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**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Health benefits of breastfeeding

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING
Monday, 26 March 2007

Members: Mr Somlyay (*Chair*), Mr Georganas (*Deputy Chair*), Mr Cadman, Mrs Elliot, Mrs Elson, Mr Entsch, Ms Hall, Mr Johnson, Ms King and Mr Vasta

Members in attendance: Mrs Elliot, Mr Entsch, Mr Georganas, Ms Hall, Ms King, Mr Somlyay and Mr Vasta

Terms of reference for the inquiry:

To inquire into and report on:

How the Commonwealth government can take a lead role to improve the health of the Australian population through support for breastfeeding. The Committee shall give particular consideration to:

- a. the extent of the health benefits of breastfeeding;
- b. evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities;
- c. the potential short and long term impact on the health of Australians of increasing the rate of breastfeeding;
- d. initiatives to encourage breastfeeding;
- e. examine the effectiveness of current measures to promote breastfeeding; and
- f. the impact of breastfeeding on the long term sustainability of Australia's health system.

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Committee met at 10.35 am

CHAIR—I now declare open this public hearing of the House of Representatives Standing Committee on Health and Ageing for its inquiry into the health benefits of breastfeeding. This is the first public hearing for the inquiry. The inquiry is exploring the health benefits of breastfeeding in considering how the government can take a lead in improving the national health by supporting and promoting the practice.

At today's public hearing the committee will hear from the Commonwealth Department of Health and Ageing. Also appearing today is the National Health and Medical Research Council—the NHMRC. The NHMRC will provide evidence on encouraging and supporting breastfeeding, which is part of the dietary guidelines for children and adolescents in Australia. The committee will also take evidence from Dr Julie Smith on the economic benefits of breastfeeding. Our last witness for today is Mrs Charndra Pile, a mother who is currently breastfeeding. It will give us a more personal perspective.

The hearing is open to the public and a transcript of what is said will be placed on the committee's website. If you would like further details about the inquiry or transcripts, please ask any of the committee staff here today at the hearing.

[10.37 am]

BRYANT, Ms Jennifer, First Assistant Secretary, Population Health Division, Department of Health and Ageing

LEARMONTH, Mr David, Deputy Secretary, Department of Health and Ageing

PATON, Ms Lesley, Director, Nutrition Section, Department of Health and Ageing

CHAIR—I welcome representatives of the Department of Health and Ageing. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I now invite you to make a brief, introductory statement before we pass on to questions.

Mr Learmonth—First of all, I should apologise to the committee for not having lodged a submission prior to the hearing. We do undertake to get one to the committee as soon as possible. But I do owe the committee an apology for that.

Beyond that, I would like to make a couple of brief remarks. The Australian government supports the recommendations made by the World Health Organisation and the NHMRC to exclusively breastfeed infants to six months of age, followed by the introduction of complementary foods with continued breastfeeding to 12 months of age and beyond if desired. We recognise that it gives the best nutritional start to infants and reduces their risks of developing obesity, cardiovascular disease and other chronic diseases later in life.

We do note that Australia has one of the highest rates of initiation of breastfeeding: 2001 national survey results indicate that 87 per cent of infants start their lives being breastfed but rates do decline somewhat by three months of age and thereafter. The rates of breastfeeding amongst Australian Indigenous women are variable. They are, however, commonly regarded as roughly comparable with those for the non-Indigenous population. It appears that the duration of breastfeeding rather than the initiation is the key here and, accordingly, we look to strategies that encourage mothers to extend the duration of breastfeeding.

The Australian government has been a strong supporter of breastfeeding in a number of ways in terms of promotion to consumers, to the public and advice to health professionals and others. I will outline just a few ways—and certainly this is not exhaustive—in which the government supports breastfeeding.

First of all, we fund the Australian Breastfeeding Association and we have done so, for example, to the tune of \$910,000 over the previous 10 years. The current funding agreement to the Australian Breastfeeding Association provides \$300,000 to help them develop and distribute a range of educational resources to existing and training of breastfeeding counsellors and community educators and to coordinate, promote and publicise the lactation resource centres resources to provide the latest research to health professionals in the wider community.

The government funds the Healthy for Life program announced in 2005. It provides \$102 million over four years. It is primarily aimed at enhancing the capacity of primary health care for the Aboriginal and Torres Strait Islander population. It does include maternal and child health services and chronic disease care, and breastfeeding is one of the areas on which the Healthy For Life program may focus, depending on the local circumstances of each state and territory.

