

**Work time, family care time decisions and workplace flexibility; issues in the
return to work following maternity leave**

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Abstract

This article explores how responsibilities for child care are managed as part of family decisions made around return to work following a period of maternity leave. We surveyed all women health professionals identified as on maternity leave on payroll records of the Health Department, Western Australia and one private sector national provider of hospital services. Survey questions were designed following a review of the literature and prior empirical work. The design enabled us to collect both quantitative information and interpretive qualitative responses from participants.

Over 50% of respondents expected to have child caring provided wholly by family members while 15% anticipated the use of formal arrangements alone. The planned arrangements for care can best be understood within a framework of a 'family budget' of time to be allocated between market-based work and child caring. Attitudes to child caring are central to this 'time economies' framework. Respondents experienced dissonance between the stated organisational family friendly policy of their workplaces and practices at the management level. Employer centred flexibility often disrupted their child caring arrangements. We identify important employment policy issues for workplaces which would facilitate optimal return to the workforce by professional women following maternity leave.

Keywords: maternity leave, workplace flexibility, child care

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Introduction

This article explores how women on maternity leave expect that responsibilities for childcare will be managed as part of family decisions made around return to work for female health professionals. The data form part of a study which considered the range of organisational issues and societal and family attitudes which bear on the decision to take maternity leave for the birth of a child and the management of issues around returning to the workplace. Our data relate only to women who have made the decision to take employer provided maternity leave; the alternative decision, not considered here, is to leave the workforce at the birth of a child.

The labour force participation rate in Australia for women in the age groups where family formation is occurring (25 to 34) increased between 1980 and 2008 from 53% to 74% (McDonald and Temple, 2008). During this period some of the barriers to work participation for women with children had been reduced in Australia. Childcare availability increased along with regulation relating to quality of childcare services, while the principle of government subsidisation of childcare was introduced and extended. Some employers introduced paid maternity leave as a component of employment conditions, though this was usually restricted to permanent full-time employees in skilled occupations. While there was no statutory paid maternity leave scheme in Australia prior to 2011, the right to 12 months unpaid maternity leave was accepted by the Australian Industrial Relations Commission in 1979 and then moved through to State jurisdictions (Parliamentary Library, 2004).

The principle of parental leave underwent a steep change from 1 January 2011 when the Australian Government's "Parental Leave Pay Scheme", providing 18 weeks payment at the National Minimum Wage for the primary caregiver of a newborn or recently adopted child, became operational (Family Assistance Office, 2011). This provides paid parental leave for a carer, usually the birth mother, who

has been in the workforce, full-time, part-time or casual, for a minimum of 10 months over the preceding 13 months. This new entitlement complements provisions under the National Employment Standards in the Fair Work Act 2009 for those employed by their employer for 12 months or more to be entitled to access up to 12 months unpaid leave and to request a further 12 months unpaid leave.

Discussion and advocacy in the lead up to the decision to implement paid parental leave has focused on women's labour market participation (Baird, 2008; Human Rights and Equal Opportunity Commission, 2002; Productivity Commission, 2009). Three issues were highlighted by the Productivity Commission. First was improved wellbeing of families associated with the ability to have extended absence from work at the birth of a child, secure from financial constraints. Second was encouragement for women to maintain a lifetime attachment to the workforce. Third was community norms relating to 'family as part of the course of life and work'. Thus it is a critical component of supporting family friendly policies (Productivity Commission, 2009).

While there was considered emphasis on the range of social outcomes by the Productivity Commission, the focus is nevertheless on women's attachment to the workforce. However, the provision of paid parental leave is only one factor influencing the complex decisions around workforce attachment of women who have given birth. Pru Goward, then Sex Discrimination Commissioner, noted that paid maternity leave is "a necessary but not sufficient condition to ensuring that working lives are based on realistic recognition that all workforce participants have obligations and priorities outside paid work" (Human Rights and Equal Opportunity Commission, 2002: 2).

