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Family Leave Benefits: a Public Health Perspective

Christine Rose Langton

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FAMILY LEAVE BENEFITS
A PUBLIC HEALTH PERSPECTIVE

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A Thesis
Submitted in Partial Fulfillment of the
Requirements for the Degree of
Master of Public Health
at the
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I would like to thank Joan Segal, my major advisor, for her efforts in reviewing and advising me on this thesis and for making graduation in Spring 2002 a reality for me. Not only did Joan make personal sacrifices at the end so I could meet the graduation deadline, she provided consistent and solid guidance from the beginning of my studies in the Master of Public Health program. She also taught me many important lessons in writing a research paper. I am appreciative to Joan for her support.

I would also like to thank my associate advisors, Barbara Blechner and Susan Reisine, for their willingness to serve on my committee, insightful input and ability to make themselves available with very short notice.

I would like to thank my friends who listened when I needed to talk and encouraged me to finish so we could finally celebrate.

I would like to thank my family for making the pursuit of graduate education an achievable goal. I thank my parents, Rosemarie and Christian Huber, who watched my children during five critical days in April 2002 while I completed my first draft. I thank my siblings and siblings-in-law who expressed sincere interest in my new endeavors, helped with the children and wished me well throughout the years. I thank my in-laws, Claire and Jack Langton, who watched the children more than usual during the past months affording me sufficient time to work on the thesis. Especially Claire, who never waited for me to ask for childcare assistance, instead she offered it whenever she could, because she truly understood the significance of this pursuit and the importance of completing the program at this time.

Most importantly, I would like to thank my husband and children. Bob has been extremely supportive of my studies during the last 10 years. Not only has Bob supported my educational goals; he fully backed my career change and accepted the sacrifices along the way. Jack and Christina were particularly good-natured during the past few months when I had to work on weekends or send them different places during our usual weekdays together. The baby inside me provided the motivation I needed to finally complete this program. I am exceedingly grateful for their loving devotion.
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Introduction

The United States is a country that prides itself on family values, particularly the importance of children. Yet, when it comes to children and working families, statistics and personal anecdotes seem to paint a different picture. The United States has some of the most advanced medical care available in the world, yet some of the poorest health outcomes in relation to other countries, particularly for children. Statistics concerning America’s children are staggering. One in three American children will be poor at some point in their childhood. One in six American children are born to a mother who did not receive prenatal care in the first three months of pregnancy. One in seven American children have no health insurance. One in 13 children are born with a low birthweight (less than 5 lbs. 8 oz). One in 26 children are born to a mother who received late or no prenatal care. One in 139 American children will die before their first birthday.¹

When looking at these statistics from a daily perspective, they are even more discouraging. Every day in America, 2,019 babies are born into poverty, 1,310 babies are born without health insurance, 825 babies are born at a low birthweight, 157 babies are born at a very low birthweight (less than 3 lbs. 4 oz), 401 babies are born to mothers who had late or no prenatal care and every day in America 77 babies die.¹ These statistics can also be broken down to a momentary view and what they reveal is particularly daunting. Every 43 seconds in America a baby is born into poverty, every two minutes a baby is born at a low birthweight, every four minutes a baby is born to a mother who had late or no prenatal care and every 19 minutes in America a baby dies.¹

Comparing these figures to international statistics also paints a disturbing picture. Among industrialized countries the United States ranks 11th in the proportion of children living in poverty, 16th in efforts to lift children out of poverty, 17th in rates of low birthweight births and 23rd in infant mortality. “Of the 154 members of the United Nations, the United States and Somalia (which has no legally constituted government) are the only two nations that have failed to ratify the U.N. Convention on the Rights of the Child.”¹

Working parents and working families face unique concerns when it comes to the interaction of their jobs and dealing with their health and the health and well-being of their children and families. There are many anticipated and unanticipated times during a person’s working years in which the need may arise
to interrupt the work cycle to address the health issues of self and others. Unfortunately, as this thesis will examine, this country, including our federal government and many employers, does not always provide the necessary supports for working families to address health and family needs appropriately. The overall health of our nation may be negatively impacted as a result.

One of many real stories regarding the lack of family leave benefits in this country comes from the Agoratus family from Mercerville, NJ. In 1992 the Agoratus’ daughter was born with a life-threatening kidney disease. Ms. Agoratus’ employer allowed her to take an extended, unpaid leave to care for her ill child. The condition for the leave specified by the employer enabled Ms. Agoratus to stay on leave until her daughter was well enough to be placed in daycare. The following year the Agoratus’ placed their daughter in daycare and Ms. Agoratus returned to work. Six months later, the daughter’s condition deteriorated and Ms. Agoratus was forced to take another unpaid leave, this time for four months. This second unpaid leave in conjunction with medical expenses associated with their daughter’s illness placed the Agoratus family in a precarious financial situation. Once the child was healthy, Ms. Agoratus worked approximately 70 hours per week for five years to help her family achieve financial stability. The Agoratus’ story is one of countless others demonstrating how the lack of supports for working families in this country has a damaging impact on our public’s health.

Can America ever escape this dire reality when it comes to the state of America’s children and working families? Many advocates for children and families hope so. As Marian Wright Edelman, founder and president of the Children’s Defense Fund (CDF), declared recently, we have a president who has “repeatedly used CDF’s trademarked mission words and has promised to Leave No Child Behind®”. Until very recently, the American economy was one of the wealthiest in history with unprecedented economic growth for almost a decade, yet the issues of children and families have often been neglected and under-funded. Obviously, there are always issues of equal significance competing in the political arena, but the current global situation poses new and unique burdens on our government. Regrettably, due to the September 11, 2001 terrorist attacks, the War on Terrorism and the current violence in the Middle East, the road to progress for children and family issues in this country will most likely be even more challenging. However, the issues pertaining to children and families are still of great magnitude and cannot
be overlooked. It is the hope of myself and many interested public health advocates that they are not forgotten.

Of course, the issues presented above and many other issues affecting our nation’s health are already being addressed in many different ways and from many different facets. For example, the issue of infant mortality is continually being addressed via advances in medical technology, by the provision of prevention programs such as putting babies to sleep on their back to prevent sudden infant death syndrome and the federally funded Healthy Start program which, among many of its activities, includes sending outreach workers into high risk communities to bring pregnant women into prenatal care during their first trimester. Activities such as these are being implemented by health care providers, social workers, local public health departments and various other individuals and organizations in our communities. These are fairly apparent and concrete ways to address the issue of infant mortality, yet many believe that programs and policies not so clearly linked to infant mortality can also make a difference. Providing family leave benefits to all working Americans is one of these notions and the topic that will be explored in this thesis.

When exploring and discussing the topic of family leave benefits there are many related and overlapping issues that also demand attention and focus. Examples of such issues include provision of affordable and quality child care and the lack of universal health insurance in this country. Although these issues are of great importance, the focus of this thesis will concentrate strictly on the issue of family leave benefits and how they impact public health. After defining the issue of family leave benefits and presenting it from a national and international perspective, I have presented my findings from an extensive literature review. Although much has already been documented on this issue from a political and workplace viewpoint, I have attempted to bring together the work that has particularly focused on this issue from a public health perspective and to demonstrate the need for expanding family leave policies in the United States. In my thesis, I have attempted to show how the provision of family leave benefits relates to positive health outcomes or at least are essential in relation to critical health issues throughout the life cycle. My findings are presented from the time a woman becomes pregnant, from infancy through childhood, from adulthood to meeting the critical health needs of the expanding elderly population in our country. I conclude with an overview of how the issue is currently being addressed at the federal and state level and with recommendations for future research in this area.
Definition of Terms

The term family leave benefits “describes a variety of ways to help people afford time off from work when a baby is born or adopted, when a close relative is seriously ill, or when workers themselves need medical care.” Several other terms are used to describe specific elements of the more generic concept of family leave. The term parental leave includes “several different types of leaves that permit women and men to take time off from work at the time of childbirth, adoption, or other family needs.” The intention of parental-leave policies is to “facilitate the reconciliation of employment responsibilities with the demands of parenting.” Parental-leave policies recognize the need for bonding and nurturing with a newborn infant. These gender-neutral policies typically allow men and women to share the leave or choose which of them will use it. Typically, although not always, “parental leave policies provide the right not only to a job-protected leave but also to some income replacement during the leave.” The term maternity leave applies to women at the time of childbirth taken for the purposes of physical recovery and caring for the baby. The term paternity leave applies specifically to fathers for the purpose of caring for the baby. Paternity leaves are usually much briefer and serve as supplements to maternity leaves. Medical leave is a term used to describe time off from work necessary for attending to a injury, illness, disability or other health condition.

United States History & Policies

The first law in the United States falling under the umbrella of family leave benefits was the Pregnancy Discrimination Act of 1978. This law guarantees that “health insurance benefits for sickness or temporary physical disability are extended to female employees disabled by pregnancy, miscarriage, childbirth, abortion, or recovery from these conditions.” Although this law assured that medical leave for pregnancy-related conditions was identical to or better than existing disability benefits and leave, it provided no other protections for pregnant women or working Americans facing unexpected health situations.

In the mid-1980s family leave benefits became an important issue in the United States, particularly to many feminists. At this time the United States was one of only two industrialized nations in the world to have no national maternity leave policy. South Africa was the other nation. California attempted to address this issue by mandating maternity leave for childbirth in that state. In 1984, a federal district court
struck down this California law citing that the law was discriminatory against men. It was the turnover of this California law that brought the issue of family leave benefits to the attention of many people interested in women's issues and civil rights. In 1984, a democratic congressman from California solicited help from the National Partnership for Women & Families (formerly known as the Women's Legal Defense Fund) to frame a bill that “would not only meet the needs of new mothers, but address a wider range of work/family conflicts affecting both women and men.” A version of this legislation was introduced in Congress every year after until the Family and Medical Leave Act became law in 1993. Although there was much support for the legislation from over 100 organizations, the opposition from business interests and trade associations was just as strong and effectively stalled the legislation for nine years. The legislation eventually passed both the House and the Senate in 1990 and 1991, but was vetoed both times by then-President George Bush. By 1993, the United States was alone in its status “as the only industrialized nation to have no national family leave policy.”

