

Paid family leave and paid sick leave as economic investments: Evidence for improving workforce stability and population health in the United States

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Abstract

The United States remains the only high-income country without a federal guarantee of paid family or medical leave, leaving coverage to a patchwork of state programs and employer-provided benefits. This review evaluates the empirical literature on paid family leave (PFL) and paid sick leave (PSL) as investments in workforce stability and population health, synthesizing quasi-experimental evidence on leave-taking, employee retention, firm performance, maternal and infant health, and employer costs. The evidence indicates that PFL roughly doubles maternity leave-taking without reducing employment, increases fathers' leave-taking, and is associated with improved maternal psychological health and reduced infant mortality. At the firm level, studies find no increase in turnover or wage costs following PFL adoption, with some evidence of improved firm productivity and profitability through reduced turnover. Paid sick leave mandates reduce presenteeism and illness transmission with little evidence of adverse employment effects. These findings challenge the assumption that paid leave mandates necessarily impose costs on employers, instead pointing to a body of evidence consistent with paid leave functioning as an investment that yields returns through retention, productivity, and population health. The review closes by identifying gaps particularly around long-run firm-level causal evidence and the interaction between state programs and a potential federal floor and offering policy recommendations for maximizing the economic and public health returns to paid leave.

Keywords: Employer outcomes; Health policy; Labor supply; Paid family leave; Paid sick leave; Workforce productivity

1. Introduction

The Family and Medical Leave Act of 1993 guarantees twelve weeks of job-protected but unpaid leave to eligible workers at covered employers, leaving a substantial share of the workforce particularly at small firms and among lower-wage workers without either job protection or income replacement during a family or medical leave event [8]. As of 2026, fourteen states and the District of Columbia have enacted mandatory Paid Family Leave programs, with two more scheduled to begin paying benefits by 2028 [9]; a much larger number of states and localities mandate Paid Sick Leave specifically.

The economic argument for paid leave has traditionally been framed as a tradeoff: benefits to workers and families are weighed against costs to employers, who must either absorb reduced productivity during a worker's absence or bear the administrative and replacement-hiring costs associated with covering it. This review evaluates that framing against the accumulated empirical evidence, organized around five channels: leave-taking behavior; parental and child health; employee retention and labor-market attachment; firm-level costs and performance; and paid sick leave specifically as a distinct but related policy instrument. Because the strongest causal evidence on PFL in the United States comes overwhelmingly from California's 2004 program, the nation's first, and by 2026 with the longest post-implementation

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window for study, much of the review necessarily centers on California, supplemented by more recent evidence from New Jersey, New York, and Rhode Island as those programs mature, and by classic international evidence from Europe [10].

2. Paid leave as investment versus cost

The standard public finance framework for evaluating an employer mandate distinguishes between two possible incidence patterns [11]. If workers value the mandated benefit at its cost, and wages are flexible, the cost of the mandate should be shifted forward into lower wages rather than borne through reduced employment; evidence from 1970s-era state maternity-benefit mandates supports this pattern, with the cost of the benefit reflected almost entirely in lower wages for women of childbearing age rather than in reduced employment [11]. This wage-shifting logic offers a baseline prediction for modern paid leave programs financed through payroll taxes: because the tax is levied broadly across the covered workforce rather than concentrated on a narrow demographic group, the same incidence logic — if it holds — predicts the cost surfaces in modestly lower wages for covered workers generally, not in reduced employment. Whether this logic extends to firm-level profitability, however, remains a separate and open question, and the evidence reviewed in Section 6 speaks to it.

A second, complementary framework treats paid leave as an investment in job continuity and firm-specific human capital. Under this view, a worker who takes leave and returns to her pre-leave employer preserves firm-specific knowledge, training investments, and workplace relationships that would otherwise be lost through turnover and replacement hiring, a channel through which paid leave could generate net benefits for firms, not merely costs, by reducing the turnover that is independently costly to employers [6]. The empirical sections below examine both frameworks: whether leave-taking increases (Section 3), whether it improves family health outcomes (Section 4), whether it affects employee retention and labor-force attachment (Section 5), and the direct test of the investment hypothesis, whether measured firm-level costs and performance change following adoption (Section 6). Table 1 previews how PFL and PSL compare along the dimensions those sections examine.