This article explores how responsibilities for childcare will be managed as part of family decisions made around return to work for female health professionals following employer provided maternity leave. The study was undertaken in 2010, prior to the introduction of the Australian Government's

“Parental Leave Pay Scheme”. Nevertheless, the issues and attitudes raised do have important implications for employers and managers who have workers taking advantage of this scheme. The health professionals in the study were already eligible for up to 14 weeks employer sponsored paid maternity leave with extension up to two years using unpaid leave. Strict eligibility criteria relating to length of employment and hours of work applied to paid leave. A further period of unpaid maternity leave could be approved by the public sector employer in cases where a further pregnancy had ensued before the approved return to work date (Department of Health, 2009a).

Literature

Maternity leave accessibility, whether paid or unpaid, is only one factor influencing the subsequent employment decisions of women workers who have given birth. The decision to return to work can be affected by feelings of guilt and self-doubt about whether a woman can be both a good mother and a good employee (Millward, 2006). Attitudes towards returning to work may change during maternity leave if the woman experiences dissonance between her attitudes and her behaviour (Houston and Marks, 2003). Her original preferences and ambitions may change as a result of limitations and constraints that are put upon her.

Particular issues with a family focus include the support a woman receives from her supervisor and peers (Buzzanell and Liu, 2007; Houston and Marks, 2003), accessible and affordable childcare facilities (Renda et al., 2009; Skouteris et al., 2007), support for breastfeeding within the workplace (Gatrell, 2007; Hawkins et al., 2007; Renda et al., 2009), flexibility of work hours on return to work (Blomfield and Horne, 2001; Renda et al., 2009), and family leave options (Renda et al., 2009). Another issue is the level and type of employment to which a woman is able to return following maternity leave. Planning for return to work during pregnancy influences whether women return after maternity leave and in what capacity (Houston and Marks, 2003). The management of maternity leave, involving managers, colleagues and the women themselves, can have a direct influence on an employee’s decision to return to work (Houston and Marks, 2003; Millward, 2006).

Buzzanell and Liu (2007) describe maternity leave as a 'conflict management process' made up of complex interactions and tensions. Breastfeeding is a related issue; Gatrell (2007:399) argues organisational attitudes have ignored 'the needs of breastfeeding mothers, or pro-actively discouraged breastfeeding'.

The literature has identified three issues in respect of the influence of formal (market based) childcare on labour supply decisions, namely availability, quality and cost (Breunig et al., 2011). Childcare cost and estimates of the elasticity of women's labour supply with respect to childcare cost has been a particular focus of investigations. Australian studies by Doiron and Kalb (2005), Kalb and Lee (2008) and Rammohan and Whelan (2007) have found that, for mothers in couple families, the mother's labour supply is not particularly responsive to childcare cost. Government subsidies for childcare which now apply in Australia (Child Care Tax Rebate and Child Care Benefit and tax concessions to employers who provide childcare) have mitigated cost pressure for most working mothers in recent years. International studies have found evidence that women's labour supply responsiveness to changing childcare costs is significantly greater than that found in Australia (Baker et al., 2008; Kornstad and Thoresen, 2007).

Cost is only one childcare variable in women's labour supply decision. Breunig et al. (2011) considered the impact on labour supply of problems relating to childcare for the combination of affordability, quality and availability. They averaged responses over three sets of questions relating to the dimensions of quality, availability and cost. They found that higher than average reports of problems within the aggregated measure were associated with fewer hours of work and less likelihood of working relative to areas with fewer difficulties. This study broadened the variables to cover issues relating to the interaction of formal and informal childcare provision such as juggling multiple care arrangements.

Maier et al. (2010: 282) consider childcare issues within a 'time economies' framework, where time allocations become central to the work/family equation (Jacobs and Gerson, 2004). In this framework, opportunities for flexibility in couples' work time support dual labour force attachment and movement of family care between partners. Maier et al. (2008) propose that the commitment of time for a maternal presence is part of the gendered expectations of motherhood in society. They note that for nurses "shift parenting" is one of the strategies for maintaining parental presence, managed through the combination of their own shift hours and the complementary work arrangements of their partner.