In 2003 the government funded the NHMRC to develop the dietary guidelines for children and adolescence in Australia, incorporating the infant feeding guidelines for health workers. This provides information on breastfeeding, including initiation, establishing and maintaining breastfeeding and common problems in their management. In 2000 the department funded the development of a resource called *Balancing breastfeeding and work*. This was designed to provide information to employers and employees about how to create a breastfeeding friendly workplace.

Finally, I would note the important activity of the government in support of the Marketing in Australia of Infant Formula or MAIF agreement, which was introduced in 1992. This is the Australian government's response to the World Health Organisation's international code of marketing of breastmilk substitutes. The department provides funding and secretariat support to the advisory panel on marketing and, of course, it is a voluntary, self-regulated code of practice. The department continues to work with signatories to the MAIF agreement and other stakeholders towards the appropriate marketing of infant formulas in Australia. I will conclude there in recognition of the time, Mr Chairman, and we would be very happy to help the committee with answers to questions.

CHAIR—You have probably answered most of my questions. We have had over 300 submissions to the inquiry. It is an issue which has created quite a bit of interest. All of us go into the inquiry with an open mind. Some of the submissions are saying that perhaps we do not have an open mind on the issue, but I assure you, we do. Do you think enough is being done in the education and training of health professionals with regard to assisting mothers to breastfeed? One of the main complaints we have had is that people do not get that advice throughout their pregnancy.

Ms Bryant—The department does work in this area. I noted that some of the submissions that the committee has received say that they get inconsistent advice from health professionals, so I think that we would have to acknowledge that clearly more could be done in that area, particularly to improve consistency of application of the material that already exists and to promote it to them. There is material and guidance in the resources that we have provided to the committee today but, given the evidence before the committee, it is an area we could look at doing a little more in.

Ms KING—What data is collected on breastfeeding rates? Does the department have any data?

Ms Paton—The data on breastfeeding rates is collected through the national health survey. We have identified, though, that it does not particularly well line up with the current recommendations to exclusively breastfeed to six months and so that is also an area that we could be further exploring. I do not actually have the national health survey questions with me

here at the moment. But if you are interested in what those questions are, we could provide those to you.

Ms KING—Is that the only data source that exists in Australia for breastfeeding rates?

Ms Paton—I understand that states and territories collect their own information as well but, in terms of national data collection, I believe that is it.

Ms KING—Even with that limited data that we do have, what is the trend showing?

Ms Paton—The trend is showing that, in terms of a comparison with the NHMRC dietary guidelines, only about a third of women are actually breastfeeding exclusively to six months.

Ms KING—Are you happy with that rate?

Ms Bryant—I am aware of the NHMRC submission, which says that breastfeeding is an effective public health policy primary health prevention measure and worthy of the support of the entire community. As the country's foremost political advisory body, obviously their recommendations carry some weight. So clearly with the breastfeeding rates of around a third, it is well below the level that the NHMRC would like to see and it is clearly something where we think there are gains to be made if breastfeeding rates can be improved.

Ms KING—When did the programs that Mr Learmonth described start? Obviously the MAIF agreement was 1992, but when did the funding to the Australian Breastfeeding Association start?

Ms Bryant—It has been going more than a decade.

Ms Paton—It has been in place since 1998 and there is committed funding through to 2008 so that is a 10-year period currently.

Mr ENTSCHE—How much work has been done on establishing reasons why? We have a very good participation rate up until three months—87 per cent—and I suppose that would also allow for those women that from a medical perspective cannot breastfeed—there has been a problem there. Is there any reason why there is such a sharp decline after three months? Is there any work that has been done in that area to establish—

Ms Bryant—I perhaps cannot comment on why the decline at three months, but the main reason that women give for choosing to breastfeed is the health benefits of breastfeeding, but factors which undermine a woman's confidence or negatively influence breastfeeding have been found to include: lack of support by a partner; a perceived or genuine lack of freedom and independence—that means that others cannot assist with feeding the baby and tasks of that nature; incorrect advice that they receive; which they find confusing; lack of role models; a perception that it is perhaps frowned upon in the community that there are pressures not to breastfeed in public places in some contexts; and cultural attitude. So it is quite a complex picture, and I think some of those factors suggest areas in which social marketing type communication to educate the community could be targeted.