Table 1 Comparing Paid Family Leave and Paid Sick Leave as Policy Instruments

Dimension	Paid Family Leave (PFL)	Paid Sick Leave (PSL)
Covered event	Childbirth/adoption, or caring for a seriously ill family member	Worker's own/family member short-term illness
Typical duration	6–12 weeks, varies by state	Days, typically accrued per hours worked
Primary mechanism tested	Leave-taking, retention, firm performance (Sec. 3, 5, 6)	Reduces presenteeism, improves care-seeking behavior (Sec. 7)
Worker/family evidence	Roughly doubles maternity leave-taking; improves maternal and infant health [1,4,16]	Reduces presenteeism; mixed evidence of increased health care utilization.
Employer-cost evidence	No net increase in turnover or wage costs; some productivity gains [5,6,13]	Little to no adverse employment or wage effect [21,24]
Where evidence is thinner	Long-run firm effects outside CA/NY; non-CA health mechanisms	Source of heterogeneity across mandates not yet isolated
Federal status, 2026	No federal mandate; 14 states + D.C.	No federal mandate; patchwork of state/local ordinances

Note: Bracketed numbers refer to the numbered references at the end of this review. Table compiled by the author to summarize points of comparison developed throughout Sections 3-7.

3. Effects on leave-taking

The best-identified evidence on PFL's effect on leave-taking comes from California's 2004 program, the first in the nation. Using March Current Population Survey data and a difference-in-differences design, evidence shows that California's PFL program more than doubled the overall use of maternity leave, increasing it from an average of roughly three weeks to six or seven weeks for the typical new mother, with particularly large increases among less-advantaged groups [1]. Using the National Longitudinal Survey of Youth (NLSY) 1997 cohort, a complementary analysis finds that California's program raised leave-use by around five weeks for the average mother and two to three days for the average

father, with the timing of increased leave-taking concentrated immediately after birth for fathers and around the point at which temporary disability insurance benefits are exhausted for mothers, consistent with a causal effect of the paid-leave program itself rather than a coincident trend [12].

Fathers' leave-taking has received growing attention as a distinct margin. Using American Community Survey data, evidence shows that fathers were 0.9 percentage points (46 percent relative to the pre-treatment mean) more likely to take leave in the first year of their child's life when CA-PFL became available, evidence that paid leave programs can shift the intra-household division of caregiving leave toward greater paternal involvement, not only extend maternal leave-taking [2]. Administrative claims data similarly show that the PFL program increased the number of leave claims filed by both men and women, and that most claimants filed only a single claim over a ten-year period, evidence against concerns that paid leave would be used repeatedly or opportunistically by a small share of workers [13].

4. Effects on parental and child health

A substantial and growing literature links PFL to measurable improvements in maternal and infant health, though effects vary across specific outcomes and studies. Using National Survey of Children's Health data, evidence shows a range of infant and parental health benefits following the state's PFL implementation, including improvements in parent-reported infant health, while analyses based on vital statistics birth certificate data show no detectable effects on birthweight or preterm birth [4]. Examining early state temporary disability insurance (TDI) programs that provided paid maternity leave prior to California's PFL law, maternity leave availability is found to be associated with improvements in infant health outcomes [14]. A study using U.S. birth and infant death data found that the state's PFL program reduced the post-neonatal mortality rate, with an estimated 339 fewer infant deaths between 2004 and 2008, again without detectable effects on birthweight or preterm birth [15]. Using a similar design applied to California and two comparison states, a reduction in infant mortality of approximately 12 percent is found following PFL implementation, with no significant change in low birthweight or preterm birth rates [16], a pattern of consistent post-birth mortality effects alongside null pre-birth (birthweight, gestation) effects that recurs across these literature suggests that PFL's infant-health benefits operate primarily through the post-birth caregiving mechanisms rather than through prenatal biological channels.

Maternal mental health shows similarly consistent, if moderate, improvements. California's PFL law is found to have improved maternal psychological health, with reductions in postpartum psychological distress following implementation [3]. A systematic review of the broader maternity leave and postpartum depression literature finds that longer leave duration, and particularly paid leave, is associated with reduction in postpartum depression in high income countries [17]. A separate narrative review of the literature on paid maternity leave concludes that paid leave is associated with beneficial effects across three domains: maternal and child mental health, including reduced postpartum depression and improved infant attachment; physical health, including reduced infant mortality and rehospitalization and increased timely well-child and immunization visits; and breastfeeding, including increased initiation and duration [18].

