BANKWEST CURTIN ECONOMICS CENTRE

# THE COSTS AND BENEFITS OF IMPLEMENTING A UNIVERSAL REPRODUCTIVE HEALTH LEAVE ENTITLEMENT IN AUSTRALIA

Research work commissioned by the Health Services Union (HSU), the Health and Community Services Union (HACSU), the Queensland Council of Unions (QCU) and Aware Super

## ABOUT THE BANKWEST CURTIN ECONOMICS CENTRE

The Bankwest Curtin Economics Centre is an independent economic and social research organisation located within the Faculty of Business and Law at Curtin University. The Centre was established in 2012 through the generous support of Bankwest, a division of the Commonwealth Bank of Australia. The Centre's core mission to deliver high quality, accessible research that enhances our understanding of key economic and social issues that contribute to the wellbeing of West Australian families, businesses and communities.

The Bankwest Curtin Economics Centre is the first research organisation of its kind in WA, and draws great strength and credibility from its partnership with Bankwest, Curtin University and the Western Australian government. The Centre brings a unique philosophy to research on the major economic issues facing the State.

By bringing together experts from the research, policy and business communities at all stages of the process – from framing and conceptualising research questions, through the conduct of research, to the communication and implementation of research findings – we ensure that our research is relevant, fit for purpose, and makes a genuine difference to the lives of Australians, both in WA and nationally.

The Centre is able to capitalise on Curtin University's reputation for excellence in economic modelling, forecasting, public policy research, trade and industrial economics and spatial sciences. Centre researchers have specific expertise in economic forecasting, quantitative modelling, micro-data analysis and economic and social policy evaluation. The Centre also derives great value from its close association with experts from the corporate, business, public and not-for-profit sectors.

# ABOUT THE FUNDING PARTNERS

## About the Health Service Union (HSU)

The Health Services Union (HSU) is a member-based union, with more than 100,000 members and counting. Our members work across the health and community services sectors in every State and Territory of Australia.

We know our members are often over-worked and undervalued, which is why we stand for continuous improvements for all workplaces, wages, and rights. Like our members, the HSU is a strong advocate for better, fairer and high-quality health and community services.

## About the Health and Community Services Union (HACSU)

The Health and Community Services Union (HACSU) is a branch of the HSU in Victoria who has been fighting for reproductive health leave. HACSU is a growing union, with over 12,000 members working in mental health, disability, and drug and alcohol services across Victoria.

HACSU members are employed in a range of occupational classifications, including nurses, allied health professionals, lived and living experience workers, disability support workers, admin workers, program and support workers, and administration.

## About the Queensland Council of Unions (QCU)

The Queensland Council of Unions (QCU) is the peak union body in Queensland, with 27 affiliated unions representing the interests of 400,000 Queensland workers.

Since its foundation in 1885, the QCU — as the peak body for the Queensland trade union movement — has strived to achieve industrial, social and political justice for Queensland workers.

As a result of the *'It's For Every Body'* campaign, the QCU successfully secured ten days of paid reproductive health leave for 265,000 Queensland public sector employees and 36,000 employees of government-owned corporations, effective 30 September 2024. This major milestone secured reproductive health leave provisions for nearly 300,000 Queensland employees.

## About Aware Super

Aware Super is one of Australia's largest super funds, with over 1.15 million members and manages around $190 billion in assets. As a profit-for-member fund, all our profits are invested back into the fund to help ensure our members achieve their retirement goals.

At Aware Super, we're always looking for ways to improve retirement outcomes for our members. That's why we're proud to support this important research into the impact of reproductive health conditions and the introduction of reproductive leave. Understanding the real-life experiences that shape our members' working lives helps us advocate for meaningful change and better long-term financial outcomes.

# CONTENTS

## List of Figures



## List of Tables

# EXECUTIVE SUMMARY

## Main results

The Health Services Union (HSU), the Health and Community Services Union (HACSU), the Queensland Council of Unions (QCU) and Aware Super have engaged the services of the Bankwest Curtin Economics Centre (BCEC) to assess the cost of implementing a universal reproductive health leave (RHL) entitlement to Australian workers. This report also estimates the financial benefits and costs offset for companies and employees related to the provision of RHL. Additionally, the economic cost of lost productivity of people with reproductive health conditions, due to absenteeism and reduced productivity, is also calculated in this report.

Reproductive health leave refers to a workplace entitlement that provides workers with several paid days specifically allocated to treat and manage reproductive health conditions or procedures. These include intense menstrual pain, endometriosis, vasectomies and hysterectomies, intense menopause and perimenopause symptoms, in-vitro fertilisation (IVF), miscarriages and terminations.

To conduct this analysis, BCEC designed a novel **workplace reproductive health survey** investigating how prevalent reproductive health conditions are among employees, to what extent these conditions affected workers' ability to attend work and by how much their work was impaired due to bothersome symptoms related to reproductive health conditions (lost productivity). The survey also collected information on employees' attitudes towards RHL, their perceptions of people taking RHL and the stigma and discrimination attached to reproductive health conditions in the workplace.

The results of this survey have been used to estimate the main parameters of the analysis in this report. These include prevalence rates for different reproductive health conditions, average days of missed work, lost productivity in the workplace, and adverse professional outcomes, among others.

The costs to businesses from implementing paid RHL for all Australian workers depends on the prevalence of different reproductive health conditions and the degree of utilisation of any RHL entitlement.

Drawing on evidence from BCEC's survey of employers and employees, **the aggregate gross cost of 12 days of paid RHL** is estimated at somewhere between $2.3 billion and $5.9 billion**, with a central estimate of $3.6 billion under the benchmark scenario.**

Put in perspective, in per capita terms, **the average gross cost of twelve days of RHL** would range from $190 to $487 per employed worker, with a **central estimate of $296 per worker per year under the benchmark scenario**.

These costs do not include the offsetting financial benefits that will accrue to businesses from the implementation of RHL. These cost offsets derive from the improved productivity, improved retention and lower retirement rates among workers who have a greater capacity to manage their health conditions due to the availability of paid RHL. These benefits can be quantified by adjusting the economic loss from people's forgone wages, decreased income due to working part-time, and employees' turnover due to people leaving the job or retiring early due to reproductive conditions.

Under different scenarios from conservative to more generous financial benefits, we estimate that the **aggregate financial benefits that would accrue to businesses from the implementation of paid RHL** will lie somewhere in the range $1.13 billion to $3.01 billion**, with a central estimate of $1.88 billion per year** – this represents a **cost offset of 53%** on the estimated mid-range up-front costs of 12 days of paid RHL and a **net cost of $1.7 billion (equating to $140 per year per person employed)**.

These costs are a fraction of the lost productivity costs incurred by Australian businesses from reproductive health conditions. The cost of lost productivity can vary significantly depending on modelling assumptions relating to the costs of absenteeism, presenteeism (loss of productivity while at work), medical expenses, and forgone wages and superannuation, whenever available. External research findings have valued the lost productivity to be as high as $26.55 billion annually.

Drawing on evidence from the new workplace survey implemented for this report, our research estimates that **the value of lost productivity due to reproductive health conditions is $21.3 billion**. Menopause, menstrual pain, and endometriosis contribute to the majority of this cost because of the greater incidence of workers experiencing these conditions and the heavier burden they carry in managing these conditions while at work.

## Key findings

Reproductive health leave refers to a workplace entitlement that provides workers with several paid days specifically allocated to treat and manage reproductive health conditions or procedures, covering intense menstrual pain, endometriosis, vasectomies and hysterectomies, intense menopause and perimenopause symptoms, in-vitro fertilisation (IVF), miscarriages and terminations.

**Annual lost productivity costs from reproductive health conditions**

- The value of lost productivity cost from reproductive health conditions is estimated at $21.3 billion per year.
- Menopause, menstrual pain, endometriosis and miscarriage are the main contributors to the value of lost productivity from reproductive health conditions.

The costs incurred by businesses from implementing paid reproductive health leave depends on the prevalence of different reproductive health conditions, the degree of utilisation of any RHL entitlement, and the accrued financial benefits from RHL. Under assumptions based on the workplace survey collected for this report and findings from existing literature, we find that:

**Gross annual costs of reproductive health leave (up to 12 days):**

- The aggregate gross cost of up to 12 days of paid reproductive health leave is estimated to be between $2.3 billion and $5.9 billion, with a central estimate of $3.6 billion.
- These gross costs equate to between $190 and $487 per employed worker, with a central estimate of $296 in gross costs per worker per year under the benchmark scenario.

**Annual benefits to businesses from implementing up to 12 days of paid RHL:**

- The aggregate financial benefits to businesses from the implementation of up to 12 days of paid RHL are estimated to be between $1.13 billion and $3 billion per year, with a central estimate of $1.88 billion per year.
- This represents a mid-range cost offset of 53% on the up-front costs of 12 days of paid RHL.

**Net annual costs of reproductive health leave (up to 12 days)**

- The aggregate net cost of up to 12 days of reproductive health leave is estimated to be $1.7 billion under mid-range assumptions regarding gross costs and cost offsets.
- These net costs equate to $140 per year per employed worker.

## Other findings

Reproductive health conditions affect a significant number of Australians. Providing access to paid leave will allow people to rest, heal and treat these conditions without worrying about the financial and workplace consequences of absence from work.

### Prevalence rates of reproductive health conditions

Prevalence rates are high for some reproductive health conditions in Australia. Menstrual pain affects more than half of the women's population, while endometriosis impacts one in seven women nationally. Menopause symptoms affect 74 per cent of middle-aged women (45 to 55), with 17 per cent forced to take extended leave due to the severity of their condition. One in 18 babies born in Australia were conceived through assisted reproductive technologies (ART), and this percentage has increased significantly over time. Our survey reveals that 8 per cent of women aged 25 to 45 undertake IVF procedures throughout the year. Miscarriages occur in 15 to 20 per cent of all pregnancies and affect one-third of all women. According to Medicare data, terminations, on the other hand, have a prevalence rate of 1,800 for 100,000 women of reproductive age. asectomies and hysterectomies for people aged 35-44 have prevalence rates of 1,200 and 220 for 100,000 people, respectively.

Given the widespread occurrence and varying prevalence of these conditions across different age groups, it is important to assess their impact on workplace participation, particularly in terms of absenteeism and presenteeism.

### Rates of absenteeism and presenteeism of people with reproductive health conditions

The impact of reproductive health conditions on the workplace is significant and mainly affects people's work through three different channels: absenteeism, presenteeism and modifications in people's professional circumstances.

In terms of absenteeism, we see that in Australia, close to 7 per cent of women miss days of work or study due to intense menstrual pain. However, for women with endometriosis or going through periomenopause or menopause, about 60 per cent miss days of work because of bothersome symptoms.

Presenteeism, on the other hand, has a heavier burden on productivity than absenteeism. Presenteeism is the loss in productivity experienced by people who, despite suffering from important reproductive health symptoms, decide to still go to work. Presenteeism has a heavier economic burden for menstrual pain, endometriosis and menopause related symptoms. It is estimated that the productivity loss of women suffering from intense menstrual pain amounts to almost 13 days per year. This number is higher for women with endometriosis and for those undergoing IVF, these women lose on average 20 days of work due to presenteeism. Our survey also estimates that for women going through menopause transitions, 26 days per year are lost due to declined productivity in the workplace.

Since productivity losses due to reproductive health conditions are significant, workplace policies such as RHL can play a key role in addressing these challenges.

**RHL can limit the productivity loss associated with reproductive health conditions**

It is important to point out that the cost of presenteeism can be mitigated, to some extent, by implementing RHL, and the gains in productivity can be significant. In the BCEC survey, people with reproductive health conditions were asked their opinions on how having access to RHL could affect their productivity, their mental health and their levels of stress. The result was unequivocal. Close to 90 per cent of people with reproductive health conditions believed that having access to RHL will increase their productivity and enhance their sense of loyalty to the company. Similarly, 94 per cent felt it would benefit their mental health while 95 per cent believed it would help reduce stress levels. These metrics show that RHL will likely significantly improve the productivity of the workforce with reproductive health conditions.

**Need for the implementation of RHL**

In addition to reducing productivity loss, the survey findings indicate a clear demand for RHL among workers. Indeed, of all people that did not take leave despite suffering from bothersome symptoms related to their reproductive health condition, 65 per cent did so as a result of their lack of leave and not out of choice. They would have liked to take leave, but it was not available to them. Hence, providing RHL will equalise the access to leave for people with reproductive health conditions.

**There is a persistent sentiment of embarrassment and shame when discussing reproductive health conditions**

It is important to point out that there is still a feeling of embarrassment attached to disclosing a reproductive health condition to an employer. Indeed, close to 60 per cent of the people declare that it is private and embarrassing to tell your employer you have a reproductive health condition. The same share of people will only feel comfortable requesting RHL if their co-workers are unaware of what the leave is used for.

**Lack of support from managers and stigma around reproductive conditions still exists**

The survey also shows that stigma and lack of support from managers around reproductive health conditions still exist in the workforce. Sixty-eight per cent of the people chose not to disclose their condition to their manager, citing various concerns. More than half (55 per cent) were uncertain whether their manager would be supportive, while 52 per cent feared that disclosure might lead to negative consequences in the workplace. Additionally, 68 per cent of respondents believed that disclosing their condition could lead to stigma in the workplace.

**Risks associated with the implementation of reproductive health leave policies**

The report has identified some of the risks associated with the implementation of reproductive health leave policies. Among them, the perpetuation of stereotypes and discrimination against women in the workplace are the highest concerns. Indeed, in our survey, even though 88 per cent of the workers think that people will not misuse RHL, close to 70 per cent believe that employers will use it as an excuse to discriminate against women.

