taylor and O'Connor 1989). Even when adults receive support from family members when sick, they recover faster and more fully from conditions such as heart attacks and strokes (Gorkin et al 1993; Tsouna-Hadjis et al 2000).

Clemens-Cope and others (2007) analyzed determinants of taking sick leave among the families of a sample of 10,790 children in low-income families using data from the Medical Expenditure Panel Survey. Only 36% of the children in working families had access to paid sick days for the entire year. Employees with paid sick days were much more likely to miss work to care for family members (44% vs. 26%).

Heymann and colleagues (1999b) analyzed data in the Baltimore Parenthood Study to assess what factors affected parents' decisions to care for sick children. The study found that parents who had either paid sick or vacation leave were 5.2 times as likely to care for their children when they were sick. In this study, half of the parents who cared for their own sick children reported that paid leave enabled them to miss work. Similarly, in recent study of Chicago and Los Angeles parents with children who have special care needs, 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 child.

In another study evaluating the relationship between maternal employment conditions and children's medical visits, Pimoff and Hamilton (1995) found that working mothers had fewer sick

child visits than non-working mothers. However, mothers who could use sick leave for doctor visits had 27% more sick-child visits than those without this benefit.

Our analysis of 2007 NHIS data also suggest that the lack of paid sick days may be a factor in delayed medical care for family members (HIP 2009). Based on NHIS, 17.2% of working adults were likely to have at least one family member whose medical care was delayed or who was not able to get needed medical care. A higher proportion of working adults who did not have paid sick days were likely to have family members who had delayed medical care or who had not received care they needed compared to those with paid sick days (23.7% vs. 12.9%). Notably, among those health insurance, those with paid sick days also experienced less delayed care (15.8% vs. 11.2%).

***Timely health care in working adults***

Timely primary care provides opportunities for disease prevention as well as early detection and management of health problems (IOM 1996). Timely primary care can potentially prevent the need for the unnecessary use of emergency rooms, hospitalization, complications, or more severe disease (AHQR 2004). For example, patients may be hospitalized or seek acute hospital care for avoidable reasons including misdiagnosis or a failure to detect the condition, inappropriate management including the lack of patient adherence to treatment recommendations, or failure by the patient to interpret symptoms as important (AHRQ 2004).

Timely ambulatory care is dependent on a number of factors including income and health insurance (Billings 1996; Newacheck 1998). Little research has explored the relationship between access to paid sick days specifically and primary care utilization. Based on 2007 NHIS data, we found that those with paid sick days were about 15% more likely to have a medical visit controlling for other potential predictors of medical visits (HIP 2009). The 2007 NHIS data also reveals that those who had paid sick days may be likely to visit an emergency room (ER) in the past year than those who did not have paid sick days (15.7% vs. 17.7%) particularly for those with health insurance.

***San Francisco's experience with paid sick day legislation***

In November 2006, San Francisco became the first city in the United States to require employers to provide paid sick days. Over 60% of voters in San Francisco supported this legislation. While formal studies of the laws implementation and impact are still underway, implementation to date has been largely unproblematic. One small survey found that "most employers were able to implement the paid sick leave ordinance with minimal to moderate effects on their overall business

and their bottom line" (Boots 2009). An analysis did not find evidence of loss of jobs in San Francisco in the year after the policy was implemented (Lovell & Miller 2008). Anecdotal assessments of the paid sick day law reported by several of the city business leaders also suggest there has been little to no impact on businesses.

***Conclusions***

A fundamental purpose of government is to ensure that day-to-day living and working conditions support health and welfare. Labor and occupational safety laws, including limits on child labor, the minimum wage, and work-time rules, were essential contributors to the dramatic gains in life expectancy in the 20th century. It is equally important today to think of labor policies as public health policies.

According to the Organization for Economic Cooperation and Development, the U.S. spends $6,102 per person on health care services—15% of our GDP and more than any other country the world (OECD 2006). Despite outspending our peers, life expectancy in the United States is a full year less than in Canada and England and three years less that Spain, Sweden, and Switzerland. One reason these other countries may be outperforming the US with respect to health is that they tend to pay more attention standards of healthy living and working conditions for all residents.