A related and mechanistically important line of research asks what parents actually do with additional leave time that could explain these health improvements. Using 2003 – 2014 National Immunization Survey (NIS) data, one study examines whether PFL changed breastfeeding and immunization behavior, two of the most commonly hypothesized mechanisms connecting parental leave-taking to downstream infant health, finding evidence of improvements in both, with larger effects among more economically disadvantaged mothers, consistent with several earlier studies finding that PFL's health benefits are concentrated among the families with the fewest alternative resources for bridging an unpaid leave period [19].

5. Effects on employee retention and labor-market attachment

If PFL primarily served to extend leave duration without protecting job continuity, it might simply delay rather than prevent labor-force exit. The evidence instead points to PFL improving longer-run labor market attachment for mothers. Using data from the California Employment Development Department, a study finds that rights to paid leave were associated with higher work and employment probabilities one year after the claim, plausibly because the leave preserves job continuity among mothers with otherwise weaker labor-force attachment and finds positive effects on earnings [13]. A separate study using the NLSY-97 similarly finds that California's paid family leave program increased mothers' employment probability, particularly nine to twelve months after childbirth, and is associated with higher weeks and hours worked during the child's second year of life, with suggestive but statistically insignificant evidence of higher wage [12].

Using Survey of Income and Program Participation (SIPP) data and exploiting the introduction of paid family leave programs in California and New Jersey, a study finds that paid leave increased labor-force attachment around childbirth, with labor-force participation rising by approximately 5 to 8 percentage points in the months around birth. The effects were concentrated among women with less than a bachelor's degree, suggesting that paid leave particularly benefited women with weaker preexisting access to paid leave. [20]. This finding is consistent with the broader thrust of the leave-taking literature reviewed in Section 3, where effects were also concentrated among less-advantaged groups [1], and points toward PFL functioning as a targeted, not merely general, labor market intervention.

International evidence from a much longer institutional history of parental leave mandates across nine European countries, similarly finds that leave entitlements were associated with increased female employment, with effects that grew with entitlement length up to a point before very long leave entitlements began to show smaller or even negative relationships with women's relative wages, suggesting that although paid leave supports women's employment, very lengthy leave entitlements may involve tradeoffs for wage progression [10].

6. Firm-level costs, turnover, and performance

A clearest evidence of whether paid leave functions as a cost or an investment for employers comes from detailed administrative and tax data on quarterly earnings records from 2000 to 2014 from the California Employment Development Department analysis finds no evidence that firm turnover or wage costs increased when leave-taking rates rose following PFL adoption [13]. This finding that employers were not burdened by higher wage costs and experienced lower expenses and turnover has been reinforced. A survey of firms with fewer than 100 workers in New York before and after that state's 2018 PFL implementation, with employers in Pennsylvania (which has no PFL program) as a comparison group, finds no negative impact of PFL on employers' ratings of employee performance, with PFL appearing to improve employers' reported ease of managing longer employee absences, particularly during the first year after implementation [5].

Using the staggered adoption of state PFL laws between 2002 and 2018 as a source of identifying variation and a large panel of publicly traded and private establishments, evidence shows that treated establishments' labor productivity rose by approximately 5 percent relative to neighboring control establishments, accompanied by reduced employee turnover and an increase in the representation of women in top executive positions, evidence consistent with PFL improving firms' access to female talent and thereby improving firm performance, rather than imposing a cost [6]. Taken together, this firm-level literature spanning a state administrative-data study, an employer survey, and a panel study of firm performance points to a conclusion at odds with the standard cost-based framing of employer mandates: The strongest available quasi-experimental evidence finds no evidence that PFL adoption increases employer costs and, if anything, suggests improvements in firm performance through lower employee turnover and enhanced workforce quality.