The absence of support from workers can also lead to a failed implementation of reproductive health leave, which will, in turn, repress its uptake from workers who need it. However, this does not seem

to be the case in Australia as more than 92 per cent of people support giving access to RHL to people with reproductive health conditions.

**Other policies helping people with reproductive health conditions**

Finally, along with reproductive health leave, other policies can be put in place to help workers mitigate the symptoms of their reproductive health conditions and increase their wellbeing at work. The survey provided some insights into the use of these alternative approaches to manage reproductive conditions at work. The analysis shows that 27 per cent of respondents opted to work from home, while 8 per cent utilised formal flexible work arrangements. A further 13 per cent relied on informal arrangements.

Other than RHL provisions, flexible work arrangements, an increase in awareness of reproductive health conditions among managers and workers, increased training of managers and providing people's control over their working environment have proven to have the highest impact in improving the wellbeing of people with reproductive health conditions at work.

# INTRODUCTION

## Setting the scene

In recent years, there has been increasing attention to workplace difficulties experienced by people suffering from reproductive health conditions. As a result, many countries have put in place policies aiming to improve the wellbeing of employees. In the last five years, menstrual and menopause leave have gained momentum, especially since Spain became the first European country to decide to implement universal menstrual health leave. But these two issues only represent a small portion of reproductive health conditions and do not benefit men in any way. This is why some calls have been put forward to introduce paid leave in the workplace that will include a larger definition of reproductive conditions, namely, reproductive health leave (RHL).

The Health Services Union (HSU), the Health and Community Services Union (HACSU), the Queensland Council of Unions (QCU) and Aware Super have engaged the Bankwest Curtin Economics Centre (BCEC) to assess the cost and benefits of implementing a universal reproductive health leave entitlement for Australian employees. Hence, this report calculates the value of this measure thanks to the implementation of a novel survey that provides the parametrisation required for this exercise. Furthermore, this report estimates the cost of lost productivity in the workplace, which is reflected by a greater loss of output due to extended absenteeism and presenteeism. Lastly, the report analyses the benefits and offset costs for Australian employees and companies of providing RHL.

By thoroughly examining the net financial impact of a universal reproductive health leave entitlement, this report aims to provide valuable insights into the feasibility of its nationwide adoption in the Australian workforce.

Currently, employees are only entitled to the use of sick or annual leave to treat and manage reproductive health-related absences, with no specific provisions in place for conditions such as menstrual and menopause health management, fertility treatments from assisted reproductive technologies, and screening prevention for breast and prostate cancer. As such, the proposal for a universal RHL entitlement seeks to address this gap by offering a designated leave that acknowledges and supports the health and wellbeing of individuals who experience reproductive health challenges. This report aims to explore the financial burden and mitigation costs of implementing this policy, with a focus on its costs for employers, employees, and the economy at large.

## What is reproductive health leave?

Reproductive health leave refers to a workplace entitlement that provides employees with a certain number of paid days specifically allocated to treat and manage reproductive health conditions or procedures. These include conditions such as intense menstrual pain, endometriosis, vasectomies and hysterectomies, intense menopause and perimenopause symptoms, in vitro fertilisation (IVF) miscarriages, and terminations, but also preventive reproductive health such as breast cancer and prostate cancer screening.

In this report, we will consider only the following reproductive health conditions or procedures:

- Intense menstrual pain
- Intense perimenopause and menopause symptoms
- Vasectomies and hysterectomies
- In vitro fertilisation (IVF) or other forms of assisted reproductive health
- Endometriosis or polycystic ovarian syndrome
- Miscarriage and termination

# HISTORY OF REPRODUCTIVE HEALTH LEAVE AND POLICIES ALREADY IN PLACE

Reproductive health leave is a relatively new concept that has not yet been implemented on a national scale. However, some aspects of reproductive health leave have been introduced in other countries, and its history is not necessarily new.

## Countries providing variations of reproductive health leave

The most common of all is the provision of paid menstrual leave. The list of countries that provide some form of menstrual leave is shown in Table 1. According to Baird et al. (2020), menstrual leave has existed since the 1920s and was first implemented in the Soviet Union in 1922, followed by a reform in 1931. Japan and Indonesia were also frontrunners and implemented menstrual leave around 1947-48.

**Table 1: Countries providing leave for particular health conditions, average number of days per year**

| Country | Year implemented | Type of leave | Number of leave days per year | Observations |
|---|---|---|---|---|
| Soviet Union | 1922 | Menstrual leave | 36 | |
| Japan | 1928 | Menstrual leave | At discretion | Has to be negotiated with employer |
| Indonesia | 1948 | Menstrual leave | 24 | Has to be negotiated with employer |
| South Korea | 2001 | Menstrual leave | 12 | |
| Taiwan | 2002 | Menstrual leave | 3 | Half pay |
| Philippines | 2004 | Menstrual leave | 12 | Half pay |
| Vietnam | 2015 | Menstrual leave | Up to 3 days | Has to be negotiated with employer |
| Zambia | 2017 | Menstrual leave | 12 | Reglementation is unclear |
| Spain | 2023 | Menstrual leave | 36-60 | |
| South Korea | 2020 | Menopause leave | 3 days | |
| Japan | 2021 | Menopause leave | 5 days | |
| Italy | 2021 | Menopause leave | 3 days | |
| Philippines | 2021 | Menopause leave | 24 days | |

Source: Baird et al. (2020)

After these pioneering countries adopted menstrual leave policies, it was not until the beginning of the 21st century that a second wave of countries implemented this policy. These countries are mostly concentrated in South East Asia and include South Korea (2001), Taiwan (2002), and the Philippines (2004).

Finally, in more recent years, Vietnam (2015), Zambia (2017) and Spain (2023) have also introduced menstrual leave policies. Even though many developing countries already offer menstrual leave, it was Spain that attracted the largest media attention since it was the first European country to vote on such a bill. Since then, many other countries have put menstrual leave on the agenda and are currently legislating on the issue.

Menopause leave, on the other hand, is less common and relatively new, and only 4 countries in the world provide women with access to menopause leave. South Korea was the first to introduce the bill in 2020, followed by Japan, Italy and the Philippines a year later. Most of these countries offer 3 to 5 days annually, only the Philippines provides a more generous entitlement equivalent to 2 days of leave per month.

## Companies providing partial coverage of reproductive health leave

Even though only a few countries are on board with menstrual and menopause leave, some companies have taken matters into their own hands, including a few Australian and international companies. Most notably, the Women's Health Matters ACT offers 24 days of paid reproductive health leave per calendar year. Other companies, such as Future Groups, Aware Super and CBUS, offer menopause and menstrual leave (Senate Inquiry, 2024). The list of national companies that, to our knowledge, offer a variation of reproductive health leave can be found in Table 2. This list does not include companies in Queensland that are now mandated to provide RHL to their employees.

Additionally, some unions have also started to strongly advocate and negotiate for RHL clauses in enterprise bargaining agreements (EBAs). Most notably, the Health and Community Services Union (HACSU) in Victoria has managed to negotiate a significant number of RHL clauses through EBAs. The HACSU campaign has been gaining momentum since 2023, and in the last couple of years, more than 11 companies have signed off RHL clauses thanks to successful negotiations. Among them, the Department of Families, Fairness and Housing, Scope Victoria, Gateways and Optia Ltd are notable.

**Table 2: Australian companies providing a variation of reproductive health leave, excluding companies located in Queensland, average number of days per year**

| Company name | Number of leave days per year | Type of leave |
|---|---|---|
| Future Group | 6 | Menopause & menstruation leave |
| Aware Super | 10 | Menopause leave |
| CBUS | 12 | Menopause & menstruation leave |
| ModiBodi | 10 | Menopause, menstruation & miscarriage leave |
| Women's Health Matters ACT | 24 | Reproductive health leave |
| Maurice Blackburn | 6 | Reproductive health leave |
| Aruma Victoria | 4 | Reproductive health leave (through EBA) |
| Headspace National | 5 | Reproductive health leave (through EBA) |
| Optia Limited | 5 | Reproductive health leave (through EBA) |
| Gateways | 4 | Reproductive health leave (through EBA) |
| Scope Victoria Ltd | 12 | Reproductive health leave (through EBA) |
| Melba Support Services | 5 | Reproductive health leave (through EBA) |
| Department of Families, Fairness and Housing | 5 | Reproductive health leave (through EBA) |

Source: Senate inquiry into issues related to menopause and perimenopause (2024)

Nationally, the Queensland Government's Reproductive Health Leave Directive provides public workers with 10 days of reproductive health leave entitlement per year from October 2024. The goal of this legislation is to "reduce the stigma associated with seeking support to manage impacts of reproductive health issues on workforce participation" (Queensland Government, 2024).

Queensland reproductive health leave can be taken by employees who (i) suffer from a chronic reproductive health condition that prevents them from going to work, (ii) for fertility treatments such as IVF, (iii) for surgery or treatment of reproductive health-related issues such as vasectomies and hysterectomies but also (iv) to attend preventative screening associated with reproductive health such as breast and prostate screening (Queensland Government, 2024).

Finally, the Victorian government provisioned up to five days of paid reproductive health leave to public employees as a result of the negotiations of the enterprise bargaining agreement with the Community and Public Sector Union in 2024 (Victorian Public Service Enterprise Agreement 2024).

# CONDITIONS AND PREVALENCES OF REPRODUCTIVE HEALTH CONDITIONS

Reproductive health conditions are a significant aspect of public health in Australia, affecting both men and women across various age groups. In this section, we will discuss the most common reproductive health conditions and their prevalence rates among the population, according to the literature.

## Intense menstrual pain

Among reproductive health conditions, intense menstrual pain and menopause symptoms have the highest prevalence in the population. This is expected as almost all women have their periods and go through menopause transitions. However, the severity of the symptoms varies significantly from one woman to another.

From the 2023 National Women's Health Survey conducted by Jean Hailes (Jean Hailes, 2023(a)), we learn that almost half of Australian women have experienced pelvic pain in the last 5 years. However, prevalence rates are much higher for women of reproductive age, where close to 70 per cent suffered from menstrual pain during the same 5-year period. Among women experiencing menstrual pain, 48 per cent reported needing to take an extended break from exercise, and 45 per cent found it hard to work or study.

## Endometriosis and polycystic ovarian syndrome

According to the World Health Organization (WHO), "Endometriosis is a disease in which tissue similar to the lining of the uterus grows outside the uterus. It can cause severe pain in the pelvis and make it harder to get pregnant". Women suffering from endometriosis and polycystic ovarian syndrome have, on average, a higher prevalence of menstrual pain (Vercellini et al., 1997) as well as a higher severity of symptoms. The Australian Institute of Health and Welfare (AIHW) estimates that one in seven women will be diagnosed with endometriosis by the time they reach 44 to 49 years old. Additionally, women with endometriosis are more likely to suffer from migraines (Sperschneider et al., 2019) and struggle with infertility; around 30 to 50 per cent of women with endometriosis struggle to conceive a child (Evans et al., 2017). Furthermore, women suffering from endometriosis occasionally undergo laparoscopic surgery to remove endometriosis lesions, adhesions and scar tissue (World Health Organization, Endometriosis fact sheet, 2023).

## Perimenopause and menopause

Menopause is defined as the last menstrual period of a woman's life, and perimenopause is the "reproductive phase in a woman's life occurring before menopause" (Australia Menopause Society). Perimenopause and menopause symptoms last on average four to six years, but that period can be extended up to ten years in some cases (Health Direct, 2025). The prevalence rate of women suffering from menopause symptoms is significant. Menopause symptoms are divided into two categories: vasomotor symptoms (VMS), which include hot flashes, joint pain, urogenital atrophy and fragmented sleep (Davis et al., 2015) and psychological symptoms, which include depression, anxiety and lowered and erratic mood (O'Reilly et al., 2024). Around 64 per cent of middle-aged women (45-64 years old) have been bothered by menopause symptoms in the last 5 years, and one in four had symptoms so severe that it had a substantial impact on their daily lives (Jean Hailes, 2023(b)).

## Assisted Reproductive Technologies (ART)

An increasing percentage of the Australian population is using assisted reproductive technologies (ART) to help couples with reduced fertility to conceive. According to Health NSW, "ART are treatments (IVF) or procedures that address fertility and can include artificial insemination, in vitro fertilisation or gamete intrafallopian transfer as well as any other related treatments or procedures". Reproductive health leave also aims to provide couples with the necessary time to make ART arrangements. The annual IVF report from the University of New South Wales shows that one in 18 children born in Australia were conceived through IVF treatments. In 2022, more than 100,000 IVF treatments were performed in Australia on 53,000 women. IVF treatments are not only financially draining but also time-consuming; a typical IVF cycle requires around six to eight visits, including doctor consultations, ultrasounds and blood tests, stimulation monitoring, egg retrieval, embryo transfer and pregnancy scans (IVF Australia). Furthermore, the hormones used to regulate women's menstrual cycles have considerable side effects such as nausea, hot flashes, gastrointestinal upset, headache, dizziness and mood swings, among others (Hvala, 2018). More importantly, the psychological distress faced by women undergoing IVF is important; 47 per cent of women experience feelings of depression often or all the time, and worse, four out of ten experience suicidal thoughts. This is according to a United Kingdom study from Fertility Network undertaken in 2022 (Payne, 2022).

## Miscarriage and Terminations

Another reproductive issue that has significant psychological consequences for women is miscarriage. The Mayo Clinic defines miscarriage as the "sudden loss of a pregnancy before the 20th week". Miscarriages occur in 15 to 20 per cent of all pregnancies and affect one-third of all women (Corbet-Owen and Kruger, 2001). Increased anxiety, depression and grief are the most common issues affecting more than half of the women going through a miscarriage, commonly accompanied by loss of appetite, weight loss, guilt, insomnia and morbid thoughts (see Van den Akker, 2011 for a synthesis of symptoms). Termination, on the other hand, is a "medical process of ending a pregnancy, so it does not result in the birth of a baby" (Health Direct Australia). The evidence of the effects of terminations on mental health is mixed; some studies find the experience of abortion can lead in extreme cases to the development of post traumatic stress disorder, depression and problems with interpersonal relationships. However, terminations also seem to have positive effects or even better psychological effects than those of women giving birth (see Zareba et al., 2020, for a brief compilation of studies).