In 1993, the federal Family and Medical Leave Act (FMLA) was the very first bill signed into law by former president Bill Clinton. The law became effective August 5, 1993. This law provides eligible employees with an entitlement of up to 12 weeks unconditional leave in a 12-month period. Employers required to provide the leave must meet the following criteria: (1) engage in a business that somehow affects commerce; (2) employ at least 50 employees for every workday during 20 work-weeks in the current or preceding calendar year within a 75-mile radius of the work-site. In addition, all public agencies, including state, local and federal employers and public schools, are covered by FMLA, regardless of the number of employees. Employees are eligible to take the leave if they have been employed for at least one year by the employer and if they have worked at least 1,250 hours in the same 12-month period with the employer. In order to qualify for leave the employee must request leave for one of the following four reasons: (1) because of the birth of a child of the employee and in order to care for that child; (2) because of the placement of a child with the employee for adoption or foster care; (3) in order to care for the spouse, child or parent of the employee, if the spouse, child, or parent has a serious health condition; (4) because of a serious health condition that makes the employee unable to perform the functions of his or her position. The law stipulates very specific conditions for meeting the definition of serious health condition, but in general terms a serious health condition means an illness, injury, impairment, or physical or mental...
condition that involves a period of incapacity or treatment connected with inpatient care in a hospital, hospice, or residential medical-care facility. It can also mean continuing treatment by a health care provider including a period of incapacity due to: (1) a health condition lasting more than three consecutive days; (2) pregnancy or prenatal care; (3) a serious chronic health condition; (4) a permanent or long-term condition for which treatment may not be effective; (5) any absences to receive multiple treatments for restorative surgery. While the employee is on leave, the employer must maintain his or her group health benefits. Upon return from leave, the employee is entitled to be restored to the employment position held before leave or to an equivalent position with equivalent benefits.\textsuperscript{11,12} There is an exclusion to the job-protected portion of the law allowing employers to make exceptions “where an employee is in the top 10% salary range in the organization and where the employer would face an economic hardship by retaining the position for the employee.”\textsuperscript{9} The leave guaranteed by the FMLA is an unpaid leave, yet employers have the option of requiring employees to use any accrued vacation leave or sick leave as part of the total 12-week leave. The original law limited the usage of sick leave under FMLA to 13 days for meeting the serious health care needs of a spouse, child or parent, but as of June of 2000 the law was expanded to allow an employee to use up to 12 weeks of accrued sick leave each year for this purpose in addition to FMLA.\textsuperscript{13}

The Family and Medical Leave Act became “America’s first federal policy explicitly designed to help employees balance work and family. It broke new ground by requiring employers to acknowledge employees’ critical family obligations,” and by recognizing that women and men share the economic and care-giving role.\textsuperscript{10} The FMLA has enabled an estimated 35 million working women and men to take leave since 1993. Contrary to the belief of those opposing the law, business does not appear to have been burdened by the law. A survey conducted in 1998 of businesses with 100 or more employees (all covered by the law) “found that 84% reported no costs or actual cost savings as a result of their family and medical leave policies.”\textsuperscript{10} Nevertheless, the law does not cover many working Americans. Due to the many qualifying conditions associated with FMLA, only 58.3% of workers\textsuperscript{14} (approximately 55 million) in the United States are covered by the FMLA, leaving 41 million workers uncovered.\textsuperscript{15}

After the passage of the law, Congress created the bipartisan Commission on Leave “to measure the FMLA’s affect on employers and employees.”\textsuperscript{10} The Commission conducted surveys in 1995 and reported on the results in a 1996 report, \textit{A Workable Balance: Report to Congress on Family and Medical
Leave Policies. The Department of Labor updated these surveys in 2000. Overall, the surveys exhibited the disappointing under usage of the FMLA benefit. The following are some of the key findings. The use rate among covered and eligible employees is 1.9% per year. Among those who took an FMLA covered leave, 6.4% used the leave to care for an ill spouse; 7.9% for maternity disability; 11.5% to care for an ill child; 13.0% to care for an ill parent; 18.5% to care for a newborn, newly adopted or newly placed foster child; and 52.4% due to reasons related to their own health. The median leave taken is 10 days long. For those who did take leave, 78.7% stated that the leave had a positive effect on their ability to care for family members. Of those reporting the leave having a positive health affect, 93.5% of these individuals indicated that the leave made it easier to comply with doctor’s instructions and 83.7% reported that the leave led to a quicker recovery time.

In both the 1995 and 2000 surveys it was found that approximately “78% of those who needed but did not take leave said that their inability to afford unpaid leave was a reason for their decision.” Thirty-four percent of leave-takers received no pay during their leave, and in 1995 “almost one in ten workers who took leave and did not receive full pay reported they were forced to go on public assistance. This rate doubled to one in five workers with annual family incomes below $20,000.” For those who did receive pay the money basically came from sick pay benefits, vacation time or disability insurance. “The workers most likely to receive wage replacement under FMLA are Caucasian, salaried, highly educated, unionized and have higher household incomes. The employees least likely to collect wage replacement are those older or younger with low levels of income and/or education and who are Latino.” In fact, “76% of low-income workers lack sick leave and 58% lack vacation leave.” Yet, low-income families have a more pressing need for family and medical leave than do families of middle or higher incomes as they tend to experience poorer health. In comparison to those of all income levels, low-income adults are nearly twice as likely to be in fair or poor health as those with higher incomes and children in low-income families are 60% more likely to be in fair or poor health. As a result of these findings, the Commission on Leave called for consideration of a “uniform system of wage replacement during periods of family and medical leave.”

Separate studies regarding leave policies in general (not necessarily FMLA leave) had similar findings. In a survey pertaining to time taken off work after childbirth conducted at 12 months postpartum,
it was found that mothers took an average of 8.5 weeks of leave. Fifty percent of the women said they wished they had taken a longer leave and an additional 17% said they should have worked fewer hours per week in the year after birth. When asked why they did not take longer leaves, 46% of the respondents reported that they needed the money or could not afford a longer leave.\textsuperscript{18}

**State Policies**

It is important to point out that the FMLA sets a minimum policy for employers, but many states and private companies provide family leave benefits that are more generous than the federal legislation. The Family and Medical Leave Act “allows states to set standards that are more expansive than the federal law”\textsuperscript{19} and in 1999, there were 19 states that had family leave laws applying to both private-sector and public employees that were in some way more expansive than the federal law. Essentially, these 19 states are considered more expansive either because they “include employers with fewer than 50 employees or because they broaden the reasons for leave to include such activities as participation in children’s school activities or for family medical needs not currently covered under the federal law.”\textsuperscript{20} The National Partnership for Women and Families provides details on their web-site of the specific elements of each state law. Table 1 provides a brief summary of their findings.
Table 1 – Summary of State Family Leave Laws as of 1999

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<th>States</th>
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<td>VT, DC, OR</td>
<td>Comprehensive family and medical leave laws that apply to employers of fewer than 50 employees. Vermont mandates coverage of businesses with 10 or more employees for leaves for new child or adoption and businesses with 15 or more employees for leaves for family members or own medical condition. The District of Columbia mandates coverage for 20 or more employees and Oregon for 25 or more.</td>
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<tr>
<td>KY, HI, MT, CT, IA, CA, MA, NH, MN, LA, PR</td>
<td>Narrower leave laws that apply to employers of fewer than 50 employees. Generally, these laws cover mandated maternity disability for small to mid-size businesses. Puerto Rico is the most liberal, mandating all businesses to provide leave for maternity disability, and the remaining states mandate leave for businesses from one to 25 employees.</td>
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<tr>
<td>CA, DC, IL, LA, MA, MN, NV, VT</td>
<td>Required leave for participation in children’s educational activities. Nevada is the most generous, with no maximum time specified; and California follows, mandating up to 40 hours per year.</td>
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<tr>
<td>MA, VT</td>
<td>Required leave for family medical needs not covered by the federal law. Massachusetts mandates 24 hours leave per 12 months for accompanying a child, spouse, or elderly relative to routine medical, dental, or other professional medical appointments. Vermont mandates 24 hours leave per 12 months for seeing to the routine or emergency medical needs of a child, spouse, parent, or parent-in-law, but no more than four hours in any 30-day period.</td>
</tr>
<tr>
<td>DC, HI, OR, VT</td>
<td>More expansive definition of a “family member” for whose illness an employee may take a family medical leave. All four states allow family medical leave for parent-in-laws, while Hawaii also includes grandparents and grandparents-in-law. The District of Columbia is the most expansive, including all relatives by blood, legal custody, or marriage, and people with whom employees live and have a committed relationship.</td>
</tr>
<tr>
<td>CA, CT, DC, LA, OR, PR, RI, TN</td>
<td>Longer periods of family and medical leave. California provides the most expansive coverage by providing an additional four months maternity disability leave on top of the federally mandated 12 weeks family leave for a total of 28 weeks per year.</td>
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Currently, five states (California, Hawaii, New Jersey, New York and Rhode Island) and Puerto Rico utilize temporary disability insurance (TDI) to help provide paid leave to workers. Under these TDI programs, all employers provide disability insurance, through which workers out on disability leave receive income. Administered as part of a state plan or via private insurance, these programs cover pregnant women on disability and women recovering from childbirth. However, fathers or those caring for other family members are not covered. While income received by workers under these state policies varies,
generally the payments are awarded on a sliding scale depending on an employee’s salary. The average payment is $229 a week, with Rhode Island having the most generous benefit of $504 a week. These TDI programs have been in effect for over 40 years.

Although these 19 states are quite progressive compared to the rest of the states in that they are providing paid maternity leave for working mothers, the unfortunate reality is that pregnant and postpartum women must be classified as disabled in order to receive the benefit. Each state law has specific language regarding eligibility for the benefit and all five states classify pregnancy as a disability. The state of California defines disability as “any mental or physical illness or injury which prevents you from performing your regular or customary work. This includes illness or injury resulting from pregnancy, childbirth, or related conditions.” The state of New Jersey is generous in that it provides up to four weeks prior to the birth of a baby as well as six weeks after the baby is born. However, in order to receive the benefit a doctor must certify that the mother is disabled. If the only way for pregnant and postpartum mothers to receive paid benefits is to be classified as sick, injured or disabled, we are probably a long way from having fathers qualify for paid leave benefits at the birth of a child. Workers who need time to take care of another family member are even less likely to be covered, as these situations are even more remotely related to having a disability than is childbirth.

The state of Minnesota is also providing a form of paid parental leave, but only to low-income working parents. The At-Home Infant Child Care (AHIC) Assistance program provides funding to qualifying families to stay home for the first year of their baby’s life. In order to qualify, the parent must meet the following conditions: be working, going to school or looking for work before the baby is born; meet income guidelines; be 18 years or older and care for their infant full-time in their home; and not currently receiving cash assistance from the state or child care assistance. Qualifying parents may participate in the program for a total of 12 months in a lifetime and the time spent can be with one infant or divided among subsequent births. The benefit is paid monthly and is dependent on family income and size.

Many American firms carry short-term disability policies that mothers can use before or after childbirth. Most companies include short-term disability as a standard benefit, but others offer it to employees for purchase. Disability benefits generally cover six weeks for vaginal delivery and eight weeks
for cesarean delivery. Short-term disability policies usually pay 50% to 100% of an employee’s salary during the disability period. It is rare, however, for fathers to be permitted to take advantage of the short-term disability benefit for paternity leave. Many companies also provide paid sick leave and vacation leave that employees use for the birth of a child or serious health condition.29

In November 2001, Working Mother magazine profiled a private company that offers an extremely generous and family friendly leave policy. Schlumberger Limited, a multibillion-dollar, worldwide provider of oil and technical services, offers a standard paid maternity leave of six to eight weeks. Moreover, the mother receives an additional six paid weeks that she can either take at the time of delivery or take as pay and use however she chooses. Additionally, parents can take three weeks off in addition to their vacation during the child’s second and third year of life.30 Competition in hiring is a considerable incentive for these type of policies as they unquestionably make companies more attractive to potential employees who are starting their families, yet they are also a way to provide flexibility and support to parents during a critical time in their lives. Unfortunately, the amount of paid leave provided by employers in this country has fallen recently. In 1986, 70% of those working in medium and large private establishments were offered some paid sick leave, but by 1997 the percentage dropped to 56.31

International History & Policies

The first national social insurance law was enacted in 1883 in Germany. This law provided health insurance, paid sick leave and paid maternity leave and was enacted as a way to bind workers and other groups to the state out of concern over rising social unrest in the country. France followed shortly thereafter with a similar policy. In 1919, the International Labor Organization (ILO) adopted its first convention pertaining to maternity protection entitling women working in industry and commerce to a maternity leave of 12 weeks. The recommendation was to offer an equal amount of leaves both before and after childbirth, but the leave after childbirth was compulsory. The convention also called for a cash benefit equaling at least two-thirds of the mother’s earnings. By 1921, the ILO recommended that this protection be extended to agricultural workers as well. Provisions to new mothers were based on the supposition that “relieving women of the pressures of the workplace for a brief time before and after birth while protecting their economic situation would protect and promote the physical well-being of women and
The second ILO convention regarding maternity protection was adopted in 1952 and extended the 12-week leave to 14 weeks (six before and eight after birth) at full wages.

