

MATERNITY PROTECTION

of

EMPLOYED W O M E N

Women's Bureau
Bulletin No. 240

U. S. DEPARTMENT OF LABOR
MAURICE J. TOBIN, Secretary

Women's Bureau
FRIEDA S. MILLER, Director

Washington : 1952



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MARSHALL J. TORREY, Director

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LETTER OF TRANSMITTAL

UNITED STATES DEPARTMENT OF LABOR,
WOMEN'S BUREAU,
Washington, March 31, 1952.

SIR: I have the honor to transmit a report on maternity protection of employed women. The 10,000,000 married women workers represent more than half of all women workers in the national labor force. Their protection before and after childbirth involves not only their status as workers and their standard of living as citizens, but the health and well-being of themselves and their families and thus the national health in years to come.

Part I of the present report deals with legislative and other provisions in the United States. Its preparation involved a field study of practices in 43 firms by representatives of the Women's Bureau.

Part II contains an analysis of the ILO Maternity Convention of 1919, a proposed revision of which is on the agenda for consideration at the 1952 session of the International Labor Conference in Geneva; also a brief review of national legislation for maternity protection in ratifying and nonratifying countries.

The field study was made and the report written by Ethel Erickson, head of the Branch of Field Research, and Hazel Hansen in the Bureau's Division of Research, directed by Mary N. Hilton.

Respectfully submitted.

FRIEDA S. MILLER, *Director.*

HON. MAURICE J. TOBIN,
Secretary of Labor.

LETTER OF TRANSMITTAL

Washington, D. C., June 1, 1914

Dear Sir:

I have the honor to acknowledge the receipt of your letter of the 28th inst. in relation to the proposed amendments to the Federal Reserve Act, and in reply to inform you that the same have been referred to the Federal Reserve Board for their consideration.

The Board has held several public hearings on the subject, and has received many suggestions from the public. It has also held several private hearings, and has received many suggestions from the public. It has also held several private hearings, and has received many suggestions from the public.

I am, Sir, very respectfully,
Your obedient servant,
W. H. Clegg, Secretary

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Maternity Protection of Employed Women

INTRODUCTION

Maternity protection of employed women in the United States has taken on increased significance with the increasing proportion of married women in the labor force. More than one-half of the women in the labor force are married. Women not in the labor force comprise the largest reserve labor pool for emergency employment, and nearly three-fourths of these are married. With the high marriage rate prevailing at the present time, the birth rate may be expected to continue at a high level for years, and problems relating to the employment of pregnant women and maternity benefits will be of concern to employers, unions, and organizations interested in the welfare of employed women.

Visitors from other countries ask, time and again, why the United States, almost alone among the industrial countries of the world, has no Federal law providing for a national system of maternity protection of its women workers.

Because of the interest in this subject, the Women's Bureau recently prepared an annotated bibliography of selected references dealing with maternity protection.¹ The present report outlines the legislation for maternity protection of employed women in the United States and foreign countries; discusses the development of less formal plans and standards in the United States, where there is little in the way of legislation; and presents findings of a field study by the Women's Bureau from employers, unions, and insurance companies on maternity benefits, maternity leave, and other special considerations for pregnant employees.

The Women's Bureau field study includes 43 firms having maternity benefits. Of these firms, 30 are manufacturing and 13 are nonmanufacturing. Products of the manufacturing plants are textiles, hosiery, hats, shoes, chemicals, pharmaceuticals, soaps, canned foods, candy, photo-engraving, publishing, radios, electrical and metal goods. The

¹ U. S. Department of Labor. Women's Bureau. Bibliography on Maternity Protection. September 1951. Mimeo D-2. 53 pp. + alphabetical index.

13 nonmanufacturing firms include retail stores, hotels, restaurants, banks, an insurance company, a public utility, and a union office. The number of employees covered by the maternity protection and benefit plans in these companies varies from less than 100 to more than 80,000. The proportions of women range from 5 to 75 percent of the total employment. In about one-half of the firms, women comprised more than 40 percent of the employees. The number of married women was not available in most companies, but most of the manufacturing plants reporting estimated that at least one-half were married; a few reported as many as two-thirds. In 7 nonmanufacturing firms, the proportion of married women varied from approximately 20 percent in an insurance company to over 60 percent in restaurants.

About two-thirds of the 43 plants had collective bargaining systems. Representatives of the firms and also, in many instances, representatives of the unions were interviewed as to the policies relating to the employment of pregnant women, maternity benefits provided, number of women leaving because of pregnancy, and number returning to work after childbirth. The claim and benefit records of individual women, wherever available, were obtained to learn about the actual experiences of employed women as claimants for maternity benefits.

SUMMARY

Legislation for Maternity Protection in Foreign Countries

There are few countries where maternity protection has not been the subject of general national legislation.

An international standard on maternity protection for women workers in industrial and commercial undertakings was adopted by the International Labor Organization at its first session in 1919. It was the third convention adopted by the ILO. Since then 18 European and Latin American countries have ratified the Maternity Protection Convention and have enacted laws to carry out its directives. Most of these countries ratified it before 1935. Many of the countries that have not ratified, in Asia as well as in Europe and Latin America, have adopted national legislation providing maternity protection equaling some if not all of the requirements of the ILO Convention. Most of the countries with maternity protection legislation include maternity benefits for employees under their compulsory social insurance systems.

Legislation for Maternity Protection in the United States

In the United States, the only national legislation giving industry-wide benefits to pregnant employees is a 1946 amendment to the

Federal Railroad Unemployment Insurance Act that provides insurance for sickness and specifically includes pregnancy and maternity disabilities.

Rhode Island is the only one of the four States with sickness compensation laws that allows benefits for disabilities attributable to pregnancy.

Six States and Puerto Rico have legislation that prohibits employers from "knowingly" employing pregnant women for specified periods before and/or after childbirth. Only the Territory of Puerto Rico provides for weekly cash benefits, the provision being 8 weeks for pregnant employees in any office, commercial or industrial establishment, or in public utilities.

In almost one-half of the States, pregnancy disqualifies a woman for unemployment insurance.

Maternity Protection in the United States through Employer and Union Sponsorship

Maternity protection in the United States for employed women has been achieved chiefly through industrial plans sponsored by employers and organized labor rather than through legislation.

Maternity leaves of absence are provided in many union contracts and, also, often are included in the personnel policies of unorganized establishments. The maternity leave period is usually 1 year, with job security and seniority retained for the leave period.

Industrial health-insurance plans have been growing in number and an increasing number of these are including maternity benefits in their coverage. Less than one-fourth of the 43 firms included in the Women's Bureau study have had maternity-benefit provisions for more than 10 years, and more than one-fourth have had them for less than 5 years. Some insurance plans still specifically exclude maternity benefits, but the majority in woman-employing industries have some provision for this type of benefit.

Maternity benefits include weekly cash benefits to compensate for some of the income loss during pregnancy, hospitalization, and surgical (obstetrical) benefits.

Weekly cash benefits for pregnancy in most plans are for 6 weeks and the amounts paid are usually related to earnings. Weekly payments of from \$22 to \$26 are common.

Hospitalization is the most commonly provided benefit. Surgical benefits for obstetrical costs are provided by most of the plans. All the plans in the Women's Bureau study had hospitalization, and all but 3 of the 43 had obstetrical benefits.

Two main types of health-insurance plans are generally followed for hospitalization and obstetrical benefits. One type pays cash allow-

ances for specified services directly to the worker on presentation of hospital bills and obstetrical charges. Commercial insurance companies are the principal carriers for this type of benefit. The other type provides a specified service rather than direct money payment. Blue Cross for hospitalization and Blue Shield for medical care are the chief agencies administering the second type. Although in most cases the indemnity allowances for maternity do not cover the total hospital and doctor bills, they do pay a substantial part of the costs, one-half or more in most instances. Complete medical care and hospitalization for maternity as well as for other disabilities are provided by a small proportion of the plans.

There is a waiting period of at least 9 months under most plans before an employee is eligible for maternity benefits.

Special Provisions for Working Conditions for Pregnant Women

Formal policies for adjusting hours of work, rest periods, and changes in job duties are rarely found. Most employers, if possible, are willing to make adjustment in working conditions on an individual basis. Since the annual incidence of pregnancy in the total group of employed women is relatively low, 30 to 40 per 1,000 women, the actual number of cases affecting employment in most plants is small and if special arrangements in working conditions are needed, they are handled as individual cases. Women are rarely dismissed for pregnancy, but are expected to leave at a reasonable time depending on their physical condition, the demands of their job, and sometimes their dealings with customers.

Experience of Claimants for Maternity Benefits

The maternity benefit claims of approximately 800 employed women were analyzed by the Women's Bureau. The median age of the women collecting maternity benefits was 26. The average period of leaving employment before childbirth was 17 weeks or about 4 months. The number of women who had returned to their jobs within a year was small and of those returning, most returned within 6 months after confinement.

Weekly cash benefits, almost always for 6 weeks, were received by 70 percent of the claimants. The average amount totaled \$134. Hospital benefits for delivery were received by 90 percent of the group. The period of hospitalization was usually a week or less.

Obstetrical benefits were received by approximately 65 percent or two-thirds of the claimants. Approximately 90 percent covered normal deliveries; the other 10 percent covered miscarriages and complicated deliveries, such as caesarean, requiring surgery.

Part I

MATERNITY PROTECTION IN THE UNITED STATES

Federal Legislation and Regulations

Maternity protection for employed women has been promoted through general national legislation by most of the industrial countries except the United States. The international standard adopted in 1919 by the International Labor Organization has served as a directive for much of the legislation even though the Convention as such has not been ratified by many of the leading industrial nations. The ILO Convention prohibits the employment of women for 6 weeks after childbirth; provides for 6 weeks leave before childbirth if requested and accompanied by medical certification of date of confinement; provides for cash benefits, medical care, and supplementary benefits; and affords some degree of protection against dismissal during extended leave of absence for maternity. The provisions of the ILO Maternity Convention and its implementation through legislation in foreign countries are discussed in part II of this report.

Federal Legislation for Railroad Employees

The only Federal legislation in the United States that provides maternity protection for employed women on an industry-wide basis is the law providing temporary disability insurance for railroad employees.

Weekly cash maternity and sickness benefits are provided railroad employees under the Federal Railroad Unemployment Insurance Act by amendments enacted in 1946 that became effective in July 1947.² Benefits and administrative costs are financed from the employer tax payable under the act.

Women represent only about 5 percent of an approximate 1,500,000 employees in Class I Steam Railways, occupational distribution of women being limited chiefly to those in "white collar" groups. Approximately 4,000 women railroad workers yearly have received maternity benefits since 1947, the number of beneficiaries having increased from 28 per 1,000 in 1947-48 to 35 per 1,000 in 1949-50. Of women receiving maternity benefits since 1947, approximately 88 percent were clerks and other office employees.

² Public Law No. 572, 79th Cong., 2d sess., 1946.

A woman railroad employee who has earned \$150 or more in railroad work during the previous base year (beginning on July 1), and who submits a statement from her physician which shows expected date of childbirth, is eligible for benefits. The "maternity period" is supposed to begin 57 days or about 8 weeks before the expected delivery date and continues for 116 days or approximately 16½ weeks.

Daily benefit rates are based on a schedule related to annual earnings and range from \$1.75 to \$5. As 1½ times the daily rate is paid for the first 14 days of the maternity period and for the 14 days immediately after the birth of the child, the total maximum benefit available is equal to 130 times the daily allowance. The maximum benefit for employees earning \$2,500 or more a year is \$650. Average total benefit received in 1949-50 was \$540 and average weekly benefit, \$33.75. Average compensable duration in 1949-50 was 112 days. Duration of the benefit period is considerably longer than that provided for weekly cash benefits in any of the establishments included in the present Women's Bureau survey.