# REPRODUCTIVE HEALTH ISSUES AND THE WORKPLACE

Most reproductive health conditions have an impact on people's ability to work. However, the size of the effect and severity of the symptoms vary greatly from one person to another. Even though the average employee may only suffer from mild discomfort related to reproductive conditions, some others have symptoms so severe that they are forced to leave the workforce entirely. The idea behind reproductive health leave is to level the field between people with mild or non-existent conditions and those who suffer from moderate and severe symptoms.

The reproductive health conditions studied in this report can have an impact on people's work lives through three channels: absenteeism, presenteeism and modifications in professional circumstances.

- **Absenteeism**, as its name indicates, relates to people who are unable to work due to the severity of reproductive health symptoms. These include people taking occasional leave to heal or treat an issue, people reducing the number of working hours per week, or people taking prolonged leave to deal with more significant reproductive health symptoms.
- **Presenteeism**, on the other hand, relates to people who, despite suffering from painful reproductive health symptoms, decide to still go to work but experience a decrease in total productivity as a result.
- Finally, the **modification of people's professional circumstances** includes employment decisions taken by workers due to reproductive health conditions rather than by preference. These include issues such as workers being unable to work in their preferred occupation, having to modify shifts and timetables, changing career paths, and passing on promotions. These decisions are taken in order to be able to cope with reproductive health symptoms.

In the following section, we explore the evidence in the literature on how different reproductive health conditions affect people's working lives.

## Absenteeism in the workplace

**Intense menstrual pain** has some of the largest effects on workplace absenteeism. Schoep et al. (2019), in a study conducted in the Netherlands, indicate that close to 14 per cent of women reported missing at least one day of work in the last 12 months. Importantly, menstrual pain-related symptoms constitute 24 per cent of total absenteeism for women working or studying. On average, women miss 1.3 days of work yearly due to intense pelvic pain. In Australia, almost half the women with pelvic pain find it hard to work and one in three miss days of work or study (Jean Haileys, 2023(a)).

It is worth noting that most of these studies include women with **endometriosis** as it is difficult to disentangle women with endometriosis from those suffering from high levels of menstrual pain. However, specific studies on absenteeism for women with endometriosis have been conducted recently. The results show a loss in work hours ranging from 4.4 hours to 7.4 hours of work per week (Fourquet et al., 2011; Nnoaham et al., 2011). In Australia, Howe et al. (2024) recently showed that almost all employed women with endometriosis have seen their work impacted in the last 6 months. Three-quarters of women have taken sick leave in the past 2 months due to the intensity of their symptoms, with an average of 7 days taken off work. Additionally, more than half have reduced their working hours as a result.

Women with **menopause**-related symptoms also have significant rates of absenteeism at work. Around one in ten middle-aged women (aged 45-65) missed days of work or study due to menopause symptoms in the last 5 years. Even more worrisome, 17 per cent of Australian women declared taking a long leave of absence from work due to this condition (Jean Haileys, 2023(b)). A study from the Mayo

Clinic in the US gives us similar figures, however, the reporting period is shorter. Among women with menopause symptoms, close to 10.8 per cent reported missing days of work in the last 12 months due to their symptoms, with an average of 3 days lost of work (Faubion et al., 2023). Interestingly, women suffering from psychological symptoms due to their menopause have worse employment outcomes than women suffering from vasomotor symptoms (VMS) only. Indeed, an additional psychological problem reduces employment rates by 1–2 percentage points, with this effect doubling if the symptoms are severe (Bryson et al., 2022).

In addition to the loss of working days, a significant number of women had to reduce their working hours as a result of their menopause symptoms. In the Mayo Clinic study mentioned above, 5.6 per cent of women were constrained to do so in the last six months prior to the survey. This is also the result of another UK study that found that women experiencing severe menopause symptoms were more likely to leave employment or reduce their working hours (Evandrou et al., 2021). However, women's ability to go on early retirement was constrained by their partners' earnings. Only women who have the financial capability to retire due to their family finances will do so. In Australia, a study from Circle In in collaboration with the Victoria Women's Trust showed that 45 per cent of the women going through severe menopause symptoms considered retiring or taking a break, but 72 per cent of them did not do so, mostly for financial reasons.

## Presenteeism in the workplace

Contrary to expectations, *presenteeism* is the most important cause of lost productivity for people with reproductive health conditions. However, presenteeism data is scarce and unavailable for most conditions under scope.

Most notably, **menstrual pain** presenteeism figures are staggering. According to Schoep et al., over 80 per cent of Dutch women report presenteeism and 23.2 days per year of decreased productivity. On average, productivity loss per day accounts for more than 30 per cent. Multiplying this by the number of days of decreased productivity equates to a total of 9 days of lost productivity per year. This figure is much higher than the 1.3 days loss of absenteeism for the same condition. Women with **endometriosis** seem to have extremely high rates of presenteeism. Sixty-five per cent of women with endometriosis symptoms declared their work was impaired in the last week, with a perceived loss in efficiency levels equal to 64 per cent (Fourquet et al., 2011). In Australia, women with endometriosis symptoms estimate that their work productivity was impacted more than 50 per cent of the time they were at their job in the last 2 months (Howe et al., 2024).

Even though there is very little research on presenteeism and **menopause**, Australian figures tell us that 21 per cent of middle-aged women find it hard to work or study because of bothersome menopausal symptoms (Jean Haileys, 2023(b)). Internationally, estimations for Dutch women show that three-quarters of women with severe menopause symptoms report a low ability to undertake work (Geukes et al., 2016). Only a few studies have tried to determine the presenteeism rates among women undergoing menopause. Among women experiencing VMS in the last 7 days, those with moderate and severe symptoms had presenteeism rates of 24.3 per cent and 14.4 per cent, respectively. This compares to only 4 per cent for women with mild symptoms. Overall, work impairment has similar rates for all age groups, with people with severe VMS suffering close to a quarter of lost productivity in their jobs (Whiteley et al., 2013). A study by the British Safety Council in the UK shows that menopause-induced absenteeism and presenteeism cause losses to employers of up to 13.8 working days annually per female employee[1].

[1] https://www.britsafe.org/safety-management/2023/navigating-the-menopause-maze-why-employers-must-act#:~:text=Estimates%20indicate%20employers%20lose%20up,%C2%A310.5%20billion%20each%20year.

## Modifications to people's professional circumstances

Finally, modifications in people's professional circumstances are mostly observed in people with **endometriosis**. Due to the bothersome symptoms of endometriosis, a significant number of women have had their professional circumstances dictated by it. According to Howe et al. (2024), 33 per cent of Australian women with endometriosis had to change jobs, 22 per cent declined a promotion, and 20 per cent had to change roles due to the severity of their symptoms. Additionally, women with endometriosis are less likely to work in their desired profession, and health-related limitations are one of the main considerations in their career choices (Sperschneider et al., 2018).

Another group that suffers from modifications in their professional circumstances are those going through ART and IVF. Even though we do not appear to have figures for Australia, in a UK survey, 15 per cent of respondents felt their career was damaged as a result of fertility treatments and 58 per cent were worried that their treatment would have an impact on their career prospects (Payne, 2022). Furthermore, in Japan, one-sixth of women left their work after starting infertility treatment, as the physical and psychological toll was too high to bear (Imai, 2021).

## Introduction

The Bankwest Curtin Economics Centre has designed and implemented a novel survey investigating the costs and benefits of reproductive health leave, supported by funding from the Health Services Union National Office (HSU), the Health and Community Services Union (HACSU), the Queensland Council of Unions and Aware Super.

The BCEC is committed to fostering research partnerships that actively involve stakeholders at every stage of the process, from shaping research questions and conducting studies to communicating and analysing the findings. The survey was designed by incorporating insights from key stakeholders, as well as an extensive literature review.

The stakeholder consultation process has led to a comprehensive list of survey questions, which has provided an extensive and unique dataset on reproductive health conditions experienced by workers, as well as their productivity loss and days of absence related to these conditions. The survey also collects information on employees' attitudes towards RHL, their perceptions of people taking RHL and the stigma and discrimination attached to reproductive health conditions in the workplace.

Whenever possible, questions and modules in the survey follow national and international standards, which allows for comparisons of the findings across different jurisdictions and countries.[2]

The survey received ethics approval from Curtin University's Research Integrity Office, and all data was collected anonymously. Informed consent was also obtained from all the respondents. The survey was distributed online by HSU, HACSU, the Queensland Council of Unions, Aware Super and other partner unions, with participants accessing the digital Qualtrics survey via a provided link.

Findings from the survey reveal some important insights regarding prevalence rates, leave utilisation, workplace and mental health effects, as well as general attitudes and perceptions toward reproductive health leave conditions and entitlements.

## Demographic profile of survey respondents

The survey was disseminated nationwide across Australia from December 2024 to March 2025, receiving a total of 1,066 responses.[3] To ensure the findings are representative of the broader workforce, all analyses have been adjusted using population weights for age and state of residence based on the Australian Bureau of Statistics' employment data (Australian Bureau of Statistics, 2025, February). This weighting process corrects for any overrepresentation or underrepresentation of specific population groups, ensuring that the reported rates and insights accurately reflect the broader working population.

The majority of survey participants, 84 per cent, identify as women. Given the fact that the survey was distributed mainly through the HSU and that health professionals are a female-dominated sector, it is unsurprising that the majority of respondents are women.

In terms of age distribution, 3 per cent of respondents are between 18 and 25 years old, 11.3 per cent between 26 and 30, 17 per cent between 31 and 35, 12.6 per cent between 36 and 40, and 16.1 per

[2] For instance, the questionnaire includes a series of questions designed to construct the Kessler Psychological Distress Scale (K10), a widely used measure of psychological distress across various studies (Kessler et al., 2002).
[3] Some responses contain missing values, as participants may have skipped certain questions and not answered every item in the survey. Hence, the analytical sample consists of 941 observations.

cent between 41 and 45. The remaining 40 per cent are aged 46 and above. The participants represent all Australian states and territories, though some states are more heavily represented than others. For example, only 10 per cent of respondents are from NSW, while the proportions for smaller eastern states such as QLD and TAS range between 13 per cent and 27 per cent.

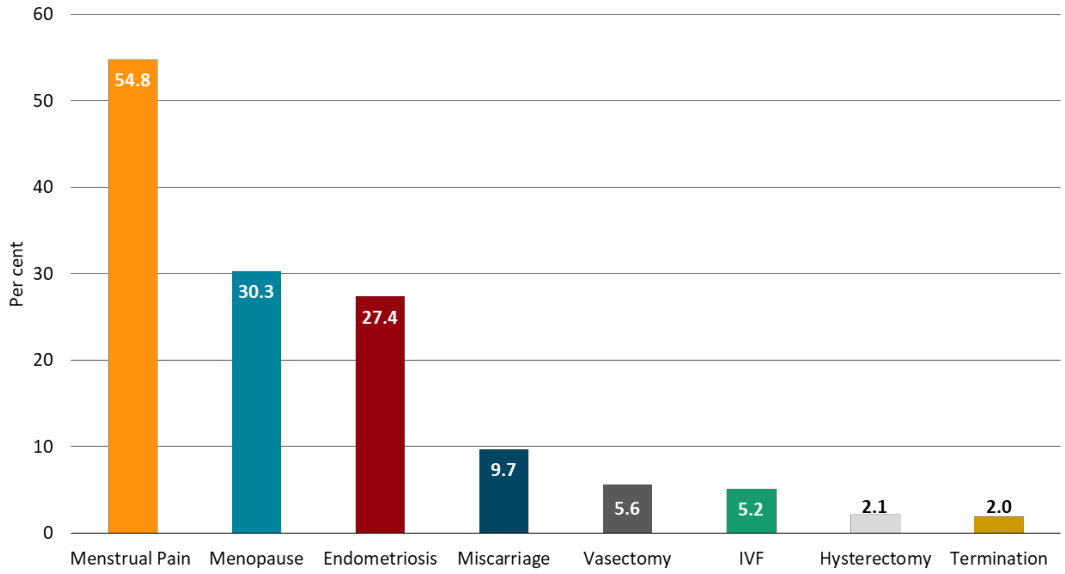
Regarding employment status, 91 per cent of respondents are currently employed, with 70 per cent in full-time positions and 30 per cent working part-time. Additionally, 71.3 per cent are employed by large companies with more than 200 employees. On average, respondents work 34 hours per week. The survey also indicates that 83.8 per cent of participants were born in Australia.

## Reproductive health conditions and entitlements

The survey collected information on whether participants had experienced reproductive health conditions or undergone procedures that impacted their ability to work. Figure 1 illustrates the prevalence rates of these conditions among respondents.

The findings indicate that approximately 55 per cent of participants reported experiencing menstrual pain severe enough to prevent them from working.[4] Additionally, 30 per cent experienced menopause-related symptoms that affected their ability to work, while 27 per cent reported having endometriosis. It is worth noting that the prevalence rates of endometriosis are higher than in the literature. This is probably related to the fact that the survey includes a larger proportion of health professionals, which means that they have higher awareness of conditions such as endometriosis relative to the average female population. This may have led to higher testing rates for this condition and, hence, higher prevalence rates. Other reproductive health experiences included termination or miscarriage (2 and 10 per cent respectively), undergoing IVF treatment (5 per cent), and having a hysterectomy or a vasectomy (around 2-6 per cent).