In addition to understanding the global context in which these policies were formulated, it is important to note that each country had its own historical and cultural reasons for beginning to enact these policies. Sweden, for example, suffered severe losses during World War II and many of its family leave policies were part of a broader pronatalist policy designed to restore the Swedish population, as well as bring skilled female workers into the labor force. Later on the Sweden policies were also an effort designed to ensure gender equity and to increase the participation of fathers in childrearing. Legislation was also easily passed in China and Italy during the 1950s because supporting working families was aligned with those countries’ values regarding women and children.

By 1975, many countries belonging to the international group Organization for Economic Cooperation and Development (OECD) had expanded their family leave policies by offering much more generous maternity leaves and moving in the direction of parental leaves. The reasons for these expansions came from several different directions. Some countries were experiencing high rates of unemployment and therefore generous maternity benefits encouraged women with very young children to withdraw from the work force, at the same time keeping child care costs down for women who remained. Other countries needed women in the work force and gender-neutral parental leave policies encouraged women to continue working. Furthermore, some countries were experiencing falling birthrates and wanted to promote maternal employment by assisting mothers in balancing home and family life and to increase fertility by reducing the costs of raising children. In 1974, Sweden was the first country to introduce the first gender-neutral leave permitting either the father or mother to stay home and care for the baby. In 1992, the European Union issued a directive mandating a paid 14-week maternity leave, which was followed in 1998 by another directive mandating a three-month parental leave.

Currently the goals of family leave benefits are multi-faceted, although not every country providing the benefits has the same underlying reason for the provision. The primary goals of family leave benefits now include:

- protecting the physical health of mother and child by assuring women a core period in which they are entitled to a leave while they recover physically from giving birth;
- promoting the emotional well-being of new parents by assuring them some time for bonding without suffering financial penalties;
- enhancing infant development by
extending parental leaves to cover at least the first six months of the infant’s life (or the
first few months after adoption); facilitating early labor force attachment of young
women by creating an incentive to defer childbirth until they have some work experience;
protecting the economic situations of families with young children by providing cash
benefits while a parent is on leave; protecting the economic situations of women by
facilitating continued labor force attachment and thereby avoiding the wage penalty that
women experience when they interrupt their work histories; enhancing gender equity and
contributing to new gender roles by extending the policy to fathers as well as mothers.6

Recent and comprehensive international perspectives on family leave benefits are well
documented by other sources.6,8 Consequently, I will not repeat these findings in this thesis, but instead I
will provide a brief overview. Table 2 documents the childbirth-related leave policies in the United States
and 10 peer nations as of 1997.
Table 2 – Childbirth-Related Leave Policies in the United States and 10 Peer Nations as of 1997

<table>
<thead>
<tr>
<th>Country</th>
<th>Type of Leave Provided</th>
<th>Total Duration (in months)</th>
<th>Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>12 weeks of family leave</td>
<td>2.8</td>
<td>Unpaid</td>
</tr>
<tr>
<td>Canada</td>
<td>17 weeks maternity leave 10 weeks parental leave</td>
<td>6.2</td>
<td>15 weeks at 55% of prior earnings 55% of prior earnings</td>
</tr>
<tr>
<td>Denmark</td>
<td>28 weeks maternity leave 1 year parental leave</td>
<td>18.5</td>
<td>60% of prior earnings 90% of unemployment benefit rate</td>
</tr>
<tr>
<td>Finland</td>
<td>18 weeks maternity leave 26 weeks parental leave Childrearing leave until child is 3</td>
<td>36.0</td>
<td>70% of prior earnings 70% of prior earnings Flat rate</td>
</tr>
<tr>
<td>Norway</td>
<td>52 weeks parental leave 2 years childrearing leave</td>
<td>36.0</td>
<td>80% of prior earnings Flat rate</td>
</tr>
<tr>
<td>Sweden</td>
<td>18 months parental leave</td>
<td>18.0</td>
<td>12 months at 80% of prior earnings, 3 months flat rate, 3 months unpaid</td>
</tr>
<tr>
<td>Austria</td>
<td>16 weeks maternity leave 2 years parental leave</td>
<td>27.7</td>
<td>100% of prior earnings 18 months of unemployment benefit rate, 6 months unpaid</td>
</tr>
<tr>
<td>France</td>
<td>16 weeks maternity leave Parental leave until child is 3</td>
<td>36.0</td>
<td>100% of prior earnings Unpaid for one child; paid at flat rate (income-tested) for two or more</td>
</tr>
<tr>
<td>Germany</td>
<td>14 weeks maternity leave 3 years parental leave</td>
<td>39.2</td>
<td>100% of prior earnings Flat rate (income-tested) for 2 years, unpaid for third year</td>
</tr>
<tr>
<td>Italy</td>
<td>5 months maternity leave 6 months parental leave</td>
<td>11.0</td>
<td>80% of prior earnings 30% of prior earnings</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>18 weeks maternity leave 13 weeks parental leave</td>
<td>7.2</td>
<td>90% for 6 weeks and flat rate for 12 weeks, if sufficient work history; otherwise flat rate Unpaid</td>
</tr>
</tbody>
</table>


In 1997, 129 of the 158 countries reporting to the International Social Security Association provided some type of paid maternity leave. The average length of leave worldwide was up to 16 weeks (four months), including six to eight weeks before and the rest after birth. For developed countries reporting to the Organization for Economic Cooperation and Development (OECD) group, the average
length of leave was 10 months. As Table 2 exhibits, the Nordic countries are even more generous with childbirth-related leaves, which range from 18 months in Denmark and Sweden to three years in Norway and Finland. The continental European countries are also generous with leaves ranging from 11 months in Italy to 3.3 years in Germany. In some countries six weeks before birth and six weeks after birth is compulsory.

Wage replacement is a component of almost every leave policy of these 129 nations. In 57 of the 129 countries providing paid maternity leave (45%), the cash benefit replaces the full wage. In most countries (57%) the benefit is between 80%-100% of wages and only six countries (5%) replace less than 40% of wages. Sixteen countries provide a supplementary, paid parental leave (i.e., above and beyond the maternity and paternity leaves.) The average length of paid leave including the supplemental leave in 16 European countries is 24 months. Seven countries provide a paid paternity leave typically a few days in length although the Scandinavian countries do more. Unfortunately, the paid paternity leaves are under utilized, but some countries such as Norway and Sweden have recently implemented incentives to have fathers take advantage of these benefits. The cash benefit received is typically part of the social insurance or social security system in almost all countries. In most countries the employer and the government contribute to the system although in several countries the employee also contributes. Most benefits are paid through the temporary disability system although several countries utilize the unemployment insurance system. Some countries also offer supplementary unpaid parental leaves. The United States, Australia and New Zealand are the only three industrialized countries that do not provide a paid parental leave, although they do provide unpaid parental leave. The United States has the shortest length of unpaid leave at 12 weeks, compared to Australia and New Zealand which provide one year unpaid leave. Family leaves to care for ill children or family members are becoming more prevalent, but are limited to a few days, except in the Nordic countries. Sweden is unique in that it provides paid time off for parents to visit a child’s school and Greece provides unpaid time off for the same purpose. Other maternity-related benefits available in some countries include a nursing allowance, a grant for the purchase of a layette and a lump sum maternity grant.

Most countries require a minimum employment history in order to receive the benefit. Almost all countries provide universal benefits; thus eligibility is not based on income and typically the benefit is tax-
Adoptive parents are typically eligible for the benefits. Coverage is extensive in the advanced industrialized countries in that almost all employed women who give birth are covered by the policies and almost all take the leave. Coverage is less extensive in the less-developed countries because large numbers of women work in the hidden or informal economy. Coverage is extensive for fathers as well, but there are large variations among countries of fathers who actually take advantage of the policies. 6

The Prenatal Health of Women

It is universally accepted that the overall general health of a pregnant woman and the personal choices she makes during her pregnancy regarding food and other substances directly impact the health of the unborn baby. The most ubiquitous guidelines recommended by practitioners suggest that pregnant women eat healthfully, consume at least 1500 mg of calcium per day, take a prenatal vitamin before and during pregnancy and avoid chemical substances such as tobacco, alcohol and illegal drugs, as well as most over-the-counter medications. Individual practitioners may make additional or modified recommendations.

Need for Medical Leave

Although many working women have normal and healthy pregnancies and are able to maintain their normal work schedule throughout their pregnancy, there are a large proportion of pregnant women for whom continuation of work may be hazardous to the mother or the baby. A study conducted by Frazier et al. 34 in 2001 found that 27.7% of their sample of 1,635 employed pregnant mothers were advised by a physician or nurse to stop working. In 59.7% of the cases the recommendation was made because of labor, high blood pressure, or vaginal bleeding. The remainder of the women were advised to stop working because of swelling, fatigue, stress, or other factors. The rate of low birthweight infants for these two groups and the group of women who were not advised to stop working was statistically significant. In the group that was advised not to work due to labor, high blood pressure, or vaginal bleeding, 13.4% had low birthweight babies, compared to 6.9% of the group experiencing swelling, fatigue, stress, or other factors and 5.8% of the group not receiving a recommendation to stop working. Clearly, a significant number of women need to take time off work during their pregnancy, underscoring the related need of expanded family leave benefits for these women.
Physical Activity

Unfortunately, there does not appear to be a consensus regarding employment-related physical activity for pregnant women and thus there are no generally accepted principles in this country regarding work and pregnancy. In 1995 Gertrud Berkowitz performed an extensive review of the literature regarding employment-related physical activity and its potential impact on pregnancy outcome. Many studies were conducted in various settings and although some do show a correlation between physical activity at work and adverse pregnancy outcomes such as preterm delivery (delivery prior to 37 weeks gestation) and low birth weight babies, many other studies cannot confirm these findings. On the other hand, there was consistency among studies on specific working conditions, suggesting that prolonged standing and long working hours may increase the risk of preterm birth.

Despite the inconsistencies, the author made the observation that there are enough findings to suggest that pregnant women may need to be relieved of certain work duties or stop working prior to delivery in order to avoid potential adverse pregnancy outcomes. Other countries seem to have taken findings such as these into consideration when formulating their maternity leave policies, whereas the United States has failed to do so. Many countries, as discussed earlier, provide paid leave both before and after delivery, while the United States only provides 12 weeks total unpaid leave. France provides six weeks paid leave prior to delivery and Italy provides eight weeks. Although the United Kingdom provides up to 11 weeks maternity leave prior to delivery, the reimbursement system is more complex and limited than in other countries.

Some countries also regulate the activities of employed pregnant women closely. In Germany, for example, pregnant women “cannot be forced to work overtime, on Sundays, holidays, or between the hours of 8 PM and 6 AM.” In France, pregnant women may be excluded from certain jobs, “such as outside work in temperatures below zero degrees Celsius.” These findings, in conjunction with the changing dynamic of women and pregnant women in the workforce, make the suggestion of providing maternity leave prior to delivery even more powerful. This is especially true since “the proportion of employed women increased from about 43% in 1970 to close to 60% in 1992.” Pregnant women are also working further into their pregnancy than they previously had. Between 1961 and 1985 in the United States, “the proportion of pregnant women who continued to work during the last trimester of pregnancy increased
from 52% to 78%, and the proportion who worked within one month of delivery grew from 23% to 47%.”