Regulations for Federal Employees

Federal employees do not have any special maternity leave or benefits. However, employees whose employment is regulated by provisions in the Federal Personnel Manual of the Civil Service Commission may use accumulated sick and annual leave as maternity leave and may return to the jobs held by them prior to taking leave. Employees may also, under specified conditions and upon Bureau authorization, be granted advance sick leave of 30 days (i. e., 6 calendar weeks, which assures employees with a 5-day workweek the equivalent of the international standard). Whether or not an additional period of leave-without-pay status is also granted is dependent upon policy established in the particular agency concerned.

Provisions concerning employment of pregnant women in military installations and activities are detailed in national regulations of each department, but modification may be made by local officers. War Department regulations prohibit employment after the thirty-second week of pregnancy; Navy Department, for a period beginning not later than 6 weeks before expected date of delivery.

State Legislation and Regulations

State legislation and regulation in the United States giving assistance to women who are employed and who become pregnant is very limited. Existing laws and regulations are concerned chiefly with the employment of women before and after childbirth; with unemployment compensation or insurance; and with State disability insurance. Some States, also, have arrangements concerning pregnant civil service employees under State Civil Service systems.

Laws Prohibiting Employment of Women Before and After Childbirth

Minimum standards recommending that women not work for 6 weeks before and for 2 months after delivery, jointly recommended by the Children's Bureau and the Women's Bureau as early as 1942, are not recognized by any of the States in their laws regulating employment of women. The six States having laws prohibiting the employment of women before and after childbirth originally enacted them 30 to 40 years ago and, as shown below, none meets the recommended minimum standards for both prenatal and postnatal leave:

	<i>Before childbirth</i>	<i>After childbirth</i>
Connecticut.....	4 weeks	4 weeks
Massachusetts.....	4 weeks	4 weeks
Missouri.....	3 weeks	3 weeks
New York.....	-----	4 weeks
Vermont.....	2 weeks	4 weeks
Washington:		
In manufacturing, food processing, and fresh fruit and vegetable packing industries.....	4 months	6 weeks
In laundry, dry cleaning and dye works industries....	4 weeks	4 weeks

None of the State laws provides for compensation during the enforced absence, and none contains a reemployment provision.

Of the United States territories, neither Alaska nor Hawaii has such laws, but Puerto Rico prohibits employment 4 weeks before and 4 weeks after childbirth, and employers must pay maternity benefits amounting to one-half of regular salary or wage during that period. An extension of 4 weeks' leave without compensation is allowed on presentation of a medical certificate, and position must be kept open for worker.

Unemployment Insurance Laws

State unemployment insurance or employment security laws concern pregnancy only as to length of time during which an unemployed pregnant employee may not receive compensation. Under laws as summarized³ after the regular legislative sessions of 1949, 21 States, Alaska, and Hawaii have special provisions for disqualification for unemployment due to pregnancy. Eleven of these disqualify a pregnant employee and 12 describe her as unavailable, but in restriction of benefit rights there is no distinction between the two.

The most common definite restriction in benefits is for a 4 months' period with variations in the prenatal and postnatal periods. Four jurisdictions that have a 4 months' period deny unemployment

³ U. S. Department of Labor, Bureau of Employment Security. "Comparison of State Unemployment Insurance Laws as of September 1949." Washington, D. C., Government Printing Office, 1949. 113 pp.

benefits for 2 months before and 2 months after childbirth; two deny benefits for 12 weeks before and 4 weeks after. Two other States specifically deny benefits for 6 months, another for 17 weeks, and in the others the period of restriction is for 1, 2, or 3 months or for an indefinite duration.

Disability Insurance Laws

Disability insurance or cash sickness compensation on a State-wide basis has been provided for by four States—Rhode Island, New York, New Jersey, and California—but only Rhode Island includes benefits for disabilities attributable to pregnancy.

Rhode Island's Cash Sickness Compensation Act, the first such State law, was passed during 1942, but did not originally specify payment of benefits during pregnancy. Under its provisions for payment of benefits to eligible individuals as compensation for wage losses due to inability to work caused by sickness, however, claims for pregnancy were also being paid for the maximum number of 26 weeks. Definite inclusion of benefits for disabilities due to or complicated by pregnancy was made later by administrative decision. In 1946 the legislature limited pregnancy benefits to 15 weekly payments.

The Rhode Island Cash Sickness Compensation Act covers the same group of workers as does the Unemployment Compensation Act—those in commercial and industrial undertakings having four or more employees. Self-employed, agricultural and railroad workers, those in domestic service and those in government and other nonprofit-making enterprises are excluded.

It is financed by a 1-percent employee tax, which is a part of the employee contribution that was formerly devoted exclusively to unemployment benefits.

As pregnancy claims are the major single cost factor in the Rhode Island program, a few facts on the number of claims and cost of benefits are detailed in this study.

Claims for pregnancy in the year ending April 1950 totaled 8,402 and represent 40 percent of total claims paid to women. They represent almost 23 percent of all claims paid in 1949-50. Because the law "lacks clarity as to the extent to which a claimant must be actively in the labor market at the onset of disability" many women claimed benefits who were not regularly employed (some voluntarily and some because of labor market conditions) when they became pregnant.

Pregnant women tended to claim benefits for a longer period than any other claimants except those with severe disabilities such as cancer

and tuberculosis. Average compensable duration was 10.1 weeks in 1949-50 as compared to 6.5 weeks for all other causes. Forty-two percent of the pregnancy claims were not terminated until the completion of the 15 weeks' limitation period.

Daily benefit rates for those who claimed pregnancy benefits in 1950 were somewhat lower than the average rate of other female claimants because of lower than average base year earnings and less regular employment. Base benefit rates ranged from \$10 to \$25 a week, but only 44.4 percent of pregnancy cases qualified for \$25 as compared with 52.8 percent for all female claimants. Average benefit rate for pregnancy claimants was \$21.01 weekly, for other women claimants \$21.68, and for all claimants other than for pregnancy \$22.95. Because of the longer average compensable duration of pregnancy, however, the average amount collected per case was \$215 as compared to \$146 for all other cases.

Payments for pregnancy are estimated to have been 16.8 percent of all payments for claims during the year ending April 1944, the first year of payments, and approximately 30 percent of total payments in the years 1947 through April 1950. They represented one-half of all payments made to women claimants in 1950.

After consideration of medical opinions and recommendations made in the interest of employees and of suggestions by the Rhode Island Department of Employment Security to reduce the costs of pregnancy compensation in the interest of maintaining the Cash Sickness Fund on a self-sustaining basis, several changes were effected in 1950 and 1951. Duration of benefit period for pregnancy was decreased from 15 to 12 weeks, minimum employment credit requirement was increased from \$100 to \$300, and credits were based on an individual benefit year instead of on a fixed benefit year. Under present operation, payments are based on extent of employment during the 4 quarters immediately preceding employee's leaving employment. Benefits are paid for a maximum 12 weeks' period, 6 weeks before and 6 weeks after delivery. Claimant must file a statement signed by her doctor approximately 8 weeks before anticipated delivery.

The costly experience of Rhode Island probably led to the specific exclusion of pregnancy benefits from the cash sickness compensation plans of other States. States differ as to their specific provisions for the treatment of pregnancy claims. In California payment is not allowed for disability lasting less than 4 weeks after termination of pregnancy. New Jersey does not pay for any period of disability due to pregnancy, miscarriage, or abortion. New York makes such payments after an individual has worked in covered employment at least two consecutive weeks after termination of the pregnancy.

Study of Rhode Island's experience will probably be used as a guide for inclusion or exclusion of pregnancy in future legislation. That there is interest in working out satisfactory State plans for providing some type of benefit for employed women who become pregnant is indicated to some extent by the inclusion of such benefits in 1951 proposals for disability insurance in several of the States.

In the Women's Bureau field study of maternity protection, information was received from several firms in New York and New Jersey that no longer paid weekly cash benefits during an absence due to pregnancy. Health insurance policies which included payment of pregnancy benefits were canceled when the firms obligated themselves for the contributions required to meet the State program, and no other arrangements were made for coverage of weekly cash benefits for pregnancy.

Provisions for State Civil Service Employees

Laws and regulations of most of the States do not include specific provisions for maternity protection of civil service employees, and as with other employing units, practice varies considerably from State to State.

In States replying to a questionnaire of the Women's Bureau in 1948, no State reported providing maternity leave with pay. Leave without pay was granted usually by administrative regulation or by practice. Most of the States permitted use of sick leave allowance for absence due to pregnancy. One State, however, specified in legislation that "Sick leave with pay is not granted for illness due to pregnancy."

Information from a number of States did not specify duration of maternity leave; others mentioned 3 months, 6 months, or 1 year, and one State restricted leave to not more than 12 months in 5 years.

Civil service regulations of New York set forth the following detailed statement: "Existence of pregnancy must be reported in writing to the head of the department not later than the fourth month and employment shall be discontinued when, in his judgment, further service would be detrimental to health. In such circumstances, maternity leave of 6 months' duration without pay may be granted. This may be extended by the appointing office to a total not exceeding 11 months without pay. The employee may be permitted to reduce such leave without pay by the use of any or all earned credits. A doctor's certificate may be required at the time leave is requested and prior to return to duty."

Employer and Union Sponsorship

Management and unions in the United States have been increasingly concerned during the last decade with welfare plans, and have either individually or jointly sponsored the increase of fringe benefits such as pensions, life and health insurance. Health insurance and other benefits were given instead of rate increases during World War II, since wage stabilization controlled and limited wage increases. The trend of increased fringe benefits has continued in the postwar period. Plans initiated by management often have been made a part of union agreements and benefits revised and increased through collective bargaining. In many instances health insurance plans have been expanded to provide maternity benefits not only for employees but also for wives.

A Bureau of Labor Statistics' survey in 1950 stated that practically every major union in the country has negotiated, to some extent, pension or health and welfare programs.⁴

Welfare plans on an industry-wide basis are still the exception, but national organizations are providing assistance to local groups in setting up their plans and are promoting standardization of benefits. The Amalgamated Clothing Workers, the American Federation of Hosiery Workers, the International Ladies Garment Workers Union, the Textile Workers Union of America, and the United Hatters, Cap and Millinery Workers—organizations with high proportions of women workers—all sponsor plans of health insurance and through these have made some provision for maternity benefits. Local groups such as the affiliates of the hotel and restaurant union negotiate and administer plans of a multi-employer type for their membership. The United Steelworkers of America and also the United Automobile and Aircraft Workers, CIO, have health-insurance plans with Nationwide coverage providing maternity benefits. The inclusion of maternity benefits in the last two organizations is of special significance to women because of the influx of women into the metal-working industries during war and defense periods.

A study by the New York Department of Labor of union and union-management administered health insurance plans, January 1951, includes an analysis of maternity benefits.⁵ Of the 304 plans reporting on maternity benefits, 171 reported maternity benefits for dependent wives and 161 for women members. Although most of the plans

⁴ U. S. Department of Labor, Bureau of Labor Statistics, Summary Report, Employer Benefit Plans under Collective Bargaining, December 1950.

⁵ New York Department of Labor, Division of Research and Statistics. Union and Union-management Administered Health Insurance Plans in New York State. January 1951. Mimeo. 59 pp.

giving benefits to wives give them also to women members, there were 143 plans that did not include maternity benefits, primarily in unions where there are no or very few women members, such as the building trades organizations and teamsters' union.

The maternity benefits afforded by the 161 plans for women members in the New York study varied in types of services and amounts allowed. Weekly cash benefits, usually for a 6-week period, were provided by 94 plans. By far the greater part (77) of the 94 that gave cash benefits, also had provision for hospitalization and obstetrical benefits. Hospitalization was the most common benefit and was provided for by 132 plans. About one-half of the plans for hospitalization were Blue Cross and most of the others provided cash reimbursement on a fixed maximum allowance for periods of 10 to 14 days. Obstetrical benefits were afforded in 116 plans with the benefits tending to follow a pattern of \$25 for miscarriage, \$50 for normal delivery, and \$100 for caesarean and ectopic complications. A flat cash allowance of from \$25 to \$75 towards maternity expenses was made by 16 organizations. General medical care during or after pregnancy was not usually reported under maternity benefits.

