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Maternity Leave in Normal Pregnancy

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Abstract

Objective: To assist maternity care providers in recognizing and discussing health- and illness-related issues in pregnancy and their relationship to maternity benefits.

Evidence: Published literature was retrieved through searches of PubMed or Medline, CINAHL, and The Cochrane Library in 2009 using appropriate controlled vocabulary (e.g., maternity benefits) and key words (e.g., maternity, benefits, pregnancy). Results were restricted to systematic reviews, randomized controlled trials/controlled clinical trials, and observational studies. There were no date or language restrictions. Searches were updated on a regular basis and incorporated in the guideline to December 2009. Grey (unpublished) literature was identified through searching the web sites of health technology assessment and health technology assessment-related agencies, clinical practice guideline collections, clinical trial registries, and national and international medical specialty societies.

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BACKGROUND

The role of obstetrical care providers in Canada is to promote and apply best practices in caring for the pregnant woman in order to minimize risk and maximize positive outcomes for both mother and infant. Pregnant women often seek input from their caregivers on the topic of maternity leave to plan cessation of work. In Canada, the importance of child care in the first year of life is recognized with benefit programs that provide financial support to families. In addition, many employers have extended these benefits through insurance plans or collective agreements to promote healthy beginnings.

CESSATION OF WORK AND PARENTAL BENEFITS

The Federal Employment Insurance program[1] provides maternal benefits for up to 15 weeks. In order to qualify, a woman must have worked 600 hours within the preceding 42 weeks. These benefits can be collected up to 8 weeks

before the expected due date and "within 17 weeks of the actual or expected week of birth." [1] The employment insurance program provides parental benefits to either parent for up to 35 weeks. The benefits can be claimed concurrently or consecutively but must be claimed within the 52 weeks following the birth. In addition, many employers will supplement benefits so that parents receive up to 95% of their salary.

Quebec is the only province that has a program that provides financial benefits for women with uncomplicated pregnancies whose work or work environment may pose a threat to them or their unborn child.[2]

Currently, a woman with an uncomplicated pregnancy is deemed to be unfit for work and to qualify for benefits at the onset of labour.

Women who experience complications of pregnancy or other illness-related problems and who are deemed unable to continue working are eligible for sickness benefits rather than maternal benefits.

Healthy women with uncomplicated pregnancies often ask their care providers to support a period of absence from work before delivery, because they want to prepare for labour; however, such a leave of absence would be considered a health-related rather an illness-related leave. There are few guidelines or standards governing the timing or duration of health-related maternity leave. In addition, there is no conclusive evidence for the ideal length of health-related prenatal maternity leave, and there are no data suggesting that such a leave of absence improves outcomes. This leads to uncertainty for care providers, resulting in inconsistent practices.

The timing of cessation of work before delivery is unique for each pregnancy and should be discussed between patient and care provider. The SOGC Clinical Practice Obstetrics Committee has reviewed and endorses the document published by the Alberta Perinatal Health Program: *Health-Related Maternity Leave in the Uncomplicated Pregnancy and Birth*.[3] This document summarizes current evidence regarding work-related risks and presents a summary of current practices and recommendations for health-related maternity leave in the antepartum and the postpartum period. It supports the federal definition, stating that women with uncomplicated pregnancies are deemed unfit to work no later than at the onset of labour. The document also expands this definition by stating that for uncomplicated singleton pregnancies, health-related maternity leave may be required for 2 to 6 weeks before the estimated date of birth.

When complications arise in the antepartum period, physicians can recommend a medical absence from the workplace if they feel it is in the best interests of the patient.

Even in uncomplicated pregnancies a health-related leave may be required to optimize maternal and fetal health, although there is no conclusive evidence of improved outcomes.[3]

Health care providers should initiate a discussion early in the pregnancy to educate women about the difference between health-related and illness-related leaves of absence. This provides an opportunity to advise women about the possible medical complications that would support an illness-related leave of absence and to inform them that issues such as discomfort, poor sleep, fatigue, and musculoskeletal pain are an unfortunate but normal part of a healthy pregnancy.

When a patient requests a medical leave of absence for an uncomplicated pregnancy, the physician is not required to support this demand. The patient should also be made aware that it is not a recommended practice for care providers to advocate an illness-related leave for women with uncomplicated pregnancy without justification.

However, physicians can and should support a health-related leave to enable a woman to prepare for the eventual delivery, although she may not receive benefits for the entire period of the leave. If care providers do support a health-related leave, the woman should be advised that it cannot be defined as an illness-related medical leave and that she would not, therefore, be entitled to receive any medical benefits. In effect, this health-related leave to prepare for childbirth would be voluntary. A woman would receive employment insurance benefits if this leave began within 8 weeks of her expected due date.

The issue of benefits is beyond the scope of maternity care providers. If a physician does recommend a leave of absence, he or she should advise the patient that she may or may not be entitled to employee benefits for the entire period. Women should be aware of the maternity benefits they are entitled to through their employer or government agency, and should be advised that a recommendation to take health-related leave in preparation for delivery does not guarantee benefits.

RECOMMENDATIONS FOR OBSTETRICAL CARE PROVIDERS

1. Understand the difference between a health-related and an illness-related leave of absence.

2. Initiate a routine discussion early in pregnancy about the issues that can present in an uncomplicated

pregnancy (e.g., discomfort, poor sleep, fatigue, etc.) so that women can plan their cessation of work.

3. Support women in taking health-related leave to prepare for labour and delivery.

4. Advise women that they can begin maternity benefits up to 8 weeks before the onset of labour.

5. Advise women that physicians cannot support an illness-related leave in an uncomplicated pregnancy and that this leave would be voluntary.

REFERENCES

1. Human Resources and Skills Development Canada. Employment Insurance (EI) and maternity, parental and sickness benefits. Available at: http://www.servicecanada.gc.ca/eng/ei/types/special.shtml#Who. Accessed April 29, 2011.

2. Government of Quebec. Quebec Parental Insurance Plan. Available at: http://www.formulaire.gouv.qc.ca/cgi/affiche_doc.cgi?dossier=3967. Accessed April 29, 2011.

3. Alberta Perinatal Health Program. Health-related maternity leave in the uncomplicated pregnancy and birth, February 2008. Available at: http://www.aphp.ca/publications_links_pub.html. Accessed April 29, 2011.