An Opportunity to Promote Health Equity: National Paid Family and Medical Leave

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When my daughter was born prematurely at 27 weeks, I was faced with the agonizing choice of staying with her in the neonatal intensive care unit or going back to work at my federally qualified community health center. Even as a pediatrician who is familiar with the enormous benefits of kangaroo care and singing, talking, and reading to newborns, I returned to work within two weeks of her birth because of my own economic situation. At the time, the state I lived in, Massachusetts, did not offer paid family and medical leave (PFML), and the clinic I worked at offered unpaid leave options. As a physician, I am enormously privileged with respect to job protection and income. However, the families I care for are particularly vulnerable to the adverse impacts of unpaid leave. I have come to recognize PFML as a health equity crisis that requires an urgent national policy solution.

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The United States is the only developed nation that fails to guarantee any kind of paid leave to workers. We lack a national paid family and medical leave (PFML) policy that encompasses: (1) paid parental leave, which would apply to both mothers and fathers after the birth of a child, adoption of a child, or fostering a child; (2) paid family leave (PFL), which would apply to caregivers of a hospitalized child, a medically complex child, or a family member such as a declining parent; and (3) paid medical or sick leave, which would allow one to manage personal or family illness. Although the 1993 Family and Medical Leave Act (FMLA) provides 12 weeks of unpaid job protection for certain workers to care for family members or tend to their own health, this arrangement fails 40% of the US workforce, including independent contractors, new employees, and workers in small businesses who are carved out of the law.1 For those employees who are eligible, many cannot take time without pay; in 2012, among workers who needed but did not take FMLA leave, 46% reported that they could not afford to take unpaid leave.1

In light of the coronavirus disease 2019 (COVID-19) pandemic, US Congress enacted emergency paid leave protections for some workers who need time off to manage the pandemic’s repercussions, including personal or family ailment, quarantine or self-isolation, and closure of children’s schools or child care facilities. These provisions have limitations, including duration of leave, eligibility for leave based on occupation and


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size of employer, and expiry of provisions after December 2020. Researchers estimate that approximately one-half of the private sector workforce is covered; however, if all employers who are eligible for exemptions take them, including health care institutions, up to 106 million workers, or approximately three-fourths of the private sector workforce, are excluded.\textsuperscript{2} Therefore, with the exception of temporary COVID-19-related protections, instead of creating a national standard, the United States has left it up to individual states to pass their respective PFML laws to help working people make ends meet when caring for a new child or when health problems require time off from work. Only 8 states, including California, Connecticut, Massachusetts, New Jersey, New York, Oregon, Rhode Island, and Washington, along with the District of Columbia, have passed PFML legislation, formulated as social insurance with near-universal coverage. Five of those states have programs in operation; the others will begin operating between July 2020 and January 2023. That leaves 42 states which still lack PFML programs to support working families. In these states, workers must rely on their employer’s voluntary generosity, but most workers are left behind. As calculated by the US Bureau of Labor Statistics on the basis of employers’ reports, 19% of civilian employees have access to PFL nationwide, and low-paid workers are less likely to have access to paid leave than those with higher pay.\textsuperscript{3} These statistics highlight the necessity of adopting a national policy that encompasses all worker types and covers a diverse array of medical and caregiving needs. Because no national PFML program currently exists, families are forced to make difficult choices between work and care, resulting in lost wages for unpaid family caregivers and propagating income, wealth, and health disparities across gender, race, and ethnicity.