Maternity benefits negotiated by collective bargaining in some of the leading woman-employing industries are indicated as follows:

1. *The American Federation of Hosiery Workers* (Independent) since 1943 has had an industry-wide health insurance plan for organized workers in the full-fashioned hosiery branch of their industry. Maternity benefits were included from the start and provide weekly cash benefits based on 60 percent of average earnings for 6 weeks, a maximum of \$7 a day re-imbusement for hospitalization for a maximum of 12 days, and an allowance of \$15 for delivery room charges.

2. *The Amalgamated Clothing Workers* (CIO) has a Nation-wide welfare plan for most branches of the industry. It includes weekly cash, hospital and surgical benefits for nonoccupational disabilities, but for maternity provides only obstetrical benefits of from \$25 to \$100.

3. *The International Ladies Garment Workers Union* (AFL) has a national policy for establishing health and welfare funds and health centers with local autonomy in the administration and services. Most of the membership is covered by health and welfare benefits. However, less than 1 percent of the total disbursements from local funds have been for maternity benefits. Maternity benefits, when paid, usually consist of a \$50 cash allowance, but most locals do not include such protection. In the New York study of union health insurance plans, 25 locals and joint boards were reported for the International Ladies Garment Workers; 14 did not have maternity

benefits; 11 gave flat grants—8 of \$50, and 3 of \$25. Health centers established by the union do not usually have prenatal clinics or any special services for pregnant members.

4. *The Textile Workers of America* (CIO) has been encouraging the inclusion of health insurance plans in all contracts of the union, and its international office reported that almost 90 percent of its membership is covered by insurance plans financed by the employer. There is no fixed plan of benefits. Benefits are bargained for on local or area levels. Union representatives estimated that more than three-fourths of their women members have maternity coverage. Usually there are weekly cash benefits for 6 weeks, hospital benefits with maximum daily allowances of from \$3.50 to \$9 for a maximum of 2 weeks, and maximum obstetrical allowances of \$50 for normal delivery, \$25 for miscarriages, and \$100 and \$150 for caesarean and ectopic deliveries. The international office employs an insurance director and gives assistance to locals in establishing their health insurance plans and setting standards for benefits and administration.

5. *The New York Hotel Trades Council* (AFL), representing 10 locals of hotel service workers, upholsterers, firemen, operating engineers, painters, telephone operators and office employees, and the Hotel Association of New York City, representing approximately 175 union contract hotels, have negotiated an insurance plan and health program for all workers covered by collective bargaining. Maternity benefits for women employees include: weekly cash benefits for 6 weeks, Blue Cross hospitalization, prenatal and postnatal care at the health center, and free obstetrical care for delivery. All services are free to the employee, being financed by a payroll tax on member hotels.

In addition to the provision of maternity benefits, many unions have negotiated for maternity leave, job security, and retention of seniority for workers absent for pregnancy and childbirth.

Types of Maternity Protection Found in 43 Firms

Scope, Administration, and Financing

The maternity benefit pattern for industrial health insurance is usually threefold: (1) weekly cash benefits to compensate for time lost from work, (2) hospitalization, and (3) surgical benefits for obstetrical care. In most industrial health insurance plans, medical care for maternity is limited to obstetrical service at the time of childbirth but some plans offering comprehensive medical service include prenatal care during pregnancy and postnatal care of the mother and child. Some plans offering general medical care for health disabilities definitely exclude maternity.

The types of benefits provided by the 43 plans included in the Women's Bureau study are:

<i>Benefits provided</i>	<i>Number of firms</i>
Weekly cash, hospital, obstetrical, and medical.....	2
Weekly cash, hospital, and obstetrical.....	26
Weekly cash and hospital.....	2
Hospital, obstetrical, and medical.....	1
Hospital and obstetrical.....	11
Hospital only.....	1

All 43 plans provided hospitalization, 40 provided obstetrical benefits, 30 provided weekly cash benefits, and 3 offered general medical care during pregnancy and after childbirth.

These findings agree closely with those of the 161 plans providing maternity benefits which were analyzed by the New York State Department of Labor (see p. 12).

Management generally assumes the responsibility for enrolling employees in health insurance plans, making payments to the insurance carrier, and handling all routine details in connection with group policies. In handling and processing claims for benefits, the participation of management varies materially. Some firms handle the processing of claims and collection of cash benefits for their employees while others take no responsibility for handling individual claims. Where there is a service plan for hospitalization and obstetrical services, such as Blue Cross and Blue Shield, cash claims for hospitalization and obstetrical benefits are eliminated. Services are claimed merely by presentation of membership cards, thus simplifying administration for both management and the claimant. The administration of many plans on a national or local basis is handled by the union or by the union and management jointly. Seven of the 43 plans included in the Women's Bureau's maternity protection study were administered primarily by unions.

Employer participation in payment of insurance premiums or cost of other health plans is generally accepted. Employers either paid all or contributed to the cost of the maternity benefits in all the 43 plans in the Women's Bureau study.

Health insurance is substantially more expensive for women than for men. Insurance companies estimate that, without maternity benefits, the disability rate for compensable illness is about 50 percent higher for women than men. In plans with 6 weeks' pregnancy benefits, twice as much is paid in benefits to women as to men; the cost of health insurance where large numbers of women are employed is much higher than for the same number of men. Where maternity benefits are included, the difference is even greater.

In industries that employ women predominantly, such as the needle trades and retail stores, weekly cash benefits especially are less fre-

quently provided for pregnancy than in industries that have a low proportion of women, such as the metal trades (for instance, steel), the automobile, and aircraft industries. In hospitalization plans such as Blue Cross, an employee must be enrolled under a family contract to be eligible for maternity protection.

Cash Benefits

Weekly cash benefits for periods of disability due to maternity are sponsored by employers or jointly by employers and unions, except as legislated for in Rhode Island and the railroad industry. They are usually part of a health insurance plan carried with a private insurance company. These cash benefits provide partial compensation for time lost and give some measure of financial aid or security during periods of disability. The scale of payments is the same as for other disabilities, but the length of time for which they are paid is shorter. Six weeks is the customary maximum for maternity benefits while for other nonoccupational disabilities there tends to be a maximum of 13 weeks under private insurance plans.

Almost three-fourths of the firms that were included in the Women's Bureau study provide weekly cash benefits. The payments may be a flat amount, a given percentage of wages or salaries, or scaled according to wage and salary brackets. Benefits are almost always less than average earnings. The cash benefits range from \$9 to \$50 a week, but most of them are from \$20 to \$30. With the upward trend of wage levels in recent years, benefits scaled to earnings tend to be higher and more desirable than flat rates.

One plan provides two benefit periods that apply to maternity. A cash benefit for 6 weeks through a joint contributory insurance plan is paid when the woman leaves for pregnancy and a second period of 6 weeks of full pay is paid by the employer at the time of childbirth to employees having a full year's service at the time of leaving. Some companies continue to pay salaried workers leaving for maternity on an informal or individual basis for limited periods.

Private insurance companies were the risk carriers for 26 of the 30 companies that had weekly cash benefits; 3 were self-insured; and 1 paid benefits through a mutual benefit association. The cost of providing cash benefits was assumed by the employer in 19 of the 30 companies and in the other 11 was financed by joint contributions of employees and employer.

Hospital Benefits

Hospitalization for childbirth has been described as "perhaps the most dramatic evidence of the relationship between hospital use and public health. . . . Thirty-seven percent of all the babies born in

1935, were born in hospitals; in 1949, when there were over a million more babies born than in 1935, about 87 percent were born in hospitals." Preliminary data indicate that in 1951 the number of live births exceeded the previous record of 3,818,000 in 1947.

Hospital benefits for childbirth in the United States provide insurance for beneficiaries against cost of board and room, of general nursing care during confinement, and of hospital "extras" or special hospital fees. Use of the delivery room and frequently use of the nursery for the child are included in maternity care provided. Protection is by cash payment of an insurance carrier either to the individual or to the hospital of a specified amount for hospitalization; or by coverage on a service basis of hospital care, usually in semiprivate accommodations; and occasionally by unlimited hospital care under a comprehensive plan.

Hospital benefits are available under voluntary group health insurance plans including (1) nonprofit plans such as Blue Cross, (2) policies of commercial insurance companies, and (3) plans of independent organizations such as self-insured plans of industry and labor unions. In the United States, 75 million persons at the end of 1950 had some form of insurance covering hospital care. However, the extent to which hospitalization for maternity is afforded is not reported.

In the Bureau's recent study, hospitalization benefit for maternity was available to women employees in all of the 43 establishments visited. In 26, hospitalization was available through Blue Cross and in 16, through private insurance companies. One firm provided complete medical and obstetrical care in a hospital and in associated clinics.

Employees may or may not be required to contribute toward cost of the premium of health insurance plans. Employers, however, have been contributing to an increasing extent. In the Bureau study, the hospitalization benefit for maternity was paid for by the employer alone in 21 establishments, by joint contributions of the employer and employees in 17, and entirely by the employees in 5. In 11 establishments where the insurance carrier was a private company and in 9 having Blue Cross, the employer paid all; in the other establishment hospitalization was included in the comprehensive medical care plan financed entirely by the employer. In all plans where the worker paid full hospitalization premium, Blue Cross was the carrier.

Blue Cross.—Blue Cross, which originated in 1932, has pioneered in providing hospitalization for maternity cases. Today it is the leading single insurance carrier of such benefits for employees. It is a nonprofit agency operating on an area basis and affiliating with a National Blue Cross Commission. Approximately 85 area plans cover 47 States, including the District of Columbia and Puerto Rico.

Basically, enrollment in Blue Cross is by subscribers and their families through groups formed at places of employment or through existing associations. By the end of 1950, it afforded hospital protection to approximately 37½ million enrollees and dependents, representing approximately one-half of the estimated total of 75 millions having some insurance against hospital costs.

Maternity benefits are available, with few exceptions, only to those enrolled under a husband-and-wife or family contract; in approximately two-thirds of the Blue Cross plans they are available only under the latter. Frequently in group participation, employers pay for single coverage, and the employee pays the difference in cost of a family contract that gives maternity coverage.

The waiting period required by Blue Cross plans before maternity hospitalization benefit may be received varies from 8 to 12 months, the most common period being 10 months. However, a number of plans have introduced waivers of waiting periods if a certain percentage of enrollment in an establishment is obtained and if the employer contributes toward the cost. Usually, waiver is granted to groups of 25 or more employees in which enrollment in the plan is 75 percent and in which there is employer contribution.

Blue Cross reported that as of July 1950, an estimated 12.2 percent of the participants in reporting plans were enrolled in employer contribution groups as compared to 7.6 percent of participants in December 1946. It was estimated that the employer paid about one-half of the premium in cases where he participated. In the 26 establishments visited by the Bureau in which Blue Cross was the carrier for hospitalization benefit, 6 had only employee contribution, 9 had only employer, and 11 had joint contribution toward premium. Included in the latter 11 were some in which general hospitalization coverage was paid by the employer but in which the additional cost for maternity coverage was paid by the employee.

Generally a special limit is placed on the number of days for which care will be provided for maternity cases or a maximum limit is placed on the benefits to be received. For normal delivery the hospital stay specified is often 10 days, but it may vary from 7 to 12 days. Accommodation offered is in a ward or semiprivate room. Maximum dollar benefits for maternity hospitalization ranged from \$50 to \$80 for normal deliveries.

The large majority of the Blue Cross plans provide ordinary nursery care for the newborn child during the mother's confinement.

Comparison of the regular Blue Cross group plans of New York City, Philadelphia, and Newark—three cities visited by the Bureau in its 1951 study—furnished information on similarities and variations in maternity hospitalization benefit provisions in adjacent areas.

