PO Box 538, Welland, South Australia, 5007.

SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO PAID MATERNITY, PATERNITY AND PARENTAL LEAVE.

2 June, 2008.

SUMMARY.

Paid maternity, paternity and parental leave are health issues. AWHN supports a social view of health which acknowledges that a wide range of factors impact on people's health, especially their economic health and well-being. Economic well-being has a major impact on life chances and on health: epidemiological evidence from multiple countries, well off and poor alike, demonstrates without doubt a very close connection between low socio-economic status and poor health outcomes.

Australian women are currently disadvantaged on almost every indicator of economic health and well-being, and much of this disadvantage stems from the mothering role. Women have poorer workforce participation rates than men, do more part-time and casual work, have lower incomes even when they are employed full-time and have less superannuation. Paid maternity leave, with additional partner leave, where appropriate, is essential to reduce the economic disadvantage that women currently face as a result of their roles as the bearers and main carers of Australia's children.

The importance of paid maternity leave to the economic security and health of birthing women and their children is recognised in all OECD countries, except the United States and Australia, and in many less well off countries as well, as pointed out in the Productivity Commission's Issues Paper. With such strong international agreement, along with the robust body of evidence on which it is based, including previous Australian research over more than two decades, arguments about the benefits of paid maternity leave should not need to be canvassed in 2008. The main issue should simply be what kind of scheme to adopt in order to bring Australia screaming into the 20th century.

There are many models operating internationally, some with much more generous benefits than others. The Australian Women's Health Network suggests that Australia adopt a system that is a "mean between extremes", to borrow from Aristotle. Having waited for so much longer than women in comparable countries, Australian women should not now have to accept a scheme pitched at the level of minimum benefits. A minimalist, 14 week maternity leave scheme, with two weeks paid paternity leave, at the level of the Commonwealth minimum wage, as recommended by the Human Rights and Equal Opportunity Commission (HREOC) in 2002, no longer meets the basic requirements of natural justice for Australian women.

Instead, Australia should put in place a more generous set of arrangements. The HREOC scheme, adjusted to provide 20 weeks maternity leave and 4 weeks paid partner leave where appropriate, should be introduced for all birthing women in Australia. Women not attached to the workforce should receive an entitlement of the same value, which would replace special maternity payments, such as the baby bonus. In addition, it should become mandatory that employers contribute to the scheme to bring the wages of working women up to 75 per cent of previous incomes, where earnings were more than the minimum wage. All birthing women in the workforce should have a guarantee that they can return to their jobs or to a job of equal status and pay on completion of maternity leave.

The Australian Women's Health Network (AWHN) is the peak organisation for women's health in Australia.

AWHN is a not-for-profit network run primarily by volunteers to maintain and advance a national voice on women's health through advocacy and information sharing. AWHN is an umbrella organisation for State and Territory Women's Health Networks and other national organisations which embrace its objects and philosophy.

The broad aims of AWHN are to maintain a national focus on women's health issues, to be a national advocacy and information sharing organization and to be an umbrella organisation for State and Territory women's health networks and for other national women's organisations which embrace our objects and philosophy.
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The main objectives of the organization are to promote a social view of health, to lobby and advocate on issues affecting women's health, to provide support for women to participate in health and well-being decision making and to promote fairness and equitable access to services within the health system, particularly for women disadvantaged by race, class, education, age, poverty, sexuality, disability, geographical location, cultural isolation and language.

Further AWHN objectives are to work towards securing women's control over and responsibility for their own sexual health and reproduction, to promote a woman-centred analysis of all models of health care and research, to support and foster the strengthening of State and Territory women's health networks and to support the development of women's health services, within a framework of consultation and best practice.

Promoting women's health and wellbeing
AUSTRALIAN WOMEN'S HEALTH NETWORK

PO Box 538, Welland, South Australia, 5007.

PAID MATERNITY, PATERNITY AND PARENTAL LEAVE: A HEALTH ISSUE.

Introduction.

The Productivity Commission's inquiry represents a long overdue opportunity to introduce a coherent national scheme of paid leave for birthing mothers and, where appropriate, their partners. Paid maternity leave will contribute to women's social and economic well-being, and consequently to good health outcomes for themselves and their children. It will also contribute to economic development by strengthening women's attachment to the labour force.