There is evidence that breastfeeding is stronger where women make up their minds to breastfeed well in advance of having a baby, so the earlier they make that decision and make that commitment, the stronger the outcome. It suggests that in terms of targeting communication we need to involve the partner and the general community, and we need to target people in advance of their pregnancies and having the baby because all of those factors are quite important.

Mr GEORGANAS—In terms of the role of the Commonwealth government—and you outlined some of the programs—what else should we be doing to promote breastfeeding and the benefits of it? You have touched on a couple of things. Are we doing those things in terms of targeting particular groups that perhaps need better education; is that happening?

Ms Bryant—It might be useful to explain to the committee that the role of the Australian government is to provide national leadership, for example, in data collection, which we clearly do; regulatory policy; looking at the MAIF agreement and framework; and national campaigns—there is scope to refine and promote our material perhaps. The role also includes the dissemination of national educational resources—and we have developed a number of those, as can be seen in the material before the committee—and the development of health workforce initiatives.

The states and territories are primarily responsible for the provision of health services, which includes the provision of antenatal breastfeeding courses; teaching women to breastfeed whilst in hospital and outpatient or community health services that support that after the birth of the baby; targeted support for particular groups like teenagers, Indigenous people and people from multicultural backgrounds et cetera; and some aspects of consumer research. So there is a role for both levels of government.

Mr GEORGANAS—Is there anything else that you think we should be doing as a Commonwealth government in terms of promoting or targeting? Are we doing enough?

Ms Bryant—I think that we are doing the things that are necessary. There is no gap where there is a total absence of activity. There is scope to do more of some things—refine material, promote material more widely—but there is not an obvious total gap.

Mr Learmonth—I think it is a truism that you could say you can do more of almost anything in any area but, as Ms Bryant has tried to outline, in terms of the principal role of the Commonwealth, which is to provide leadership in areas like research, guidelines to consumers and health professionals, data and so on, there is a substantial range of activity which the Commonwealth government undertakes and has done for some time. The states and territories are really at the delivering end of things; that is a separate issue.

Mr ENTSCH—You mentioned lack of support from partners, convenience et cetera. Is there any evidence available on the impact of aggressive marketing by baby formula companies to influence people to make the change?

Ms Paton—We are not aware of any evidence on the influence of marketing—in Australia, that is—because, as you know, we have the MAIF agreement, which restricts the marketing of manufactures and importers. However, we understand that there is evidence from overseas about the impact of marketing of infant formula on breastfeeding rates and that that is the reason that

the WHO code was developed a couple of decades ago to protect breastfeeding from those influences.

Mr ENTSCHE—We label a lot of things suggesting that it is better not to do something from a health perspective, and there is no argument that breastfeeding is by far the best health outcome for a child. Has there been any consideration given to labelling formulas et cetera, reinforcing the value of breastfeeding as opposed to any other alternative means of making consumers aware when they are buying these products?

Ms Bryant—I am not aware of any labelling of that kind. In terms of labelling, control and promotion of formula as a food, it is regulated under the food standards arrangements. Under the Foods Standard Code, it is standard 2.9.1, infant formula products; and standard 2.9.2, food for infants. The standards cover definitions, the composition and labelling requirements for breastmilk, and substitutes and complimentary foods for infants. I think they preclude any representation being made in relation to the nutritional composition of the infant formula unless the standard expressly permits it. So they are not allowed to make health claims in respect of the formula, but I am not aware of the code saying anything like: ‘Breastfeeding is best. only use this as the second choice.’

Mr ENTSCHE—The best alternative.

Mr Learmonth—I think we rely on other mechanisms to give that information to the community through funding of the Australian Breastfeeding Association, through resource centres, through guidelines and through a range of other material by which we hope to raise the profile and the benefits of breastfeeding, but we do it separately rather than through the packaging of the alternatives.

Mr ENTSCHE—Do you see any value in having it made available as a means of raising awareness on the packaging of alternative products?

Mr Learmonth—I am not sure I would like to speculate on that.

Ms Bryant—FSANZ is developing a new standard for nutrition, health and related claims and, although infant formula is ineligible for health claims to be made, we could see whether it was appropriate for FSANZ to look at whether positive messages are appropriate for inclusion, but again it is something on which we would have to seek advice.

Mr Learmonth—I think the philosophy reflected in the regulation around foods goes to the extent of claims that the manufacturer can make about its own product and I cannot recall any element of that regulatory environment that would seek to promote or otherwise encourage comparative claims.