In all three cities, maternity benefits are available only under a family contract.⁶ Length of waiting period is 10 months in all of New York State, except where a waiver is granted; in Philadelphia it is 12 months; and in New Jersey it is specified as 240 days after joint enrollment for husband and wife. Maximum length of maternity hospitalization is 10 days in New York and Philadelphia and 8 days in New Jersey. Total maximum paid in New York is \$80, in Philadelphia \$75, and in New Jersey \$124. Philadelphia allows an additional \$4 per day toward nursery charges sometimes necessary for the newborn child after the mother's discharge from the hospital. Care of child during mother's stay in the hospital and use of delivery room are specified as being included in the maximum allowances of both Philadelphia and New Jersey. For care involving caesarean sections, ectopic pregnancies, or premature terminations of pregnancy not resulting in childbirth, Philadelphia does not allow additional time, but New York provides regular hospitalization benefits for a maximum of 21 days.

Variations similar to these exist among plans within States or in other adjacent areas because plans have developed autonomously out of local community needs. Within an area, however, maternity benefits are the same. Greater uniformity of benefits in general is recognized by the Blue Cross as being desirable, but a standard or national contract for all areas, proposed in 1947, was adopted by very few plans.

Possibilities for more uniformity in Blue Cross plans affecting employed workers in Nation-wide industries are demonstrated, however, by 1950-51 contracts in the national steel and automobile industries. Uniform benefits at uniform rates are provided by agreement with employers having employees in 40 or more States. Provision for maternity benefits in the steelworkers' (CIO) contract includes hospitalization on a full service basis for a period not exceeding 10 days for any one pregnancy. Benefits are not available until expiration of a 9 months' period after enrollment for those not employed by the company on the effective date of the program. Financing is joint-contributory, one-half of the cost being paid by the company and one-half by insured employees.

Increasing interest by companies in insuring under such national contracts paved the way for establishment at about the same time of a new Blue Cross function in New York City known as Health Services, Inc., created for the purpose of giving assistance in working out the problems entailed in providing a company with industry-wide health coverage.

⁶ In Philadelphia, benefits are available under husband-wife plan, but at same cost as for family contract.

Problems in connection with continuance of insurance protection when workers are laid off or change location have been met to some extent by many of the Blue Cross area plans. It is now generally possible to transfer from one area to another with no new waiting period required for eligibility for maternity benefits. In the last few years, reciprocity of service benefits as well as reciprocity of enrollment has been introduced in many of the plans; under the arrangement with an Inter-Plan Service Benefit Bank, subscribers needing hospital care when away from their homes receive benefits of the plan with which they are enrolled.

Private Insurance Companies.—Group health insurance under private insurance companies has developed during the past two decades and coverage for maternity benefits has developed chiefly in the past decade. More than three-fourths of the firms in the Women's Bureau survey did not have maternity benefits 10 years ago.

Insurance companies by the end of 1950 were estimated as carriers of insurance covering approximately 34 million of the 75 million persons in the United States having some form of insurance for hospital care. Twenty million had group policies. In 1949 maternity protection was included in 93 percent of group insurance hospitalization certificates covering employees. Insurance companies provided the hospitalization benefits for maternity cases in 16 of the 43 establishments visited in the Bureau study.

Almost all private insurance policies now limit the amount payable for maternity coverage to a specific amount in money or to a specific number of days, whereas 3 years ago many companies were experimenting with the idea of carrying maternity without a specific limit. The two most common plans of maternity coverage provide either a maximum 14-day period for room and board plus an allowance for extras, or an over-all amount equal to 10 times the daily hospital benefit.

Type of benefit provided for employees in 14 of the 16 establishments in the Bureau study that were insured by private companies included a maximum number of days' care at a stated amount, and usually an additional sum for incidental special hospital fees such as delivery room, care of the infant, and medicine. Range in number of days provided was from 6 to 14, most common being 14 days. Range in daily amounts paid was from \$5 to \$10, about two-thirds of the plans paying \$7 or more. Total maximum hospitalization benefit, including allowance for extras, ranged from \$50 to \$228.

Less standardization of maternity benefits exists among policies of various insurance companies and among companies within a city serviced by the same insurance company than among Blue Cross

plans. Maternity hospital benefit is a part of a composite "package" of insurance provided by the employer or purchased under a joint arrangement by the employer and employees. Extent of benefit depends, among other factors, upon amount employer has contracted to pay for all types of employee insurance benefit; extent of his interest in a particular item such as maternity coverage; and level of local hospital costs. In four firms in the Bureau study that were serviced by the same insurance company, four different plans of coverage were provided. One plan, financed by the employer, provided 14 days of benefit at \$5 and special hospital fees of \$50. A second employer-financed plan provided 14 days at \$8 with special fees of \$40. A third, financed equally by employer and employees, specified maximum 14 days' hospitalization at \$7 with \$35 for extras, and a fourth, two-thirds financed by employer contribution, provided \$10 a day with a maximum of \$100 for board and room and extra services.

Insurance agents report they are selling an increasing number of policies with daily benefits of \$9 and \$10.

Potential maximum total benefits available under commercial insurance coverage in the Bureau survey were higher than under Blue Cross, but as maximum length of stay allowed under insurance plans seems to be longer than the average length of confinement, actual amount received during a maternity hospitalization period may be considerably less than the maximum allowed.

Average claim for duration of hospital expense during maternity has been found to be less than 14 days. Average claim durations in 1945 of maternity hospitalization experience (of employees and of dependents) of a typical company was 9 days, although range of duration for 77.5 percent of the employees was from 8 to 14 days. Average duration for hospitalization found in the 1951 Bureau study was 6 days. Three-fourths of the employees claimed benefit for 7 days or less.

Payments of benefits by private insurance companies are usually made directly to the individual. However, insurance companies during the last few years, through their Health Insurance Council, have developed plans by which the insured person may assign the collection of benefits directly to a hospital. The hospital accepts such assignments of benefits in place of cash deposit. This offers some of the advantages of the Blue Cross hospital admission plan.

Obstetrical Benefits

Benefits for obstetrical care are a part of the surgical care schedule and in most insurance plans are limited to payments or credits for delivery or miscarriage. Insurance for payment of doctors' fees is not nearly as common as for hospitalization. While 75 million persons in 1950 were protected by hospital insurance, 48 million of them, approximately two-thirds as many, had insurance against cost of

physicians' services.⁷ Obstetrical benefits, like hospitalization for maternity, are among the newer developments in group insurance and before 1940 were rarely included in health insurance plans.

Commercial insurance companies and medically sponsored plans such as Blue Shield are the common carriers of surgical care plans. Private insurance companies carry most of the surgical coverage and though benefits for obstetrics are optional, 94 percent of the group certificates of women employees in force in 1950 were reported as providing for maternity care. Nonprofit plans such as Blue Shield have developed rapidly in the last decade and are second among the carriers of group surgical expense, and provision is made in all plans of this type for maternity benefits under family contracts.

All but 3 of the 43 plans for maternity protection included in the Women's Bureau study had provisions for obstetrical benefits. Of the 40 plans, 21 were insured with commercial companies; 15 were subscribers to nonprofit plans—Blue Shield and Group Health Insurance—for the firms visited; 3 offered obstetrical services including prenatal and postnatal care in comprehensive medical care plans; and 1 gave an obstetrical allowance through a mutual benefit plan.

Obstetrical benefits are usually provided in the form of cash payments for specified services. The maximum amounts allowed on a cash indemnity basis in the firms visited varied considerably. The most common maximum schedule for obstetrical payments was: \$50 for normal delivery, \$25 for miscarriage, and \$100 for caesarean or other surgery. The preceding was the pattern for 11 of the 21 plans carrying insurance with a commercial company; 9 provided more generous benefits and 1 had a lower schedule. For the 21 plans, the range in maximum benefits was from \$30 to \$100 for normal delivery, \$12.50 to \$70 for miscarriage, and \$50 to \$200 for complicated deliveries. In general, benefits in contracts written in the last few years are more generous than earlier ones. Maternity or pregnancy benefits for both obstetrical and hospitalization benefits under most insurance company policies are payable if childbirth occurs within 9 months of the termination of employment and the payment of premiums. An average waiting period of 9 months after the effective date of insurance is usually required for obstetrical benefits as well as for hospitalization.

The benefit patterns for 12 Blue Shield plans included in the maternity study of the Women's Bureau for the three areas represented were:

<i>Obstetrical service</i>	<i>Pennsylvania</i>	<i>New York</i>	<i>New Jersey</i>
Normal delivery.....	\$60	\$75	\$125
Miscarriage.....	25	50-75	75
Caesarean, ectopic, operative.....	100	125	225

⁷ Report of Committee on Labor and Public Welfare, U. S. Senate Report No. 359, Part I, p. 40.

Two plans insured with Group Health Insurance, a nonprofit plan similar to Blue Shield serving the New York area, offered the standard benefits of this organization, \$70 for normal delivery, \$50 for miscarriage, and \$100 for caesarean or operative delivery; the third company in this group offered double these amounts through payment of higher premiums and enrollment in a special plan.

Commercial insurance companies, in some areas, have agreements with physicians to accept the specified allowances as full payment from lower-income subscribers while from persons with incomes above the plan's income limits, the doctors are permitted to charge additional fees. Payment is most often made directly to the policyholder, but assignment of the benefit directly to the physician may be arranged. Such plans, sponsored by State medical societies, have been developed in Wisconsin, Rhode Island, Tennessee, and Maine. The family income limit in 1950 was \$3,600 in the first three States and \$3,000 in Maine.

Blue Shield is a nonprofit organization and operates under different names in different areas, such as United Medical Services in New York and Medical Service Association in Pennsylvania. Blue Shield was incorporated in March 1946 by nine medical care groups and by November 1950 it included 71 plans. Member plans are sponsored either directly by a medical association or are officially approved by such a group, and with the exception of a very few plans write only surgical-medical insurance. Most plans are coordinated with Blue Cross and recruit their membership largely from such accounts, adding surgical coverage to hospitalization.

A typical nonprofit Blue Shield surgical plan in 1949 offered full service surgical benefits to subscribers and their families with incomes below \$3,100 and for single persons with income below \$2,050. It was estimated that from one-fourth to one-third of the Blue Shield members receive service benefits and the rest receive cash payments for surgical services. Increasing interest in developing partial or full service coverage for subscribers with incomes above the present limits was reported.

Comprehensive Medical Care Plans

In addition to group health insurance plans carried by insurance companies and nonprofit organizations such as Blue Cross and Blue Shield, a large number of local and independent group plans, more than 250, covering about 4,000,000 persons, have been organized throughout the country. Sponsors of these plans include medical societies, community-wide groups, cooperative or consumer groups, and industrial groups such as unions, other employee groups, and employers. Services offered vary in the range of benefits provided

but usually include more comprehensive medical care such as physicians' services in the home and office, clinical, laboratory, and sometimes nursing and dental services. Information is not available as to the extent to which maternity benefits are provided by these plans; some definitely exclude maternity benefits while others offer complete prenatal, delivery, and postnatal care of the mother and child.

In the Women's Bureau survey, three comprehensive medical care plans with maternity benefits were included, one employer sponsored, one employer-employee, and one accepting group memberships on a community-wide basis.

The employer financed and sponsored plan offers complete medical care to approximately 18,000 employees and about 32,000 dependents in a manufacturing enterprise. For maternity, an employee or wife of an employee receives prenatal, delivery, and postnatal medical services for herself and child at clinics, home, or hospital. A local hospital, endowed by this manufacturing firm, has a modern and well-equipped maternity wing, and it was reported that over 300 women employees of this company and many more wives of employees had been afforded maternity care during 1950.

The New York Hotel Trades Council and Hotel Association plan in New York City has a comprehensive medical care plan for hotel employees covered by union agreement. In addition to its insurance and hospital program it operates a health center where a wide range of free medical services are offered. Prenatal and postnatal services are offered at the Health Center and also the services of staff physicians for delivery and maternity care in hospitals. Hospitalization is provided through Blue Cross. (See p. 13.)