Healthcare Professionals and Family/ Work Balance

Data for this study were drawn from women health professionals. Professional women working in the health industry face particular industry issues. Nurses, Allied Health Professionals (AHPs) and medical doctors are often required to undertake shift and on-call work. Barron and West (2005: 153) found that a 'large number of (employment change) episodes...end in people giving up nursing to care for families'. Davey et al. (2005) found that while most nurses had worked full-time before their maternity leave, 81% returned to work on a part-time basis. Maier et al. (2008) found that workplace based occasional and extended hours childcare would assist in the retention of nurses. Others found availability of flexibility in work patterns and shift structures was a major influence on nurses returning to work (Blomfield and Horne, 2001; Durand and Randhawa, 2002; Maier et al., 2008). The juggling of multiple roles has been identified as a major reason why nurses choose to work part-time (Jamieson et al., 2007).

For female medical doctors returning to work after maternity leave, the provision of suitable childcare with extended opening hours located on-site is important (End et al., 2004; Verlander, 2004). In the study of female medical doctors by Potee et al. (1999), nannies had provided the greatest amount of childcare. Mayer et al. (2001) found that respondents wanted workplace-based childcare facilities and flexible schedules to accommodate childcare; they concluded women are

leaving specialties such as surgery for 'more controllable lifestyle specialties' (Mayer et al., 2001:649).

However, the picture on workplace-based childcare is inconclusive. Skouteris et al. (2007) considered the transition of both mothers and babies on the mother's return to work, comparing where workplace-based relative to non-workplace-based care is provided; they conclude there is no difference in transition experience between workplace and non-workplace-based care as long as the quality of care is high. Robinson et al. (2003: 431) found that while 40% of respondents had workplace-based childcare available, only 12% used it. However, 43% had reported that crèche hours were not compatible with either their or their partner's working hours.

Women and the Health Workforce

Females represent a high proportion of qualified practitioners in most health professions. For nursing and midwifery in Australia this proportion reaches just over 90% (AIHW, 2010b); AHPs are also highly feminised (Australian Health Workforce Advisory Committee, 2006). Female medical practitioners in 2008 comprised 35% of employed practitioners, up from 32.4% in 2004 (AIHW, 2010a), reflecting the increasing proportion of new graduates who are female; females accounted for 49% of hospital non-specialist clinicians, though for only 23.6% of specialists.

The investment by society in the training and development of healthcare professionals is very substantial and maintaining the workforce attachment of women healthcare professionals following childbearing is an important productivity issue for the economy. For the individual health industry employer there are also significant financial costs associated with labour turnover, an important reason for employers to seek to retain women following their maternity leave. Jones and Gates (2007) report the costs per nurse in the US at from \$US22,000 to \$US64,000 while Anon (2010) reports that the costs of replacing rural staff in Australia were \$A20,000 for a nurse, \$A74,000 for a doctor and \$A22,000 for an AHP.

Methodology and data collection

The aim of this research programme was to explore the career expectations and experiences and return-to-work decision parameters of women healthcare professionals who are on maternity leave.

A questionnaire was developed and piloted following an extensive survey of the national and international literature on women in the workforce and maternity leave.

The quantitative data collection had sections on prior work patterns and experience, current maternity leave and related return-to-work decisions and expectations, future maternity leave planning, attitudes to profession, attitudes to women and the workplace, and demographic information. To facilitate the collection of rich nuanced data for exploring the varied individual situations and decision making the questionnaire design included open-ended questions (Appendix One). These related to reasons for not returning to work on completion of current leave, opportunities in the workplace for breastfeeding, expected childcare arrangements for return to work, trade-off of family and career and an invitation to raise other issues relating to the return to work following maternity leave. The focus of this paper is on expectations relating to how the return to work would be managed.