**Preterm Birth**

In 1995 Berkowitz and Papiernik looked at the rate of preterm births in relation to maternity legislation available in eight European countries and the United States. The only country that showed a decline in the rate of preterm births from 1970 to 1988 was France. France is also the only country that has instituted a national program to prevent preterm birth. This national program is multi-faceted in its approach, including a major component that extends the amount of sick-leave during pregnancy for women with the most physically demanding work and those exhibiting cervical changes. The French program had several components and there has not been a randomized controlled study to determine which components may have had a greater impact on the reduction of preterm births. It is suggested that each component may have contributed to a modest change in the rate and that the overall combined effect was responsible for the observed decline. The authors do point out that although the other countries reported in the article have maternity legislation policies, it is not clear if these policies have any beneficial impact on preterm rates. Nonetheless, they go on to make the argument that maternity legislation policies were not necessarily designed to reduce preterm rates. Rather, they were designed to protect maternal health and to provide infants with a good start in life.

A study conducted on another aspect of the French program found a link between not receiving maternity benefits and preterm rates for socially disadvantaged pregnant women. In France, every pregnant woman, regardless of employment status, receives a monthly grant of approximately $165. The grant is paid from the start of the fourth month of pregnancy up until the baby is three months old. However, to receive this grant pregnant women must make at least three prenatal visits, essentially one visit per trimester. The proportion of preterm birth rates was 18.3% for women who did not receive maternity benefits versus 6.8% for women who did receive the benefits. The majority of women who did not receive maternity benefits were already at risk for preterm birth since they lived in poor social conditions.

Another analysis by McQuide et al. documented prenatal care incentives that exist in 17 European countries. These incentives range from direct financial incentives to indirect non-financial incentives such as housing priority and transportation provisions. It is universally accepted that early prenatal care during
pregnancy may lead to improved birth outcomes. The authors highlight the fact that a larger proportion of pregnant women begin prenatal care earlier in their pregnancy in European countries versus the United States and that prenatal care incentives in place in European countries do not exist in the United States. However, further study is needed to determine which incentives most directly encourage prenatal care attendance. Although these findings do not directly relate to the thesis topic of increasing family leave benefits for working parents, they do highlight the importance of targeting at risk populations and lend support to the notion that financial incentives may help improve overall pregnancy outcomes.

The Postpartum Health of Women

Physical Health

There are many different health issues impacting women after the birth of their child, also commonly known as the postpartum period. It is universally accepted that women need to recover from the physical demands of childbirth and labor, although the length of time needed to recover physically is somewhat disputed by various experts. From a medical perspective, women who experience a normal vaginal delivery require six weeks in order “for their reproductive organs to return to their non-pregnant state.” Women who experience a cesarean delivery require eight weeks for the same reason plus an additional two weeks for surgical recovery. These time frames are generally the standard length of time provided by employers who offer their employees paid maternity leave benefits.

Research has confirmed that women experience a variety of common physical symptoms throughout the first postpartum year. In the early postpartum period, many women complain about breast discomfort, vaginal discomfort, hemorrhoids, constipation, fatigue, sexual problems, poor appetite, increased sweating, acne and dizziness. Several of these symptoms, including hemorrhoids, fatigue, breast symptoms, dizziness and sexual problems, persist up to three months postpartum. Constipation and vaginal discomfort are frequently seen up to nine months postpartum. Twenty percent of women are still experiencing sexual problems at one year postpartum. Respiratory symptoms appear for many women at three months postpartum and continue to be experienced by 40% of postpartum women at one year, with a higher prevalence occurring for women who return to the work force. McGovern et al. highlight other potential problems:

Less common physical problems include carpal tunnel syndrome, excessive vaginal bleeding, gynecologic or urologic infections, mastitis, thyroiditis, and urinary retention or
stress incontinence. Factors that may potentially exacerbate postpartum recovery include: preexisting disease, lower socioeconomic status, maternal age extremes, nonwhite racial identity, single parent status, detrimental health habits, labor and delivery complications, or having an infant with neonatal complications.

The goal of maternity and family leave policies “has been to promote maternal and infant health, to facilitate the development of parent-child attachment, and to provide economic security.” In 1997 McGovern et al. reported on findings from their ongoing investigation regarding the effects of family leave policies in relation to maternal health, with a focus on the role of time off work and factors associated with postpartum health for a sample of employed mothers. This study used a model of health and workforce participation to estimate the production function of the mother’s health. The model measures the mother’s health as a function of two types of variables: 1) predetermined exogenous variables that were independent of the personal choices made by the mother (e.g., “personal and household characteristics, maternal and infant acute illness symptoms, and the timing of the interview”); and 2) endogenous variables that were explicit choices made by the mother (e.g., “mother’s time off work and purchased goods and services.” The study was conducted in Minnesota and it is important to note that at the time of the study state law provided a more generous family leave benefit than the current federal FMLA by allowing women who work at establishments of 21 or more employees to take a minimum of six weeks unpaid leave (FMLA requires 50 employees). Three scales were utilized to assess overall maternal health status: a mental health scale assessing depression, anxiety, and general positive affect; a vitality scale assessing energy and the lack of fatigue; and a role function scale assessing the combined effect of physical and emotional health problems, or fatigue, on an individual’s daily activities.

The results of the study were not exactly what the authors had expected. The findings showed the effect of time off work on maternal health to be U-shaped: brief maternity leaves were associated with good health, but positive health effects did not appear fully until 20 weeks. The authors propose that the initial negative relationship between time off work and maternal health may be due to omitted variable bias in that prenatal or pre-pregnancy vitality was not measured. The authors suggest that women with higher prenatal vitality most likely exhibit higher postpartum vitality and, therefore, go back to work sooner. Specifically, the study found that women experienced optimal vitality at 12 weeks postpartum, optimal mental health at 15 weeks postpartum and optimal daily role function at 20 weeks postpartum. Conversely, the study also found that women experienced diminished levels of well-being at seven months postpartum. The
symptoms experienced were infectious, including cold and flu symptoms, and non-infectious, such as stiff joints, neck or back pain. The negative health effects experienced at seven months postpartum appear to be related to the mother’s return to work, most likely resulting from children entering day-care environments. The authors believe that their findings suggest that the traditional six-week recovery period supported by the medical profession may not be appropriate for all postpartum women, “particularly employed women who may lack the flexibility to adapt their job demands or schedules to accommodate needs for rest and recuperation throughout the postpartum year.”

Mental Health

Even though physical recovery is accepted as a consequence of childbirth, the mental health issues of mothers during the postpartum period are much less understood and often go unattended. According to Gjerdingen and Chaloner, “for many women, the birth of a baby is associated with mental health problems.” During the first postpartum year, “baby-blues” are experienced by 50% to 80% of women, postpartum depression by 16.5% to 24% and psychosis by 0.1% to 0.4%. Although depression is most prevalent at six to eight weeks postpartum, it is still seen in approximately 12% of women at six months postpartum. In 1994, Gjerdingen and Chaloner reported the results of their study analyzing the relationship of women’s postpartum mental health to employment, childbirth and social support. In particular, the authors were interested in postpartum mental health status in relation to length of maternity leave and number of hours worked during the postpartum year. The questionnaires utilized included four mental health scales; a physical health checklist; a pregnancy, labor and delivery complication checklist; five questions from different scales regarding social support; a work activity scale; a recreational activity scale; questions pertaining to the infant; and several other demographic questions. Generally, anxiety, depression, and overall mental health were found to be the most problematic a few weeks after delivery, and much less problematic at one year after delivery.

The results pertaining to the work-related variables indicate the importance of new mothers receiving work-related support.

Length of maternity leave and number of work hours were both significantly related to new mothers’ postpartum mental health. Approximately 80% to 83% of women in this sample returned to the work-place after delivery, and the average amount of time devoted to the job between the third and twelfth months was 35 hours per week, with a range of 2 to 81 hours. Women who had taken more than 24 weeks’ maternity leave had better
mental health outcomes at 9 and 12 months postpartum. Mental outlook was also brighter for women who spent fewer hours at their jobs. The relationship was significant at each interval except at 1 month postpartum, when only 5.7% of women had returned to work.\textsuperscript{41}

The authors concluded “that taking a longer maternity leave and limiting work hours during the postpartum period may have positive health consequences for mothers with infants.”\textsuperscript{41}

Another study looking at depression and anxiety during the postpartum period found significant association between the two and length of maternity leave and number of hours worked. Women who work full-time during the postpartum period were found to have higher levels of anxiety than part-time working mothers and homemakers. The authors suggest that “the first year postpartum is a unique time when full-time employment is more stressful, and therefore more likely to be associated with elevated levels of anxiety, compared to other times in women’s lives.”\textsuperscript{18} The authors suggest that federal legislation should guarantee part-time working arrangements for postpartum women and policies allowing gradual return to work. In regards to depression, the study concluded that the generally recommended medical leave of six weeks “can be a risk factor for depression when combined with another risk factor such as marital concerns or lack of work rewards. Longer leaves of 12 weeks were associated with low levels of depression, whether one of these other risk factors was present or not.”\textsuperscript{18} Thus, a minimum of 12 weeks’ maternity leave is recommended to protect the mental health status of postpartum women. The authors did not study levels of depression beyond 12 weeks postpartum.\textsuperscript{18,32}

Another important concern during the postpartum period for married families is the quality of the marital relationship after the birth of a child. Many studies have demonstrated that the birth of a baby poses additional stress on couples and that the quality of marriage may decline for short periods after a new child is introduced to the family. In 2001 Hyde et al.\textsuperscript{42} examined the effects of length of maternity leave on marital compatibility and found that shorter maternity leaves were associated with more dissatisfaction with division of household labor. Since such dissatisfaction has been linked to both psychological and marital distress, shorter maternity leaves can be considered a risk factor for psychological and marital distress. The authors found that 74% of their participants thought their maternity leave was too short and the most common reason cited for not taking a longer leave was their inability to afford to do so. The authors contend that paid maternity leaves would “allow families the necessary time to transition to a new baby and thus strengthen marriages rather than strain them.”\textsuperscript{42}
Infant Health

Infant Mortality

In the field of public health, the infant mortality rate of a country is universally accepted as a valid indicator of the overall health status of a nation. Infant mortality is reported as the number of infant deaths within one year of birth per 1,000 live births. This rate can be broken down into two categories; neonatal deaths, which occur within the first 28 days of life, and post-neonatal deaths, which occur between 28 days and one year. The most recent figures available for infant mortality in the United States are from 1999. The infant mortality rate in that year was 7.0 deaths per 1,000 live births, with 4.7 occurring during the neonatal period and 2.3 occurring during the post-neonatal period. Regrettably, the United States experiences wide disparities among racial groups in regards to infant mortality. Blacks or African Americans experience an infant mortality rate of 14.0, while Whites have an overall infant mortality rate of 5.8. It is important to note that in many cities and communities in the United States the racial disparities are even greater. Another notable disparity exists with regards to the age of the mother. Teenagers in the United States experience the highest infant mortality rate for a particular age group: 17.0 for mothers under 15 years of age and 10.2 for mothers 15 to 19 years of age. Women who are 30 to 34 years of age have the lowest infant mortality rate at 5.8.\(^43\)

When looking at infant mortality from an international perspective, the United States does not fare well in comparison to other industrialized nations. Although infant mortality rates have fallen over the past several decades in all developed nations, the United States’ ranking relative to other nations has steadily deteriorated. In 1950, the U.S. ranked 7th among nations; by 1970 it had fallen to 16th; by 1980, 20th; and by 1999 down to 23rd.\(^44\)\(^1\) An analysis performed by Williams\(^44\) in 1994 analyzed the potential factors as to why 10 European countries have better infant mortality rates than the United States. For the 10 countries analyzed the infant mortality rate ranges from 4.0 in Norway to 6.0 in Ireland and the United Kingdom.\(^45\) Williams’ analysis details many different factors, both medical and social, that most likely impact the infant mortality rate and help to understand the disparity between the United States and other developed nations.\(^44\)