The Health Insurance Plan of Greater New York provides medical care on a group enrollment basis for employed persons and their dependents. Comprehensive medical care is available to approximately 275,000 subscribers. General medical care is available in homes, physicians' offices, 30 medical care centers, and 2 group practice units in hospitals. Under HIP all women enrolled, whether married or single, whether on the "employee-only" or the family contract are entitled to obstetrical service without restrictions of any kind. There is no waiting period under HIP coverage. Complete prenatal and postnatal care is given and in cases of complications diagnostic aid is available without additional charge. All HIP subscribers are expected to carry hospital insurance under a separate contract. For employees of divisions of New York City enrolled in this plan, there is a joint contract with Blue Cross and one collection for medical and hospitalization coverage is made by HIP. The contract of HIP for municipal employees of New York City includes

the personnel in the public school system and in many of the departments in which large numbers of women clerks are employed. In the Women's Bureau study one of the companies visited had HIP coverage for medical care, Blue Cross for hospitalization, and in addition provided weekly cash benefits.

Maternity Leave

A minimum of 6 weeks' maternity leave before delivery and at least 2 months' leave of absence after delivery is recommended, with a reasonable extension of leave allowed beyond the 2 months following delivery if needed for the physical welfare of the mother.

Maternity leave is primarily the right or privilege to take a voluntary leave of absence for maternity and maintain job security and seniority. However, it is sometimes used to set the time limits during which an employee is prohibited from working before and after childbirth and the conditions under which employment may continue during pregnancy.

It is generally recognized that employment in occupations involving lifting, balancing, continued standing, contact with poisonous substances, or heavy work of any kind should be avoided during pregnancy. Further research is needed to determine the effect of employment in general on the health of pregnant women and on their infants. In deciding whether or not to discontinue work sooner, therefore, or when to return to work after childbirth, a woman should follow the advice of her physician.

When she does leave she should have some assurance of job security for return to her former job or a comparable one within a reasonable period after childbirth. If there is no provision or definite policy covering maternity leave, separation from the job for pregnancy constitutes termination and return to work is on a reemployment basis; the worker then has no assurance that she will have a job to return to or that her seniority will be protected.

Maternity leave protects a woman against discharge or loss of seniority rights and protects her reinstatement rights after childbirth. Leaves of absence for illness or other justifiable reasons are allowed by most employers and maternity leave often is assumed to come under general leave policies without any special provision. However, if the general leave period is short, maternity leave in effect may be precluded because of its longer duration. Special leave policies for maternity, therefore, are often spelled out when the numbers or the proportions of women are high and sometimes include additional provisions to safeguard the expectant mother's welfare.

About three-fourths of the manufacturing firms and one-half of the nonmanufacturing firms included in the Women's Bureau field study had leave policies that gave some measure of job security for maternity leave. The duration of leave—the total time allowed before and after childbirth—varied from 6 months to indefinite periods of more than a year, with the most usual time being 1 year in both manufacturing and nonmanufacturing establishments.

Granting of formal leave of absence implies that accumulated seniority will be retained. In every firm visited in the Women's Bureau study that allowed maternity leave, seniority credited at the time of leave was retained or frozen during the leave period; and a few other firms that did not grant formal leave recognized past seniority if the worker was reinstated. About one-half of the firms allowed an accrual of service while on maternity leave, the time accrued varying from 1 month to 1 year. Accrual of service credit up to a year was the most common provision. At the expiration of leave after maternity, a physician's statement of the employee's fitness to resume her job is customary.

Policies prohibiting the employment of pregnant women for specified periods before and after childbirth, even where they exist, are administered on a flexible basis depending on the duties of the job and the needs of the employee. None of the firms included in the field study considered pregnancy a cause for immediate dismissal. Prenatal periods during which employment was prohibited were more common than postnatal prohibitions. Sixteen of the 43 firms included reported that they either required or expected pregnant employees to leave at specified periods of their pregnancy. Of these, eight required women to leave their jobs in the fourth or fifth month of pregnancy or earlier; seven allowed them to work to the end of the sixth or seventh month; and one required manufacturing workers to leave in the fifth month and office workers in the seventh.

In the one firm that expected the women to leave by the end of the third month, most of the women operated metal-working machines such as punch presses and stood continuously while working, so it was felt that the work was too strenuous and somewhat hazardous for pregnant women. The possibilities of transferring operatives in this firm to more sedentary jobs were considered slight, and, except in special "need" cases, a change in job duties was not considered.

Representatives of a number of firms stated that they let the women decide for themselves how long they should stay on the job and that the women took care of it satisfactorily for all parties concerned. A publishing house reported that women were expected to leave "when their condition becomes noticeable."

The following is a statement of policy from a company which sets definite prenatal time limits on employment:

PREGNANCY.—"Length of time employee permitted to work—It has been our policy to permit an employee who is pregnant, to continue to work until she is 6 months pregnant, unless she is physically unable or unless she voluntarily terminates her employment before 6 months.

"Reason for time limit—This 6 months' limit has been set by our plant physicians and is for the protection of the employee and the company. The plant physicians have extended this time in very special cases to permit employees to qualify for certain benefits. However, the extended time has been limited to 1 week or 2 weeks."

Since only a small proportion of the women leaving for pregnancy return within a year after childbirth, most of the firms do not have any policy as to the postnatal period during which employment is prohibited. Of the 43 firms included only 7, all of which were manufacturing firms, reported on specified postnatal leave, and the periods ranged from 1 month to approximately 8 months. In the latter case, maternity leave was required to begin not later than the end of the fifth month of pregnancy and to continue for a year. Two or three months after childbirth were minimum time limits for return to work.

General leave clauses are included in many more union agreements than are special maternity leave provisions. The Bureau of National Affairs in its analysis of union contracts reports that about four-fifths of the agreements contain leave of absence clauses. A little less than one-sixth of the contracts (chiefly manufacturing) provide maternity leave. About one-half of the union firms included in the Women's Bureau study—these were all woman-employing industries—had negotiated definite maternity leave clauses. The provisions included in maternity leave clauses vary greatly. Some merely provide that leave will be granted for pregnancy. Others set forth eligibility requirements for leave and reinstatement, over-all time limits, prenatal and postnatal time periods, the retention and accrual of seniority, and some provide standards for safeguarding the welfare and working conditions of pregnant employees.

The following five excerpts from union agreements illustrate different types of maternity clauses:

"Leave of absence, without loss of seniority, for appropriate periods, subject to extension upon reasonable request, will be granted to employees in case of illness, pregnancy, or injury."

"A female employee with 10 months or more of continuous company service shall be granted a leave of absence upon presentation of a certificate from her physician denoting pregnancy."

"Female employees who may become pregnant shall be allowed a leave of absence for a minimum period of six (6) months and a maximum period of one (1) year. The leave of absence of any such female employee shall commence within 3 to 6 months after she becomes aware of her pregnant condi-

tion and shall end within 3 to 6 months after the date of childbirth. The first 6 months of any such absence from service shall not be deducted in determining the total length of service with respect to seniority."

"Maternity leave provisions.—Employees with 60 days or more days of service since last date of employment or reemployment are entitled to maternity leave under the following conditions: (1) The employee will be required to report to the plant physician as soon as she becomes aware of her condition; (2) she will be required to leave her work on or before the end of the fifth month; (3) a minimum absence of 9 months is required in all maternity cases; (4) at the expiration of 9 months' absence, the employee must notify the personnel office that she is ready to assume her work, or furnish medical evidence that her health would not permit her to return to work immediately; (5) failure to report at the expiration of the 9 months' period is equivalent to resignation and is subject to conditions governing resignations; (6) it will be necessary for the employee to be examined by the plant physician before she is allowed to return to work; (7) when the employee returns to work, full seniority will be given. During the employee's absence or leave her life, surgical, and hospitalization insurance will be continued in full force by the company and the employee will be entitled to disability and surgical benefits if insured for 9 months at time placed on leave—in accordance with the provisions of the policy with the . . . Insurance Company."

"The following provisions shall apply to employees who become pregnant: Whenever an employee shall become pregnant, she shall furnish the company with a certificate from her physician stating the approximate date of delivery, the nature of the work she may do, and the length of time she may continue to work. Thereafter, upon the request of the company she shall furnish an additional certificate containing like information every 30-45 days. She shall be permitted to continue to work, in suitable employment, in accordance with her physician's recommendation and she shall be allowed to work until 2 months before the expected date of delivery, if her physician certifies that she is able to continue working. She shall not be employed on the midnight shift; nor more than 8 hours a day nor more than 48 hours a week; nor at any work requiring heavy lifting, or continuous standing or moving about, or other work listed as hazardous for pregnant women by the Children's Bureau and the Women's Bureau of the U. S. Department of Labor; and she shall be allowed a 15-minute rest period during each half of the work shift. Whenever she is required to interrupt her employment upon the advice of her physician she shall be immediately granted a leave of absence until she is able to return to work. Upon presentation by her of a certificate from her physician that she may return to work, she shall be so returned, and her seniority shall accumulate during the period of such leave of absence. She may return to work after delivery upon the presentation of a certificate from her physician that she is able to work. Upon her return she shall be placed in suitable employment in accordance with the recommendation of her physician. Upon the expiration of a period of 2 months after delivery, the company shall have the right to require a physician's certificate in support of her request for a continuation of her leave of absence, at intervals of not less than thirty (30) days. It is understood that these clauses applying to employees who become pregnant shall not be construed to deny or restrict, but shall be deemed to enlarge, any rights (including rights involving leaves of absence or light employment) to which they may be entitled under any other provisions of this contract."

Women representatives of the AFL and CIO organizations met in the Women's Bureau in 1944 and proposed the following standards for maternity leave:

- (1) Pregnancy not grounds for dismissal.
- (2) Transfer to other duties on physician's written statement.

- (3) Granting of maternity leave of not less than 6 weeks before delivery and 2 months after delivery, with additional leave up to 1 year on presentation of doctor's certificate.
- (4) Accumulation of seniority for the first 3½ months and retention thereafter of full seniority until 1 year from date of leaving.
- (5) Charging to maternity leave, at employee's written request, of all unused sick and vacation leave, and payment of compensation accordingly.
- (6) Return to former job or one of comparable pay.

Percent of women workers on maternity leave.—Numbers were not available on the exact incidence of maternity among employed women, but it was estimated by 1 of the large commercial insurance companies that under health insurance plans including maternity benefits, about 40 women employees out of 1,000, or 4 percent, received benefits during the course of a year. Under the railroad sickness compensation law, the average was 35 women per thousand or 3½ percent in 1949.

Of the 43 firms included in the Women's Bureau field survey, 32 were able to supply information on the number of women that had given pregnancy as their reason for leaving their jobs during the preceding year. The median was 4 percent, or 40 per thousand, agreeing with the estimate given by the commercial insurance company. One-fourth (8) of the firms reported only 2 percent. One-third reported more than 5 percent.

Women currently on maternity leave were reported on by 31 of the 43 firms and more than one-half of these either had no women on maternity leave or less than 2 percent.

Percent of women returning from maternity leave.—Reports of the firms and the individual records of women receiving maternity benefits indicated that the majority of women receiving maternity leave do not return to their jobs, at least to the same firm, before the expiration of their leave period. Records for 1950 of the number of women leaving for pregnancy and the number of women returning after maternity leave were available for 29 of the firms visited. For the 29 firms the number leaving was 6 times as great as the number returning after childbirth. A larger proportion of women employed in manufacturing returned than in nonmanufacturing industries such as insurance, banking, retail trade, hotels, and restaurants. In a few of the manufacturing plants included in the study the proportion of women returning was 30 percent or slightly over; in others it was less than 3 percent. In the six nonmanufacturing plants providing information on the numbers leaving and returning, the number leaving because of pregnancy was about eight times as great as the number returning after childbirth.

Maternity leave for teachers.—With the increasing number of married women teachers, a policy for maternity leave faces school boards and teachers' organizations. The National Education Association, in a study of teacher personnel administration for the school year 1950–51 in public schools throughout the United States, asked the following question: "If your teaching staff includes married women, is leave of absence given for maternity?" The findings were as follows:

Size of city	Number of school systems reporting	Maternity leave—		Percent providing
		Provided for	Not provided for	
Total.....	1,606	807	799	50
500,000 or over.....	16	15	1	94
100,000 to 500,000.....	78	66	12	85
30,000 to 100,000.....	235	140	95	60
10,000 to 30,000.....	341	169	172	50
5,000 to 10,000.....	393	188	205	48
2,500 to 5,000.....	543	229	314	42

In cities of more than 100,000 population, maternity leave was granted by approximately 90 percent of the public school systems. In the smaller cities leave policies of any kind are less common. Often in small school systems, teaching contracts are on a year to year basis and teachers have little security of tenure.