GENDER DISPARITIES
Disproportionate caregiving burdens fall on women, limiting them from labor force participation and advancement and forcing their families to forgo much needed income that could help promote increased safety and security. On the basis of statistics before the current pandemic, of those who needed leave but did not take it, 64% were women.\textsuperscript{3} For women who take leave after giving birth, nearly 1 in 4 return to work within 10 days.\textsuperscript{4} For new mothers, lack of access to PFML poses substantial health risks. One in 5 women are at risk for developing postpartum depression within the first year after childbirth; alarmingly, maternal suicide in the first year postdelivery encompasses 20% of mortalities for all women.\textsuperscript{4} Several studies have highlighted the positive impact on postpartum depression, breastfeeding rates, intimate partner violence rates, and overall physical health for new mothers who take PFL.\textsuperscript{4} Paid leave in connection with a child’s birth is not just a maternal and infant issue, however. Most fathers are not able to take paid paternity leave. However, when fathers do take leave, their relationship and bond with their child is strengthened over the longer term.\textsuperscript{5} Additionally, when fathers take PFL, their engagement in the home increases and becomes more equitable, making it easier for mothers to return to work.\textsuperscript{5} Research from Sweden also reveals the impacts on women’s earnings: for each month of leave a father takes in Sweden, his wife’s earnings go up by 7%.\textsuperscript{6}

The benefits of PFL in improving maternal health, encouraging male participation at home, empowering female advancement in the workforce, and promoting gender equity cannot be understated.

RACIAL AND ETHNIC DISPARITIES
Wealth gaps between white families and families of color are well established; they exist and persist because of long-standing discriminatory policies and perpetual racism. Therefore, families of color are disproportionately susceptible to the economic consequences of personal or family medical issues, which lack of PFML exacerbates. Only 23% of Latinx and/or Hispanic workers and 41% of Black workers report having any type of paid leave to use for serious medical or family needs, including paid maternity or parental leave.\textsuperscript{7} In addition to wealth and economic disparities, people of color experience more chronic health conditions and are more likely to have multigenerational households, therefore resulting in more caregiving responsibilities. Paid leave is essential for communities of color.

The rate of preterm birth and having a low birth weight infant among Black women is 14% and 13%, respectively, compared with 9% and 7%, respectively, among white women.\textsuperscript{8,9} Adding to these disparities, the infant mortality rate of 5.8 deaths per 1000 live births makes the United States 33rd of 36 member countries of the Organization for Economic Cooperation and Development\textsuperscript{10}; furthermore, the infant mortality rate for non-Latinx/Hispanic Black infants is 11.4 deaths per 1000 live births.\textsuperscript{11} Compelling evidence illustrates that 10 weeks of maternity leave reduces infant mortality at a rate of 1% to 2%, whereas 30 weeks of maternity leave reduces infant mortality by 7% to 9%.\textsuperscript{12} Positive effects of paid parental leave on rates of preterm births, low birth weight infants, and infant mortality rates would help close these racial and ethnic gaps, reduce health care costs, and benefit the economy.

POLICY SOLUTIONS TO PROMOTE HEALTH EQUITY
Given the limitations of the FMLA, which disproportionately excludes
low-income individuals, women, and workers of color; among others, and discriminates against modern family structures, enacting a national PFML policy that provides coverage to all working people is long overdue. Fortunately, national PFML is gaining momentum. There is broad national public support for paid leave in the context of birth, adoption, personal illness, or a family member’s illness based on national public opinion surveys. In Congress, a national PFML policy has bipartisan support: the Family and Medical Insurance Leave Act would create a comprehensive national program that would meet the needs of all American workers with personal or family health issues. The current COVID-19 pandemic underscores the fragility of worker and community health and the frailty of economic security when paid leave is unavailable. With COVID-19, Congress enacted a limited, but still historic, national paid leave standard that could be expanded on to create permanent protections.

Although the American Academy of Pediatrics does not yet have a policy statement related to national PFML, pediatricians are uniquely positioned to advocate for PFML with the following actions: (1) familiarize oneself with local and state PFML policies; (2) educate families, particularly low-income and those of color, regarding PFML to address eligibility and access; and (3) partner with advocacy organizations to campaign for PFML and educate lawmakers about its benefits. As the leading child health professional medical organization, the American Academy of Pediatrics has the special opportunity to issue a policy statement on PFML to inform future legislation. The time to promote health equity through PFML is now; future infants’ lives depend on it.

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ABBREVIATIONS
COVID-19: coronavirus disease 2019
FMLA: Family and Medical Leave Act
PFL: paid family leave
PFML: paid family and medical leave

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