Data from responses to open ended questions were managed using NVivo software and analysed using qualitative analysis methods. Data were coded into themes and subthemes. Data collection was undertaken between June and September 2010. The Department of Health, Western Australia (DHWA) and one private sector healthcare provider facilitated the study by sending the questionnaire to all staff in designated health professional occupations who were currently (June 2010 for DHWA, September 2010 other provider) on their payroll records as on maternity leave. Some respondents had returned to work in the time between the payroll cut-off date and the mailing out and return of the survey instrument. DHWA advised that some staff may also undertake casual work while maintaining their status as being on maternity leave. While the questions related to intent to return to work, for these reasons some respondents had already returned. Some

respondents who had returned to work following an earlier maternity leave did include comments related to that experience in the open-ended responses. The researchers treated these as valid observations, relevant to their decision making about return to work.

'Health professional' was defined as all nurses, medical doctors, physiotherapists, occupational and speech therapists, psychologists, social workers, pharmacists, dieticians and medical imagers. Approximately 920 surveys were distributed by DHWA and 150 by the private provider. We received 340 responses from DHWA staff, a response rate of 37% and 48 responses from staff of the private provider, a response rate of 31%.

Demographics and work experience

Of the 388 respondents, 243 were in nursing including midwifery, 31 were medical doctors and 114 were AHPs (Table 1). Only 12% of respondents were aged 29 or less; over 75% were between 30 and 39 years of age. These data are consistent with the trend evident in Australia for women to have their families later. ABS data (Australian Bureau of Statistics, 2010) show that in 2008 42% of women who had their first child were aged 30 years and over, up from 33% in 1998.

The mean number of years that the respondents had practised their profession was 10.7. However, the standard deviation of 4.8 years indicates wide variability in prior practice. Respondents were divided 50% in full-time work and 50% in part-time work prior to their current maternity leave. Mean hours per week for those working part-time was 21.5 and the mean number of years of part-time work 2.7, with standard deviation of 3.1 years.

These women were experienced professionals, likely to have occupied mid-career level positions and be at a pivotal point in their career development. With mean professional experience of over 10 years they would have developed valuable professional skills and some would be in leadership roles.

Respondents were generally either married or in a relationship (97%). Most partners were in paid full-time employment; 6% were in part-time employment, 3% not in paid employment. Almost 28% indicated that their partner had taken or would take paternity leave.

Most respondents (85%) had either one or two children. For almost 50% this was their first child. One or more career breaks prior to the current maternity leave were reported by 55% of respondents. Of these, 67% had taken previous breaks for maternity leave while 59% reported career breaks for travel, study, health or other reasons. Following their last career break, 85% of respondents re-entered the workplace at their prior level of employment; 7% reported re-entering at a higher level and 8% at a lower level.

Results/Findings

Current maternity leave and return to work plans

Management had discussed, prior to their leave, the conditions of return to work after maternity leave with 40% of respondents. Three issues noted as discussed at that time were their options to decrease hours or to be allocated set shifts upon return, to extend their maternity leave beyond the paid leave (14 weeks) and unpaid entitlement, and assurance sought by respondents that they would return to the same position/conditions.

The mean length of the current maternity leave was 1.1 years, standard deviation 0.6 years. Women with two or more children were more likely to have plans to take a longer period of maternity leave (45% planned 10 months or longer) compared with those with one child (34% planned 10 months or longer).

Of the respondents, 78% anticipated returning to their employer on completion of their period of currently arranged leave. The reasons given by those not anticipating returning on completion of the current period of leave are detailed in Table 2. Of the 80 respondents in this category, 65% intended to seek further paid or unpaid leave, 12% expected to resign to stay home with children while

around 20% intended to resign and seek another employer. More than half of those intending not to return at the end of their currently arranged leave indicated unwillingness to use out of home childcare as a reason, while unsuitable hours for family responsibilities was given as another. Cost and availability of childcare appears not a major issue in their decision. Lack of suitable breastfeeding facilities was given as a reason by over 20% despite the employers having policies to encourage breastfeeding. The DHWA policy statement, for example, indicates 'a work environment that supports breastfeeding and where reasonably practicable, breastfeeding facilities and resources in or near the workplace' (Department of Health, 2009b).

