A large body of evidence documents that the early life environment affects people’s health and economic outcomes throughout the life cycle. Coupled with the fact that the US has relatively poor infant health ratings, particularly for preterm births and infant mortality, this research suggests that early childhood interventions may be beneficial for population health and the economy as a whole. One such intervention is paid family leave (PFL), which allows workers to take time off to care for newborn children or ill family members.

The US is the only one of the thirty-five Organization for Economic Co-operation and Development (OECD) countries that does not offer paid leave to new mothers, and one of the eight OECD countries that do not provide paid leave to fathers. While there is currently no federal PFL, policy maker support for such leave has been growing: Six states and the District of Columbia have passed PFL legislation, and from December 2017 to December 2019, the federal Employer Credit for Paid Family and Medical Leave (Section 45S of the Internal Revenue Code) provides a tax credit to employers offering PFL. In the 2016 election campaigns, for the first time in history, both Democratic and Republican presidential candidates endorsed some form of PFL.

This brief outlines the PFL policy landscape in the US and the ways in which PFL may affect population health. It discusses empirical research on the effects of PFL on child and parental health, both in the US and in other countries. It concludes by exploring the policy implications of this research and commenting on additional research that is needed to better understand the health effects of PFL.

PAID FAMILY LEAVE POLICIES AND POPULATION HEALTH

Available evidence suggests that the introduction of paid family leave for up to one year may yield child and maternal health benefits in the short and long run.
serious health condition. There are strict eligibility requirements for FMLA, such as needing to have worked at least 1,250 hours for an employer with fifty or more employees during the twelve months before the start of the leave. The most recent data indicate that only about 60 percent of private-sector workers are eligible for FMLA, and 46 percent of those eligible report not being able to afford taking unpaid time off work.

With no federal law to support it, the provision of paid family leave is therefore a matter of state and employer policy. Four states (California, New Jersey, New York, and Rhode Island) have implemented PFL policies, and two more (Washington and Massachusetts), as well as the District of Columbia, have enacted PFL measures that are set to take effect in 2020 or 2021. These policies vary in specifics, such as statutory leave duration, benefit amount, and job protection (that is, the right to return to the same or a near-identical job after taking leave) (see exhibit 1).

In addition, about 13 percent of civilian employees access PFL through their employers, but such access is limited and unequal. Employer-provided PFL is more prevalent among high-paying, professional occupations and within large companies. In 2017, 6 percent of workers in the lowest-paying quartile of jobs had access to PFL, compared to 24 percent of workers in the highest-paying quartile. Additionally, only 6 percent of service workers had employer-provided PFL.

Five states (California, Hawaii, New Jersey, New York, and Rhode Island) and Puerto Rico have State Disability Insurance (SDI), which provides partial wage-replaced leave for workers with temporary disabilities and for mothers preparing for and recovering

### EXHIBIT 1

<table>
<thead>
<tr>
<th>Features of state paid family leave policies</th>
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<tr>
<td><strong>State</strong></td>
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<td>California</td>
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“Thirteen percent of civilian employees access PFL through their employers, but such access is limited and unequal.”

may be eligible for longer leaves if they experience delivery complications. Birth mothers in states that have both PFL and SDI programs (California, New Jersey, New York, and Rhode Island) can take additional leave through PFL after completing their SDI leave. For example, mothers in California with an uncomplicated vaginal delivery can take a total of twelve weeks of partially paid postpartum leave through SDI and PFL.

Mechanisms Connecting PFL And Health

Paid family leave may affect population health through multiple channels. First, children of parents who take leave may receive more parental care and breast-feeding, if parents are able to stay home longer after birth instead of returning to work immediately. Similarly, children may receive more immunizations and more consistent medical care, if parents can go to doctor appointments more easily while on leave.

Second, child health may improve from the extra resources parents get from PFL benefits, especially when the parents may otherwise take unpaid leave or quit their jobs. Families may be able to afford more nutritious food, for example.