7. Paid sick leave as a related but distinct instrument

Paid sick leave addresses a different, shorter-duration event than PFL, but raises a structurally similar cost-versus-investment question for employers and has been studied using a similar quasi-experimental approach applied to the more numerous state and local PSL mandates enacted since the mid-2000s. Using variation in the timing of state PSL mandates, evidence suggests that paid sick leave availability reduced the likelihood that workers came to work while sick, decreasing presenteeism, with implications for workplace productivity and disease transmission [7]. A study of San Francisco's early 2007 municipal paid sick leave ordinance, one of the first in the nation, shows substantial increases in paid sick leave coverage and generally strong employer support despite some reported implementation challenges [21]. Using matching based DiD and Medical Expenditure Panel Survey (MEPS) data to examine the impacts of PSL mandates on worker absenteeism and healthcare utilization, evidence shows that gaining paid sick leave increased sickness-related absenteeism among female workers, while estimates for office-based health care utilization were largely statistically insignificant. [22]. A study of Connecticut's 2012 mandate finds modest but negative short-run employment effects using a synthetic-control approach, one of the few studies in this literature to find a negative labor-market effect, underscoring that the near-uniformly favorable findings from California-based PFL research do not automatically generalize to every PSL setting or design [23]. Reviewing this broader body of evidence, a study finds that U.S. PSL mandates had little to no adverse effect on employment or wages, a conclusion broadly consistent with the PFL firm-performance literature reviewed in Section 6 despite the two policies addressing different leave events [24].

8. Policy landscape

As of 2026, fourteen states and the District of Columbia have enacted mandatory statewide PFL programs, with California (2004) the earliest and Minnesota and Delaware (2026) and Maine (2026) the most recent to begin paying benefits; two additional states, Maryland and Virginia, have enacted programs not yet paying benefits as of 2026 [9]. These programs vary substantially in wage replacement rates, maximum leave duration, and financing structure, which complicates simple pooling of estimates across states and is itself a source of the heterogeneity in effect sizes documented throughout this review.

Despite this expansion, roughly three-quarters of U.S. workers remain outside any state PFL mandate and instead depend entirely on employer discretion, with employer-provided PFL benefits available to only about a quarter of American workers nationally [9]. Paid leave coverage is somewhat more widespread but remains similarly uneven across states, industries, and firm sizes, with lower-wage and part-time workers systematically less likely to have access to either benefit.

9. Discussion: Reconciling the cost and investment framings

The evidence reviewed above does not fit comfortably within either pure cost framing or pure investment framing of paid leave mandates. Consistent with the classic wage-shifting result for maternity mandates [11], in which employer-borne costs were largely passed through to the wages of the targeted group via labor market adjustment, current state PFL programs vary in how directly they build this incidence into their financing design: some fund benefits entirely through employee-side payroll contributions, others split contributions between employers and employees, and a smaller number rely on an employer-side tax alone. When paid leave is financed through employee payroll contributions, workers bear the cost immediately through statutory payroll deductions, rather than through the gradual wage adjustments documented by Gruber (1994) for employer-funded mandates. Layered on top of this financing structure, the firm-level evidence reviewed in Section 6 suggests an additional, non-mechanical channel: reduced turnover appears to generate employer savings that partially, and in some firm-level studies, substantially offset the administrative and staffing costs associated with employee absences [5,6].

At the same time, the health literature reviewed in Section 4 identifies benefits that are not captured in firm-level cost-accounting exercise: reduced infant mortality, improved maternal mental health, and increased breastfeeding and immunization rates represent population-health returns that accrue to families and, over the longer run, to public insurance programs and the broader health care system, rather than to the employers who finance and administer the leave. A complete accounting of paid leave's economic return would need to weigh employer-level effects, worker and family welfare, and downstream public health-system savings jointly, a synthesis that, no study in this literature has attempted, and which Section 10 identifies as a priority for future research.

This accounting problem is sharpened by the fact that PFL is not the only policy lever aimed at the same postpartum outcomes. Community-based maternity care workforce interventions, doulas and perinatal community health workers are increasingly financed through state Medicaid programs, whereas paid family leave programs are generally financed through payroll-based social insurance systems. An evidence review finds that doula care is associated with improved maternal and infant health outcomes and more positive childbirth experiences, alongside persistent barriers in reimbursement, workforce training, and public awareness [25]. Because both instruments plausibly operate on the same postpartum mechanisms this review emphasizes, continuity of care, early detection of complications, and support during the period when formal medical contact typically declines, a mother with access to both paid leave and doula or community-health-worker support may experience effects that are not simply additive: leave provides the time to use postpartum support services, while that support may in turn shape how leave time is used. No study identified in this review estimates this interaction directly, and doing so is a natural extension of the causal designs already applied separately to PFL and to doula care.