Return to work and childcare

Along with the quantitative data, data from the open-ended questions were analysed to explore attitudes, issues and influences on the decisions of these women relating to their return to work and related childcare issues. The key themes which emerged from these data are used in the discussion below, with supporting comments illustrative of the themes and subthemes which emerged.

Attitudes to having others provide care:

One theme to emerge was that participants express feelings of anxiety and guilt in having others involved in the care of their child. For those planning not to return to work on completion of the current term of leave, family responsibilities and unwillingness to use out-of-home care were identified as the major decision triggers (Table 2). For those anticipating they would return to work, their attitude to having others provide care for their children was a cause of stress and guilt.

- *Traumatic just being away from child and knowing someone is caring for them. Also a degree of guilt. Even though I love my work.*
- *I would not return to a full-time position requiring my child to be in child care much more than this (half-time) as I don't feel it is 'right' for me or my kids.*
- *It has been a very difficult decision to make re care. (I have returned to work) ...*

Respondents who planned to return to work on completion of their current maternity leave were asked to list all expected childcare arrangements. In these childcare arrangements (Table 3) the roles of the spouse/partner and other family members are clearly very significant. Approximately 51% of respondents anticipated arrangements that involved only a mix of family/friends with no formal childcare envisaged. A further 34% envisaged a mix of formal and family based care. Only 15% envisaged use only of formal childcare facilities. The considerations of work-time management and related workplace support behind the choices made between family-based care and market-based care are explored below.

Workplace flexibility and Management and workplace attitudes

Accessibility of workplace flexibility:

Both employing organisations have clear policy statements relating to workplace flexibility. Nevertheless, a theme from the data which respondents highlighted as a result of negotiations with their employer, workplace observations and experience of prior leave, was the difference between the organisational talk and the walk when it came to family friendly workplaces. One respondent noted that the organisation *'has family friendly policies which are rarely accessible...'*. Management was often seen as an impediment to family friendly workplace flexibility, though in some cases work peers also contribute to a sense of lack of support.

- *generally found my managers to be inflexible and difficult when discussing my return to work...I realise other workplaces are better than this..*
- *to be able to do family friendly hours without negative comment, bullying by staff and management...*
- *Management are not happy with part-time workers.*
- *Management have very outdated views of females in the workforce and family isn't put first...*
- *Manager only concerned with filling the roster and will not be flexible.*

- *those that don't or haven't had children less supportive; my peers are in their 50s, they never worked in a family friendly environment.*

Employer focused flexibility:

A related theme was the impact that flexibility expected by management to meet its needs will have on expected work hours and ability to plan childcare arrangements.

- *Management offers contracts only three shifts a week, I am forced to go casual.*
- *I won't be supported to work part-time as it "may not suit the department".*
- *Day care is not possible as the days I work change every week, unable to negotiate permanent days.*
- *...it's your wants versus theirs.*

Whereas job-sharing has been considered one means to support professionals to continue to develop their career and maintain career relevance and is explicitly mentioned in a DHWA policy statement, one subtheme which emerged was that this is often not supported by management.

- *Job-sharing is much more difficult to obtain at my workplace than it used to be a few years ago.*
- *My current employer does not allow job-sharing which is a shame as I know a few who would go back if this were an option.*

Those who did have management which was prepared to be flexible noted that this support is important.

- *Anaesthesia is very supportive of females*
- *I have a very supportive line manager and this has made the difference in my adjustment*

Childcare arrangements

Family-based care:-the informal childcare system:

Table 3 indicates that informal care arrangements revolving around spouse/partner, parents, family and friends play a very large part in the care arrangements for initial return to work. Overall, 51% of

respondents expected to rely wholly on a mix of informal care (partner, family, friends), on their return to work.

The informal care system, which involves family time management for the provision of care, raises a number of issues relating to flexible working arrangements. These include joint flexibility between partners or the woman and other family members, stability of working hours/shifts and the ability to find substitute arrangements for unexpected events/work demands.