It is 89 years since the ILO created the first global standard for the protection of working women before and after childbirth, the Maternity Protection Convention. Since that time, the protection provided under the Conventions has been expanded and, by 1998, over 120 countries had already adopted a paid maternity protection scheme in some form. As the ILO argues:

> Over time, the principles of ILO maternity protection Conventions have been universally embraced, with the result that at least some of these basic elements of maternity protection have been adopted into the legislation of virtually every nation in the world, regardless of whether they have ratified Conventions on maternity protection or not (ILO 2007).

Australia has been criticised repeatedly by international agencies for being a policy free zone in relation to this important women's right. It is extremely hard to understand why Australia should be so far behind comparable countries, and even harder to understand why the situation is so similar to that in the UnitedStates. Rectification is overdue.

70 per cent of Australian women of childbearing age are now in the paid workforce. Without income during this period of high expenses, women's economic security, as well as their rights as workers, is seriously undermined. Under current arrangements, two thirds of Australian women have no access to maternity workplace entitlements. Low income women, in industries such as retail and hospitality, are least likely to

have maternity entitlements but are the group most in need of financial security at this time.

Paid maternity leave, alongside an equivalent benefit for women not in the paid workforce, should be an entitlement for Australian women. For employed women, it should be a workplace entitlement like other forms of leave, such as sick leave. For women not participating in the workforce, an equivalent minimum wage level payment should be an entitlement and a preventive health measure to relieve the additional financial cost surrounding childbirth and newborn care. Paid maternity leave should have nothing whatever to do with the baby bonus, now a means tested benefit. It should be in no way a welfare measure but rather a workplace entitlement and/or a maternity right.

The Health Benefits of Paid Maternity Leave.

It hardly seems necessary to repeat the arguments that set out the benefits of paid leave arrangements that ensure that women are not financially and otherwise penalised when they give birth to a child. Such arguments have been reiterated many times by international bodies such as WHO and ILO. In Australia, early in this decade, HREOC undertook consultations, carried out research and did economic modelling on the issue. It is self evident that while women continue to take unpaid leave to care for children (and others), gender inequality will remain a feature of the workplace, women will suffer higher levels of economic insecurity, which often lasts throughout the lifespan, and women's health, among other things, will suffer as a result. Similar arguments can be made in relation to the impact of part-time and casual work on women's life chances: where paid maternity leave is unavailable, women are more likely to sever or disrupt their full-time attachment to the workforce. Instead of going over familiar arguments, AWHN instead wishes to stress the connections between economic security, good working conditions, appropriate work/family balances and good health.

AWHN recognises the central role played by the social determinants of health (as well as some biological and genetic factors) in health outcomes and subscribes to a social view of health. In this perspective, following the WHO, health is the state of physical, mental, emotional and social well-being, and not merely the absence of disease or infirmity. A social view of health acknowledges that health is affected by a wide range of social, economic and political factors. Consequently, in an ideal world, health considerations would be a high priority in policy areas apart from those usually located in the health portfolio.

The strong link between economic insecurity and poor health is firmly established in the literature of the social determinants of health (see for example, Leon 2001; Marmot 2002; Mechanic 2003; Steinbrook 2004; Graham, 2004; Levin and Browner 2005). Economic security, physical security, educational achievement, mental and emotional well-being and access to affordable, high-quality services all contribute to good health outcomes. Economic insecurity, often resulting from poor workforce participation, which in turn is frequently a byproduct of the mothering role, gives rise to a raft of problems, all associated with poor health outcomes, and can lead to serious marginalisation and social exclusion for the least advantaged women.

Australian women spend less time than men in the paid workforce. They have reduced job security in part-time and casual work with fewer career opportunities, they often face sexism, racism and homophobia in the workplace, they are clustered in low income and low status occupations and they frequently have few savings with which to support themselves at the end of their working lives and, typically, have much less superannuation than men. These aspects of women's lives make them sick. It is for these reasons that economic health and well-being heads the list of AWHN's five priority areas for women's health[1] (AWHN 2008: 19). The list of priority areas was compiled on the basis of evidence presented to AWHN's Fifth National Women's Health Conference in 2005 and other consultations.

Women's health and well-being is not only important to women themselves but is closely related to the health of others around them. The health of mothers, for example, is of vital importance to the health of infants and children. There are numerous are the spin-off effects: healthy women are more productive, they participate more in the paid and unpaid workforces and the demand for costly health services is minimised. As the government of South Australia argued in 2005 "improving the health of all women will improve the health of the whole community" (quoted in AWHN 2008:7).

AWHN's "Mean between Extremes" Paid Maternity Leave Scheme.