Some of the medical factors looked at by Williams include the fact that prenatal care in Europe is performed mainly by mid-wives and general practitioners, whereas obstetricians perform almost all of the prenatal care in the United States and mid-wives are uncommon. Many more births occur at home in
European countries, with the highest rate of one third of all births occurring at home in the Netherlands. Home visitation by trained nurses also is very common in Europe and very unusual in the United States. All women in the Netherlands, Norway and Belgium are visited prenatally. The other European countries visit women at home when they have missed an appointment. Lastly, intrapartum care in the United States tends to be far more interventional than European care, with the most poignant example being the fact that rates of caesarian section in the U.S. are roughly twice those of most European countries.44

Although these medical differences are most certainly important contributing factors to the difference in infant mortality rates between the United States and these 10 European countries, the article highlights some highly significant social differences as well. It is important to mention that some experts in the field believe it is inappropriate to compare the United States to these European countries since the demographics of the two differ so greatly, particularly because the U.S. has much larger groups of racial minorities than any of the European nations.46 Williams disputes this notion with some telling facts. The author points out that as the United States developed, there were “rapid improvements in transportation and communication resulting in greater uniformity of language and custom than exist in Europe, even within the smallest countries.”44 As an example, Switzerland, which is about half the size of Maine, has four distinct national languages spoken. Furthermore, foreign labor in Europe has resulted in substantial minority populations existing in every European industrialized country. These immigrant populations face poor social conditions such as “inadequate housing, underemployment, and occasional acts of discriminatory violence.”44 The author believes that “these immigrant populations must bridge linguistic and cultural barriers far greater than those faced by the U.S. African-American population, and by most other U.S. minority groups.”44 Conversely, the author also points out that third-world conditions exist for disadvantaged groups in the United States and that “poverty as it exists in the United States is virtually unknown in Europe.”44

Although many of the social benefits available in European and other industrialized nations are documented earlier in this thesis, Williams cites specific examples linking these benefits to improved infant mortality rates and thus, some examples are reiterated for this discussion. Williams believes that European countries have achieved favorable perinatal outcomes despite their diverse cultural and linguistic heterogeneity largely because of three factors: (1) social programs to alleviate poverty and improve living conditions among women and children; (2) prenatal health care models that emphasize social factors and are closely linked to social
supports; (3) health care delivery systems designed to offer accessible care to all citizens with little or no direct financial obligation at time of service.44

Some specific examples of social supports that most likely impact infant mortality are providing free contraception for women who want to prevent pregnancy and various financial and social supports for women who do become pregnant. Moreover, Williams notes, women usually “register for benefits when they begin prenatal care and receive incentives consisting of the following; transportation privileges; freedom from strenuous and night work; paid leaves from employment to obtain care; and priority for housing benefits.”44 In addition to family leave benefits previously described, cash payments also known as birthing bonuses and monthly allowances for child rearing exist in nine of these countries. Almost all of these benefits are given regardless of financial need and typically those with financial needs are offered additional benefits.44 Although the United States provides excellent medical care to mothers and infants, we lag far behind the European countries when it comes to the social supports available to pregnant women and this reality is most likely related to our poor infant mortality rate in relation to other nations.

A study reported by Christopher J. Ruhm47 lends even stronger support to the view that extended and paid parental leaves reduce infant deaths. Ruhm’s hypothesis was based on the notion that the more time parents invest in their children, particularly their young children, the more likely the children are to experience positive health outcomes. A universally accepted example of this view is the improved health outcomes of babies who are breastfed (further discussion in Infant section.) In Ruhm’s detailed investigation of the relationship between parental leave and child health, aggregate data from 16 European countries for the period 1969 through 1994 was used. This study focused on job-protected leave versus social insurance payments that are independent of work histories. Job-protected leave prohibits the dismissal of the employee during pregnancy and guarantees job-reinstatement at the end of the leave. Ruhm used an econometric model that included several variables expected to be related positively to child health such as health care expenditures as a percent of GDP and share of the population with health insurance coverage. These variables were found to predict infant mortality rates by statistically significant amounts and lent support to the notion that length of parental leave could also predict infant mortality rates. The analysis proxied pediatric health by using the incidence of low birth weight and several mortality rates: neonatal, postneonatal, child and elderly. The child mortality rate included deaths between one and five years of age. The elderly mortality rate is the standardized death rate of persons greater than or equal to 65
years of age and was used to test for omitted variables bias. Variables were also used to control for time and country effects.

The study concluded that more generous paid leave is found to reduce infant and child deaths. In comparing countries offering an average of 21 weeks paid leave, a 10-week extension in paid leave (with or without job-protection) is predicted to reduce infant mortality rates by 2.5 to 3.4%. Since infant mortality is so rare, these effects translate to small absolute effects. “A 2.5% decrease in infant mortality corresponds to a drop in the infant death rate from 13.2 to 12.9 per thousand live births.”\(^47\) By contrast, unpaid leave was unrelated to infant mortality, since parents are probably “reluctant to take time off work when wages are not replaced.”\(^47\) Additional findings by the author included:

- Leave entitlements substantially reduce predicted mortality during the post-neonatal period and early childhood. For example, a 10-week extension (in paid leave) is predicted to decrease post-neonatal deaths by 3.7 to 4.5% and child fatalities by 3.3 to 3.5%. A 50-week entitlement is predicted to reduce post-neonatal fatalities by approximately 20% and child mortality by roughly 15%.\(^47\)

Although these predicted rates appear high they are small in comparison to the actual reduction of 60% in the rates during the study period. And as already mentioned, these large percentage reductions translate to small actual reduction in deaths, so it makes the reductions seem that much more plausible.

The study did not find a correlation between leave policies and neonatal mortality and this was not surprising since many of the causes of neonatal mortality are related to conception and early pregnancy conditions that would most likely not be impacted by a longer leave from work. The study also did not find a correlation between parental leave and the death rate of persons 65 and over as expected, suggesting that the study adequately controlled for any false correlation between parental leave and overlooked factors having general effects on health.\(^47\)

Ruhm took the results of his findings one step further and conducted a cost-effectiveness analysis with his data. The analysis predicted that “between 91 and 172 years of parental leave are required to save one life and the cost of one life saved is between US$2.0 and US$3.8 million (in US$1997).”\(^47\) The author suggests that these calculations demonstrate that the provision of parental leave may be a cost-effective method of improving health. The author provided several suggestions as to why his analysis most likely understates the benefits of parental leave:

- First, the measured health improvements are limited to reductions in mortality, whereas many gains may take the form of better health for living children. Second, the
advantages for children and families need not be restricted to health (e.g. improved cognition or reductions in household stress). Third, previous research suggests that leave rights may improve the labor market status of women. Fourth, the leave payments may partially offset other types of government spending (e.g. by reducing the utilization of subsidized child care or decreasing public spending on medical services), lowering the true cost of providing it.47

An earlier study reported by Winegarden and Bracy48 in 1995 had more convincing findings regarding the reduction of infant mortality in 17 industrialized nations. The authors of this study hypothesized that infant mortality would decline as paid maternal leave was lengthened. The following factors would most likely contribute to the decline: mothers remaining at home with newborn babies longer would encourage breastfeeding and improve the quality of infant care; and the positive income effect would increase the resources available for infant care and thus improve the chances of survival. This study also used an econometric method for analysis and found an estimated reduction of 0.5 infant deaths per 1,000 live births for each added week of paid maternity leave. These authors used a variety of tests that they feel strongly minimized the problem of omitted variables.

Low Birthweight Infants

To fully understand the issue of infant mortality, one must also look at the percentage of infants who are born with low birthweights, as low birthweight is a major underlying cause of infant death. Infant birthweight is broken down into two categories for analysis purposes; low birthweight pertains to infants weighing less than 2500 grams (5 lbs. 8 oz.) at birth and very low birthweight pertains to infants weighing less than 1500 grams (3 lbs. 4 oz.) at birth. The percentage of low birthweight babies born in the U.S. is 7.6 and the percentage of very low birthweight babies is 1.5. The racial disparities that exist for infant mortality exist for birthweight as well, although the disparities in mother’s age are not as drastic.49 The topic of low birthweight infants could have been presented in either the section on Prenatal Health or this section as there are implications for both the working pregnant mother and the health of the infant. In 1996 Gennaro reported that mothers of low birthweight infants “had more need for leave time during pregnancy and in the postpartum period.” In Gennaro’s study, 95% of employed mothers of low birthweight babies took unexpected leave due to their pregnancy complications and 96% of these mothers needed more time than expected after delivery. Low birthweight infants always stay in the hospital longer than the mother. In this particular study, the average length of infant hospital stay was 32 days. This reality poses a major dilemma for working parents with financial constraints. Since many of these mothers
had to use a portion of their guaranteed 12 week leave during pregnancy and then another four weeks while their infant was hospitalized, little time was left to spend with the infant at home before returning to work. Thus, only 27% of the employed mothers were able to return to work after their infants were born. This figure is dramatically lower than the figure of 80% of employed mothers returning to work after the birth of their child reported in other studies. Since many of the employed mothers in this study were in low paying jobs, had limited paid leave and were forced to leave their jobs after the birth of their child, many wound up on public assistance.

**Breastfeeding**

Breastfeeding has proven to be beneficial for both mother and baby. For the mother, breastfeeding is associated with lower rates of breast and ovarian cancers. For the child, breastfeeding is associated with lower rates of diarrhea, lower respiratory infection, otitis media and certain immunologic disorders. Furthermore, breastfeeding appears to reduce the risk of certain chronic conditions later in life. The American Academy of Pediatrics recommends women breastfeed their babies for one year.\(^{50,51}\) Unfortunately, many women in this country do not breastfeed or, if they do, it is only for a short period of time. As of 1998 in the United States 64% of new mothers breastfed their baby, but this number drops to 29% at six months postpartum and to 16% at one year.\(^{52}\)

There are various reasons as to why women do not initiate and/or continue breastfeeding. One particular variable that appears to have a significant impact on women's decisions surrounding breastfeeding is the employment status of the mother. Although initiation of breastfeeding does not appear to be related to the mother’s work status, studies have shown that the duration of breastfeeding is directly related to the mother’s work status (full-time, part-time or not employed), as well as the length of maternity leave available to the mother. Visness and Kennedy\(^{53}\) found that “among those breast-feeding mothers who did return to work, those with longer leaves breastfed for longer durations. White professional women were the most likely to combine work and breast-feeding and breastfed for the longest durations.”\(^{53}\) Roe et al.\(^{54}\) found that the duration of work leave contributes significantly to the duration of breastfeeding. In this study, each week of work leave increased breastfeeding by about one half of a week. The authors found that returning to work in the first 12 weeks postpartum is related to the greatest decrease in breastfeeding duration. In yet another study regarding breastfeeding and work-related issues, Fein and Roe\(^{55}\) concluded
that “part-time work is an effective strategy to help mothers combine breastfeeding and employment. Working full-time at three months postpartum decreases duration of breast-feeding, but working part-time for four or fewer hours per day does not affect duration, and working part-time for more than 4 hours per day decreases duration less than does working full-time.”55 A fourth study confirmed that full-time working mothers had a shorter duration of breastfeeding, but a comparison of full-time versus part-time work or length of leave was not included in the analysis.56 It appears fairly obvious that expansion of family leave benefits, particularly paid maternity benefits, could only have a positive impact on the duration of breastfeeding and even possibly the initiation of breastfeeding.