Almost 62% of participants indicated that their partner would be involved in care arrangements on their return to the workplace. Participants commented that they will work different hours from their partners to enable the family to rotate child caring, effectively 'shift parenting'. Many expected to work night duty and/or weekends as their partner can then care for the child/children. A subtheme was flexibility of the partner's work. These work/family arrangements need to be continuously negotiated and renegotiated within the family as well as with employers:

- *I am fortunate that my husband's job is also flexible so I am able to go back to work and we share childcare between us... not want to put our daughter in childcare.*
- *...believe he should be raised by his parents so we are making arrangements with work so we can both be involved....*
- *My husband's employer does not respect my part-time job so I am the one always juggling.*
- *... I will probably do majority night shifts around my partner's job.*
- *My spouse is also a nurse so we would have to work opposite shifts or opposite days off...*
- *...my return to work is dependent on working shifts when my husband is home to care for our baby....*
- *partner looks after baby one night, my mum does the next.*

Relatives/friends (mostly parents, 53%) were a further part of the mix of arrangements to be used by 60% of respondents. Again, these arrangements necessarily entail negotiations with employers, in some cases multiple employers, around suitable flexibility.

- *My elderly parents will take care of my children. I have to organise my shifts to cater for their needs.*
- *Will only return to work part-time ... my mother is able to look after my kids and if she can't do it, my husband can take one day off per week as he runs his own business.*
- *I work nightshift every second weekend to enable husband and mum to look after child whilst I am at work and asleep... this worked for one child, not sure about two. My husband took child to work on Friday but not sure if he will be able to take two.*
- *my mother has changed her work shifts so she can look after our daughter.*

Use of formal market based care:

Only 15% of these women indicated that they will rely on formal childcare only, although formal care was in the mix with partner and family for a further 24%. Medical doctors and other health professionals were more likely than nurses to utilise formal childcare facilities. The range of shift alternatives likely to be available to nurses may contribute to their care decisions. While some nurses suggest cost relative to pay is one issue for them, from Table 2 it appears that cost of care was of minor importance in the decision of those not returning to work on completion of the current term of leave.

For healthcare professionals a major issue is unsuitability of hours of operation of formal care for their work patterns. Opening and closing times of most childcare facilities do not correlate with the shifts of many in the health care industry. Further, users are required to book children in for set days whereas some staff are unable to negotiate set rosters.

- *My department has three shifts and I could only do one of those shifts because of day care.*

- *...problem...when your partner also works shifts and childcare would not be an option due to early starts and late finishes.*
- *Shiftwork makes childcare as an option very difficult; i.e. my day care centre opens at 7.30am yet I start work at 7am.*
- *Day care only takes set days, I would need to negotiate to work certain days.*
- *Difficult rostering arrangement in not being able to do set shifts on set days to correlate with day care.*

On-site employer-sponsored childcare:

One major theme to emerge was the perceived value of on-site employer-sponsored childcare. Facilities specifically for health workers at or near the workplace are provided by outside contractors for some of the Perth tertiary hospitals though it appears these do not generally provide hours significantly different from other formal facilities. Analysis by individual workplace was not possible; however, no respondents commented on such facilities while many sought to make the case for on-site care. What was not discussed was the extent to which, in practice, such facilities would be used if provided (Robinson et al., 2003; Skouteris et al., 2007). Participants proposed that on-site childcare facilities would provide peace of mind, enable participants to place children at a younger age, and resolve issues for shift workers and those with roster changes by providing suitable and flexible hours of operation. Participants canvassed advantages to employers, including employees returning to work earlier, working more hours or returning full-time. Facilities and flexibility for breastfeeding was a related subtheme for some, despite a strong DHWA breastfeeding policy being in place, though others stated they would not return while breastfeeding.