Third, infant and long-term health outcomes may be better if PFL access lowers maternal stress during pregnancy, perhaps due to increased financial and job security. Maternal stress during pregnancy has been shown to adversely affect both infant and long-term child well-being.

Fourth, access to PFL may have beneficial effects on parental health. In addition to potentially lowering prenatal and postpartum stress, taking time off work to recover from childbirth and to bond with the new child may improve maternal mental and physical health. Fathers may also benefit from bonding with the baby.

Finally, taking leave to care for a sick child or family member may improve recovery and prevent the spread of disease, conveying additional health benefits of PFL.

Evidence Of Labor Market And Health Impacts

Most research on PFL has focused on women’s (and to a lesser extent men’s) leave use and labor market outcomes (Maya Rossin-Slater as well as Claudia Olivetti and Barbara Petrongolo provide recent overviews). Paid leave, in contrast to unpaid leave, increases leave usage, especially among disadvantaged mothers. Additionally, there is some evidence that PFL may increase employment and job continuity of mothers after their children turn one. Studies on leaves earmarked specifically for fathers in European countries (colloquially referred to as “daddy months” or “daddy quotas”) suggest that there is no detrimental impact of such policies on fathers’ future earnings or employment, though fathers substantially increase leave taking. Research on the effect of PFL on firms is sparse, but existing work suggests no detrimental effects on wage costs or employee turnover.

The majority of existing research on the health effects of PFL focuses on children’s outcomes. Earlier work on the impacts of unpaid leave provided through the FMLA shows that it led to small increases in birthweight and large reductions in infant mortality rates. However, these health benefits were apparent only for children of relatively advantaged mothers, which
is consistent with prior evidence that such mothers were most likely to be eligible for, and able to afford to use, unpaid leave.

In contrast, mothers and children from less advantaged backgrounds particularly benefit from access to paid leave. One study shows that the introduction of paid maternity leave through the SDI system in five states led to a reduction in the share of low birth-weight and preterm births, especially for unmarried and black mothers.

Researchers have also examined the impacts of California’s PFL policy (CA-PFL) on child health. Studies have shown that the introduction of CA-PFL increased breast-feeding rates among new mothers and reduced infant hospitalizations. Other researchers have found evidence of longer-term health effects, especially among disadvantaged children. Specifically, the implementation of CA-PFL was associated with reduced rates of overweight, attention deficit hyperactivity disorder, and hearing-related problems among elementary school-age children. These health issues are inversely related to breast-feeding and prompt medical checkups during infancy and positively associated with prenatal stress and nonparental care, which are all plausibly affected through the availability of PFL.

The evidence from Canada and Europe on the child health effects of PFL is more mixed. Early research that compared PFL programs across European countries found that policies that provided longer leaves were associated with lower child mortality rates, but other differences between countries with more and less generous policies could confound these correlations. Two studies on the introduction of PFL policies in Norway found benefits for children: One showed that the implementation of paid maternity leave in 1977 led to a decline in children’s future high school dropout rates and an increase in children’s future wages at age thirty, while the other found that the 1993 introduction of leave earmarked specifically for fathers improved school performance at age sixteen for children whose fathers were more educated than their mothers were. In contrast to the research on the introduction of PFL, numerous studies have found little to no effect on child health outcomes of extending preexisting PFL in Canada and Europe. However, these findings are not necessarily informative for policy in the United States. First, the effect of expanding already generous PFL entitlements may be very different from the effect of introducing paid leave for the first time. Second, the social safety net and other programs in those countries tend to be more generous. Thus, the potential gains to be had in the US may be greater than these studies suggest.

Much less research has focused on the maternal and paternal health effects of access to PFL. To date, this research suggests that the introduction of PFL may have health benefits for mothers, whereas the extension of existing leave has less effect. A study on the introduction of paid maternity leave in Norway in 1977 found that it had beneficial medium- and long-term health effects for mothers, including improvements in body mass index, blood pressure, pain, and mental health, and that it increased healthy behaviors such as exercise and not smoking. The authors also studied subsequent reforms that lengthened the paid leave entitlement and found diminishing maternal health returns as leave length increased. Research using Canadian data found that an increase in PFL length from six months to one year had no effect on self-reported maternal health.