Mr ENTSCHE—I am a proud grandad of a little girl recently and I represent an area that is fairly remote and sparsely populated, and I checked with her mum—my daughter-in-law—before I got involved in this and asked her what was made available to her because I noticed that she changed relatively quickly from breastfeeding to feeding the child, and she had virtually no material made available to her at all. She lives in one of the more remote areas and so she would not have had access to a lot of this material. I would suggest there are a lot of people in a similar

situation where they do not have that information available and the only person that they are in contact with is somebody who is working at either the hospital or the clinic where they go to and they basically follow the advice that they are getting from that one individual. I would argue that she probably did not make an informed decision, as such, based on one individual. I am just wondering whether or not having something like that will trigger something for people in that situation that would allow them to at least question it, because there is no reason why she could not have continued.

Mr Learmonth—It might be possible she was aware of the benefits and I think, as you are suggesting, that the people she had been in contact with, hospitals and maternal centres and so on, provide the support to all health professionals by way of guidelines, research and the messages provided by the government. It is up to the states and territories in delivering those services to make use of that material that is available.

Mrs ELLIOT—I was interested in the point you spoke about there being a rapid decline in breastfeeding after three months. In particular, I am interested in any statistics or research in relation to the lack of family friendly work environments or working conditions that pose impediments to the continuation of breastfeeding, and if you have any research specifically on that if that is a major issue, as you said, that after three months we are seeing this decline. What specific research do you have on that?

Mr Learmonth—I am not sure what there is that is specific. The committee probably already knows we did provide some \$268,000 over a couple of years to fund Curtin University to monitor mothers' feeding practices of breastmilk, formulas and so on over a 12-month period. It was the Perth Infant Feeding Study Mark II. I understand the author is behind us and appearing so he may have some more particular information about why there are those changes in time.

Ms Paton—Certainly we are aware that the Australian Breastfeeding Association has an accreditation program to accredit work places that are breastfeeding friendly and they may have further information about the current status of support in work places, but we have not specifically done any research on that area within the department.

Mr Learmonth—For the record, I should say that the department is an accredited breastfeeding friendly workplace. It has been credited and reaccredited.

Ms KING—You may not have the figure there for the total funding that is allocated by the Commonwealth to its role in promoting breastfeeding. What would that be across all of the areas that you have mentioned in terms of research, data collection and health promotion?

Mr Learmonth—I think we would have to take it on notice.

Ms KING—I thought you might.

Ms Bryant—We can tell you individual bits but we have not tallied it.

Mr Learmonth—We will pick it up in the submission.

Ms KING—It would be helpful. It would also be helpful to have that over a time scale. Perhaps I will leave it to the secretariat to make a suggestion as to that time scale. I am just interested to see whether it has increased or decreased and what components make up part of that, both in terms of administration and in—

Mr Learmonth—Providing us with a time frame would help.

Ms KING—That would be helpful. Is there any specific arrangement or agreement between the states and territories in relation to the promotion of breastfeeding? Does it come under the public health outcome funding agreements at all?

Ms Paton—No, it does not.

Ms KING—So there is no actual agreement between the Commonwealth and the states. I see you have there a document entitled *Towards a national system for monitoring breastfeeding in Australia*. Obviously that indicates that there is a group of departmental people meeting to discuss data collection. I would not mind hearing about that, but also I would interested to hear if there is any group of state and territory and Commonwealth officials that meets to discuss this particular policy area.

Ms Paton—This was just a report that was done as a one-off. It does not represent a committee.

Ms KING—How old is that?

Ms Paton—I think the report is from 2001.

Ms KING—Thank you. Is that an AIHW report or is it a Health and Ageing report?

Ms Paton—It was done by the University of Queensland and the University of Sydney but it was funded by the Commonwealth Department of Health and Ageing.

Ms KING—Thank you.

Mr Learmonth—You asked about groups of assorted bureaucrats. Thinking about it, I can run through the hierarchy. I am not sure whether you are familiar with the Australian Health Ministers Conference, which is all the health ministers, and there is the Australian Health Ministers Advisory Committee underneath that.

Ms KING—I used to work in your department.

Mr Learmonth—Excellent! Under AHMAC there are a new series of principal committees that have been established quite recently. One of them is the Australian Population Health Development Principal Committee, on which I am the Australian government representative.

Ms KING—Is breastfeeding on the agenda?