In addition to expanding policies, there are other ways employers can support working mothers who breastfeed. Healthy People 2000 made numerous recommendations for enabling employed women to breastfeed including “provision by employers of extended maternity leave, part-time employment, facilities for pumping milk or breastfeeding, and on-site child care.”57

Infant Well-Being

Much research has been conducted on the effect of maternal employment on the infant. Most studies to date have found either no or few differences between employed and non-employed women in the quality of interactions with their infant.58,59,60 Some studies have even suggested that employed women spend more time with their infants and are more interactive with their infants than non-employed women, particularly when it comes to verbal stimulation.61 There is, however, a paucity of studies looking at specific aspects of maternal employment, “such as length of the mother’s maternity leave or number of hours worked, and the impact on mother-infant relationships and infant development.”62 Some research suggests that returning to work prior to the infant being six months of age is more favorable than returning when the infant is between seven and 12 months of age “due to issues of attachment and stranger anxiety.”63 Other studies have found that returning to work during the second year of the child’s life is problematic “due to issues related to child compliance and behavioral regulation.”64 Studies focusing on hours of employment have found that part-time maternal employment is “associated with more optimal development in children than full-time employment.”63 Also, mothers who returned to work in the first year were found to have infants who exhibited more insecure attachment and mothers who work more than 20 hours are more likely to have infants “who exhibited an anxious-avoidant attachment pattern.”65
Overall, the authors are essentially saying that it is imperative for mothers and infants to bond and when making decisions regarding when to return to work, it is important to take this into consideration.

In 1997, Clark et al. published results from their study addressing length of maternity leave and its relation to mother-infant interactions. In particular, the authors assessed whether certain variables might contribute to or prevent a positive mother-infant relationship. Research was conducted when the infants were four months old. The study found that greater levels of maternal depression, when combined with shorter maternity leaves, “was significantly associated with lower amounts of maternal positive affective involvement, sensitivity and responsiveness with one’s infant.” In contrast, a longer maternity leave “may buffer the effects of these symptoms on her relationship with her infant by not compounding the stress of balancing work and family roles.” A longer leave may also “allow the mother to develop a greater sense of competence and less depressive symptoms, because infants become both more regulated physiologically and are more socially responsive and reinforcing to parents at 3-4 months of age.”

The study also found a significant correlation between length of maternity leave and infant temperament. “For women who viewed their infants as being more prone to distress or who generally exhibited a more difficult temperament, the authors suggest that early return to work may be particularly stressful and contribute to poorer quality mother-infant interactions.” Infant temperament in and of itself has been found to be a predictor of the quality of the mother-infant relationship and thus early maternal employment could potentially intensify this situation by “reducing a mother’s time and energy to meet her infant’s special needs in a sensitive manner.” Shorter maternity leaves were also associated with more negative affect and behavior in the mother. Examples of this negative affect included “frustration, displeasure with infant, lack of sensitivity and responsiveness to infant’s cues and inconsistency.” The authors of this study believe that these findings underscore the significance of “length of maternity leave as an important factor in mother-infant interaction quality” and that unpaid parental leave policies requiring early return to work place many mother-infant relationships at risk, and may affect their infant’s functioning.

The studies cited indicate the positive consequences of policies that allow parents, particularly mothers, to spend more time with their infants and less time working during the early years of a child’s life and that provide more supports for parents to be able to this. The number of families that would benefit
from more generous leave policies is significant. While 34% of mothers with children under age three were in the workforce in 1975, this figure reached 61% by the year 2000. By the mid-1990s, “about six million infants and toddlers were in some form of regular, nonparental care for an average of 25 hours per week.”

Research has shown that workers who receive income during their maternity leave will stay home longer before returning to work. One study found the difference in duration of leave between women with and without paid leave to be approximately four weeks. This is a substantial amount of time when infant bonding and nurturing is the consideration.

Adoption

The lack of family leave benefits to many Americans and more so the lack of paid benefits in this country poses unique challenges for families adopting a new-born or older child. This issue has become more important because adoptions in the U.S. have been increasing each year, affecting more and more families. In 1992, there were 127,441 children adopted in the United States. Because emotional bonding and trust building is essential when a child is first adopted, experts recommend the following guidelines for newly adoptive parents: (1) take the maximum allowable time before trying to go back to work; (2) take time to adjust to the arrival of the new family member; (3) take time to establish a routine and a relationship with the new child; and (4) “plan for a period of isolation, a time to spend getting to know one another before babies or young children go into daycare, or older children start school.”

Yet, the reality for many adoptive parents is that because adoption is an expensive process and the income they receive is crucial, taking time off from work to spend the critical time needed early on is often difficult. Adoption can cost up to $20,000 in administrative and travel costs. Many working adoptive parents are not covered by FMLA, or if they are covered, they cannot afford to take unpaid leave. Also, one in three families who adopt are single-parent families, making the child provider also the sole source of income.

Pediatric Health

When Children Are Sick

Unfortunately, there appears to be a paucity of research examining the particular effects of family leave policies on children’s health. However, research conducted has demonstrated the positive effect that parents can have on the health outcomes of their sick children. In the book, The Widening Gap: Why
America’s Working Families Are in Jeopardy and What Can Be Done About It. Jody Heymann makes the following assertions:

Parents have long played an essential role in the health care of their children, and many studies over the course of decades have demonstrated the importance of parents’ involvement when their children are sick. When their parents are present, sick children have better vital signs and fewer symptoms, and they recover more rapidly from illnesses and injuries. Furthermore, the presence of parents shortens children’s hospital stays by 31 percent. Because parental care has proved so important, pediatricians have increasingly offered parents the chance to become involved in different aspects of their children’s health care.

Regrettably, children get sick and get sick often in this country. Fortunately, few children have major illnesses, yet an overwhelming majority of children have frequent common illnesses that require care and absence from school or child care. In addition, there are an estimated 10 million children with chronic conditions in this country. According to Heymann et al., “more than one in three families face a family illness burden of two weeks or more each year”, while “approximately one in four families face a family illness burden of three weeks or more each year.” A separate study found that employed parents missed an average of 4.2 work days per year because of a sick child.

In order to care for their sick children, working parents often rely on their own sick leave to take the necessary time off work. Nevertheless, it was revealed that between 1985 and 1990, “28% of mothers lacked sick leave the entire time they worked and more than two thirds lacked sick leave some of the time.” Employed mothers of children with chronic conditions fared even worse with regards to the availability of sick leave. Almost “40% of mothers whose children had asthma and 36% of mothers whose children had chronic conditions lacked sick leave for the entire period they worked.” Parents living in or near poverty were especially hard pressed because 80% of these mothers had less than one week of sick leave.

A further study by Heymann et al. reports on the findings from the Baltimore Parenthood Study that in part researched the numbers of working parents who stayed home with their sick children and how they were able to do so. The study found that 58% of parents continued to go to work when their children were sick. Of the 42% who were able to stay at home with their sick children, more than half said they could do so because they received some type of paid leave. Twenty-nine percent used paid vacation or personal days, 14% used paid leave designed to allow them to care for sick family members, and 11% used their own paid sick leave; 11% took unpaid leave; and 7% used flexible working hours. The study
confirmed that “the parents who received some type of paid leave were significantly more likely to stay home with their sick children. Those parents who had either sick leave or vacation leave were 5.2 times as likely to care for their sick children themselves” as those who did not have such benefits. Sadly, “parents who were single, living near or below the poverty level, or had a high school education or less were significantly more likely to stay at work when their children became sick.” When considering figures such as the ones just presented it is important to keep in mind the proportion of mothers in the workforce. In 1997 the percentage of mothers of pre-school aged children in the workforce was 65% and the percentage of mothers of school-aged children in the workforce was 78%.

In another study conducted by Heymann, the Urban Working Families Study, 41% of parents interviewed indicate that “their working conditions had negatively affected their children’s health.” In some cases children were unable to make needed doctors’ appointments. In other cases, children received inadequate care during earlier stages of their illness, resulting in a more serious condition. Heymann further reported that although parents recognize “these problems, many know that if they take time off from work to meet their children’s health needs, they would lose essential pay and possibly even their jobs. Often parents felt they had little choice but to gamble by either sending their children to child care or school sick or leaving them home alone.” Thirty-four percent of parents in the study “reported that caring for their sick children led to difficulties at work; 12%, to lost pay; and 13%, to loss of promotions or jobs.”

In yet another study focusing on working families where a representative sample of 870 adults living across the United States were interviewed each day for a week about working while caring for family members, the reasons for people taking time off work were found to be “far more varied and complicated than those covered by FMLA.” Only 29% of reported work-related absences were for health-related problems. According to the study, 22% took time off to “address problems with child care, 5% to provide for elder care, 3% to address children’s school needs, 10% to provide transportation to family members, 16% to provide other instrumental support, 3% to cope with a death, 1% to deal with divorce, and 15% to provide emotional or other support.” Heymann points out that most of the children’s illnesses requiring parental absence from work would not have qualified under the FMLA as major illnesses.
Childhood Injuries

In addition to chronic conditions and common illnesses that affect children and their working parents, injuries are also a major problem for American families. “Each year between 20-25% of all children sustain an injury severe enough to require medical attention, missed school, and/or bed rest.”\textsuperscript{74} Sadly, unintentional injuries are the leading cause of death for children one to 21 years of age in this country. “For every childhood death caused by injury, there are approximately 34 hospitalizations, 1,000 emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home.”\textsuperscript{74} The situation is even worse for American adolescents. “At least one adolescent (10-19 years old) dies of an injury every hour of every day; about 15,000 die each year. For every injury death, there are about 41 injury hospitalizations and 1100 cases treated in emergency departments.”\textsuperscript{75} It is easy to surmise that these unfortunate statistics also have an impact on working parents. In 1999 Gofin et al. reported from their study on the impact of childhood and adolescent injuries that 79% of working mothers and 60.9% of working fathers were absent for at least one day as a consequence of their child’s injury. The absenteeism rate of parents whose children suffered from burns, traffic crashes and falls was even higher.\textsuperscript{76}

In 1997 Osberg et al.\textsuperscript{77} reported on a study looking specifically at the impact of childhood brain injury on work and family finances. Traumatic brain injury (TBI) is a major type of childhood injury resulting in approximately 100,000 pediatric hospital admissions per year in the United States. The work variables studied included time lost from work, cut back in hours and having to stop working because of the child’s injury. Although the findings for this study lumped together the impacts of work and family finances, the results did show that parents of children who were more severely injured, those with four to nine impairments at discharge, those with children who stayed in the hospital the longest and those with children who were discharged to inpatient facilities reported significantly more difficulties with work and family finances. The authors make the claim that “availability of vacation and sick time, and having an understanding employer, could mitigate the potential negative work and financial effects.”\textsuperscript{77} I will take that claim one step further and assert that a paid family leave policy would dramatically reduce the financial and work burden of parents with children who have suffered a traumatic brain injury.
Adolescence

Although I was unable to find any research pertaining to adolescent health issues in relation to family leave policies, an article in the September 18, 2000 issue of *Time* shed some interesting light on this issue. The article highlighted working parents who make the decision to quit their jobs or cut back hours in order to spend more quality time with their teenagers. Many parents realize the teenage years are a very vulnerable time for their children and understand that the more time spent with them the better chance they have of preventing typical teenage problems. A ten-year study conducted by Catalyst, a research group dedicated to advancing women in business, found that half of the professional women in the study who switched from full-time work to part-time work after the birth of a child were still working part-time at the end of the study. This demonstrates that even though children are older many parents still value the time spent with family versus the time committed to employment. Teenagers tend to engage in risky behavior such as alcohol and drug abuse, cigarette smoking and sexual activity, all of which have the potential of jeopardizing their health. It is logical to suggest that parents who have more flexible work environments or who are entitled to more extensive family leave benefits would be more available to their teenagers and thus, potentially, be able to help minimize these risky behaviors.

