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Review

The maternal health outcomes of paid maternity leave: A systematic review

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ABSTRACT

Paid maternity leave has become a standard benefit in many countries throughout the world. Although maternal health has been central to the rationale for paid maternity leave, no review has specifically examined the effect of paid maternity leave on maternal health. The aim of this paper is to provide a systematic review of studies that examine the association between paid maternity leave and maternal health. We conducted a comprehensive search of electronic databases (Medline, Embase, CINAHL, PsycINFO, Web of Science, Sociological Abstracts) and Google Scholar. We searched websites of relevant organisations, reference lists of key papers and journals, and citation indices for additional studies including those not in refereed journals. There were no language restrictions. Studies were included if they compared paid maternity leave versus no paid maternity leave, or different lengths of paid leave. Data were extracted and an assessment of bias was performed independently by authors. Seven studies were identified, with participants from Australia, Sweden, Norway, USA, Canada, and Lebanon. All studies used quantitative methodologies, including cohort, cross-sectional, and repeated cross-sectional designs. Outcomes included mental health and wellbeing, general health, physical wellbeing, and intimate partner violence. The four studies that examined leave at an individual level showed evidence of maternal health benefits, whereas the three studies conducting policy-level comparisons reported either no association or evidence of a negative association. The synthesis of the results suggested that paid maternity leave provided maternal health benefits, although this varied depending on the length of leave. This has important implications for public health and social policy. However, all studies were subject to confounding bias and many to reverse causation. Given the small number of studies and the methodological limitations of the evidence, longitudinal studies are needed to further clarify the effects of paid maternity leave on the health of mothers in paid employment.

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1. Introduction

Gender inequalities in health exist in part as a result of differences in income and rates of paid and unpaid work between women and men (Borrell et al., 2014). While women's participation in the labour force has increased markedly since the middle of the twentieth century across most Western developed nations, gender inequalities in employment participation, socioeconomic resources, and family responsibilities persist. Gender segregation in the labour market is due in part to the horizontal division of the labour market in which working women tend to be employed in certain sectors and professions with lower levels of remuneration (Artazcoz et al., 2007), but also as a consequence of women experiencing a higher burden of unpaid work, such as domestic tasks and caregiving (Borrell et al., 2014; Doyal, 2000). Although differences in labour force participation are less pronounced between women and men without children, cross-national studies have

Abbreviations: OR, Odds Ratio; PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses; PROSPERO, International Prospective Register of Systematic Reviews; RD, Risk Difference; USA, United States of America.

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demonstrated large inequalities in employment hours and income between women and men who have children (Hegewisch and Gornick, 2011; Misra et al., 2011). Employed mothers must juggle work and family responsibilities, which often leads to reduced employment hours (Glass, 2004) and the potential of disengaging from the paid workforce completely. This is particularly the case for women with young children (Keck and Saraceno, 2013). The competing demands of employment and family care can affect mothers' career pathways and lifetime earnings potential as a consequence of interrupted working patterns (Glass, 2004). Having children may reduce women's access to material resources and the psychosocial benefits of paid work with potentially deleterious impacts on their health and wellbeing.

Gender inequalities in employment outcomes vary between countries, suggesting that they are influenced by factors such as cultural and social values, and legislative and policy regimes (Borrell et al., 2014; Pfau-Effinger, 2005). Governments have an important role to play in reconciling gender inequalities through implementing policies such as maternity leave. Enacting such work-family policies may lead to improvements in women's health and wellbeing by minimising the conflict between work and family responsibilities and by providing mothers with time to recover physically from childbirth, bond with their child, and adapt to new roles while providing job protection (Borrell et al., 2014; Productivity Commission, 2009).

While maternity leave has become a standard entitlement in many countries, the length of leave, the monetary value of the wage replacement, and leave eligibility vary (Hegewisch and Gornick, 2011). Variations in policies are exemplified by comparing countries like France and Germany with the United States of America (USA). France and Germany offer over 160 weeks of job-protected leave for mothers (20 weeks of which are paid in France, 42 weeks paid in Germany) whereas in the USA the federal government provides mothers with 12 weeks of job-protective leave, none of which is paid (Ray et al., 2010).