Mr Learmonth—There is an early childhood and maternal aspect to that. We are looking at forming a subcommittee to look at policy cooperatively between the states and the Commonwealth on that, but the agenda is ‘under development’—I think that would be the best way to describe it.

Ms KING—Does that replace the National Public Health Partnership?

Mr Learmonth—That is it.

Ms KING—So that is now defunct?

Mr Learmonth—Yes. It has been subsumed.

Ms KING—When was the last national health promotion campaign in relation to breastfeeding? I cannot remember one; that is the reason I am asking.

Ms Bryant—I am not aware of us having done a national social marketing campaign. It has tended to be in the production of more targeted resources to health professionals and others but not to the general community.

Ms KING—Thanks.

CHAIR—We are asking questions blindly because we do not have a submission at this stage, and it will be necessary when we take further evidence to call the department back later on in the inquiry. Next week we are going up to North Queensland to some remote communities to have a look at the problems up there. Mr Entsch has arranged that, in his electorate. In looking at the health benefits of breastfeeding, I suppose conversely we are also looking at the health effects of not breastfeeding. Is there any clear indication of the health benefits or the converse in the research the department has been responsible for sponsoring? Take the obesity program that we are all involved in. Does breastfeeding have an impact on the incidence of obesity, for instance, that the Commonwealth is trying to grapple with?

Ms Bryant—The dietary guidelines on page 6 contain a list of health advantages of breastfeeding for infants and for mothers, and there is a list that the committee may wish to refer to. I am also aware that in its submission to the inquiry the NHMRC also listed a number of benefits, including possible reduced risk of obesity and so on later in childhood or in later life. Certainly, a number of benefits are listed in their dietary guidelines and their submission.

CHAIR—We have had over 300 submissions to this inquiry, which is quite a large number and far more than we actually expected, so it will take some time to examine the proposals put forward in those. We will certainly get back to the department so it can give us its views on some of the things that have emerged in the inquiry.

Mr ENTSCHE—It is clear that there is no leadership in focusing on a national breastfeeding campaign. Has there ever been a national campaign by a government at any stage which has focused specifically on breastfeeding?

Mr Learmonth—None of us can actually recall one, but we will take it on notice.

Mr ENTSCHE—I would be interested to see whether or not there has ever been one. It seems that, while it is tied in with a whole range of other things there, it has not been a particular focus and, given the value of it and the impacts of not doing it, maybe it is time we looked at something like that. I would be interested to see whether there is anything we can draw from previous governments which may have done something.

Ms Bryant—As we said before, I think the work has mainly been focused on targeted products for the different audiences but not a broad campaign of the sort you are speaking of.

CHAIR—We will explore that during this inquiry over the next couple of months. Does anyone have any further questions of the department at this stage?

Mr ENTSCHE—We found that in remote areas there is very little information or statistics on this. I just wonder whether anything has or is being done to collate information, particularly in the remote areas?

Ms Bryant—I think Indigenous people are sampled as part of the survey work that Ms Paton referred to before, so there is data collected as part of our national surveys. Mr Learmonth mentioned before the Healthy for Life program and the work we do through that to promote breastfeeding and other aspects of child and maternal health in Indigenous communities. The department funds a project officer for the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan and is a member of the steering committee. NATSINSAP provides a framework for national action to improve nutritional status of Aboriginal and Torres Strait Islander peoples in a broad sense, and breastfeeding is a subset of that.

Ms Paton—The Australian Bureau of Statistics has a National Aboriginal and Torres Strait Islander Health Survey. I think the last one was in 2004-2005 so that would be another source of information.

Mr ENTSCHE—When we were preparing this, the information we were provided with regard to information on remote areas was very light. They said that there was not much information available on that. And it is not just specific to Indigenous people; it would be specific to people living in the more remote areas. I suppose they would be suffering from many of the same challenges.

CHAIR—We are getting a lot of cooperation from the states in this inquiry. They will be providing submissions and evidence to the inquiry, so the relationship between the Commonwealth and the states will come into focus but very much on a voluntary and cooperative basis. We are looking forward to it. Thank you for appearing today.

[11.12 am]

BINNS, Professor Colin, National Health and Medical Research Council

CLUTTON, Mrs Cathy, Acting Executive Director, Policy and Practice Branch, National Health and Medical Research Council

CHAIR—I welcome representatives of the National Health and Medical Research Council to give evidence. Do you have any comments to make on the capacity in which you appear?

