



## Paid sick leave and preventive health care service use among U.S. working adults<sup>☆</sup>



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### ABSTRACT

Managing work and health care can be a struggle for many American workers. This paper explored the relationship between having paid sick leave and receiving preventive health care services, and hypothesized that those without paid sick leave would be less likely to obtain a range of preventive care services.

In 2016, cross-sectional data from a sample of 13,545 adults aged 18–64 with current paid employment from the 2015 National Health Interview Survey (NHIS) were examined to determine the relationship between having paid sick leave and obtaining eight preventive care services including: (1) blood pressure check; (2) cholesterol check; (3) fasting blood sugar check; (4) having a flu shot; (5) having seen a doctor for a medical visit; (6) getting a Pap test; (7) getting a mammogram; (8) getting tested for colon cancer.

Findings from multivariable logistic regressions, holding 10 demographic, work, income, and medical related variables stable, found respondents without paid sick leave were significantly less likely to report having used six of eight preventive health services in the last 12 months. The significant findings remained robust even for workers who had reported having been previously told they had risk factors related to the preventive services.

These findings support the idea that without access to paid sick leave, American workers risk foregoing preventive health care which could lead to the need for medical care at later stages of disease progression and at a higher cost for workers and the American health care system as a whole.

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### 1. Introduction

The benefits of preventive health care services include preventing illness and disease, slowing disease progression, and saving lives (Maciosek et al., 2010). It can also reduce health care expenses which topped \$3 trillion in the United States in 2014 by keeping disease from progressing and becoming costlier to treat (Health expenditures, n.d.). Federal health care initiatives have embraced the increased use of preventive health care services for Americans (Health expenditures, n.d.; Yong et al., 2011; Healthy people 2020, n.d.). Nevertheless, The Centers on Disease Control and Prevention report that Americans use clinical preventive care at about half the recommended rate (CDC. Preventive health care, n.d.).

Twenty million people have gained health insurance coverage through the Affordable Care Act (ACA) (Health insurance coverage

and the affordable care act, 2010–2016, n.d.). Since 2010, the ACA eliminated the cost-sharing requirements for 15 preventive screenings recommended by the U.S. Preventive Services Task Force including those for blood pressure, cholesterol, diabetes, and certain cancer screenings as well as influenza vaccinations for all insured adults (Preventive services covered under the ACA, n.d.). Despite this progress, barriers to accessing preventive health care services still exist.

Managing both employment and health care can be a struggle for many working Americans. Of the 68% of the civilian workforce that has paid sick leave benefits, only 31% of part-time workers have access to them (Selected paid leave benefits, n.d.). Compared to 22 similarly developed countries, the United States is the only one that does not mandate employers to provide paid sick leave benefits or include paid sick leave in a universal social insurance plan (Heymann et al., 2010). Sick leave not only allows workers to self-quarantine when they are ill, but also gives them time away from work to see a doctor for health care. When sick leave is unpaid or unavailable, workers may not be able to afford time away from work to get timely and preventive medical care. In the U.S., legislative momentum is building toward providing sick leave benefits for more workers. Legislation mandating paid sick leave has passed in 7 states (Connecticut, California, Massachusetts, Oregon, Vermont, Arizona, Washington), 29 cities, two counties and

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Washington, DC to date (A Better Balance, n.d.). At the federal level, in 2015, the Obama Administration signed an executive order requiring any company that contracts with the federal government to provide a minimum of seven paid sick leave days (Weisman, 2015).

Anderson's Health Behavior Model provides a theoretical framework for explaining health service use, and posits that behaviors can be predicted by analyzing predisposing, enabling and need factors (Kehrer et al., 1972). Predisposing factors are often measured using demographic characteristics including sex, age, race/ethnicity, and marital status. Enabling factors include socio-economic variables such as education, income, employment status and health insurance. Need factors are measured by general health status. The objective of this research was to examine the extent to which paid sick leave benefits are an enabling factor in explaining use of preventive health care services.

While previous research has evaluated paid sick leave in relation to cancer screenings, outpatient care, and having seen a medical professional, this is the first study to analyze these variables using data collected after the implementation of the ACA (Peipins et al., 2012; Cook, 2011). We also include preventive care variables never before analyzed in relation to paid sick leave including blood pressure, cholesterol, diabetes, and flu vaccinations. Since more workers are insured, and the ACA mandates that private insurers cover routine preventive screenings at no cost to the insured, what other factors contribute to low rates of preventive care use? We test the hypothesis that workers without access to paid sick leave benefits will be less likely to get needed preventive health care services than workers with access to paid sick leave benefits after controlling for sociodemographic variables.