**Figure 1: Prevalence rates by reproductive health condition**



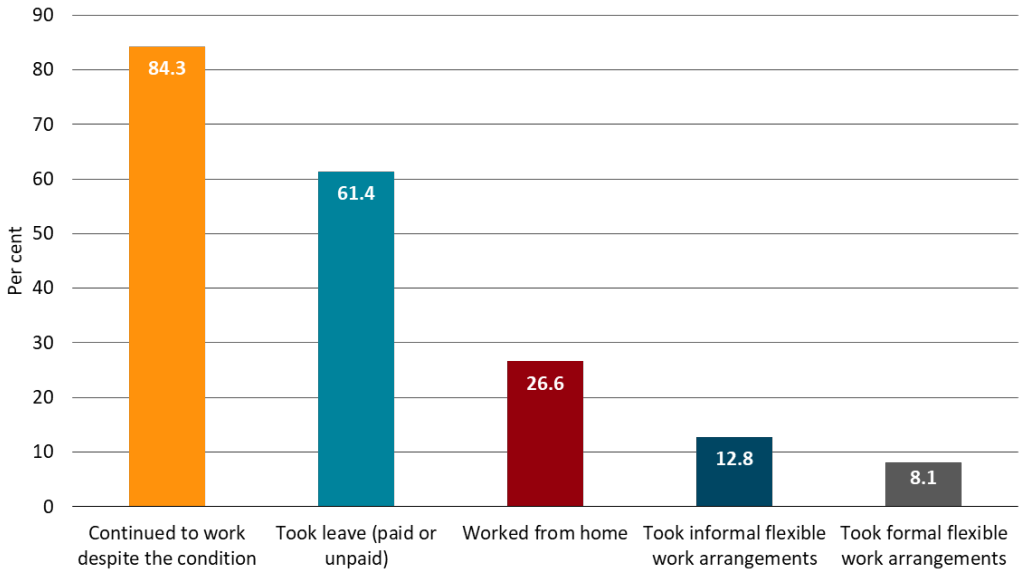

Notes: The prevalence rates do not total 100% because respondents may have experienced multiple conditions in the past 12 months. The rates have been adjusted using population weighting.

Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive health leave Survey

[4] Population weights constructed from ABS employed population data (Australian Bureau of Statistics, 2025, February) have been applied to all subsequent analyses.

The survey also explored the ways respondents managed their reproductive health conditions while balancing work responsibilities, as shown in Figure 2. The analysis shows that approximately 61 per cent of participants took leave, whether paid or unpaid, to address their health needs. Additionally, 27 per cent opted to work from home, while 8 per cent utilised formal flexible work arrangements. A further 13 per cent relied on informal, flexible arrangements. Notably, despite experiencing reproductive health challenges, 84 per cent of respondents chose to continue working without taking leave or adjusting their work arrangements.

**Figure 2: Ways of managing reproductive health conditions**




Notes: The percentages do not total 100% because respondents may have managed their condition in more than one way in the past 12 months. The rates have been adjusted using population weighting.

Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive Health Leave Survey

Among the respondents who took leave due to reproductive health conditions, further analysis reveals that 60 per cent used sick leave, 11 per cent opted for annual leave, and 17 per cent accessed reproductive health leave. These figures align with expectations, as reproductive health leave is not yet universally available to employees across all Australian states. Additionally, 44 per cent of those who took leave did so without pay.

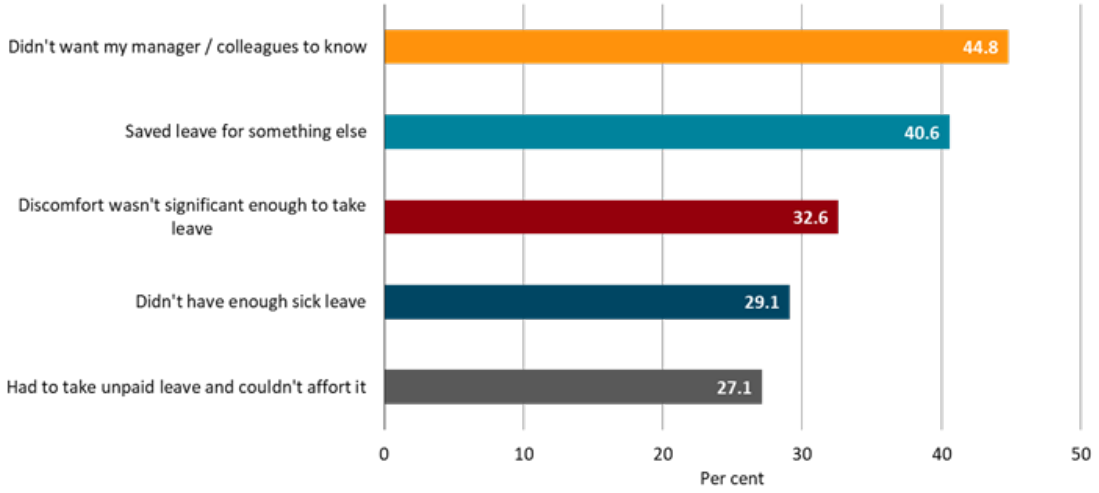
These findings highlight the varied ways individuals navigate reproductive health issues in the workplace, as well as the potential need for more supportive workplace policies. Analysis also shows differences in leave uptake and highlights the potential need for more inclusive policies to support employees dealing with reproductive health issues.

The survey also included questions for participants who experienced pain or discomfort due to a reproductive health condition but chose not to take leave. These questions aimed to understand the reasons behind their decision.

The results, presented in Figure 3, reveal that 33 per cent of respondents felt their pain or discomfort was not severe enough to warrant taking leave. Additionally, 29 per cent reported that they had no remaining sick leave available, while 41 per cent had sufficient leave but preferred to save it for other purposes, such as personal matters or vacations. Financial concerns were also a factor, with 27 per cent stating that they would have had to take unpaid leave, which they could not afford. Notably, 45

per cent of respondents stated that they did not want their manager or colleagues to know about their reproductive health condition.

**Figure 3: Reasons for not taking leave despite reproductive health conditions**




Notes: The percentages do not total 100% because survey participants may have chosen more than one response to this question. The rates have been adjusted using population weighting.
Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive Health Leave Survey

Of those people who did not take leave despite their reproductive health condition, **65 per cent did so as a result of their lack of leave and not out of their own choice**. This means that the reason behind people not taking leave is the result of a constraint; they would have liked to take leave, but it wasn't available to them.

These findings provide important information on the considerations employees face when deciding whether to take leave, including workplace culture, financial constraints, and the availability of appropriate leave policies.

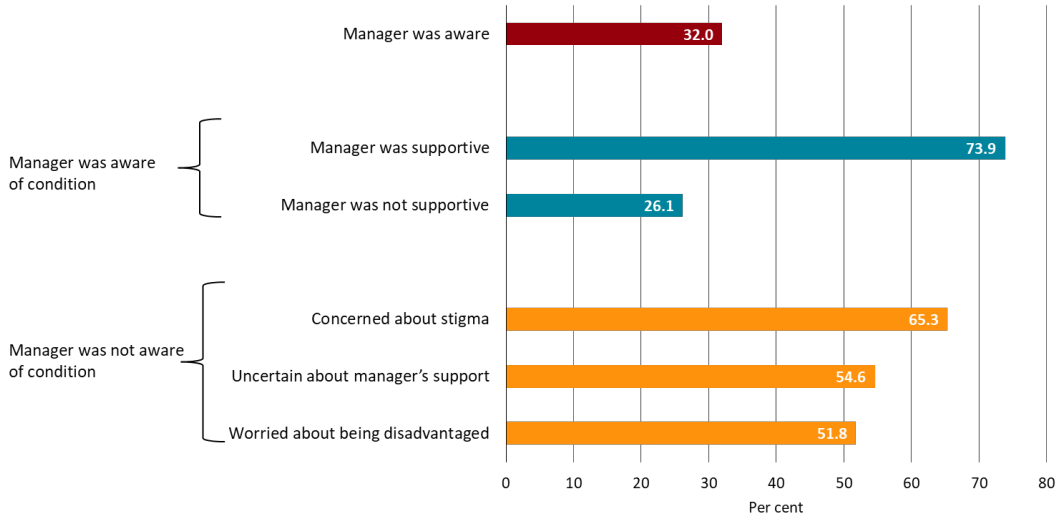
The survey also included a set of questions examining respondents' willingness to disclose their reproductive health condition to their manager, as well as any concerns they had about doing so. The findings from this module are presented in Figure 4.

Overall, 32 per cent of respondents reported that their manager was aware of their condition, and among them, 74 per cent stated that their manager was supportive. At the same time, 26 per cent of those whose manager was aware reported a lack of support.

Sixty-eight per cent of people who are experiencing a reproductive health condition chose not to disclose their condition to their manager, citing various concerns. More than half (55 per cent) were uncertain whether their manager would be supportive, while 52 per cent feared that disclosure might lead to negative consequences in the workplace. Additionally, **68 per cent of respondents believed that disclosing their condition could lead to stigma in the workplace.**

These results highlight the significant barriers to open conversations about reproductive health in the workplace, emphasising the need for better support systems and policies to create a more inclusive and understanding work environment.

**Figure 4: Workplace support and concerns regarding reproductive health disclosure**




Notes: The percentages do not total 100% because participants were able to select multiple responses for the same question. The rates have been adjusted using population weighting.
Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive Health Leave Survey

## Reproductive health and mental health

The BCEC Reproductive Health Leave Survey also includes a set of questions designed to construct the ten-item Kessler Screening Scale for Psychological Distress (K10), a widely used measure in various studies to assess psychological distress (Kessler et al., 2002). However, the BCEC has adapted these items specifically to assess psychological distress concerning the reproductive health conditions experienced by respondents.

As a result, this K10 index does not measure overall psychological distress but rather the distress specifically linked to reproductive health issues. Due to this targeted approach, the findings are not directly comparable to other K10 indices used in broader health or other household surveys across Australia.

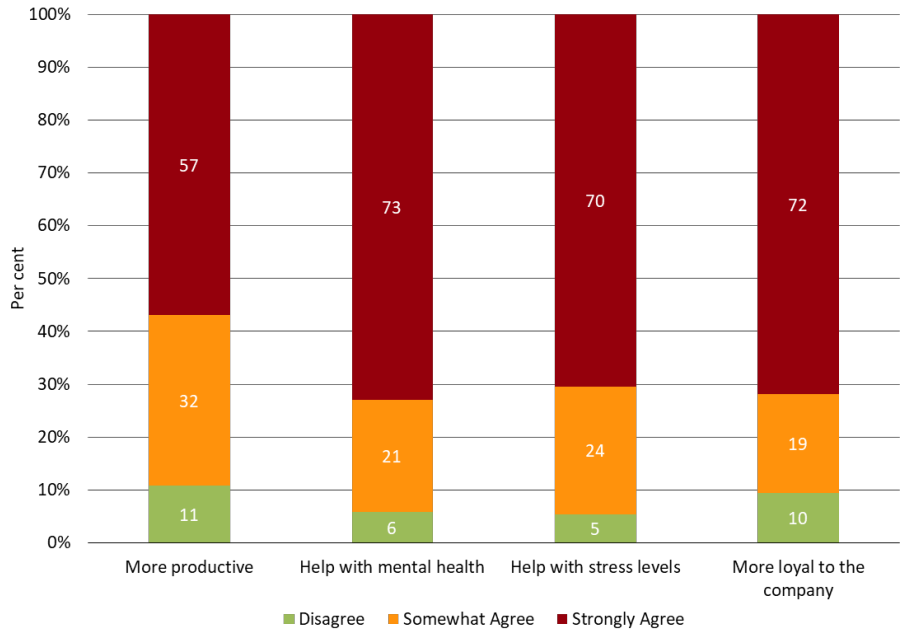
The results indicate that for 74 per cent of respondents, their reproductive health condition had a significant impact on their mental wellbeing. Eighteen per cent reported a moderate effect on their mental health, while the remaining 8 per cent indicated it had no impact at all. This highlights a possible connection between reproductive health and mental health, emphasising the need for supportive workplace policies and healthcare interventions to address these challenges.

## Attitudes toward reproductive health leave

The survey included a dedicated module designed to capture respondents' beliefs and attitudes toward reproductive health leave entitlements and benefits. This section aimed to assess perspectives for two different groups, those who had experienced a reproductive health condition and those who had not; this allows us to identify any disparities in their views.[5]

To gain deeper insights, respondents with a reproductive health condition were asked whether access to reproductive health leave would positively impact their productivity at work, mental health, stress levels, and sense of loyalty or belonging to their company.[6] The results, presented in Figure 5, indicate a very strong support for these statements.

**Figure 5: Perceived reproductive health leave benefits**




Notes: The percentages do not total 100% because participants may have chosen more than one response for the same question. The rates have been adjusted using population weighting. The sample consists of workers with a reproductive health condition who did not have access to reproductive health leave.
Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive health leave Survey

The vast majority of respondents expressed positive views on reproductive health leave. Specifically, 89 per cent believed it would improve their productivity, with 57 per cent strongly agreeing, 32 per cent somewhat agreeing, and 11 per cent disagreeing with such a statement. Similarly, 94 per cent felt it would benefit their mental health, including 73 per cent who strongly agreed and 21 per cent who somewhat agreed. Additionally, 95 per cent believed it would help reduce stress levels, with 70 per cent strongly agreeing. Lastly, 90 per cent indicated that reproductive health leave would enhance their sense of loyalty and belonging at work. These results highlight the widespread recognition of the potential for reproductive health leave to improve both employee wellbeing and workplace engagement.

[5] The survey also gathered insights from respondents who had access to reproductive health leave regarding their attitudes toward it. However, due to the limited sample size, since reproductive health leave is not widely available across all states in Australia, conducting a meaningful analysis was not feasible.
[6] These participants did not have access to reproductive health leave.