Overall, based on the research I and others have conducted, paid sick day legislation would be a practical and evidence-based public health policy to prevent communicable disease and to enable timely, preventative care for ourselves, our children and our elders. Guaranteeing the right to earn and use a minimum number of paid sick days may foster a workplace culture that is more conducive to appropriately taking time off when sick. Paid sick days would facilitate existing workplace policies designed to prevent food borne disease outbreaks. Adopting paid sick days would eliminate the perplexing contradiction between our strategies for containing new strains of influenza and labor laws. Finally, a paid sick day law has potential to reduce health disparities and control health care costs.

I thank you for your consideration of this testimony.

**References Cited**


1. Agency for Healthcare Research and Quality (AHRQ). (2004) Prevention quality indicators overview. Available at http://www.qualityindicators.ahrq.gov/pqi_overview.htm.
2. Available at: http://www.cdc.gov/flu/keyfacts.htm.
3. Bhatia R, Farhang L, Heller J, Capozza K, Melendez J, Gilhuly K, Firestein N. A Health Impact Assessment of the California Healthy Families, Healthy Workplaces Act of 2008. (2008) Oakland, California: Human Impact Partners and San Francisco Department of Public Health.
4. Billings J, Anderson GM, Newman LS. (1996) Recent findings on preventable hospitalizations. Health Affairs 15:239-49.
5. BLS (Bureau of Labor Statistics). (2006) Employment characteristics of families in 2005. Washington, D.C.: U.S. Department of Labor. Available at: http://www.bls.gov/news.release/pdf/famee.pdf.
6. Boots SW, Martinson K, Danziger A. (2009) Employers' perspectives on San Francisco's paid sick leave policy. Washington, D.C.: Urban Institute. Available at http://www.urban.org/publications/411868.htm
7. Calderon-Margalit, R, et al. (2005) A large-scale gastroenteritis outbreak associated with Norovirus in nursing homes. Epidemiol Infect. 133(1):35-40.
8. CDC (Centers for Disease Control and Prevention). (2008) U.S. Key Facts about Seasonal Flu. Available: http://www.cdc.gov/flu/keyfacts.htm.
9. CDC (Centers for Disease Control and Prevention). (2006) U.S. norovirus technical fact sheet. Available at: http://www.cdc.gov/ncidod/dvrd/revb/gastro/norovirus-factsheet.htm.
10. CDC (Centers for Disease Control and Prevention). (2008b) Preventing the spread of influenza (the flu) in child care settings: Guidance for administrators, care providers, and other staff Available at: http://www.cdc.gov/flu/professionals/infectioncontrol/childcaresettings.htm.
11. CDHS (California Department of Health Services) / Surveillance & Statistics Section. (2008). Available at: http://www.cdph.ca.gov/data/statistics/Pages/CD_Tables.aspx.
12. CDPH (California Department of Public Health). (2006) Recommendations for the prevention and control of viral gastroenteritis outbreaks in California long-term care facilities. Richmond, CA: California Department of Health Services.
13. Chung PJ, Garfield CF, Elliott MN, Carey C, Eriksson C, Schuster MA. (2007) Need for and use of family leave among parents of children with special health care needs. Pediatrics 119(5):e1047-55.
14. Clemens-Cope L, Perry CD, Kenney GM, Pelletier JE, Pantell M. (2007) Access to and use of paid sick leave among low-income families with children. Washington, D.C.: Urban Institute.
15. Copeland KA, Harris EN Wag NY, Cheng Tl. (2006) Compliance with American Academy of Pediatrics and American Public Health Association illness exclusion guidelines for child care centers in Maryland: Who follows them and when. Pediatrics. 118:1369-1380.
16. Davis K, Colins SR, Doty MM, Ho A, Holmgren AL. (2005) Health and productivity among U.S. workers. Washington D.C.: The Commonwealth Fund.
17. Ferguson NM, Cummings DA, Fraser C, Cajka JC, Cooley PC, Burke DS. (2006) Strategies for mitigating an influenza pandemic. Nature. 442:448-52.
18. Germann TC, Kadau K, Longini IM Jr, Macken CA. (2006) Mitigation strategies for pandemic influenza in the United States. Proc Natl Acad Sci USA. 103:5935-40.
19. Glass RJ, Glass LM, Beyeler WE, Min HJ. (2006) Targeted social distancing design for pandemic influenza. Emerging Infectious Diseases. 12:1671-81.
20. Gorkin L, Schron EB, Brooks MM, Wiklund I, Kellen J, Verter J, Schoenberger JA, Pawitan Y, Morris M, Shumaker S. (1993) Psychosocial predictors of mortality in the Cardiac Arrhythmia Suppression Trial-1 (CAST-1). American Journal of Cardiology. 71:263-267.
21. Guzewich J, Ross M. (1999) Evaluation of risks related to microbiological contamination of ready-to-eat food by food preparation workers and the effectiveness of interventions to minimize those risks. Available at: http://www.cfsan.fda.gov/~ear/rterisk.html.
22. Halloran ME, Ferguson NM, Eubank S, Longini IM Jr, Cummings DA, Lewis B, Xu S, Fraser C, Vullikanti A, Germann TC, Wagener D, Beckman R, Kadau K, Barrett C, Macken CA, Burke DS, Cooley P. (2008) Modeling targeted layered containment of an influenza pandemic in the United States. Proc Natl Acad Sci USA. 105:4639-44.
23. Hartmann HI. (2007) The Healthy Families Act: Impacts on workers, businesses, the economy, and public health. Testimony before the U.S. Senate Committee on Health, Education, Labor, and Pensions. February 13, 2007.
24. Heymann SJ, Earle A, Egleston B. (1996) Parental availability for the care of sick children. Pediatrics. 98:226-30.