## 2. Methods

### 2.1. Data sources and analytic sample

The NHIS has been conducted annually since 1957 and is managed by the National Center for Health Statistics (NCHS) which uses a multi-stage area probability design to produce a representative sample of non-institutionalized U.S. households. The interviews, in which respondents are asked about an array of health topics, are conducted with households in person or by phone with a randomly selected adult household member using computer-assisted personal interviewing (CAPI). More information on the NHIS is available at [http://www.cdc.gov/nchs/nhis/about\\_nhis.htm](http://www.cdc.gov/nchs/nhis/about_nhis.htm).

In 2016, the authors downloaded NHIS Public Release 2015 data from the National Center for Health Statistics (NCHS) website. The NHIS Basic Module contains the Family Core, Persons Core, and Sample Adult Core. The Family Core collects information on all family members in sampled households. The Sample Persons Core data are recorded for each person within each family. The Sample Adult Core data are recorded for one randomly selected adult within each family. By combining these data modules, and keeping the sample adult as the observational unit, data can be used from across the three datasets.

The analytic sample of 13,545 adults is derived from the merged Sample Adult ( $n = 33,672$ ) dataset. It includes adults aged 18–64 (excluded 1253 with age 65 or over) with current paid employment at the same job for at least one year. Respondents who reported that they work without pay, work in a family business, are self-employed, looking for work, or not working (excluded = 14,522) were excluded from the sample. Respondents that had missing data for an independent variable or any of the control variables were excluded (excluded = 1323). The paid sick leave variable used measures whether the worker has paid sick leave in their current job; however, the dependent variables used focuses on a previous 12-month time frame. To safeguard the validity of our measures, and assure we correctly classified workers paid sick leave status, we excluded those workers who had been employed for <12 months (excluded = 3029).

### 2.2. Measures

The primary independent variable, paid sick leave, was measured using a self-reported response (y/n) to the question “Do you have paid sick leave on this MAIN job or business?” The dependent variables included in this analysis represented eight preventive health screenings and services recommended for adults by the U.S. Preventive Service Taskforce and covered by the ACA (Starfield et al., 2008; U.S. Preventive Services Task Force, n.d.; Preventive services covered under the ACA, n.d.). Questions asked respondents about receipt of the following services from a doctor, nurse, or other health professional, “during the past 12 months did you receive...” 1) a blood pressure check; 2) cholesterol check; 3) fasting test for high blood sugar or diabetes; 4) influenza vaccine (shot or flu mist); 5) mammogram (only females); 6) Pap smear or Pap test (only females); 7) any test for colon cancer (including blood stool tests, colonoscopy and sigmoidoscopy); and 8) have they seen or talked to a “general” doctor or health care provider about their health.

Consistent with the Andersen model, three categories of ten theoretically relevant control variables related to the adult respondent's preventive health care service utilization were included. The three categories included 1) predisposing factors, 2) enabling factors, and 3) need factors. Variables that composed the predisposing factors included sex, age (in years), race/ethnicity (Hispanic, Non-Hispanic white, Non-Hispanic black, non-Hispanic other), and marital status (married/unmarried). Enabling factors included highest level of education (less than high school, high school degree or GED, some college), full-time work status (working  $\geq 35$  h in a previous week), total family income (ranging from less than \$35,000 to greater than \$100,000) and health insurance coverage (insured or uninsured). Need factors included having a limiting health condition (y/n), and health status (excellent/very good/good or fair/poor).

Because some of the guidelines for covered preventive care services under the ACA are specific to sex, age, pre-existing conditions and/or have health conditions (e.g., being overweight or obese), our analysis took these factors into account. To explore the extent to which receipt of paid sick leave was related to preventive care services for respondents who were at higher risk, the analyses used additional controls for ever having “been told by a doctor or other health professional that...” the respondent had: hypertension, high cholesterol, diabetes or pre-diabetes, coronary heart disease, had a heart attack, any kind of heart condition or heart disease, angina, asthma, or a stroke. Analyses using the interactions of these specific variables with paid sick leave were performed but are not reported since they added little explanatory information.

### 2.3. Statistical analysis approach

Eight separate multivariable logistic regressions were performed using paid sick leave as the primary independent variable to explain each of the outcome variables related to obtaining preventive medical services in the last year, and including each of the control variables listed above. Analysis were run separately for the entire analytic sample and for a subset of adults based on published guidelines regarding age, sex, weight and risk factors (see footnotes Table 2).

All analyses were performed using SAS software (version 9.4) in the fall of 2016.

## 3. Results

In the sample, a total of 8505 (62.8%) had paid sick leave benefits, and 5040 (37.2%) did not. The sample's full demographic profile is displayed in Table 1.

Based on multivariable logistic regressions performed to examine the relationship between paid sick leave and obtaining preventive care services, for workers without paid sick leave, the odds were that

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