A comparative analysis of respondents with and without reproductive health conditions reveals notable differences in their opinions on reproductive health leave (Figure 6).

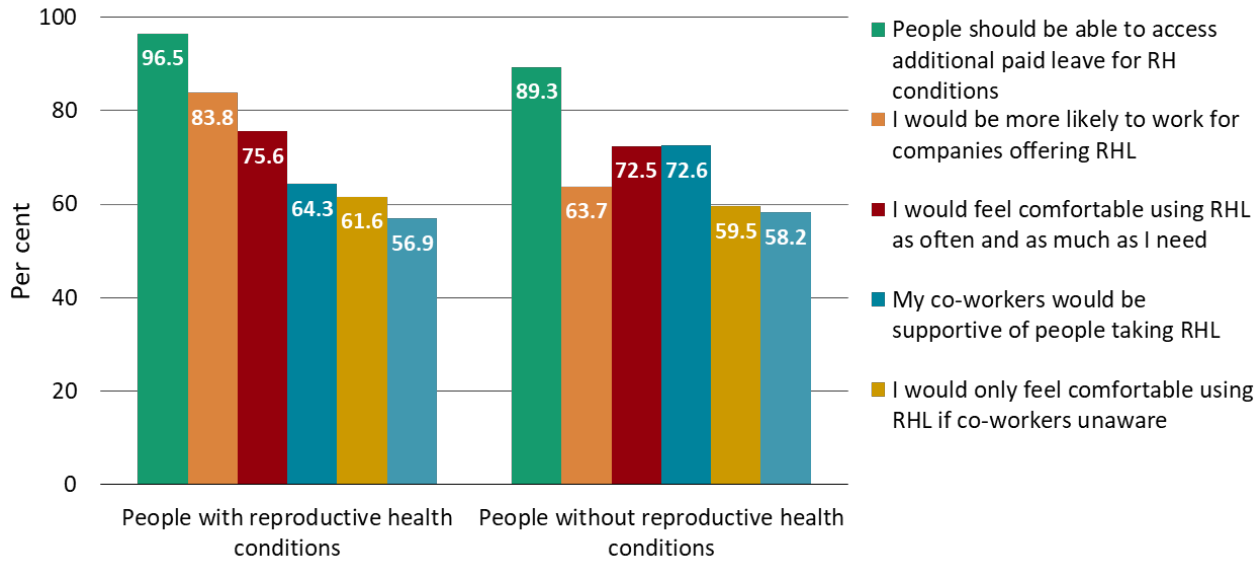
For example, 97 per cent of individuals with reproductive health conditions believe that people should have access to additional paid leave for reproductive health issues compared to only 89 per cent for those without such conditions. However, both groups share similar views on reproductive health leave accessibility. Seventy-six per cent of individuals with a reproductive health condition and 72 per cent of those without one believe that they will feel comfortable using reproductive health leave as often as needed. Likewise, 62 per cent of those with a condition and 60 per cent of those without would only feel comfortable requesting leave if their co-workers were unaware of what the leave is used for.

Interestingly, when asked about whether people's co-workers would be supportive if they accessed RHL, there is a ten percentage points gap in the responses between the groups of individuals with reproductive health conditions to those without such (64 to 73 per cent). This means that people experiencing health conditions feel that they would be less supported by their co-workers if they decided to take RHL.

It is important to point out that there is still a stigma attached to disclosing a reproductive health condition to an employer. Indeed, close to 60 per cent of the people declare that it is private and embarrassing to tell your employer you have a reproductive health condition.

Finally, respondents with reproductive health conditions have a strong preference for working for an employer that offers RHL provisions. They are 84 per cent more likely to prefer working for a company that offers reproductive health leave compared to only 64 per cent for those without conditions. This shows that if companies want to increase loyalty and recruit better personnel, it is advantageous to offer RHL to their employees. This is especially true in a sector where labour supply is rare. In those cases, providing RHL can make a difference in attracting better candidates.

**Figure 6: Support for reproductive health leave, comparing attitudes of employees with and without reproductive health conditions**




Notes: The percentages do not total 100% because participants may have chosen more than one response for the same question. The rates have been adjusted using population weighting.
Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive Health Leave Survey

Further analysis, presented in Figure 7, reveals that both individuals with and without reproductive health conditions largely dismiss the idea that reproductive health leave would be misused as an excuse to skip work (11 vs. 14 per cent). However, both groups share concerns that employers may use reproductive health leave as a basis for discrimination (70 vs. 69 per cent).

This means that even though people genuinely believe that people will not misuse RHL, they believe that employers will use it as an excuse to discriminate against women. This is an important concern that should be taken into consideration when deciding about the implementation of RHL.

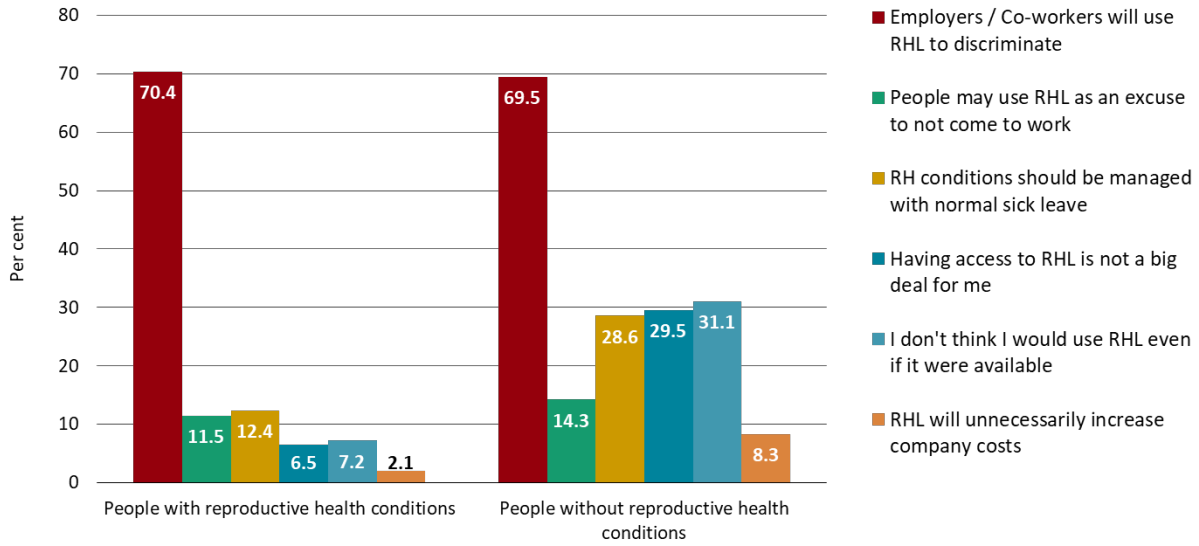
Finally, the survey found significant differences between the individuals with reproductive health conditions and those without in what concerns their attitudes towards RHL. The latter groups seem less empathetic and more dismissive of the importance of RHL for people experiencing difficulties related to their reproductive health condition.

Only 12 per cent of people with a reproductive condition believe that such conditions should be managed solely with sick leave compared to 29 per cent for those without reproductive health conditions. Individuals with reproductive health conditions are also four times less likely to state that RHL is not a big deal to them, with only 7 per cent holding this view compared to 30 per cent of those without such conditions. Similarly, just 7 per cent of those affected by a reproductive condition say they would not use reproductive health leave even if it were available to them, compared to 31 per cent of those without a condition.

Concerns about reproductive health leave imposing an unnecessary financial burden on employers are also lower among those with reproductive health conditions, at 2 per cent compared to 8 per cent in the other group.

These findings highlight a contrast in how reproductive health leave is perceived, with those directly affected by reproductive health conditions placing greater value on its availability and necessity.

**Figure 7: Concerns and attitudes toward reproductive health leave, a comparison between employees with and without reproductive health conditions**




Notes: The percentages do not total 100% because participants may have chosen more than one response for the same question. The rates have been adjusted using population weighting.
Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive Health Leave Survey

## Estimation of lost productivity of reproductive health conditions based on the BCEC survey

Reproductive health conditions entail significant costs to the economy in terms of lost productivity due to absenteeism and presenteeism associated with conditions such as menstrual pain, menopause, endometriosis and miscarriage. Many employees experience reduced efficiency due to absenteeism (missed workdays) and presenteeism (reduced performance while at work) (Schoep et al., 2019). These conditions can profoundly impact workplace performance, affecting both individuals and businesses.

This report provides data-driven estimates of the costs of lost productivity in Australia due to absenteeism and presenteeism related to reproductive health conditions based on the BCEC survey data.

### *Absenteeism*

The first step in the estimation of productivity loss involves identifying the number of employed people experiencing reproductive health issues. To do this, we use the prevalence rate obtained from the survey, which is calculated as the share of respondents that responded "yes" to the question: "In the last 12 months, have any of the following reproductive health conditions/procedures made it hard for you to work or prevented you from working?". For some of the conditions where there are not a sufficient number of responses for a given condition, such as vasectomy and hysterectomies, for instance, Medicare data is used instead to portray a more accurate picture of prevalence rates. Peer-reviewed articles and reports are also used as an alternative source in case Medicare data is not available.

Next, the proportion of employees who took time off work conditional on having a given condition is determined across age groups and gender categories based on the responses to the question "Thinking about the condition you had in the last 12 months. How did you manage this situation at work?". This is captured by the proportion of respondents that reported leave uptake of any kind to manage their conditions.

Absenteeism is then estimated by multiplying the number of employed people who took time off work for reproductive health reasons in the last 12 months by the median number of days of leave utilisation and the median daily wage rate by gender and age group. The data on workforce and wage rates, including the number of employees and average weekly earnings, are sourced from the Australian Bureau of Statistics (ABS) catalogue number 6337.0.

### *Presenteeism*

Presenteeism, on the other hand, is calculated by multiplying the number of days of decreased productivity in the last 30 days by the estimated average degree of lost productivity per day (on a scale from 1 to 10). These measures correspond to the results from the survey of the two following questions: "For how many of the days you've worked in the last 30 days do you feel your work productivity has diminished because of your menstrual pain issues?" and "On the days of diminished productivity at work in the last 30 days. On a scale from one to ten, on average, how much was your productivity impacted due to your menstrual pain?". This calculation provides the total number of days of lost productivity in the last 30 days. We then multiply it by the prevalence rates of people with

reproductive health conditions and the median wage rate by age group. The resulting figure indicates the presenteeism values per condition.

### *Total cost of lost productivity*

The total cost of lost productivity across all reproductive health conditions in Australia is estimated at $21.3b annually, mostly due to the large cost of presenteeism (Table 3). Looking at the breakdown by reproductive health condition, menopause is the largest contributor ($7.4b), with the cost of presenteeism ($6.5b) being about three times higher than that of absenteeism ($890m). Menstrual pain has the second largest impact on productivity ($4.8b loss), and presenteeism accounts for 95 per cent of the loss, at $4.5b. The loss in productivity related to endometriosis is estimated at $4.6b, and presenteeism accounts for over three-quarters of the cost ($3.6b).

The estimates show that menopause and menstrual symptoms, as well as endometriosis, often impair productivity while at work rather than from the impact of direct absences from work. For miscarriage, the estimate stood at $3.7b, with both absenteeism ($1.4b) and presenteeism ($2.3b) contributing relatively equally to the economic burden associated with this condition. Together, these four reproductive health conditions account for about 96 per cent of the total cost of lost productivity due to presenteeism and absenteeism.

**Table 3: Total estimated costs of lost productivity due to absenteeism and presenteeism related to reproductive health conditions ($million)**

| | Cost of absenteeism | Cost of presenteeism | Total |
|---|---|---|---|
| Menstrual pain | 255 | 4,536 | 4,791 |
| Perimenopause and menopause symptoms | 890 | 6,540 | 7,431 |
| Endometriosis or polycystic ovarian syndrome | 997 | 3,607 | 4,603 |
| Miscarriage | 1,370 | 2,306 | 3,676 |
| Others | 161 | 642 | 803 |
| **Total** | **3,673** | **17,631** | **21,304** |

Source: BANKWEST CURTIN ECONOMICS CENTRE| Authors' calculations based on data from BCEC survey, Medicare and ABS Cat. 6337.0.

The total costs of productivity loss associated with other reproductive health conditions, including IVF, vasectomy, hysterectomies, and pregnancy termination, are relatively negligible, estimated at $0.8b. All of these costs related to absenteeism and presenteeism capture the loss in productivity due to illness at work and do not include medical or other costs incurred.

These calculations show that the **cost of lost productivity due to presenteeism and absenteeism is estimated at $21.3 billion**. Menopause, menstrual pain, endometriosis and miscarriage contribute to most of this cost because of the heavy burden of presenteeism of these conditions.

## External estimations of economic costs of reproductive health conditions

To compare the estimates with the evidence in the literature, a rough estimate of the economic costs of lost productivity of reproductive health conditions in Australia can be estimated (based on evidence from external research).

Due to data availability, these costs only include the following conditions: intense menstrual pain, endometriosis and menopause symptoms. In this estimation, we will include the cost of absenteeism, presenteeism (loss of productivity while at work), medical expenses, carers' costs, and forgone wages and superannuation whenever available. Table 4 shows the conditions and studies used to estimate the cost of not implementing reproductive health leave as well as the type of cost included. Details of these studies can be found in Appendix A of this report.