One study provided correlational evidence of negative maternal health outcomes related to mothers’ return to work during their children’s infancy. The authors found that in the US, among mothers of six-month-old infants, maternal work hours were positively associated with depressive symptoms and self-reported parenting stress and negatively asso-
associated with self-rated overall health. Another study showed that for mothers who worked before childbirth and returned to work in the first year, having less than twelve weeks of maternity leave and having less than eight weeks of paid maternity leave were both associated with increases in depressive symptoms, and having less than eight weeks of paid leave was associated with a reduction in overall health status.

To our knowledge, there has been no research using natural experiment or policy reform designs on the effect that taking leave has on fathers’ health. Correlational studies using Swedish data found a negative association between taking parental leave in the first 30–135 days of an infant’s life and all-cause mortality as well as alcohol-related deaths for new fathers, but other differences between fathers who did and those who did not take leave might have confounded the relationship.

**Policy Implications**

Several policy takeaways are evident from the research to date. Paid leave, in contrast to unpaid leave, increases leave usage and duration, especially among disadvantaged parents who are least able to afford unpaid time off. But even in states with nearly universal PFL eligibility, leave use is not equal across workers. One study found that in California, workers with low earnings and who were employed in small firms were less likely to use CA-PFL, compared to their counterparts with higher wages and in larger firms. This evidence suggests that higher wage replacement rates and universal access to job protection (which is currently provided only to workers in larger firms who qualify for the FMLA) may be important for increasing leave take-up.

Moreover, the available evidence suggests that the introduction of leave of up to six months to one year may yield child and maternal health benefits in the short and long run. Studies on leave expansions in other countries suggest decreasing marginal benefits to leave beyond this length.

In 2017 and 2018, the American Enterprise Institute and Brookings Institution convened two working groups of experts to discuss the costs and benefits of PFL and to develop a plan for a federal PFL program for policy makers’ consideration. They released two reports, one with a plan for a proposed PFL program and another highlighting disagreements within the group regarding a plan for family care leave.

Various PFL programs have also been proposed by policy makers. More than twenty states have pending PFL legislation. At the federal level, the Democratic-sponsored Family and Medical Insurance Leave (FAMILY) Act was put before Congress for the fourth time in February 2019. The FAMILY Act would create a paid leave program, funded by a new payroll tax, within the Social Security Administration and would cover all family-related caregiving for up to twelve weeks. Other current federal proposals include six weeks of paid leave for new mothers and fathers, funded by the Unemployment Insurance system, as requested in the 2019 budget of President Donald Trump. Additionally, in August 2018, Sen. Marco Rubio (R-FL) introduced in Congress the Economic Security for New Parents Act, which would allow parents to delay retirement and use their future Social Security benefits for two months of parental leave to care for newborns.

“The introduction of [PFL in California] increased breast-feeding rates among new mothers and reduced infant hospitalizations.”
Future Research Needs

Despite the wealth of existing research on PFL, important knowledge gaps remain. First, as discussed above, we know little about the health effects of PFL on parents—especially fathers.

"Paid leave, in contrast to unpaid leave, increases leave usage...especially among disadvantaged parents."

Second, nearly all of the current research focuses on leave surrounding the birth of a child. There is almost no evidence on how leave taken to care for an ill family member affects population health.

Third, more research is needed to understand how PFL legislation affects employers. We know little about how employers deal with work interruptions due to employees’ taking leave or whether employers respond to PFL mandates by changing their own benefit packages, hiring practices, or other aspects of jobs.

Finally, there is little evidence of the health effects of specific PFL features—the length of leave, the level of wage replacement, or whether employees get job protection while on leave. One study shows that a higher weekly benefit amount for CA-PFL did not increase leave duration, but might promote job continuity and future program participation (or paid leave taking) among high-earning mothers. Similar research on the health effects of different leave features might help inform PFL policy structure. This type of research may be possible as the newly enacted state PFL laws take effect in the coming years or as additional states pass their own PFL programs.