A study of the Research Division of the National Education Association on maternity leave in 1948 showed that the duration of leave and provisions for job security varied materially. Of those that set up definite periods for prenatal leave, a large majority required that teachers leave before the sixth month of pregnancy. A few expected their employees to leave as soon as they became aware of their pregnancy. Periods of postnatal leave varied from 7 weeks to 3 years after childbirth. The most usual provision was a minimum absence of 1 year for maternity. Some school systems allow reinstatement only at the beginning of the school year or semester, so minimum time allowance may actually be considerably longer than the specified period.

About one-half of the systems reported that if an employee's former position is not open upon her return, she will be placed at the level for which she is qualified as soon as there is a suitable vacancy. Only a few reports gave any indication of payment being made for any part of the leave period.

Working Conditions for Pregnant Women

In her book, "Women in Industry; Their Health and Efficiency," Dr. Anna M. Baetjer concisely points out some of the factors that must be considered in the employment of women during pregnancy. She states:

It is obvious that pregnancy places a definite limit on the ability of women to do physical work, since a pregnant woman fatigues more readily, has poorer balance, may be adversely affected by industrial poisons, and is unable to respond normally to the physiological demands of strenuous physical work.

Pregnant women should not be employed on work requiring heavy labor, constant bending or stretching, irregular shifts, long hours, night work, a constant posture, good balance, or exposure to harmful chemical substances. There is, however, no reason why a pregnant woman should not be allowed to continue certain types of work if her physical condition is satisfactory, if the conditions of work are properly controlled, and if the industrial physician supervises her placement.

Many supervisors interviewed by Women's Bureau agents consider it a good policy to encourage women to report their pregnancy in the early stages so that special consideration may be given them. The incidence of pregnancy per 100 employed women only averages 3 or 4 annually, so some adjustments in duties or assignments for these are minor problems handled on an individual basis. The special considerations given may be more than compensated for in the retention of the services of an experienced employee for several months.

Most of the firms do not have hard and fast policies as to working conditions, job transfers, hours of work, and rest periods for pregnant workers. A supervisor or an industrial nurse may authorize an extra rest period if needed. Assignments to lighter physical work if the job has appreciable physical strains or for rotation from standing to sitting jobs are possible in many factories. In large retail establishments, a pregnant saleswoman might be transferred to light stock or light clerical work, such as telephone sales. Part-time work schedules for pregnant employees in retail trade and restaurants oftentimes can be arranged to meet the needs of pregnant workers and also those of the employer.

Changes in working conditions are commonly made on an individual basis with consultation as necessary with the industrial nurse and the medical department. Company doctors may be asked to advise on suitability of jobs and working conditions for the pregnant.

Employers do not usually offer any medical services or advice to pregnant employees through plant medical departments, as it is generally felt that this should be left exclusively to personal physicians. One company included in the study had a complete medical care plan and prenatal and postnatal medical services that were available at the plant clinic, located near the factory plant. In other plans offering

complete medical services these were available at health centers or clinics serving the community.

Some firms require certification of physical fitness to work from the pregnant employee's own physician, but this is usually only for employment extending into the last months of pregnancy. On return to work at the expiration of maternity leave, employees frequently are required to bring a statement from their own physician of physical fitness for reinstatement and also to have the approval of the company's medical department.

The Women's Bureau and the Children's Bureau, consulting with union and medical representatives during World War II, made the following general recommendations for working conditions for pregnant women:⁸

Pregnant women should not be employed on a shift including the hours between 12 midnight and 6 a. m. Pregnant women should not be employed more than 8 hours a day nor more than 48 hours per week, and it is desirable that their hours of work be limited to not more than 40 hours per week.

Every woman, especially a pregnant woman, should have at least two 10-minute rest periods during her work shift, for which adequate facilities for resting and an opportunity for securing nourishing food should be provided.

It is not considered desirable for pregnant women to be employed in the following types of occupation, and they should, if possible, be transferred to lighter and more sedentary work:

- (a) Occupations that involve heavy lifting or other heavy work.
- (b) Occupations involving continuous standing and moving about.

Pregnant women should not be employed in the following types of work during any period of pregnancy, but should be transferred to less hazardous types of work.

- (a) Occupations that require a good sense of bodily balance, such as work performed on scaffolds or stepladders and occupations in which the accident risk is characterized by accidents causing severe injury, such as operation of punch presses, power-driven woodworking machines, or other machines having a point-of-operation hazard.
- (b) Occupations involving exposure to toxic substances considered to be extrahazardous during pregnancy, such as:

Aniline.	Nitrobenzol and other nitro compounds
Benzol and toluol.	of benzol and its homologs.
Carbon disulphide.	Phosphorus.
Carbon monoxide.	Radioactive substances and X-rays.
Chlorinated hydrocarbons.	Turpentine.
Lead and its compounds.	Other toxic substances that exert an
Mercury and its compounds.	injurious effect upon the blood-
	forming organs, the liver, or the
	kidneys.

Because these substances may exert a harmful influence upon the course of pregnancy, may lead to its premature termination, or may injure the fetus, the maintenance of air concentrations within the so-called maximum permissible limits of State codes, is not, in itself, sufficient assurance of a safe working condition for the pregnant woman. Pregnant women should be transferred from workrooms in which any of these substances are used or produced in any significant quantity.

⁸ U. S. Department of Labor, Women's Bureau and Children's Bureau. Standards for Maternity Care and Employment of Mothers in Industry, July 1942.

Experience of 831 Claimants for Maternity Benefits

To learn about the women who are the recipients of maternity benefits, the Women's Bureau in 1951 obtained data from firms visited or their insurance carriers, covering the time lost for maternity, the actual benefits received, the jobs in the firms, and ages for about 800 women who had received maternity benefits during the preceding year.

Since maternity benefits are only one segment of health insurance programs and since often little effort is made to keep records that can be readily identified and related to maternity claimants, it was difficult to obtain complete coverage of maternity cases for a year from all of the firms visited. Sometimes records of benefits are kept only by the insurance company and the employing firm has no information on the benefits actually collected. In other cases, the records were available only in the union office administering the health insurance plan and data were not kept in such a manner that the utilization of benefits for maternity could be separated readily. Also, where hospitalization and surgical benefits offered are on a service basis, neither the employer nor the unions usually had any detailed information on the value of benefits collected.

However, it was possible to obtain a complete coverage or a representative sample of maternity claims from some of the firms visited and to supplement this by records from insurance companies and union offices. Altogether records for 831 women claimants of maternity benefits for childbirth or miscarriage in about 200 firms and organizations were collected. Of the 831 women claimants, 784 received benefits for childbirth and 47 for miscarriage (see p. 37). More than 90 percent of deliveries were reported as normal. The women claimants were employees of manufacturing firms, retail trade, banks, insurance companies, union offices, and hotel and restaurant industries.

The Claimants

The ages of the women workers at the time of childbirth ranged from 16 to 46 with a median age of 26. Most of the women were in their twenties. Only about one-fourth were over 30. The clerical group for whom records were available tended to be even younger than the other groups. Saleswomen and restaurant workers tended to be a bit older, with a higher proportion over 30. Only 8 percent of the women were over 35.

Being for the most part a young group, it is to be expected that the work histories available for most of the women would be short. Almost one-half of those reporting on time with the firm had been employed less than 5 years and only about 10 percent had as much as 10 years' seniority.

The Children's Bureau and Women's Bureau have recommended maternity leave of at least 6 weeks before and of 2 months after childbirth. Most of the women left their jobs during the second 3 months of pregnancy. Seventeen weeks or about 4 months before childbirth was the average time of leaving. The average time of leaving work was 16 weeks before delivery for production workers, 18 weeks for clerical workers, 20 weeks for sales, and 21 weeks for restaurant workers. Approximately 20 percent left in the first 3 months, 50 percent in the second 3 months, and 30 percent in the last 3 months of pregnancy. Of those continuing to work in the last 3 months, about one-half—15 percent of the total—continued to work during the eighth and ninth months of pregnancy. Four production workers had worked up to the last day of their pregnancy. On the whole, clerical and service workers tended to leave earlier than factory workers. While about one-third of the production workers had continued employment during the last 3 months of pregnancy, about one-fifth of the clerical and one-sixth of the restaurant and store workers had worked as long as this.

Records of the date of returning to work were available for only a small group. Less than 10 percent of the women whose maternity claim records for the year 1950 were obtained were reported as having returned at the time of the study—May 1951. Of the 67 reporting on dates of return to work, 4 women (less than one-tenth) had returned as soon as 6 weeks after childbirth. A little more than one-third had returned within 3 months, and by the end of 6 months by far the greater part—almost four-fifths of those returning—were back at work.

The total time lost from work—prenatal and postnatal absence combined—was ascertained for those for whom the date of return was available. The time-span ranged from 6 weeks to 67 weeks. The average time lost was 32 weeks or about 8 months. Two-thirds of the women lost 6 months or more and about two-fifths lost 9 months and more. Of those who had returned, less than one-tenth had been away from their jobs as long as a full year.

The Benefits

Maternity benefits included weekly cash payments as partial compensation for lost earnings, and cash payments or prepaid service for hospitalization and obstetrical care. Sometimes full medical care (prenatal, delivery, and postnatal) was included. Maternity benefits in some firms were limited to one of the listed services; in others they comprised a complete service of weekly cash, hospitalization, and obstetrical benefits; and in one, comprehensive medical care was included. The records from this firm have been included with those

tabulated under hospitalization and obstetrical benefits. The types of benefits and the distribution of the women receiving them were:

<i>Benefits</i>	<i>Percent of women</i>
Total.....	100
Weekly cash benefit, hospitalization, and obstetrical.....	37
Weekly cash and hospitalization.....	25
Weekly cash and obstetrical.....	1
Weekly cash benefit only.....	8
Hospitalization and obstetrical.....	28
Hospitalization only or obstetrical only.....	1

Weekly cash benefits.—Weekly cash benefits were collected by 70 percent of the women and in most cases they were coupled with other benefits. When only one type of benefit was provided, the weekly cash benefit was the most common single provision. This benefit gives the woman actual cash that makes up for some of the wages she loses during pregnancy. Practically all the women receiving cash benefits collected the full lump sum for 6 weeks, the customary period for maternity cash benefits. Only four received less. The average (median) cash benefit in lieu of wages for the women was \$134, or the equivalent of little over \$22 a week for 6 weeks. The maximum cash benefit was slightly over \$300 and the minimum a little under \$50. Almost two-thirds of the women received from \$100 to \$175 as a lump sum and about one-tenth received \$200 or more. Clerical workers and salespeople received somewhat larger amounts than the factory workers, while the service workers in restaurants received considerably less.

Hospitalization.—Hospital benefits were received by 90 percent of the women. About two-thirds of the women received cash reimbursement for hospital expenses from group policies carried with commercial insurance companies. A small proportion of these received a flat cash allowance such as \$60 or \$80 to apply on their hospital bills. Most of those protected by commercial company policies were paid hospital benefits on a fixed maximum scale of from \$5 to \$9.50 daily for a limited period, and usually received an additional allowance for extra charges for delivery room, laboratory fees, and other special services. The most usual allowance for board, room, and care was \$7 a day. The period of hospitalization for childbirth was a week or less for approximately three-fourths of the women reporting. The hospital stays were:

<i>Days in hospital</i>	<i>Percent</i>
Less than 5 days-----	10
5 days-----	20
6 days-----	22
7 days-----	22
8 days-----	15
9 and 10 days-----	8
More than 10 days-----	3

The total amounts paid under commercial insurance contracts for room, board, care, and extra charges showed a wide range of from \$10 to \$240, but almost three-fourths of the women received amounts falling in the brackets from \$40 to \$90. The average cash reimbursement for hospital charges was \$66.25.