**Table 4: Conditions and studies used to estimate the cost of not implementing reproductive health leave**

| Author | Year | Country | Condition | Costs included |
|---|---|---|---|---|
| O'Shea et al. | 2024 | Australia | Menstrual pain | Absenteeism, presenteeism, medical expenses, costs of carers |
| Armour et al. | 2019 | Australia | Endometriosis | Absenteeism, presenteeism, medical expenses, costs of carers |
| Malmberg et al. | 2024 | Nordic countries | Menopause | Absenteeism and presenteeism |
| AIST | 2023 | Australia | Menopause | Forgone wages and superannuation due to early retirement |

Source: BANKWEST CURTIN ECONOMICS CENTRE

The total cost of some of these studies has been calibrated to fit the Australian data to draw comparisons. These calibrations can be found in Appendix B of this report.

Given these calibrations based on evidence from external research, the estimated economic costs of reproductive health conditions can be as high as $26.55 billion annually. This estimate is slightly higher than the figure obtained using BCEC survey data due to differences in prevalence rates and estimated workdays lost per year due to presenteeism.

It is worth noting that these figures do not include all types of costs for all conditions as well as other relevant costs such as the value of foregone promotions, occupational changes, loss of employment and reduced hours of work. Neither do they include the replacement costs incurred by employers for recruitment and training new personnel in positions left by people suffering from reproductive conditions nor the government loss in taxation due to absenteeism, forgone wages or reduction in working hours.

# COST ANALYSIS OF PROVIDING A UNIVERSAL REPRODUCTIVE HEALTH LEAVE IN AUSTRALIA

## Data and estimation approach

In this section, we estimate the cost to employers of providing up to 12 days of paid reproductive health leave (RHL) to employees for three different scenarios of leave utilisation.

Most of the data needed to calculate this cost comes primarily from the survey conducted by the BCEC in partnership with the Health Services Union (HSU), the Health and Community Services Union (HACSU), the Queensland Council of Unions (QCU) and Aware Super. In addition to the survey data collected, some of the parameters are sourced from nationally representative datasets, including Medicare Statistics from Service Australia, the Australian Bureau of Statistics (ABS) and peer-reviewed journal articles.

This report provides the first comprehensive analysis of the prevalence of reproductive conditions and estimates the cost of paid universal RHL provisions in Australia.

The first step in the estimation of the cost of providing RHL to Australian workers is the same as the estimation of absenteeism numbers calculated for the purpose of productivity loss (previous chapter). It involves calculating the prevalence rates of health conditions as well as the leave utilisation per condition.

Having these key parameters, the cost of up to 12 days universal RHL provisions is estimated by multiplying the number of employed people who took time off work for reproductive health reasons in the last 12 months by the median number of days leave utilisation and the median daily wage rate for the respective gender and age group. The data on workforce and wage rates, including the number of employees and average weekly earnings, are sourced from the Australian Bureau of Statistics (ABS) catalogue number 6337.0.

## Estimations and analysis of results

Table 5 presents an overview of the prevalence rates of the major reproductive health conditions used in the analysis. The prevalence rate varies significantly across different age groups and types of reproductive health conditions. The table shows that the highest prevalence rate of menstrual pain is recorded for women in the age group of 25 to 34 (49.6 per cent), followed by the age group 35 to 44 (32 per cent). The prevalence of menstrual pain is the highest of all reproductive health conditions, representing close to half of the female employees of reproductive age.

For this exercise, the prevalence rates of menstrual pain have been modified to avoid a double counting of observations with people suffering from endometriosis. Endometriosis symptoms often include severe menstrual pain, and it is difficult to disentangle whether the number of days specified in menstrual pain are related to endometriosis symptoms or menstrual pain alone. Hence, to avoid double counting, all people who have answered that they experienced simultaneously menstrual pain and endometriosis symptoms are not counted in the prevalence rates of menstrual pain. Hence, the prevalence and leave utilisation of menstrual pain excludes people with endometriosis.

The prevalence rate for perimenopause and menopause starts as early as age 25 to 34 and peaks at ages 45 to 54, with 74.2 per cent of respondents in this age group reporting bothersome menopause symptoms. For endometriosis, the prevalence rates are the highest at age 35 to 54 before declining at a later age. It is worth noting the high prevalence rates of IVF for people of reproductive age (25-45

years old); close to 8 per cent of people in this group undertake an IVF treatment. The prevalence rates for the other reproductive health conditions also vary significantly across the age groups.

**Table 5: Prevalence rates of reproductive health conditions by age groups, Australia 2025**

| | Under 24 years | 25 to 34 years | 35 to 44 years | 45 to 54 years | 55 to 65 years |
|---|---|---|---|---|---|
| Menstrual pain | 24.2% | 49.6% | 32.0% | 25.9% | 0.0% |
| Perimenopause and menopause symptoms | 0.0% | 2.5% | 30.4% | 74.2% | 50.2% |
| Endometriosis or polycystic ovarian syndrome | 4.8% | 9.6% | 14.2% | 14.2% | 2.2% |
| In vitro fertilisation (IVF) or other forms of ART | 0.0% | 8.6% | 7.0% | 0.3% | 0.3% |
| Vasectomy (Service Australia - Medicare) | 0.0% | 0.5% | 1.2% | 0.4% | 0.0% |
| Hysterectomies (Service Australia - Medicare) | 0.0% | 0.0% | 0.2% | 0.0% | 0.0% |
| Miscarriage | 5.7% | 11.5% | 16.4% | 2.5% | 0.0% |
| Termination (ABS estimates based on South Australia) | 1.6% | 1.8% | 0.8% | 0.0% | 0.0% |

Notes: Vasectomy applies to males only, and IVF applies to both males and females. All remaining conditions apply to females only. ART=Assisted reproductive technology. The prevalence rate for menstrual pain excludes those that report endometriosis to avoid double counting. The prevalence rates for each age group do not vary by employment type (full-time vs part-time).
Source: BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations based on BCEC survey data and Medicare data.

Another key factor required for the computation of the cost of universal RHL is the estimated average number of days off work as a consequence of each of the reproductive health conditions. While it is ideal to elicit the information on the average number of days off work from the survey response to the question, "Could you tell us which type of leave you used and how many days you took?" there were no sufficient responses across the conditions.

To mitigate this issue, we use the responses from a hypothetical question that asks, "If you could have taken as much leave as you needed for your condition, how many days in total would you have taken in the last 12 months?". To adjust for potential response biases to this question, the number of days for leave utilisation are re-weighted using parameters from peer-reviewed articles in addition to the population weights applied across gender and age.

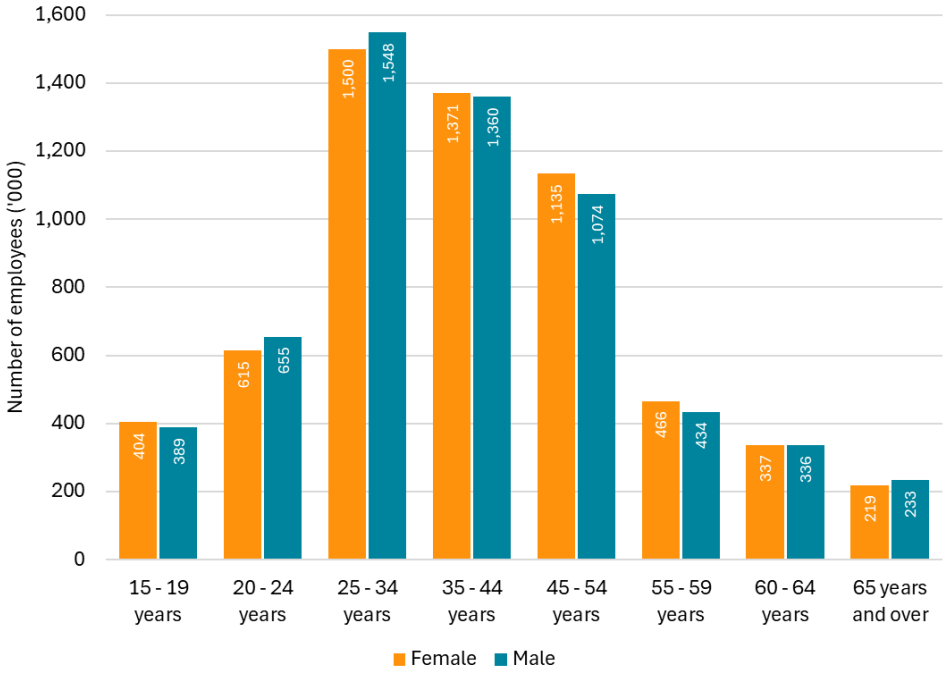
**Table 6: Median number of days off work related to reproductive health conditions**

| | Under 24 years | 25 to 34 years | 35 to 44 years | 45 to 54 years | 55 to 65 years |
|---|---|---|---|---|---|
| Menstrual pain | 12 | 10 | 12 | 12 | |
| Perimenopause and menopause symptoms | 0 | 10 | 10 | 7 | 9 |
| Endometriosis or PCOS | 12 | 10 | 12 | 10 | |
| In vitro fertilisation (IVF) or other forms of ART | 0 | 14 | 0 | 0 | |
| Vasectomy* | 2 | 2 | 2 | 2 | 2 |
| Hysterectomies* | 12 | 12 | 12 | 12 | |
| Miscarriage | 12 | 12 | 12 | 12 | |
| Termination* | 8 | 8 | 8 | 8 | |

Notes: Vasectomy applies to males only, and IVF applies to both males and females. All remaining conditions apply to females only. ART=Assisted reproductive technology, PCOS=polycystic ovarian syndrome. *Based on the literature. Weights are applied to the leave utilisation rates in the cost estimation to adjust for response bias.

Source: BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations based on BCEC survey data and evidence from literature.

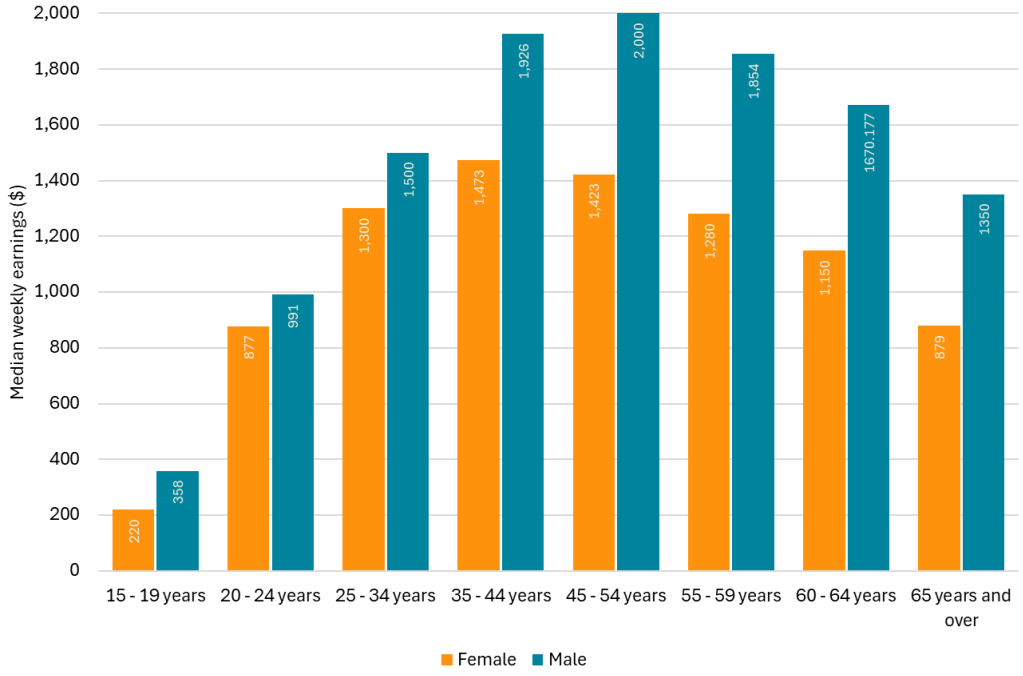
**Figure 8: Employed persons by age and gender, Australia, August 2024**




Source: ABS Cat: 6337.0 - Employee Earnings, Australia, August 2024.

To estimate the costs to employers of universal RHL provisions, we use data on employment and median weekly earnings by age and gender from the ABS's database of Employee Earnings (Cat. number 6337.0). Figure 8 shows the distributions of employed persons by age and gender. The number of employed people is the highest in the age group of 25 to 34 for both males and females followed by that of 35 to 44. There is no significant gender difference in the number of employed people across the age groups.

**Figure 9: Median weekly earnings for employees by age and gender ($), Australia, August 2024**




Source: ABS Cat: 6337.0 – Employee Earnings, August 2024.

Despite the narrow differences in terms of the number of employed persons by gender, there is a significant gender gap in the median weekly earnings of employees across all age groups (Figure 9). In each age group, the median weekly wage for females is consistently lower than that of males. The gender pay gap is more pronounced after age 35, when most women would have decided to have children. The median weekly wage for both genders increases with age first, peaking in middle age and declining thereafter. These substantial variations in the wage distributions across age groups indicate that it is essential to account for these variations using age and gender cohorts in the estimations of the costs of universal RHL provisions. This has significant implications for policies related to RHL provisions and other initiatives aimed at narrowing the gender gap in wages.

Having estimated the prevalence rates for each major reproductive health category and making use of the employment and weekly median earnings data, the costs of up to 12 days of paid RHL provision are estimated using a bottom-up approach by age and gender.

Table 7 presents an example of the calculations in the case of menstrual pain. Based on the parameters obtained from the BCEC survey, the estimated cost of providing up to 12 days of RHL related to menstrual pain is about $219 million. A similar approach is utilised to estimate the costs of RHL provisions across all reproductive health conditions. The total cost estimates of RHL provision are reported in Table 8.