The Health of Working Adults

Clearly, the health needs of working adults and the relation of these needs to the lack of family leave benefits crosses all spans of the life cycle. Working adults often have to take time off to care for their children, as already discussed, and care for their elderly parents as well, as discussed in the following section. The FMLA also allows workers to take unpaid leave to attend to their own major illnesses. As documented throughout this thesis, unpaid leave is often too much of a financial burden for many working adults, particularly those in single households or those living in or near poverty. Yet, many working adults have medical emergencies and chronic conditions that require them to take a leave.

Chronic Conditions

As people age the likelihood of being diagnosed with conditions such as cancer, arthritis, heart problems, diabetes, and other chronic illnesses increases. These are often health situations that require care over a long period of time, sometimes for extended periods for surgery or at other times simply for routine visits to various health professionals. Many Americans also have pressing mental health needs that require
attention. Addressing these health needs is often problematic for working adults because almost all health care appointments must be scheduled during typical working hours, sometimes requiring time off without pay. As this thesis has already demonstrated, unpaid leave poses severe financial burdens for many Americans. The five states with temporary disability insurance already provide a safety-net for working Americans, and many employers provide these benefits as well. However, there are still many employers who do not. Thus, many working adults ignore or delay their health needs because they simply cannot afford to take time off from work without pay. Unfortunately, inaction typically exacerbates these conditions and almost always leads to more pressing health needs down the road.

**People Experiencing Domestic Violence**

Sometimes the need for leave for working adults is not always medical in nature. Domestic violence is also an issue that relates to the need for expanded family leave policies. Statistics demonstrate that domestic violence jeopardizes victims' employment. According to the National Partnership for Women & Families, “25 to 30% of battered women cite abuse as the reason they lost their jobs. Studies of battered women have found that 50 to 55% of abused women missed work because of abuse and over 60% reported arriving late due to abuse. Fifty-four percent of employed battered women missed three days of work each month because of abuse.” Often they require time away from work to take the necessary steps to protect themselves against domestic violence. The necessary steps include “going to court to obtain protection orders against their batterers, seeking medical treatment, obtaining forensic documentation of wounds for legal purposes, seeking new living arrangements and seeking child care.”

**People With Disabilities**

Currently, there are more than 54 million Americans, or 20% of the population, with disabilities. Approximately half of these individuals have a severe disability, affecting their ability to see, hear, walk, or perform other basic functions of life. In 1990, the Americans with Disabilities Act (ADA) was passed, providing basic civil rights protections to individuals with disabilities. Among many of the stipulations, the law includes various employment related protections, including allowances for extended medical leave. When the FMLA was introduced in 1993 there was some confusion as to when employees are protected under ADA versus FMLA. Essentially, the FMLA provides for a shorter leave for more specific and serious health conditions than the ADA. Yet, in order to qualify under ADA, an individual must have a
qualified ADA disability which is an impairment that substantially limits one or major life activities. While there is no set limit under ADA for length of leave as there is with FMLA, the employer is permitted to terminate an employee who is on an ADA disability leave after a certain length of time if the situation imposes an undue hardship on the employer.  

The passage of the ADA law was a major milestone for people with disabilities, particularly in relation to work issues. Yet, Americans with disabilities tend to have a lower level of educational attainment and are poorer than those without disabilities. Not only is it difficult for people with disabilities to find a job, but it is also logical to assume that unpaid medical leaves are extremely challenging for them. Measures to provide people with disabilities with wage-replacement while on medical leave would be beneficial.

**Elder Care**

Just as there is a dearth of research on family leave policies and their relationship to the health of working adults, there appears to be even less research on the impact of family leave policies to the health of the elderly population. Yet, the proportion of the elderly population in the United States is constantly growing as are the health needs associated with this population. Census data has shown that while the U.S. population increased six-fold between 1870 and 1990, the population of Americans 65 years old and older increased twenty-seven-fold. Whereas there were just over one million Americans (3% of the population) 65 and older in 1870, in 1999 more than 34 million Americans (13% of the population) were 65 or older. The proportion of people 85 years and older is expected to be the fastest growing portion of the elderly population during this century.  

Although many people in the elderly population are in good health and lead active lives, others face significant limitations due to chronic conditions or disabilities. According to the National Partnership for Women & Families, “one in six adults 65 years old or older who are not living in institutions have difficulty bathing, dressing, getting around inside or outside the home, or with other activities essential to living independently.” Of those 85 years and older, half need such assistance. Typically the care given to the elderly population is provided by their adult children, many who work themselves. “Nearly one in four households (22.4 million families) provide care for elderly relatives” and “the majority of family caregivers (52%) are also employed full-time.” The reality is that adult children who care for their
parents often need to take time off from work to provide this care. However, as already described, the FMLA only provides unpaid leave for a parent when there is a serious medical condition, not for routine care. Nor does the FMLA allow for workers to take care of extended family members such as an aunt, uncle, or grandparent. Of those Americans who need leave but cannot afford to take it, "nearly one in three need leave to care for an ill spouse or parent."83 It estimated that by 2020, "about 40% of the workforce will be caring for older parents."83

A personal anecdote exemplifying the challenges of working adults caring for elderly parents comes from the Leonburno family in West Islip, NY. In 1997 Ms. Leonbruno's father was diagnosed with a deadly form of kidney cancer. Since her mother was being treated for breast cancer, she was unable to care for her husband. During a six-month time-frame, Ms. Leonbruno took intermittent leave under the FMLA to bring her father to his cancer treatments or visit him at the hospital. Although Ms. Leonbruno was grateful for the time, she estimates that she lost $15,000 in wages and three years later was still dealing with the financial ramifications.84

The Canadian government appears to have acknowledged this problem and is in the process of attempting to address the issue. A proposal for a comprehensive intergovernmental strategy for end-of-life care is currently before the Canadian legislature. The proposal suggests that people who take time off work to care for terminally ill family members receive the same benefits that new mothers receive--55% of their salaries for 26 weeks. The proposal is being referred to as "eternity leave."85

**Current United States Action**

Many experts, advocates and politicians are aware of the research presented throughout this thesis and attempts are being made at many different levels to address the family leave issue. Presently, at the federal level, nine bills relating to family leave have been submitted to the 107th United States Congress, which is targeted for completion in October 2002. A brief summary of each bill is presented in Table 3. As is the case with many social policies, the policies recommended in these bills presume an incremental approach towards change. Even though the proponents of the bills would prefer to see the United States aligned with our international counterparts in relation to the issue of family leave policies, it would be fruitless to attempt radical changes all at once. Although these bills are somewhat conservative in comparison to international policies and even some state policies, there is a strong likelihood that these bills
will not even be considered during this congressional session. Many similar bills were presented to the 106th Congress and not only were they not passed, it appears they may not have even been properly reviewed. Considering the current political climate resulting from the terrorist attacks of September 11, 2001, the probability is slim that any of these bills will pass in the near future.
<table>
<thead>
<tr>
<th>Bill Number &amp; Name</th>
<th>Summary *</th>
<th>Most Recent Action</th>
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| S.18 The Right Start Act of 2001 | ✦ Extend the FMLA to employees of mid-sized companies by lowering the threshold for FMLA coverage to 25 employees.  
✦ Allow employees to take leave for other important family needs such as education and literacy and to address domestic violence and its effects.  
✦ Includes the Family Income to Respond to Significant Transitions Insurance Act which provides $400 million in demonstration projects to provide full or partial wage replacement during times of family and medical leave. | 1/22/2001  
Read twice and referred to the Committee on Health, Education, Labor and Pensions. |
Referred to House Subcommittees: Workforce Protections, 21st Century Competitiveness & Education Reform. |
| H.R. 2328 The Family Fairness Act | ✦ Extends the FMLA to part-time workers who have been employed for at least 12 months by their employer. | 9/28/2001  
Referred to the House Subcommittee on Workforce Protections. |
| S.940 A bill to Leave No Child Behind | ✦ Includes the Family Income to Respond to Significant Transitions Insurance Act which provides $400 million in demonstration projects to provide full or partial wage replacement during times of family and medical leave. | 5/23/2001  
Read twice and referred to the Committee on Finance. |
| H.R. 1990 A bill to Leave No Child Behind | Same as S.940.                                                            | 7/25/2001  
Referred to House Subcommittees: Employer-Employee Relations, Workforce Protections, 21st Century Competitiveness, Education Reform and Select Education. |
| H.R. 226 Family Income to Respond to Significant Transitions Insurance Act | ✦ Establishes $400 million in demonstration projects to provide full or partial wage replacement during times of family and medical leave. | 3/2/2001  
Referred to the House Subcommittee on Workforce Protections. |
<table>
<thead>
<tr>
<th>Bill Number</th>
<th>Description</th>
<th>Date</th>
<th>Committee</th>
<th>Source</th>
</tr>
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<tbody>
<tr>
<td>H.R.2287</td>
<td>Extends the FMLA to include care for a domestic partner, parent-in-law, adult child, or sibling.</td>
<td>9/18/2001</td>
<td>Referred to the House Subcommittee on Workforce Protections.</td>
<td>The summaries only reflect those portions of the bill specifically related to providing family leave benefits and/or expanding family and medical leave.87,88</td>
</tr>
<tr>
<td>H.R.2784</td>
<td>Allows employees to take additional leave to participate in or attend their children’s and grandchildren’s educational and extracurricular activities. Requires employers to grant four hours of leave time for this purpose during any 30-day period and a total of 24 hours during any 12-month period.</td>
<td>1/24/2002</td>
<td>Referred to the House Subcommittee on Workforce Protections.</td>
<td></td>
</tr>
<tr>
<td>H.R.1312</td>
<td>Allows employees with minor children to take leave after the death of a spouse.</td>
<td>6/20/2001</td>
<td>Referred to the House Subcommittee on Workforce Protections.</td>
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</table>

Nonetheless, there are many organizations that continue to work diligently to advocate for these bills. The American Public Health Association issued a policy statement in November 2000 supporting expanded family and medical leave. The policy statement included four main provisions for expansion: (1) expand the FMLA to include paid family or medical related leaves; (2) allow states to use surplus unemployment insurance for paid parental leaves; (3) provide family and medical leaves to those who work for companies of 20 or more employees; and (4) expand the FMLA definition of “immediate family” to include an employee’s spouse, child, parent, or any other primary caregiver.16 If the FMLA were to lower its threshold from 50 to 25 employees or more, an additional 13 million working Americans would be afforded protection, bringing the percentage of the covered workforce from 57.5% to 71.3%.15 As previously mentioned, the National Partnership for Women & Families is spearheading this effort and drafted much of the legislation that is before Congress. Many other organizations are also supporting the effort in various ways. These organization include the American Association of University Women; American Federation of State, County and Municipal Employees; Children’s Defense Fund; Communication Workers of America; Disability Rights Education and Defense Fund; Equal Rights
Advocates; Mexican American Legal Defense and Education Fund; National Association for the Advancement of Colored People; National Council of Jewish Women; National Parenthood Network on Disabilities; National Women’s Law Center; and Union of Needletrades, Industrial and Textile Employees.89

In 2001, 26 states had some type of family leave benefit proposal under active consideration. Many of these proposed models would build on existing disability insurance or unemployment systems. The U.S. Department of Labor brought the idea of using unemployment insurance as an avenue for paid family leave to the forefront in June of 2000 when it published a rule explicitly permitting state laws “to allow new parents to collect unemployment insurance while out on leave (known as Baby UI).”22 This rule is consistent with other nontraditional uses of unemployment insurance such as relocation of a spouse or the inability to find child care. Many believe utilizing existing unemployment insurance systems is the ideal proposal since every state already has a system in place. A few other proposals represent completely new ideas such as establishing independent family leave funds paid for by small increases in payroll taxes, tax credits for families and employers, and allowances for new parents who stay home with their babies.22 One creative solution recently passed by the Massachusetts Senate is a pilot plan that would use surplus funds from a health insurance program for the unemployed to give new parents 12 weeks off at half pay.21 Once more, the National Partnership for Women & Families’ web-site provides extensive detail on the proposed legislation for each state. A brief summary of these state proposals is provided in Table 4.
Table 4 – Summary of 2001 Proposals to State Legislatures regarding Family Leave Benefits