Hospital charges were obtained for 146 women who were covered by commercial insurance policies. The extent to which the amounts received met the costs for maternity hospitalization is indicated in the following:

<i>Percent of hospital bill reimbursed</i>	<i>Number of women</i>	<i>Percent of women</i>
Total women reporting-----	146	100.0
Less than 20 percent of bill-----	2	1.4
20, under 30 percent of bill-----	10	6.8
30, under 40 percent of bill-----	17	11.6
40, under 50 percent of bill-----	32	21.9
50, under 60 percent of bill-----	45	30.8
60, under 70 percent of bill-----	27	18.5
70, under 80 percent of bill-----	7	4.8
80, under 90 percent of bill-----	3	2.1
90 percent and over-----	3	2.1

Almost 60 percent of the women received amounts for hospitalization that covered 50 percent or more of their hospital bills.

Individual claimant records were obtained for 128 women receiving hospital service under Blue Cross coverage in two areas, Philadelphia and New York City. In Philadelphia the women received hospital services up to a maximum charge of \$75 for normal delivery and in New York City up to \$80. In the case of caesarean or other deliveries involving complications, more generous benefits were allowed.

Records of the actual charges made by hospitals and the payments made by the Blue Cross to the hospitals were obtained for 44 maternity cases in one Philadelphia company. Three-fourths, or 33 cases, had been allowed \$75 in services toward their hospital bills. This was the maximum allowance for normal delivery. For 8 of the remaining 11 cases, the hospital bills were less than \$75 and were fully covered. The other 3 cases had involved complications in delivery and the service allowances were: Full coverage of a bill of \$123.20, \$186.55 coverage of a bill of \$212.55, and \$218.10 coverage of a bill of \$254.

The following shows a summary of the payments and charges for room, board, care, and incidental hospital expenses for the 44 cases for which Blue Cross service payments were available:

Total charges for all services (44 cases).....	\$4, 292. 50
Total Blue Cross payments to hospital.....	3, 529. 05
Average total charge per case.....	97. 50
Average total Blue Cross payment per case.....	80. 20
Average hospital stay.....	6.2 days
Average daily charge for room and care of mother.....	8. 85
Average daily Blue Cross payment for room and care of mother.....	8. 50
Average additional charge for extras per case.....	42. 75
Average Blue Cross payments for extras per case.....	26. 95

The additional charges allowed cover such items as delivery room, dressings, and nursery care of the infant.

The number of records on which Blue Cross hospital payments were available was small but seemed representative in bearing out statements made by representatives in firms that did not have the detailed information on service payments.

Occasionally women employees are covered by Blue Cross through family contracts carried by their husbands and may also collect under cash reimbursement hospitalization plans at their own place of employment.

Records were included from one firm that pays for complete medical services for its employees. Women employees in case of pregnancy after 6 months' employment are eligible for prenatal medical care, hospital and obstetrical services for delivery, postnatal care, and complete medical care of the infant for 1 year. Medical care of the mother continues for 1 year from date of leaving employment even though she does not return to work.

Obstetrical or surgical benefits.—Two-thirds of the women received surgical benefits; that is, obstetrical allowances or services. These benefits were provided by commercial insurance policies, group medical plans such as the Blue Shield, or by complete medical care plans.

More than one-half of the obstetrical benefits reported were cash allowances paid by commercial insurance companies. The most usual payment for normal delivery was \$75, paid to approximately 50 percent of the women, and next was \$50, paid to approximately 30 percent. More than 90 percent of the claims were for normal delivery, and practically all the benefits paid by commercial insurance companies ranged from \$50 through \$75. For caesarean and other deliveries involving surgery, payments of \$100 or more were usual.

For the group covered by Blue Shield and other group medical care plans, records were not available on the costs or extent of the services

received. Under income limitation plans, some, undoubtedly, received full compensation for obstetrical service. Others were entitled to service on an indemnity basis, and the customary benefits in the plans included were allowances of \$60 and \$75 for normal delivery and \$100 and \$125 for caesarean sections and ectopic pregnancies.

Records available of amounts paid by the women for delivery fees and the cash compensation received included only eight women. All of these had paid \$75 or more and none had received as much as \$75.

Women covered by complete medical care in one large firm for which records were available received unlimited obstetrical services paid for entirely by the employer.

Combined benefits.—When a worker receives weekly cash, hospital, and obstetrical benefits, a substantial part of maternity costs are covered. More than one-third, 286 of 784, received the combined weekly, hospital, and obstetrical benefits. Total benefits were reported in dollars for 199 and the range in benefits was from \$160 to \$576 with an average \$297. About one-half fell in the brackets from \$225 to \$300, and for 10 percent, benefits totaled \$400 or more. Even when only one or two types of benefits were received, the financial assistance is a material aid at a time when extra costs are a drain on family resources.

Occasionally women fail to collect the benefits that are due them either because of lack of information about their rights or in some cases mere inertia in filing claims. Employees may fail to understand and carry out their own obligations in instances where the plans are financed by joint employer-worker contributions and do not arrange to continue their payments after leaving for pregnancy.

Benefits for miscarriage.—Six percent or 47 of the 831 women's records covered miscarriages. They have not been included in the preceding discussion of benefits received by claimants. The time lost for miscarriage varied from 1 to 36 weeks, with more than one-half of those reporting on time lost returning to their jobs within 7 weeks.

The types of benefits received for miscarriage were:

<i>Type of benefit</i>	<i>Number of women</i>
Total reporting.....	47
Weekly cash, hospital, and obstetrical.....	16
Weekly cash and hospital.....	12
Weekly cash and obstetrical.....	2
Weekly cash only.....	12
Hospital and obstetrical.....	4
Hospital only.....	1

The total weekly cash benefits received ranged from \$11 to \$230, covering periods from 4 days to 6 weeks. About one-half of the women receiving these benefits were paid for the full 6 weeks, the usual maximum period for maternity benefits.

Blue Cross and full medical care plans provided hospitalization for about one-third of the women with miscarriage claims. No information was available on the extent of services provided to these women. For the 19 women receiving cash reimbursement for hospital expenses the amount showed a wide range from \$5 to \$134; five women received between \$30 and \$40 and seven, between \$70 and \$80. Nine women eligible for hospitalization had made no claims and probably were not hospitalized.

Reimbursements for surgical benefits ranged from \$25 to \$50 and the usual amount paid was \$35.

Combined weekly, cash, hospital, and obstetrical benefits ranged from \$119 to \$332, with the most common \$270 to \$275.

Need for Further Study

The Women's Bureau study of maternity protection was concerned only with some of the facets of the employment of pregnant women such as legislation and regulations, personnel policies and practices for maternity leave, and types of benefit plans sponsored by employers and labor organizations that provide financial assistance and medical care during pregnancy and childbirth. With the large numbers of young married women that are employed, there is undoubtedly need of study and research by appropriate agencies that would provide a sound health basis for evaluating policies and standards for maternity leave, working conditions, and medical benefits. A few questions on which additional and current information for comparable groups of employed women and other women would be helpful follow:

Does employment during pregnancy have any relation to medical care problems during prenatal and postnatal periods and to more complicated deliveries?

What is the incidence of miscarriage, premature deliveries, and stillbirths among employed women as compared with other women living on similar economic levels?

Does the nature or character of the work performed during pregnancy affect the development and well-being of the infant?

Is full-time employment harmful for the pregnant woman? Would part-time work be more satisfactory for the woman and also for her job performance?

Better record keeping by employers of pregnancy absences, duration of maternity leave, date of childbirth or delivery, benefits paid, special services given, and adjustments in working conditions are needed for basic information.

Part II

MATERNITY PROTECTION LEGISLATION IN FOREIGN COUNTRIES

International Labor Organization Maternity Protection Convention

The International Labor Organization, at its first session in 1919, adopted a Maternity Protection Convention (No. 3). By the provisions of the ILO Constitution member countries are obligated to bring the provisions of adopted Conventions to the attention of the appropriate authorities within whose competence the matter lies, for the enactment of legislation or other action. This Maternity Convention is to be considered for revision at the ILO Conference meeting in 1952.

The Convention, ratified by 18 countries prior to 1951, concerns the employment of women in industry and commerce before and after childbirth and provides for the following:

Scope, Maternity Leave, Maternity Benefits, Nursing Facilities. "Article 3. In any public or private industrial or commercial undertaking, or in any branch thereof, other than an undertaking in which only members of the same family are employed, a woman—

- (a) Shall not be permitted to work during the 6 weeks following her confinement.
- (b) Shall have the right to leave her work if she produces a medical certificate stating that her confinement will probably take place within 6 weeks.
- (c) Shall, while she is absent from her work in pursuance of paragraphs (a) and (b), be paid benefits sufficient for the full and healthy maintenance of herself and her child, provided either out of public funds or by means of a system of insurance, the exact amount of which shall be determined by the competent authority in each country, and as an additional benefit shall be entitled to free attendance by a doctor or certified midwife. No mistake of the medical adviser in estimating the date of confinement shall preclude a woman from receiving these benefits from the date of the medical certificate up to the date on which the confinement actually takes place.
- (d) Shall in any case, if she is nursing her child, be allowed half an hour twice a day during her working hours for this purpose.

Protection of Employment—Job Security. "Article 4. Where a woman is absent from her work in accordance with paragraph (a) or (b) of Article 3 of this Convention, or remains absent from her work for a longer period as a result of illness medically certified to arise out of pregnancy or confinement and rendering her unfit for work, it shall not be lawful, until her absence shall have exceeded a maximum period to be fixed by the competent authority in each country, for her employer to give her notice of dismissal during such absence, nor to give her notice of dismissal at such a time that the notice would expire during such absence."

These provisions apply to women in the described employment irrespective of age or nationality and whether married or unmarried.

Ratifying countries.—All but 2 of the 18 countries ratifying did so prior to 1935. Greece was the first country to ratify, and on June 13, 1921, when the second country, Rumania, registered its ratification, the Convention became effective. Other European countries that ratified included Bulgaria (1922), Spain (1923), Latvia (1926), Yugoslavia (1927), Germany (1927), Luxemburg (1928), Hungary (1928), and France (1950). Eight Latin-American countries ratified—Chile (1925), Cuba (1928), Uruguay (1933), Colombia (1933), Argentina (1933), Nicaragua (1934), Brazil (1934), and Venezuela (1944). Thirteen of these ratifying countries are currently members of the ILO⁹ and represent approximately one-fifth of the countries comprising its membership.

Although complete agreement with the Convention has not been effected in all of the ratifying countries, partly because of differing national problems, considerable progress in the implementation of national legislation on various aspects of the employment of pregnant women has been made since the early years of the Convention.

With respect to maternity leave granted, differences exist in the total duration of leave as well as in the extent of compulsory leave. All 13 ratifying member countries provide maternity leave for employed women, but in three—Colombia, Greece, and Uruguay—leave period is of 8 weeks' duration instead of 12 weeks. Provisions in some ratifying countries, however, require prenatal as well as post-natal leave periods. In addition many go further than the Convention by protecting workers against dismissal for pregnancy.

In connection with payment of benefit, differences exist in connection with the financing of benefits received—compulsory social insurance or compulsory employer obligation; requirements of employment or insurance coverage prior to eligibility for benefit; amount of cash benefit; and extent of other benefits received for maternity. All the ratifying countries, with the exception of Uruguay, provide cash benefits and medical care for employees under a system of compulsory social insurance. In some, the operation of the insurance laws has not yet been extended to employees in the whole national territory; and in some, payment of benefits for certain groups of employees is made directly by the employers.

Cash benefits are received in lieu of wages by employees in all of these countries. Approximately one-third of the ratifying countries in 1951 gave allowances equal to the full wage; in others, the percentage of basic earnings paid ranged from one-third to two-thirds. However, adequacy of cash benefits provided must be considered in relation to the whole benefit program.