**Table 7: Estimation procedures of the cost of universal RHL provision in the case of menstrual pain by age groups**

| | Under 24 years | | 25 to 34 years | | 35 to 44 years | | 45 to 54 years | | 55 to 65 years | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Full-time | Part-time | Full-time | Part-time | Full-time | Part-time | Full-time | Part-time | Full-time | Part-time |
| Employed persons, Aug 2024 ('000s), ABS Cat. 6337 | 305 | 714 | 1,018 | 483 | 834 | 538 | 747 | 388 | 516 | 506 |
| Median weekly earnings, Aug 2024 ($), ABS Cat. 6337 | 1,232 | 591 | 1,534 | 773.1 | 1,816 | 937 | 1,725 | 900 | 1,600 | 836 |
| Prevalence (%) (BCEC survey) | 24% | 24% | 50% | 50% | 32% | 32% | 26% | 26% | 0.0% | 0.0% |
| Estimated number of employed people experiencing menstrual pain, ('000s) | 74 | 173 | 504 | 239 | 267 | 172 | 194 | 101 | 0.0 | 0.0 |
| Projected share of those experiencing - time off work (BCEC survey) | 24% | 24% | 29% | 29% | 27% | 27% | 0% | 0% | 0% | 0% |
| Leave utilisation median day (BCEC survey) | 2.4 | 2.4 | 2.0 | 2.0 | 2.4 | 2.4 | 2.4 | 2.4 | 0.0 | 0.0 |
| Estimated cost of RHL provisions ($m) | **11** | **12** | **90** | **22** | **64** | **21** | **0** | **0** | **0** | **0** |
| **Estimated total cost of RHL provisions ($m)** | **219** | | | | | | | | | |

Notes: Weights are applied to the leave utilisation rate to adjust for response bias.
Source: BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations based on BCEC survey and ABS labour force survey data.

Reliable estimations of universal RHL provision are a crucial aspect of financial planning, operational efficiency, and long-term sustainability of employers across Australia. This report utilises a data-driven approach to estimate the cost of paid RHL provisions under three scenarios: low, medium and high leave uptake rates. Under the low scenario, the key assumption is minimal uptake of leave. The medium scenario is our benchmark scenario as it reflects the most realistic projection of leave utilisation. The high scenario accounts for model uncertainty by including the maximum uptake of RHL provisions, which informs the upper-case scenario of the cost estimate.

Based on our estimates, **the total cost to employers of providing up to 12 days of universal RHL entitlements is estimated to be in the range of $2.3b under the low scenario to $5.9b under the high scenario**, with the preferred mid scenario valued at $3.6b annually (Table 8).

A closer look at costs of RHL by employment type reveals that full-time employees account for $2.7b, equivalent to about three-quarters of the total RHL cost to employers, while part-time employees account for $864 million (24.2 per cent) under the preferred scenario. Given the nature of reproductive health, over 99 per cent of the estimated cost is associated with women's reproductive health leave provisions. Menstrual pain, menopause, endometriosis and miscarriage account for the largest share of the cost, accounting for over 95 per cent of the total combined cost under the medium scenario.

**Table 8: Estimated total costs of RHL provisions ($m)**

| | Estimated cost ($m) | | |
|---|---|---|---|
| Scenario | Full-time | Part-time | Total |
| Low | 1,756 | 557 | 2,313 |
| Medium | 2,707 | 864 | 3,571 |
| High | 3,605 | 1,164 | 5,884 |

Source: BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations based on BCEC survey and Medicare data and ABS Cat 6337.0.

To put that in perspective, in per capita terms**, the total cost of RHL per employed person is about $296 per year in the benchmark scenario** and a maximum of $487 for the high scenario. These figures show that the cost per employee is not considerable relative to the overall payroll costs to employers. Additionally, these estimations do not include any possible offset costs arising from the benefits of providing RHL.

# MITIGATED COSTS OF IMPLEMENTING REPRODUCTIVE HEALTH LEAVE

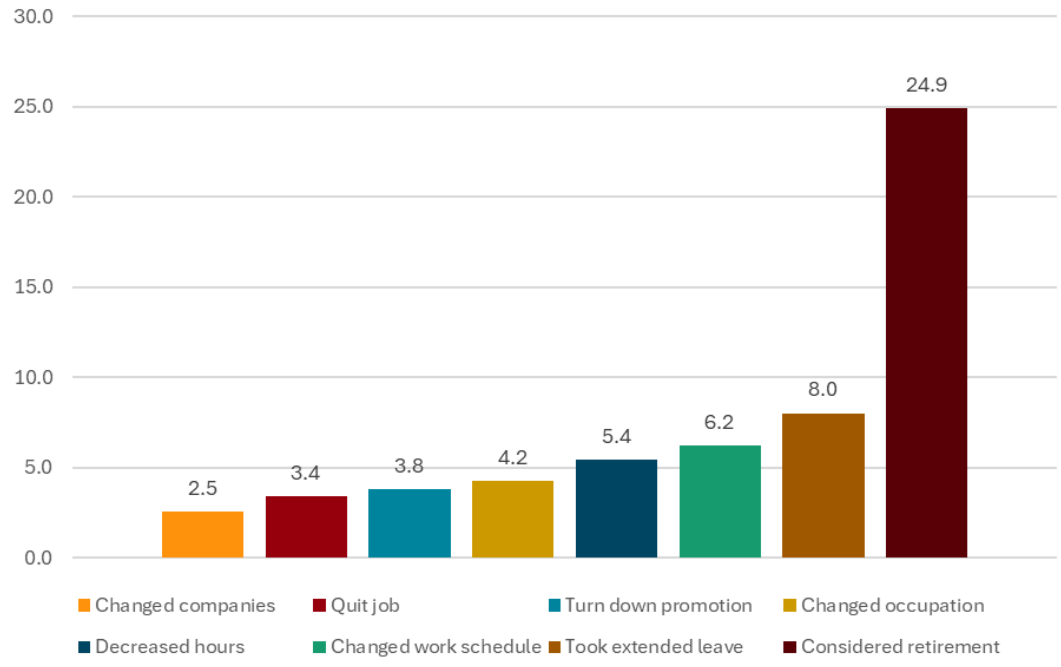
As we have seen in previous chapters, implementing RHL has non-negligible financial costs to the economy. However, important spillovers will also benefit companies and employees. The benefits arising from providing RHL can be seen as offset costs, and even though they might not be able to completely compensate for the cost of implementing such a policy, it would definitely decrease its price tag. This chapter estimates the offset costs and benefits of implementing a nationwide RHL under three different scenarios.

The financial implications of not implementing reproductive health leave are linked to the economic loss of people's forgone wages and decreased income due to working part-time, taking time off or losing the opportunity to work due to reproductive conditions. However, it also includes the economic loss related to presenteeism and the loss of productivity from people who decide to go to work while experiencing severe symptoms.

The parameters necessary for this calculation are based on the results of the BCEC's RHL survey. This survey has not only collected information on employees' reproductive health conditions but also gathered data on the number of people who suffered from significant work disruptions as a consequence of their reproductive health issues.

Figure 10 examines the impact of reproductive health conditions on workplace experiences and career decisions. It shows the percentage of people with reproductive health issues who suffered an adverse work event in the last 12 months as a result of their condition.

**Figure 10: Percentage of people with any reproductive health conditions suffering an adverse work event in the last 12 months, by type of adverse event, Australia**




Notes: The percentages do not total 100% because survey participants may have chosen more than one response or none of them. 61% of the respondents chose "none of the above" in this survey question. The rates have been adjusted using population weighting.

Source: Bankwest Curtin Economics Centre | Authors' calculations from the BCEC Reproductive health leave Survey

People having considered retirement in the last 12 months is by far one of the most significant adverse work events for people with reproductive health conditions. This result is largely driven by women experiencing menopause who do not see any other choice but to leave the labour force to cope with perimenopause and menopause associated symptoms. The rest of the workplace adverse disruptions have much smaller rates, varying from 2.5 per cent for people changing companies to 8 per cent for employees taking extended leave from work.

Six per cent of respondents modified their work schedules to accommodate their health needs, while 5.4 per cent reduced their working hours. Additionally, 4 per cent transitioned to a different role within their company, and 3.8 per cent declined a promotion opportunity. Career mobility was also affected, with 2.5 per cent changing employers, 8 per cent switching occupations, and another 3.4 per cent leaving their jobs entirely. These findings highlight the significant impact that reproductive health issues can have on workforce participation, career progression, and long-term employment decisions.

We use these parameters, along with our presenteeism estimates presented in the previous chapter, to calculate the offset costs of implementing RHL under three different scenarios. The first conservative scenario is based on adverse workplace outcomes being improved for 3 per cent of the people having experienced an adverse disruption in employment. The second scenario is our benchmark scenario for which outcomes are improved for 5 per cent of people having a major workplace event, and our most generous scenario improves outcomes by 8 per cent. These scenarios are relatively conservative as they do not imply a substantial shift in workplace disturbances.

The outcomes under our benchmark scenario are described below. This scenario improves the outcomes of 5 per cent of the employees experiencing a significant adverse work event and productivity loss.

**(1) Increased productivity**: Implementation of RHL would limit by 5 per cent the loss in productivity (presenteeism) of people experiencing reproductive health conditions.

**(2) Decrease the number of people reducing working hours:** Implementation of RHL will increase by 10 per cent (or by half a day for full-time workers) the number of working hours of 5 per cent of people who had to decrease their number of working hours due to their reproductive health condition.

**(3) Decrease the number of people turning down a promotion:** Implementing RHL will increase by 10 per cent the wages of 5 per cent of the people who turned down a promotion because of their reproductive health condition.

**(4) Prevented people from taking extended periods of leave from work:** Implementation of RHL will prevent 5 per cent of the people who took extended leave from taking 40 days of leave.

**(5) Prevented people from leaving their job:** Implementation of RHL will prevent 5 per cent of the people quitting their job from leaving the workforce, hence, preventing forgone wages.

**(6) Decrease the number of people changing occupations:** Implementation of RHL will increase by 10 per cent the wages of 5 per cent of the people that had to change their occupation due to their reproductive health condition.

**(7) Diminish turnover cost of companies:** Implementation of RHL will prevent 5 per cent of the people who had to leave their jobs due to reproductive health conditions from leaving their place of work. Turnover costs are evaluated conservatively at $5,000 per lost employee.

**(8) Prevented people from retiring:** Implementing RHL will prevent 5 per cent of people from retiring due to their reproductive health conditions. We assume that 10 per cent of the people

answering that they have considered retirement due to reproductive health conditions would eventually end up retiring.

The calculations of the offset costs of providing RHL for the three scenarios are presented in Table 9. It is worth pointing out that the offset costs do not include any diminished costs of absenteeism. This is because it is expected that the number of people taking leave for reproductive health conditions and the amount of leave that they take will not decline as a consequence of RHL. However, improvements in productivity loss and adverse work events will likely occur. The offset costs range from $1.1 billion for the low scenario to $3 billion for the high-end scenario.

**Table 9: Offset costs of implementing reproductive health leave, three different scenarios (3%, 5% and 8%), in thousands of AUD.**

| Offset costs considered | Offset costs (3%) | Offset costs (5%) | Offset costs (8%) |
|---|---|---|---|
| (1) Increased productivity | 536,129 | 893,548 | 1,429,678 |
| (2) Decreased the number of hours at work | 23,051 | 38,418 | 61,468 |
| (3) Turned down a promotion | 17,370 | 28,950 | 46,320 |
| (4) Took extended leave from work | 57,955 | 96,591 | 154,546 |
| (5) Quit job | 190,152 | 316,920 | 507,073 |
| (6) Changed occupation | 22,379 | 37,298 | 59,678 |
| (7) Decreased turnover costs | 90,332 | 150,554 | 240,886 |
| (8) Considered retirement | 190,715 | 317,858 | 508,572 |
| **Total** | **1,128,083** | **1,880,138** | **3,008,221** |

Source: BANKWEST CURTIN ECONOMICS CENTRE | Authors' calculations based on BCEC's Reproductive Health Leave survey.

Under a benchmarked scenario, **the benefits of providing reproductive health leave are estimated to be $1.88 billion annually**. If we compare the offset of providing RHL with its direct financial costs, this ratio equals 53 per cent under the mid-range scenario. This means that even though RHL implementation is likely to cost $3.5 billion, **just over half of the costs can be offset by the benefits to businesses** in terms of increased productivity, lower turnover rates and decreased modifications of the composition and structure of the labour force.

Depending on the combination of scenarios between direct financial costs and cost offsets, this ratio can vary from 19 to 100 per cent of recovery costs.

Increases in the productivity of people with reproductive health conditions represent the largest cost offset at around $890 million (5 per cent scenario). This is followed by the recovery of forgone wages of people whose retirement was prevented thanks to RHL ($320 million) or those that have left their job ($315 million). Another large benefit also comes from the decline in turnover costs for companies, which will recover $150 million in avoided hiring costs.

The gain in productivity can indeed be significant. This was illustrated earlier by the answers to the RHL survey (see Figure 5) where people were asked their opinions on how having access to RHL could affect their productivity, mental health and levels of stress. The results were unequivocal. Close to 90 per cent of people with reproductive health conditions believed that access to RHL would increase their productivity and enhance their sense of loyalty to the company. Similarly, 94 per cent felt it

would benefit their mental health and reduce stress levels. These metrics show that RHL will significantly improve the productivity of workers with reproductive health conditions.

Hence, the costs of providing RHL need to be measured against the benefits and spillover effects of such measures. The improvement in people's mental and physical health, the reduction of stress levels and the increased sense of belonging to the company can have considerable effects on people's productivity and adverse career decisions. This will not only lead to better economic outcomes for companies but also lead to improved health and wellbeing outcomes for the overall population.

## OTHER BENEFITS OF IMPLEMENTING REPRODUCTIVE HEALTH LEAVE POLICIES

There are multiple benefits to implementing reproductive health leave beyond providing people with the necessary time off to treat and heal their conditions.