25. Heymann SJ, Earle A. (1999a) The impact of welfare reform on parents' ability to care for their children's health. American Journal of Public Health. 89(4):502-5.
26. Heymann SJ, Toomey S, Furstenberg F. (1999b) Working parents: what factors are involved in their ability to take time off from work when their children are sick? Arch Pediatrics and Adolescent Medicine. 153:870-4.
27. Human Impact Partners and San Francisco Department of Public Health (HIP). (2009) A Health Impact Assessment of the Healthy Families Act of 2009. Oakland, California.
28. Institute of Medicine (IOM). (1996) Primary care America's health in a new era. Washington D.C.: National Academic Press. Available at: http://uclibs.org/PID/103619
29. Jones TF, Angulo FJ. (2006) Eating in restaurants: a risk factor for foodborne disease? Clinical Infectious Diseases. 43:1324-8.
30. Li JH, Birkhead GS, Strogatz DS, Coles FB. (1996) Impact of institution size, staffing patterns, and infection control practices on communicable disease outbreaks in New York State nursing homes. American Journal of Epidemiology. 143(10):1042-9.
31. Lovell V. (2006) Washington DC.: Institute for Women's Policy Research.
32. Lovell V. (2008) Valuing good health in California: The costs and benefits of the Healthy Families, Healthy Workplaces Act of 2008. Washington D.C.: Institute for Women's Policy Research.
33. Lovell V, Miller K. (2008) Job growth strong with paid sick days. Washington D.C.: Institute for Women's Policy Research. Available at: http://www.paidsickdaysca.org/pdf/IWPR_CA_report.pdf.
34. Mead PS, Slutsker L, Dietz V, McCaig LF, Bresee JS, Shapiro C, Griffin PM, Tauxe RV. (1999) Food-related illness and death in the United States. Emerging Infectious Diseases. 5:605-625.
35. Newacheck PW, Stoddard JJ, Hughes DC, Pearl M. (1998) Health insurance and access to primary care for children. New England Journal of Medicine. 338:513-9.
36. OECD (Organization for Economic Cooperation and Development Health Data) 2006 Available at: http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html
37. Pimoff and Hamilton (1995) The Time and Monetary Costs of Outpatient Care for Children. The American Economic Review. 85: 117-121.
38. Smith T. (2008) Paid sick days: A basic labor standard for the 21st century. Chicago, IL: National Opinion Research Center, University of Chicago. Available at http://news.uchicago.edu/news.php?asset_id=1433.
39. Taylor M. and P. O'Connor. (1989) Resident parents and shorter hospital stay. Archives of Disease in Childhood 64: 274-276.
40. Tsouna-Hadjis E., K.N. Vemmos, N. Zakopoulos, & S. Stamatelopoulos. (2000) First-stroke recovery process: The role of family support. Archives of Physical Medicine and Rehabilitation 81:881-887.
41. USDHHS (Department of Health and Human Services) (2007) U.S. Community Strategy for Pandemic Influenza Mitigation. Available: http://www.pandemicflu.gov/plan/community/commitigation.html#V.