- *Onsite childcare must seriously be considered ... opening at shift times would be really useful ... when your partner also works shifts and childcare would not be an option due to early starts and late finishes.*

- *On-site day care at the hospital would be fantastic and allow a lot of mothers to return to work....Day care is not possible as the days I work change every week....*
- *On-site quality childcare would make a huge difference to my capacity to work.... would benefit more than 50 registered nurses returning to full-time positions.*
- *If there was an on-site quality childcare facility I would be much more willing to return to work sooner. ...I also would need to be given the time to breastfeed.*
- *Possibly if there was a childcare with workplace flexibility to feed my child when they needed it, would make my decision to return easier.*
- *A specific quiet room for expressing would be helpful, as would a crèche.*
- *I intend to breastfeed for one year. I would be more likely to return to work if there was on-site childcare so I could go and breastfeed rather than express.*

Cost, availability and quality of care:

Other issues raised in the literature were cost, availability and quality. These had resonance with some of the respondents. However, while the cost of formal childcare was a concern to some, only six of the 80 respondents who expected not to return to work at the completion of their arranged leave cited childcare costs as an issue, while seven cited availability of places. Part-time work also has an impact on the value of the government's child care tax rebate.

- *Day care is too expensive and would take the majority of my wage.*
- *The cost of child care is the reason I don't work more.*
- *Day care is my only option but as my pay isn't great it would not be worth paying for..*
- *Good care is difficult to find.*
- *Childcare rebates should apply even if working less than 16 hours per week.*

Discussion and Policy implications

Our data show that women health professionals taking maternity leave are likely to be experienced professionals, hold mid-career-level positions and be at a pivotal point in their career development. Their mean length of planned maternity leave was just over 12 months. The provision of care for their child/children was the central issue for these women as they planned their return to the workplace following maternity leave. While approximately 20% of the women were planning to seek extension of their current leave only 10 women planned to resign to stay home with their children.

These women did express feelings of guilt and anxiety about not being the one providing care, a sentiment the literature has also identified (Millward, 2006). Many also noted there appeared to be inconsistency between organisational statements on family-friendly policy and their own experience /expectations from management at the workplace level. Employer focused flexibility and practices placed considerable stress on their ability to plan and maintain childcare arrangements.

Childcare arrangements anticipated to be in place for the return to work relied overwhelmingly on the family, including partners and extended family. Some of the respondents noted that there was a values base to this decision: *'he should be raised by his parents'*.

The arrangements for childcare can best be understood within a framework of a 'family budget' of time to be allocated by members of the family between market-based work and child caring. This is consistent with the 'time economies' framework of work-time/family-time (Jacobs and Gerson, 2004; Maher et al., 2010). The available time budget will be dependent on individual circumstances such as the possibility of commitment of time by extended family, the spread of potential work time hours of family members and the flexibility available to family members in work-time hours. Attitudes to child caring are central to this time economies framework. This does not fit easily within a solely financial calculus, although that must also be given recognition. Attitudes of respondents included unwillingness to place younger children in formal childcare, a preference for family based responses to caring and feelings of guilt in not being the one providing care. Of our respondents, the

majority (Table 3) expected to have child caring provided wholly by family members (including extended family). A further 34% would use a mix of family and formal childcare; only 15% anticipated the use of formal arrangements alone.

The provision of on-site childcare was strongly supported by these respondents. For some their advocacy appears related to this being a proxy for the family involvement, allowing breastfeeding and other opportunities on-site to facilitate care. The other aspect of this support relates to flexibility, with respondents expressing the expectation that on-site care would help solve some of the issues inherent in the health sector around roster times, roster changes and on-call activities

Employee centred workplace flexibility would be the critical resource for these women and their families as they, their partners and extended family sought to manage the demands of their work and non-work domains (Skinner and Pocock, 2011); in this case the demands of work time and child caring time. However, we have noted respondents found inconsistency between organisational level family friendly policies and their experience in the workplace. For individual women, what matters is the support at line management level.