Internationally, paid maternity leave schemes vary enormously in the benefits offered. For example, New Zealand has 14 weeks leave, whereas Sweden has upwards of 65 weeks. The World Health Organization recommends exclusive breastfeeding of babies until the age of 6 months for mothers who are not HIV positive, and continued breastfeeding with supplemental foods for up to two years. While the ILO Convention of 2000 stipulates a minimum of 14 weeks paid leave, it recommends that countries move towards an entitlement of 18 weeks. The United Kingdom has recently endorsed a period of 26 weeks.

Australian women have waited a long time for paid maternity leave and should not have to make do with a scheme based on minimal standards. Ideally, a period of the leave of at least 26 weeks should be put in place but, as a compromise position to begin with, AWHN recommends 20 weeks, with 4 weeks paid partner leave, where appropriate. 20 weeks leave will allow birthing women to recover physically, bond with their infants and establish breast-feeding, without severe financial stress. Four weeks paid partner leave will contribute to the flexibility of family arrangements, facilitate family bonding and likewise promote economic well-being. The aim should be to move to 26 weeks seen as politically possible.

The funding arrangements that AWHN recommends again represent a middle position. Paid maternity and partner leave or equivalent entitlement should be made available to all birthing women, at the level of the minimum wage. This is desirable, both on economic security and thus health grounds, and to overcome the inequities

[1] The other four priority areas are women's mental health and well-being, prevention of violence against women, women's sexual and reproductive health, and access to publicly funded health services.

perceived by many as flowing from discrimination against those women not in paid work. A universal scheme will avoid the charge that it discriminates against those women not in the paid workforce. We should remember, too, that not all women with no workforce attachment have well off partners. Women not in the paid workforce include students, women with disabilities, women who live in geographically remote areas where there is little work, including Aboriginal women, and marginalised women.

Maternity leave/maternity entitlement should be publicly funded, up to the level of the minimum wage, so as to avoid the danger that women and men of childbearing age will be discriminated against by employers. Women not attached to the workforce, and their partners, where appropriate, will have an entitlement equivalent to the value of 20 weeks paid maternity leave. This entitlement will replace the baby bonus and other sundry maternity payments and thus will be administratively simpler and cheaper.

In most OECD countries, social insurance systems are in place and employers and employees both contribute towards the cost of parental leave. Schemes differ markedly in terms of level of remuneration. Norwegian women are paid 100 per cent of prior earnings for 44 weeks or they can take 54 weeks leave at 80 per cent of previous earnings while Japan pays 60 per cent of wages for 14 weeks.

Without social insurance in Australia, it becomes administratively more difficult, but not impossible, for employees to make contributions. Administrative ease suggests, however, that employees and those not permanently employed might best contribute to the scheme through the tax system. However, arrangements should be put in place for mandatory employer contributions as operate for other forms of workplace entitlement. Employer contributions should top up incomes to a chosen percentage of previous earnings, where previous earnings exceeded the minimum wage. A "mean between extremes" suggests that, initially, income be set at 75 per cent of prior earnings, with a view to achieving full income replacement levels over time. It should be stressed here that while paid maternity leave will greatly benefit Australian women, especially lower income women, a scheme which does not achieve full income replacement runs the risk of creating economic stresses and thus contributing to poor health outcomes.

In addition to paid leave, birthing women should have mandated job security. Pregnant women and new mothers should not live in fear that they may lose their jobs or their career prospects as a result of being pregnant, absent on maternity leave or because they have just given birth. Therefore, it is essential that they be given a guarantee of continued employment in an equivalent position after return from maternity leave. This guarantee is a core element of maternity protection arrangements, necessary for peace of mind and the mitigation of financial worries.

A national paid maternity leave/maternity entitlement scheme is necessary to redress the inequalities experienced by women workers relative to men as a result of childbirth. It will improve Australia's international reputation as we at last move to comply with the requirements of CEDAW, to which we are a signatory, albeit with reservations, and the ILO Maternity Leave Convention.

A government-funded, employer supplemented paid maternity leave/entitlement scheme will promote gender equity and protect family incomes for the period that women need to recover from childbirth and involve themselves in the unpaid work of

caring for newborn children. As such, it will move some way towards social responsibility for unpaid work, which use an enormous benefit to society but a cost generally paid by individual women. It will relieve women of much of the financial stress of being temporarily unable to earn. It will promote the recommended practices of breast-feeding and mother-baby bonding. It will remove the financial stress that can follow when partner's take unpaid leave to carry out family responsibilities. It will help to maintain women's workforce attachment and so improve their economic security throughout the lifespan. All of these benefits will promote better health outcomes for women, with corresponding health benefits flowing to children, families and communities.

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