⁹ Does not include Germany (old), Latvia, Nicaragua, Rumania, and Spain.

Medical assistance under national legislation is available in some countries during all of the pregnancy period and after confinement. Less use of hospital facilities is provided than in the United States. Two countries have provisions for reducing cash benefits by 50 percent in case of hospitalization. Supplementary benefits provided in ratifying countries include layettes, nursing allowances in the form of 10 to 25 percent of basic earnings or a flat grant, and milk for children not nursed by mothers. Some of the countries have supplementary legislation designed to protect the health of pregnant employees, such as prohibitions on employment in occupations involving the handling of lead or lead compounds or alloys.

National Legislation in Nonratifying Member Countries

Many ILO members that have not ratified Convention No. 3 have national legislation relating to maternity protection for employees. The following list of member countries that had not ratified the Maternity Convention by 1950 shows that most of them provide for some maternity leave and for maternity benefits. Benefits are usually provided under compulsory social insurance.

MATERNITY PROTECTION PROVIDED FOR PREGNANT EMPLOYEES THROUGH LEGISLATION IN ILO MEMBER COUNTRIES THAT HAD NOT RATIFIED THE MATERNITY CONVENTION BY 1950 ¹

Country	Maternity leave	Cash benefits	Medical care	Country	Maternity leave	Cash benefits	Medical care
Afghanistan				Ireland	x	x	
Albania		x	x	Israel			
Australia	x	x	x	Italy	x	x	x
Austria	x	x	x	Lebanon			
Belgium	x	x	x	Liberia			
Bolivia	(²)	x	x	Mexico	x	x	x
Burma				Netherlands	x	x	x
Canada ³				New Zealand	x		x
Ceylon				Norway	x	x	x
China	(²)			Pakistan	x		
Costa Rica	x	x	x	Panama	x	x	x
Czechoslovakia	x	x	x	Peru	x	x	x
Denmark	x	x	x	Philippines			
Dominican Republic	x	x	x	Poland	x	x	x
Ecuador	x	x	x	Portugal	x		x
Egypt	x			Salvador		x	x
Ethiopia				Sweden	x		x
Finland				Switzerland	x	x	x
Guatemala	x	x	x	Syria			
Haiti	x	x	x	Thailand			
Iceland ⁴				Turkey	x	x	x
India	x	x	x	Union of South Africa	x	x	x
Iran	x	x	x	United Kingdom	x	x	x
Iraq	x			United States ³			

¹ German Federal Republic, Indonesia, Viet-Nam have become members since March 1, 1950, and Japan rejoined in November 1951. (See p. 45.)

² Optional.

³ Leave and benefit provisions for Canada and the United States are not provided for on a Nation-wide basis and have been omitted from this table. Details for the United States are included in earlier sections of the report.

⁴ A plan for the introduction of compulsory national insurance covering sickness and maternity was being considered.

SOURCE.—ILO Committee on the Application of Conventions and Recommendations, Proposed Revision of the Maternity Protection Convention, 1919, No. 3, G. B. 112, C. A. C. R., D.5, 112th Session, Geneva, May-June 1950, pp. 19-27, and special tabulation of maternity benefits following page 60.

In a few of the nonratifying countries maternity benefits are available under public service plans that provide out of public funds for women residents.

Legislative provisions regulating the length of leave periods before and after childbirth vary from 4 to 14 weeks in nonratifying countries. Compulsory prenatal leave ranges from 8 days to 6 weeks and compulsory postnatal leave from 2 to 8 weeks. Optional leave of 26 weeks is provided after 1 year's continuous service with the same employer in Sweden.

Extent of benefit provided also varies among the nonratifying countries. Amount of weekly cash benefit is usually a percentage of earnings, rates varying from 25 percent of average basic earnings to 100 percent of basic earnings in the countries reporting.

Countries which did not report either compulsory leave or benefits for pregnant employees include Afghanistan, Burma, Ceylon, China, Ethiopia, Iceland, Israel, Lebanon, Liberia, Philippines, Syria, and Thailand.

Proposed Revision of ILO Maternity Convention

Several of the member countries, realizing that in the course of three decades since the adoption of the Maternity Convention there have been changes in the economic and social conditions affecting the employment of women, an increase in medical knowledge and practice, and wide adoption of comprehensive systems of health insurance, have recommended consideration of revision. Such consideration is in keeping with the provision of the Convention that the Governing Body of the ILO present to the General Conference, at least once in 10 years, a report on the operation of this Convention. Reports were scheduled for consideration at the 1952 Conference. Some of the suggestions made by member countries for consideration are noted here:

- (1) More flexibility in coverage and leave that would make it reasonably possible for a number of countries to conform.
- (2) Broadening of coverage to include as far as possible all employed women, such as those in agriculture, and domestic service.
- (3) Review of length of leave in light of present-day medical opinion including prenatal as well as postnatal.
- (4) Possible changes in cash, medical, and supplementary benefit provisions.
- (5) Strengthening of job security and job seniority provisions.
- (6) Safeguarding of health on the job, including restrictions on employment involving hazardous activities and possible transfer to other work.

Maternity Protection (Agriculture) Recommendation

The General Conference of the ILO adopted Recommendation No. 12 in 1921, urging that each ILO Member take measures to insure to women wage earners employed in agricultural undertakings protection before and after childbirth, similar to that provided by Convention No. 3 for women employed in industry and commerce.

Statements on Selected Countries

A detailed discussion of maternity protection in foreign countries will not be attempted in this bulletin, but brief statements of items covered by national legislation in countries in different regions are included here to indicate variations in coverage, leave, and benefits.

Latin-America.—Seven Latin-American Member countries, including some of the most industrialized, have ratified the Maternity Convention. Nine of the ten Member countries that have not ratified have implemented some of the provisions of the Convention with legislation.

Terminology describing coverage varies, but most of the laws have more general coverage than the "industrial and commercial undertakings" of the Convention, such as "all employment" and "paid employees." Peru and Venezuela have special laws which apply only to workers in agriculture. Application of protective legislation to workers in this important industry was given special emphasis at a 1949 conference of the American States Members of the ILO, and is an agenda item for the 1952 Conference.

Total length of leave provided varies from 5½ weeks in Mexico to 14 weeks in Panama. Six of the nine nonratifying Latin-American countries that prohibit employment of women during part of the maternity period also report some national provision for cash benefits during the enforced unemployment period.

Prior to a resolution adopted in 1939 by American States Members of the ILO, payment of maternity benefits was considered a direct obligation of employers in many of the Latin-American countries. This resolution, however, provided that maternity allowances should be paid by means of a social insurance plan or out of public funds. All of the nonratifying member countries now have some coverage under compulsory social insurance, but in some of the countries employers are still responsible because the insurance system does not yet extend throughout the whole country. In Costa Rica, Guatemala, and Panama, for instance, where the insurance system is being put into operation by stages, employers pay most of the benefits. In Peru there are separate insurance acts for wage earners of small means and for salaried employees. In Chile, one of the ratifying countries, the insurance plan for wage earners only pays benefits for 2 weeks

before and 2 weeks after confinement, and the employer has to pay for the balance of the leave period. He must also pay for extension of leave for wage earners who have not worked long enough to get social insurance benefits. Employers in Chile must also pay full wages to salaried employees during the entire legal leave.

Most common weekly benefit in the nonratifying countries is 50 percent of basic earnings, and at least half of the Latin-American countries provide prenatal and postnatal care as well as obstetrical services at confinement.

Great Britain.—Maternity cash benefits for employed women in Great Britain under a national health insurance scheme of 1911 and medical care for pregnant women administered by local organizations were substantially increased by the enactment in 1946 of the National Insurance Act and the National Health Service Act.

Under the National Insurance Act, employed women receive a maternity grant to help with the general expense of confinement and, if they have qualified through employment for insurance in their own right, they are eligible for a maternity allowance for 13 weeks, beginning 6 weeks before confinement. Work during the benefit period is prohibited; this has the effect of a statutory maternity leave provision.

Contributions under the National Insurance Act are made by the insured, the employer, and the government. An employed married woman may elect not to contribute as an employee, but to receive an allowance instead as a dependent under her husband's insurance. As a dependent, she is eligible for a smaller weekly allowance for 4 weeks after confinement. Both insured persons and dependents receive the same maternity grant.

Medical care for all pregnant women—whether employed or not—is included in the general medical care provided under the National Health Service Act. Prenatal and postnatal care and obstetrical services of a midwife or doctor are provided through the local health authorities, who supervise the work of Health Centers and administer the Midwives Acts of 1902–36.

New Zealand.—National legislation for employees in New Zealand provides maternity leave. Leave legislation covers factories only and provides a total of 6 weeks' compulsory leave after confinement but makes no provision for prenatal leave. No weekly cash benefits are paid. Medical service during the prenatal period, obstetrical service, and postnatal treatment are provided free to all residents as part of the benefits offered under the Social Security Act of 1938. Maternity hospital service in a public hospital or obstetrical nursing at home is provided to residents for a 14-day period.

India.—The first national legislation for maternity protection for women workers in India was an act passed in 1941 providing mine workers with 1 month's optional leave before and 4 weeks' compulsory leave after confinement, and providing cash benefits for the 8-week period.

For factory workers, total maternity leave provided varies from 4 to 12 weeks, according to differing legislation of various provinces; five of the nine provinces provide 8 weeks (4 weeks' optional and 4 weeks' compulsory). Maternity leave is compulsory for plantation workers in two provinces—in one province for 6 weeks, in the other for 8.

A compulsory insurance act of April 1948 (not yet in operation) provides that employees with low earnings, in factories of 20 or more workers, would receive a daily flat maternity allowance. This allowance is for a 12-week period, of which not more than 6 weeks may precede confinement. In addition, the covered worker would receive medical care.

Japan.—In Japan, maternity benefits for groups of women workers have been provided under some type of social insurance system since 1927.

Compulsory coverage now extends to those in establishments of five or more employees. Those not eligible for compulsory coverage are eligible for voluntary coverage under a National Health Insurance Plan. This is a system of community medical care plans, more or less independent, but coordinated, supervised, and in part financed by the national and prefectural governments.

Under compulsory insurance, benefits include a maternity allowance to compensate for loss of wages—the rate of benefit is 60 percent of earnings or 40 percent if hospitalized. Benefit is payable for 42 days before and 42 days after confinement. This allowance is in addition to obstetrical care in a hospital and a lump sum for delivery expense.

Since 1944, there have been no requirements such as length of employment or length of insurance coverage, but benefits are payable only if confinement takes place within 6 months after employee has left covered employment. Financing of benefits is shared by the employer, employee, and the government.

Scandinavian countries.—All three of the Scandinavian countries had some maternity protection legislation prior to 1900. The provisions for maternity leave and benefits vary considerably.

All three have compulsory postnatal leave and two have optional prenatal leave. Denmark prohibits the employment of industrial workers for 4 weeks after confinement. Norway has 6 weeks optional

prenatal and 6 weeks compulsory postnatal leave. Sweden allows optional prenatal leave of 2 weeks and has compulsory postnatal leave of 6 weeks with optional postnatal leave of 6 months for employees who have 1 year's continuous service with the same employer.

Norway, under the amended health insurance act of 1930, has compulsory cash maternity benefits for all wage earners below a specified income level and voluntary insurance for other employees that pays benefits for 12 weeks. Denmark, under a voluntary insurance act of 1933, as amended, provides cash maternity benefits of 80 percent of wages for employed women for 14 days after confinement. No cash benefits are paid for maternity by the insurance system or public service act in Sweden.

In connection with obstetrical and medical services, Denmark provides midwife's assistance and medical care if necessary. Norway provides care by midwife or payment for obstetrical services, including care in maternity homes or hospitals. If an employee is hospitalized, she does not receive cash benefits, but during her stay in the maternity home or hospital, a family allowance is provided under social insurance. The voluntary social insurance system in Sweden is to be replaced by a Public Service Act entitling all residents to medical benefits, which for maternity will include prenatal and postnatal health supervision at health centers, attendance by midwife, and hospital treatment.

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