10. Directions for future research

Several evidentiary gaps limit how confidently these findings can be generalized. First, the firm-performance literature, while methodologically strong, remains concentrated on California, New York, and the set of states with staggered PFL adoption through the late 2010s; as more recent programs (Colorado, Minnesota, Delaware, Maine) mature, researchers will be able to test whether the turnover-reduction and productivity findings documented in Section 6 replicate in different labor-market and industry contexts, including states with substantially more generous wage-replacement rates than California. Second, most of the health literature reviewed focuses on California, one of several early PFL states

where PFL is layered on top of a pre-existing temporary disability insurance system; less is known about how PFL's health effects operate in states adopting a PFL program without that institutional predecessor. Third, very little of this literature directly estimates the long-run health care utilization and cost effects that would be needed to complete the accounting problem identified in Section 9, that is, whether the population-health improvements documented following PFL adoption translate into measurable reductions in downstream health care spending large enough to be weighed against program financing costs. Fourth, the PSL literature reviewed, while generally favorable, is more heterogeneous in its findings than the PFL literature, and the source of that heterogeneity, differences in mandate generosity, enforcement, or interacting state labor-market conditions, has not been systematically isolated.

11. Policy recommendations

The evidence reviewed here supports several policy directions. First, given the consistent finding that PFL's leave-taking and post-birth labor-market attachment benefits are concentrated among lower-income and otherwise disadvantaged families [1,20], expanding PFL coverage, whether through a federal floor or continued state adoption, should be expected to have its largest proportional benefit for exactly the workers currently least likely to have access to any form of paid leave. Second, because the strongest available firm-level evidence finds no net cost burden and, in several studies, a net benefit to employers through reduced turnover [5,6,13], policy debate should weigh this evidence directly against the a priori cost concerns that have historically slowed federal action, rather than treating employer cost as an unresolved or a theoretical question. Third, given that the health benefits of PFL appear concentrated in the post-birth caregiving period rather than in prenatal outcomes [15,16], leave duration and timing design (for example, ensuring adequate leave is available after birth rather than only during pregnancy) may matter more for realizing these benefits than aggregate program generosity alone. Fourth, paid sick leave and paid family leave should be evaluated and financed as complementary but distinct instruments, since the evidence in Section 7 indicates that PSL's benefits operate mainly through reduced presenteeism and disease transmission, a different mechanism than PFL's leave-taking and retention channels. Finally, given the gaps identified in this review, any federal paid leave program should be designed with built-in data infrastructure linking leave claims to firm-level and health care utilization records, to allow the kind of causal evaluation that has made the California and New York evidence bases as strong as they are.

12. Conclusion

The empirical literature on paid family and sick leave in the United States has grown substantially since California's 2004 program, and the resulting evidence base does not support the traditional framing of paid leave mandates as a straightforward cost imposed on employers in exchange for benefits to workers. PFL roughly doubles maternity leave-taking [1] and increases fathers' leave-taking [2] without detectable employment losses; it is associated with improved maternal psychological health [3], reduced infant mortality [15,16], and increased exclusive breastfeeding rates concentrated among disadvantaged families [19]; it improves post-birth labor-force attachment, particularly for less educated mothers [20]; and firm-level evidence finds no increase in turnover or wage costs, with some evidence of improved productivity and financial performance through reduced turnover [5,6,13]. Paid sick leave shows a similarly favorable, though more heterogeneous, pattern of reduced presenteeism and little evidence of adverse employment effects, while evidence on increased health care utilization is more mixed [7,21,22,24]. Taken together, this literature is consistent with paid leave functioning as an investment in workforce stability and population health rather than solely a cost; a perspective with important implications for the ongoing federal policy discussions over a national paid leave standard.

Compliance with ethical standards

Disclosure of conflict of interest

There is no conflict of interest.

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