The health sector, being a 24/7 operation, does offer specific employment conditions such as evening and week-end shifts which were utilised by many of the respondents to achieve the work/childcare balance they sought. However, employer centred flexibility (Skinner and Pocock, 2011: 68) often created substantial difficulties because this could reduce their work options or disrupt their caring arrangements. They also noted that some roles were not suited to flexible or part-time work but that alternative arrangements which may meet their and the employer's needs, such as job sharing, were not available in practice.

From these results we identify three important issues relating to workplaces and women's return to the work. The first is the dissonance experienced by some between stated organisational family friendly policy and line management decisions and attitudes. Statements of policy alone will not

achieve the behavioural change required to achieve flexibility; they must be accompanied by programmes to achieve relevant workplace cultural change.

A second important issue, given the role that spouse/partner is expected to have in the provision of the childcare which facilitates the mother's return to work, is the importance workplace flexibility for men can have in facilitating the overall family-time/work-time budget. Skinner and Pocock (2011) note that flexibility is more commonly sought by women, especially in relation to childcare and argue the case for de-gendering workplace flexibility.

Lastly there is the need to explore the potential for on-site formal childcare, along with effective implementation of breastfeeding policies, to be managed to overcome some of the work flexibility issues. Robinson et al. (2003) found only a small minority of those eligible used on-site childcare when provided. Unless hours provided mesh with working hours required, this provision is unlikely to provide support for the return to work.

Perhaps the last word should go to the respondent who commented, *"It's a constant juggle and negotiating and planning"*.

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Tables

Table 1. Profession of respondents

<i>Professional designation</i>	<i>Number</i>	<i>Percentage</i>
Registered Nurse/EN	212	54.7
Registered Midwife	31	8.0
Medical doctor	31	8.0
Psychologist	20	5.2
Physio./Occupational/Speech Therapist	50	12.9
Other Health Professional	44	11.3
Total	388	100.0

Table 2. All influences on decision not to return to work on completion of current period of maternity leave

<i>Influences on decision</i>	<i>Number</i>	<i>Percentage of not returning (n=80)</i>
Lack of affordable childcare	6	7.5
Lack of available private childcare	7	9.0
Lack of employer-provided childcare	26	32.5
Unwillingness to use out-of-home childcare	45	56.0
Unsuitable work hours for family responsibilities	36	45.0
Difficulty negotiating conditions of return	8	10.0
Practical difficulties related to workplace (distance, transport, parking)	10	12.5
Lack of opportunity to breastfeed	17	21.0
Unsupportive workplace environment	6	7.5
Lack of confidence to return to professional position	5	6.0
Other (includes return overseas, husband relocating, husband's job roster)	14	17.5

Table 3. Who will care for children on your return to work?

<i>Care arrangements</i>	<i>Frequency</i>	<i>Percentage</i>
N/A, not return to work	8	2.1
Spouse/partner	239	62.1
Day-care	201	52.2
Other relative	207	53.8
Friends	25	6.5
Negotiate my shifts/sessions	55	14.3
Nanny/housekeeper	9	2.3
Difficult to categorise/other	4	1.0

Appendix One

Health Professionals' Maternity Leave Survey, 2010.

Open ended questions relating to child care and return to work:

Question 15 Prior to taking your current maternity leave did management discuss with you the conditions of your return to work after maternity leave? For yes or no please provide details.

Question 17 If you do not anticipate returning to your current employer at the completion of your period of maternity leave will you:

- Seek further unpaid leave?
- Take further paid leave?
- Resign to stay home with your children?
- Resign and find another employer?

Any comments on the decision?

Question 19 Would the opportunity to continue breastfeeding, such as an on-site breastfeeding facility, influence your decision to return to work after maternity leave? For either yes or no please elaborate.

Question 22 Do you expect to be well supported by your peers on your return to work after maternity leave? For either yes or no please provide any comments.

Question 27 Who would take care of your child/children if you were to return to work (circle all appropriate answers; see table 3 for list)? Comments?

Question 47 Any comments or suggestions which you would like to make about the decisions and issues relating to the return to work in your professional capacity following maternity leave.