### Reservation of sick leave

Reserving sick and personal leave for other health conditions and caring responsibilities will provide people with reproductive health conditions with equitable access to workplace leave. This means that employees with reproductive health conditions will be able to use their sick leave for general health issues and won't have to use all their leave entitlements to treat that condition.

### Normalising discussion about reproductive health issues

Importantly, implementing reproductive health leave will help normalise discussions about reproductive health issues. There is scientific evidence that topics like menstrual pain, menopause, ART, terminations and miscarriages are considered taboo in the workplace and are rarely discussed with colleagues and managers (Grandey et al., 2020). But, if reproductive health leave was available, people would be, for instance, more likely to discuss their pregnancy earlier in the journey. If they happened to have a miscarriage, they would be more likely to talk about it if they were able to take leave for it. Normalising reproductive health conditions would make people more knowledgeable and understanding of other people's situations.

# RISKS ASSOCIATED WITH THE IMPLEMENTATION OF REPRODUCTIVE HEALTH LEAVE POLICIES

It is important to understand that other than the financial cost of implementing reproductive health leave, there are other risks related to implementing such a policy.

## Perpetuation of stereotypes

First of all, the introduction of reproductive health leave is more likely to benefit women than men as women suffer from more reproductive health conditions than men. As a result, reproductive health leave could perpetuate stereotypes of women being weaker, less reliable and more expensive workers than men. This is the argument put forward by King (2020) about menstrual leave contributing to menstrual stigma instead of normalising it. This will, in turn, worsen discrimination in the workplace against women. Indeed, the BCEC survey shows that 65 per cent of respondents with reproductive health issues did not tell their manager because they were concerned about stigma.

While the stigmatisation of people taking menstrual leave can happen in the case of a type of leave directed exclusively to menstrual pain, this is less likely to be the case for reproductive health leave. This is because reproductive health leave encompasses multiple conditions. Hence, when employees take reproductive health leave, other workers or managers will not necessarily know which condition the leave is being taken for. As a result, this would reduce the stigma attached to a particular reproductive condition.

## Discrimination against women in the workplace

It is hard to predict whether reproductive health leave will have an impact on workplace discrimination against women. Women will indeed be more likely to take reproductive health leave as they are affected by more reproductive conditions than men. However, it is hard to predict if employers will modify the number of women they recruit or if they will avoid promoting or passing on responsibilities and opportunities to women of a certain age. Regarding public perception, fewer than 8 per cent of BCEC survey respondents believe that reproductive health leave would lead to higher company costs.

For instance, women in their 50s will be considered more expensive as they will be more likely to use reproductive health leave due to menopause, hence, employers may prefer to promote or hire a man or a woman of another age instead. Discrimination in the workplace still occupies women's minds, and some women fear that reproductive health leave may exacerbate it. For example, the BCEC survey reveals that 70 per cent of respondents are concerned that employers might use reproductive health leave as a basis for discrimination. Similarly, previous studies show that more than four in five women agree that some employers or co-workers would not understand if someone took menstrual/menopause leave, and three-quarters of women agree with the statement that some employers or co-workers would use menstrual/menopause leave to discriminate against women (Jean Hailey, 2023(c)).

## Absence of support from workers

Another risk of implementing reproductive health leave can come from the absence of support from other workers. For instance, in a US study on menstrual leave, 15 per cent of people thought that women would likely abuse the policy and use it even if they didn't need it; this compares to 12 per cent in the BCEC survey in the Australian context. Another 33 per cent of people thought menstrual leave would have implications in the workplace, and 21 per cent wondered what men would get out

of it (Barnack-Tavlaris, 2019). The latter argument is less likely to weigh in the case of reproductive health leave since reproductive health leave will benefit both men and women.

Nevertheless, in Australia, there is some evidence that workers are generally supportive of reproductive health leave. The BCEC survey indicates that more than 90 per cent of respondents support the provision of additional paid leave for individuals with reproductive health conditions and close to 70 per cent believe their co-workers will be supportive if they accessed reproductive health leave. Similarly, the 2023 National Women's Health Survey found that 63 per cent of women endorse the introduction of period leave, while 65 per cent support leave for menopause (Jean Hailey, 2023(c)). People with more severe symptoms of menstrual pain or menopause show higher support rates than those with mild symptoms.

## Failed implementation and execution of reproductive health leave

It is worth noting that the implementation of reproductive health leave and its variations is not always successful. Policy execution and cultural norms seem to play a big role in defining the success of reproductive health leave. For instance, leave uptake is low in some countries with menstrual or menopausal leave due to embarrassment or concerns of discrimination. Menstrual leave still divides women in Japan and Indonesia, where blue-collar women support the policy and white collar women oppose it. This is mainly due to poor hygienic conditions experienced by women working in factories, resulting in them being more likely to take leave (see Baird et al., 2020).

In Australia, leave uptake could also be a concern, as shown in the 2023 National Women's Health Survey. This survey shows that less than half of the respondents would be comfortable asking for menstrual/menopause leave as often and for as much time as needed. Only when the symptoms are severe do women feel free to take leave (Jean Hailey, 2023(c)). On the other hand, the BCEC survey shows that 70 per cent of the respondents feel comfortable enough to ask for or use reproductive health leave as often and for as much time as needed. Also, 84 per cent of respondents continue to work despite facing reproductive health challenges. Meanwhile, 61 per cent took leave, whether paid or unpaid, to manage their condition, and 27 per cent opted to work from home. Additionally, 8 per cent used formal flexible work arrangements, while 13 per cent relied on informal flexibility to accommodate their needs.

Furthermore, Australian women still feel embarrassed and do not want to talk about their menstrual/menopause health issues. In the BCEC survey, 45 per cent of participants indicated that they preferred to keep their reproductive health condition private from their manager and colleagues. Additionally, 68 per cent reported that their manager was unaware of their condition. Previous studies also show that more than 60 per cent of women agree with the statement "It is private and embarrassing to tell your employer you have your period", and half of them would only be comfortable asking for menstrual leave as long as their co-workers didn't know what it was for (Jean Hailey, 2023(c)).

Some of these issues could be avoided by implementing a reproductive health leave policy instead of a targeted menstrual and/or menopause leave policy. Given the fact that reproductive health leave is broader, people are likely to feel less embarrassed to ask for leave and more likely to take it.

# OTHER POLICIES AND WORKPLACE ENTITLEMENTS HELPING PEOPLE WITH REPRODUCTIVE HEALTH CONDITIONS

While reproductive health leave is the main focus of this study, other company policies have proved to be effective in increasing the wellbeing of people with reproductive health conditions. As a consequence, people are less likely to miss work and have higher productivity if they work while sick.

Flexible work arrangements are one of the main policies that can help people going through reproductive health conditions. Some flexibility in starting and finishing shifts and having a sense of control over one's timetable decreases the number of days people miss from work (Safwan et al., 2024). The BCEC survey supports this perspective, revealing that 27% of respondents with reproductive health conditions chose to work from home, 8% used formal flexible work arrangements, while another 13% relied on informal flexibility.

There is also scientific evidence that increased awareness of reproductive health conditions by managers as well as employees has a significant impact on people's experiences of menopause and menstrual symptoms (Griffiths et al., 2013). Raising awareness of reproductive conditions as potential issues in occupational health and training managers to make necessary adjustments for people with reproductive conditions is paramount (Fenton & Panay, 2014). Awareness campaigns to help normalise and make employees support people with reproductive health conditions are important; this will allow workers to have a positive attitude and not feel embarrassed talking about reproductive conditions (Fenton & Panay, 2014). Information and advice from employers about reproductive health conditions and their impact in terms of productivity and job structure can also be helpful, along with access to informal support in the workplace (Griffiths et al., 2013). Also, the BCEC survey highlights overwhelmingly positive attitudes toward reproductive health leave and its benefits, with 89 per cent of respondents believing it would boost productivity, 94 per cent seeing benefits for mental health, 95 per cent stating it would help reduce stress, and 90 per cent feeling it would strengthen their sense of loyalty and belonging in the workplace.

Supportive environments with flexible work arrangements, working from home access, flexible work schedules and strong management support play a role in decreasing the experienced symptoms of menopause, as shown by Bariola et al. (2017).

Individual control over the work environment can help reduce the symptoms of some reproductive health conditions. For instance, having access to air conditioning and being able to control room temperature improves the experience and productivity of women experiencing menopause and going through hormonal treatment for IVF purposes (Bariola et al., 2017). Even though the impact of working from home on people with reproductive conditions has not yet been studied in the literature, this working arrangement is likely to improve people's control over their work environment. This will, in turn, improve people's wellbeing and provide better management of their symptoms, as explained by Brewis (2020).

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# APPENDIX A: AVAILABLE STUDIES ON PRODUCTIVITY LOSS RELATED TO REPRODUCTIVE HEALTH CONDITIONS

There are a few studies that try to estimate the costs of loss productivity of reproductive health conditions. A compilation of the available studies on this matter, with a particular focus on the case of Australia, is shown below.

### *Menstrual pain and endometriosis*

The cost of menstrual pain and endometriosis bears the highest cost among reproductive conditions. According to recent work by O'Shea et al. (2024), the estimated economic cost of intense menstrual symptoms in Australia is $14 billion per year. Most of the productivity costs come from absenteeism, which accounts for 59 to 68 per cent of the total productivity loss, depending on age. Women in middle age are the ones bearing the highest costs. Furthermore, in conditions like endometriosis and chronic pelvic pain, it is estimated that the total economic burden equals $6.5 billion every year (Armour et al., 2019), assuming a 10 per cent prevalence rate. Most of this cost (75 to 84 per cent) comes from lost productivity, with presenteeism accounting for almost 60 per cent of all lost productivity.

### *Perimenopause and menopause*

Studies on the cost of lost productivity due to absenteeism and presenteeism in Australia in perimenopause and menopausal women do not exist at the moment. However, some international studies could shed some light on these costs. A study from the Mayo Clinic shows that absenteeism in the US due to menopause symptoms accounts for USD $ 1.8 billion annually. However, this study does not include productivity loss due to presenteeism, loss of employment, reduced working hours and early retirement (Faubion et al., 2023). Another study, this time in the Nordic countries, found that the loss in productivity per year equates to 250 million euros in Denmark, 520 million euros in Norway and 400 million euros in Sweden (Malmberg et al., 2024). The total loss in productivity of all Nordic countries is close to 1.4 billion euros. It is worth noting that the combined population of the Nordic countries is similar to that of Australia (27 million). Presenteeism accounted for 64 per cent of productivity loss in Denmark, 86 per cent in Norway and 90 per cent in Sweden.

Some approximations about the cost of early retirement have been done in Australia by the Australian Institute of Superannuation Trustees (AIST). They estimated that menopause costs $17 billion to women due to forgone wages and superannuation for every year of early retirement. This amounts to $112 billion over the total lifespan, as the early retirement of women is, on average, 7.4 years earlier than men (AIST, 2023). However, as pointed out by Jean Hailes (2023 (b)), this is likely to be an overestimate as the parameters of their model were based on a prevalence rate of 25 per cent of women taking prolonged absences from work or going into early retirement due to the severity of the menopause symptoms. According to the Jean Hailes study, this rate is more likely to be 17 per cent.

### *Other reproductive health conditions*

To our knowledge, there exists no study on the cost that ART and IVF have on presenteeism and absenteeism in the workplace, nor of the physical or psychological consequences on work performance and productivity. Hence, it is difficult to estimate the cost of these treatments on people's working lives.

Only one study has considered the implications of miscarriages on labour market participation to our knowledge. A recent paper by Kalsi and Liu (2024) in the US estimates that after a first miscarriage,

women's annual wages fall on average by USD$1,800 in the first year after miscarriage and by close to USD$5,000 each year after that (for a consecutive period of seven years). This amounts to an income loss of 18 per cent. This is mainly due to reduced hours of work and fewer weeks of work per year. As the consequences of terminations and abortion on people's productivity are unclear, no study looks at the financial cost of this procedure on workplace outcomes.

# APPENDIX B: CALIBRATION OF THE CURRENT STUDIES ON LOST PRODUCTIVITY TO FIT THE AUSTRALIAN SCENARIO

The economic cost of lost productivity of reproductive health conditions can be estimated for Australia based on the existing literature. This estimation will allow us to compare our own estimates of lost productivity. The main studies used for this estimation are found below:

| Author | Year | Country | Condition | Costs included |
|---|---|---|---|---|
| O'Shea et al. | 2024 | Australia | Menstrual pain | Absenteeism, presenteeism, medical expenses, costs of carers |
| Armour et al. | 2019 | Australia | Endometriosis | Absenteeism, presenteeism, medical expenses, costs of carers |
| Malmberg et al. | 2024 | Nordic countries | Menopause | Absenteeism and presenteeism |
| AIST | 2023 | Australia | Menopause | Forgone wages and superannuation due to early retirement |

However, in order to take into account new developments in research and to fit some international studies to the Australian context, some calibrations have been implemented:

- The AIST calculation has been calibrated to a modified prevalence rate of 17 per cent rather than the original 25 per cent. This is because the AIST calculations are based on ABS data that shows that 25 per cent of women take an early retirement at the age of menopause, and hence, it is quite likely that these workers decide to retire due to bothersome menopause symptoms. However, some women decide to retire early, without menopause being the main cause. The new calibration comes from the 2023 Women's Health Survey, which finds that 17 per cent of women took an extended leave from their profession due to menopause symptoms.
- Additionally, the estimations of the Nordic countries have been adjusted to fit Australia's labour force participation. Indeed, the labour force participation of Australian women is much lower than in the Nordic countries. On average, 78 per cent of women are employed in the Nordic market compared to only 63 per cent of Australian women. Furthermore, labour costs and prevalence rates of Australian employees are closer to that of Sweden than to the rest of the Nordic countries, hence, we take Sweden's per person costs as a benchmark.

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