The generosity of maternity leave allowances (e.g. length of leave and wage replacement) combined with related policies such as public childcare or paternity and partner leave, can influence mothers' caring practices and employment decisions (Ray et al., 2010). Recent debates have focused on the ideal length of leave, and in some countries such as the USA and until recently, Australia, about whether or not mothers have a right to paid leave. Multiple studies have examined the impact of length of leave on women's engagement with the labour force. It has been found that the absence of paid leave or shorter paid leave lengths (less than 12 weeks) can have detrimental effects on women's rates of returning to work (Hegewisch and Gornick, 2011; Misra et al., 2011). Women may have to resign from their jobs to take time off to care for their young children and may experience problems re-entering the workforce (Keck and Saraceno, 2013). Research also suggests, however, that very long leave may lead to lower wages and discrimination in the workplace (Hegewisch and Gornick, 2011; Misra et al., 2011). For example, in countries such as France and Norway legislative provisions allow women to remain out of the workforce for up to three years after the birth of their child. This has resulted in lower labour market attachment, particularly among women with multiple children and those with lower levels of education (Hegewisch and Gornick, 2011). Very long leave may also have the unintended consequence of further entrenching the feminisation of parental care (Hegewisch and Gornick, 2011) and increasing gender wage gaps, particularly if long parental leave is predominantly available to and taken by mothers (Morgan and Zippel, 2003).

Less is known about the impact of leave allowances on maternal health. There is evidence that many women in the postpartum period experience poor mental health (O'Hara and Swain, 1996), however recent studies have highlighted the prevalence of other health outcomes, such as backache, headache, fatigue, sex-related concerns, perineal pain, and gastrointestinal problems (Cheng and Li, 2008). Maternity leave may minimise these negative health outcomes. Two reviews to date have examined maternity leave and maternal health: Borrell et al. (2014) and Staehelin et al. (2007). Both reviews suggested that maternity leave (unpaid or paid) improves maternal mental health. However, studies examining general and physical health outcomes such as backache, extreme tiredness, vitality, outpatient clinic visits and lack of sleep found no associations with maternity leave, with the exception of one study which found a positive association between longer leave and self-reported health. A recently published paper reported a U-shaped association between length of leave and postpartum depressive symptoms, with increasing leave being beneficial up to six months postpartum (Dagher et al., 2014). While these papers provided some evidence about the effect of maternity leave on mental health, they did not distinguish between paid and unpaid maternity leave. The objective of this review is to provide a synthesis of the research examining the effects of paid maternity leave, and length of paid leave, on maternal health. A synthesis of the evidence is important for both public health and social policy as improved maternal health is one of the aims of paid maternity leave policies.

2. Methods

This systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Liberati et al., 2009). Our search strategy, inclusion criteria, and methods of analysis were specified in advance and documented in a protocol registered with the International Prospective Register of Systematic Reviews (PROSPERO) (www.crd.york.ac.uk/prospero), registration number: CRD42012003187. Ethics approval was not required as no primary data were collected.

2.1. Eligibility criteria

Studies were considered for inclusion if they examined maternal health outcomes associated with paid postnatal maternity leave (including both government-sponsored and employer-sponsored leave), the exposure of interest was paid maternity leave, and the study had a relevant comparison group defined as:

1. Studies examining paid maternity leave versus no paid maternity leave;
2. Studies comparing different lengths of paid maternity leave.

Paid maternity leave could be measured at a policy level (i.e. access to leave of a specified duration at a particular time point in a region) or an individual level (i.e. an individual did or did not take leave). Studies in which the comparison group consisted of women who were not employed during pregnancy were excluded because the samples were likely to be intrinsically too different, in terms of potential health confounders such as age, socioeconomic status, household structure, and relationship status. There were no restrictions on whether women were receiving maternity leave or had returned to paid employment at the time of data collection.

All study designs were eligible, including studies in which participants were surveyed at one point in time (cross-sectional studies and ecological studies) and studies conducted over time (cohort studies, case–control studies, repeated cross-sectional studies and randomised controlled trials). Both quantitative and

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