<table>
<thead>
<tr>
<th>States</th>
<th>Summary</th>
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<tbody>
<tr>
<td>AZ, FL, HI, IL, KS, IA, MD, MA, MN, NE, NJ, NM, OR, PA, TX, VT, IN</td>
<td>Extend unemployment insurance benefits to new parents during leave or to employees taking leave to care for a seriously ill family member.</td>
</tr>
<tr>
<td>NJ, NY</td>
<td>Extend temporary disability insurance systems, where they exist, to cover some or all types of family and medical leave.</td>
</tr>
<tr>
<td>HI, MA, NH, WA</td>
<td>Establish a new temporary disability leave insurance fund out of which family leave benefits are financed.</td>
</tr>
<tr>
<td>IL, MA, MN, VT</td>
<td>Allot general fund money to provide income during parental or full family and medical leave.</td>
</tr>
<tr>
<td>CO, HI, MS</td>
<td>Establish tax credits for employers who provide family leave benefits.</td>
</tr>
<tr>
<td>CT, HI, OK, IA, CO</td>
<td>Allow employees with sick leave to use this leave to care for a sick child or other family member or for purposes relating to a child's adoption or educational activities.</td>
</tr>
<tr>
<td>OK</td>
<td>Allow employees to contribute accrued sick or annual leave to co-workers taking family and medical leave.</td>
</tr>
<tr>
<td>ME, MN, OR</td>
<td>Establish studies of the costs and benefits of providing paid family leave.</td>
</tr>
</tbody>
</table>


The U.S. Department of Labor estimates that paid leaves for babies in the United States would cost between $5 and $10 billion dollars per year, which is a relatively small amount in relation to the overall government budget or even the annual military budget. In fiscal year 1993, the United States expended $10 billion on child care and preschool programs which amounts to about one half of 1% of the total federal budget. Generally, estimates of other countries show that all supports to families and family leave benefits account for 3%-3.5% of the gross domestic product. Estimates conducted at the state level approximate that family leave programs can be less than one dollar per employee per week.

The American public appears to be in favor of more progressive family leave benefits. According to the National Partnership for Women & Families, 90% of Americans believe that employers and businesses should do more to support working families. Seventy-two percent think the government should do more. Eighty-two percent of all employees aged 18-34 say they support expanding the FMLA to provide paid leave. Eighty-nine percent of parents of young children and 84% of all adults support
expanding disability or unemployment insurance as a vehicle for paid family leave. “Eighty-four percent of Americans support giving people 24 hours of unpaid leave per year to take family members to regular doctors’ appointments or to meet with children’s teachers and 79% support expanding the FMLA to ensure that it covers more small employers.” Clearly, a majority of the American public would like to see us move in the direction of our European counterparts by offering more expansive family leave policies.

**Future Research**

As indicated throughout this paper, there are definite areas within this topic for which there is a paucity of research. Certainly, any research looking at direct impacts of family leave policies in relation to health issues is most definitely needed, particularly in the area of adolescent health and elderly health. International policies, as well as the impacts of these policies on their societies, are well documented. While it appears that federal initiatives may be stalled at the present time, there may be opportunities to uncover the impact of these emerging state policies as states begin to enact new legislation. If states could provide evidence that their more expansive family and medical leave policies are related to improvements in the health of certain groups of people, this may be the key to passage of proposed policies that continue to be submitted to the U.S. Congress. Moreover, if the states begin passing their proposed paid leave policies, it will be critical to demonstrate the impacts of these policies.

One particular area of research that could begin now without waiting for additional policies to be enacted would be to analyze the public health impact of the five states that already provide a form of paid disability leave through their temporary disability programs. Additionally, research can be conducted on the 19 states that already provide family and medical leave benefits that are more expansive than the FMLA. In preparing this thesis I combined these two potential areas of research and performed a brief examination of data that could potentially be used as the basis for further research.

Each year, the Children’s Defense Fund, an organization whose mission is to “Leave No Child Behind® and to ensure every child a healthy start, a head start, a fair start, a safe start and a moral start in life and successful passage to adulthood with the help of caring families and communities,” prepares a report entitled *The State of America’s Children*. This report includes a comprehensive set of data documenting all aspects of children’s livelihood in America with an overall picture of the United States, as well as state by state and international comparisons. The 2001 version, which is the most recently available
report, includes state rankings for several different health, social and educational indicators: children's health coverage, babies born to mothers who received early prenatal care, infant mortality, babies born with low birthweight, child immunizations for two-year-olds, children living in poverty and state spending per student for public elementary and secondary pupils. The rankings, which are all based on 1998 data, include the 50 states plus Washington, D.C. When the National Partnership for Women & Families refers to the 19 states that provide expanded family and medical leave, they include Puerto Rico, which is not included in the Children's Defense Fund's state rankings. Excluding Puerto Rico, that leaves 18 states with expanded family and medical leave coverage. As previously documented, there are five states that provide paid maternity leave through temporary disability insurance. Since three of the five states also provide expanded family and medical leave coverage, I added in the two additional states to come up with a total of 20 states that currently support working parents above and beyond the federal government. If I were to formulate a research hypothesis for further study it would be that the 20 states providing expanded support for working parents would have health outcomes that are significantly better than the remaining 30 states and Washington, D.C.

The health outcomes studied would have to be narrowed to those that could possibly be related to benefits allowing and/or paying people to take time off from work to attend to the health care needs of themselves and others. Three of the health indicators included in the 2001 State of America's Children report are ones that researchers have attempted successfully and unsuccessfully to link to the provision of family leave benefits and that have been documented in this thesis: incidence of early prenatal care, incidence of low birthweight and infant mortality. I looked at these three indicators in relation to the 20 states that provide expanded support for working parents¹ (from this point forward I will refer to these 20 states as "expanded states"). Essentially, I observed the percentage of expanded states ranked in the Top 10, Bottom 10, Top 20, Bottom 20, Top Half and Bottom Half of all states for these three health indicators. The results of my observations are displayed in Table 5.
Table 5 – Percentage of “Expanded States” in State Rankings for Selected Health Indicators *

<table>
<thead>
<tr>
<th>Health Indicator</th>
<th>Top 10</th>
<th>Bottom 10</th>
<th>Top 20</th>
<th>Bottom 20</th>
<th>Top Half</th>
<th>Bottom Half</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incidence of Early Prenatal Care</td>
<td>80%</td>
<td>30%</td>
<td>50%</td>
<td>35%</td>
<td>44%</td>
<td>36%</td>
</tr>
<tr>
<td>Incidence of Low Birthweight</td>
<td>60%</td>
<td>30%</td>
<td>45%</td>
<td>30%</td>
<td>48%</td>
<td>32%</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>70%</td>
<td>20%</td>
<td>70%</td>
<td>20%</td>
<td>56%</td>
<td>24%</td>
</tr>
</tbody>
</table>

* “Expanded States” is defined as those states that as of 1999 offer family and medical leave coverage that is more expansive than the federally mandated Family and Medical Leave Act and the five states that currently provide paid leave for maternity disability.

The incidence of early prenatal care and infant mortality indicators for expanded states in the Top 10 ranking versus the Bottom 10 ranking demonstrates the largest difference in percentages. Eight out of 10 expanded states (80%) ranked in the Top 10 for best incidence of early prenatal care versus only three out of ten expanded states (30%) with the worst incidence of early prenatal care. Similarly, seven out of ten expanded states (70%) ranked in the Top 10 for infant mortality versus only two out of ten expanded states (20%) having the worst ranking for infant mortality. Potentially even more convincing of the notion that policies available in the expanded states may be positively related to health outcomes is the fact that 14 out of 20 expanded states (70%) ranked in the Top 20 states for best infant mortality rates versus only four out of 20 expanded states (20%) ranking in the Bottom 20. Furthermore, out of the five states that provide paid leave for maternity disability, two of them (California and New York) were ranked in the Top 10 for Infant mortality and all five of them (New Jersey, Hawaii and Rhode Island additionally) were ranked in the Top 20 for infant mortality.

I am aware the data I present are mere suggestions and are by no means scientific. Nonetheless, I do feel they suggest that further research into this particular issue may be worthwhile. Infant mortality may be the best indicator to begin linking state health outcomes to mandated family leave policies since not only does it show the most promise in the data presented here, but other research has already proven a correlation. Obviously, there are many different variables occurring within each state that would need to be identified and then held constant to perform valid statistical analysis of state data. For example, these states may provide other programs and safety nets such as health insurance for uninsured children or well-
developed prevention programs. It may be the combination of programs, rather than family leave policies by themselves, that may make the greatest difference on the various health indicators. The data also demonstrates that even though some states already provide expanded leave policies, their rankings on certain health indicators are still low. Thus, it might be prudent for all states to consider expanding their current policies even further with proven programs such as prenatal care incentives.

Conclusion

This thesis has presented reasonably convincing evidence for expanding family leave benefits in this country. If each study, statistic and article written was viewed on an individual basis it seemingly would be difficult to make a strong case, but looking at all of this information cumulatively it is difficult to ignore the facts. One would hope that the generous family policies of our international counter-parts could alone serve as an incentive to enact change, but obviously this is wishful thinking. So, we must look deeper to illustrate why it is so important that we truly value families and children in our country. This thesis has demonstrated this point in all aspects of the human life-cycle. Pregnant women have special and unexpected health needs that often interfere with employment. Infants need time with their mothers to develop secure relationships and experience healthier lives. Children who have routine illnesses or traumatic injuries need their parents to help them get better sooner. Adults often experience their own unexpected illnesses or need time from work to take care of other family members’ unexpected and routine illnesses. The quickly growing elderly population has unique needs that are best met by family members. There are critical times in the life-cycle where simply having the appropriate amount of time can make a considerable difference in the overall well-being of our families. Yet, time is money and most Americans simply cannot afford the time unless they have money to offset it.

It is my recommendation that all Americans, particularly those with the power to do something legislatively, begin thinking critically about these issues. We must make changes now to see the differences in the future. If we are to meet the health objectives outlined in Healthy People 2010, expanding family leave legislation would be one critical step towards meeting those goals. European countries all mandate a minimum 14-week paid maternity leave. At a minimum, the United States should do the same. The European countries presented in this paper offer an average 24 months paid parental leave. This standard is something to strive for at all levels in our country: federal, state and employer.
Experts recommend that mothers stay home with their infants for at least 24 weeks for optimal bonding and development, and the United States should also try to achieve this for our working parents. Eighty-five percent of all working women will become pregnant at some point in their working lives. Thus, expansion of family leave policies would impact a significant number of American women and their families.

Yes, our country is at war as of the writing of this thesis and there are many other pressing needs at this time. Yet, the issues presented in this thesis are too important to leave behind. If we truly want to improve the health of our citizens now and in the future, expanding family leave policies is one component of the overall picture that seemingly could make a difference. The evidence regarding the positive health impact of family leave policies from our international counter-parts is strong. According to surveys presented in this thesis, the American public is ready for change. Many private employers already provide for working families in various and unique ways. States are moving forward in enacting good legislation to support working families. Despite the current global problems, it is time for our federal government to show that the United States truly does value children and families so that better health outcomes can be achieved.
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