Prof. Binns—I am Professor of Public Health at Curtin university, but I have been invited along by the NHMRC. I should also add I have a couple of other hats on that have been mentioned this morning. I am the member of APMAIF and I am a member of the specialist advisory group of AHMAC.

CHAIR—I am required to say this: although the committee does not require you to speak under oath, you should understand that these hearings are a formal proceedings of the Commonwealth parliament. The giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Having said that, I invite you to make an introductory statement to the committee.

Mrs Clutton—Thank you for inviting the National Health and Medical Research Council to attend this hearing. The NHMRC recognises the importance of breastfeeding in promoting the healthiest start to life for young Australians. Indeed, the research and statistics presented in the dietary guidelines for children and adolescents in Australia shows overwhelmingly that exclusively breastfeeding a baby for the first six months of life affords the child benefits that continue for many years, if not into adult life. Rather than reiterating the content of the NHMRC submission, we would be pleased to respond to questions from the committee, but I will ask Professor Binns if he would also like to make some introductory comments before that.

Prof. Binns—I would like to congratulate you on having an inquiry into such an important topic. There is nothing more important for the health and wellbeing of infants and children in Australia than breastfeeding. That actually carries through to adulthood, because we now know that many adult diseases, such as obesity, diabetes and heart disease have their origins in early nutrition. Breastfeeding is an extremely important part of that. The Australian government and the NHMRC have done a very good job in promoting breastfeeding. We are second only to the Scandinavian countries amongst the Western countries in our success in breastfeeding. Over the last three or four decades the incidence of initiation of breastfeeding has increased dramatically, so it is now about 90 per cent. Where we have failed is in the duration so that the percentage of mothers still breastfeeding at six months is around 50 per cent, probably just a little bit lower. That has not changed for the last two decades and that is a big disappointment.

May I also suggest to the committee that, when you are considering breastfeeding, you look at the definitions of breastfeeding. The most important thing with any breastfeeding—breastfeeding maybe with supplements of something else, or full or exclusive breastfeeding—is that the baby gets sufficient breastmilk for almost all of its nutrition, and that is what we are

after. We want to see perhaps 80 per cent of Australian infants being fully breastfed or exclusively breastfed until six months of age and that would bring substantial benefits to the Australian population.

Ms KING—I just want to pick up on the issue around data collection. How adequate is our current data collection? Do we actually know what the rate is?

Prof. Binns—It would be most unfortunate if I criticise the hand of the people that paid my airfare to come here, but you have to remember that data of breastfeeding is difficult. Currently, the government relies on retrospective collection. In the national health surveys you ask mothers of children, who may be three or four years of age, ‘How did you breastfeed your baby?’ They can remember very accurately whether they breastfed and for how long, but the time at which they introduced solid foods gets blurred. So we have pretty good statistics on any breastfeeding. We do not have good statistics on exclusive or full breastfeeding, which require cohort studies. We need to interview the mothers as they go. That is the strength of the studies which the health department has funded my group to do in Perth.

Mr GEORGANAS—You mentioned figures that show we fare second to the Scandinavians, 90 per cent, I think, in the first of the three months—

Prof. Binns—No, that is discharged from hospital.

Mr GEORGANAS—And then we decline to 50 per cent six months after the discharge from hospital. How does that figure compare to the other developed OECD countries? Do you have any stats on that?

Prof. Binns—We have very good stats on that. As I said, we are right up in the top but we are second to—

Mr GEORGANAS—Even six months down the track, when we declined to 50 per cent?

Prof. Binns—We would be about middle of the range at that point.

Mr GEORGANAS—Have we looked at any studies—because the lifestyles would be identical—to see why we have had such a decline, compared with other countries that have not had that decline and what the differences are?

Prof. Binns—We have lots of information as to what encourages mothers to breastfeed. There are some factors that we now know about which affect duration. For example, mothers are now in hospital only for 24 to 48 hours before they are discharged. That is before breastfeeding is fully established. They need support in the first weeks after they get home. All around Australia there has been a decline in community support for breastfeeding mothers. They are not visited as regularly as they should be in the home. If a mother in Western Australia with a breastfeeding problem wants to go and visit a community health nurse, she has to make an appointment. There might even be a waiting time of a week or two weeks. If she has sore breasts during that period, she simply goes to the chemist and buys a can of formula and stops breastfeeding. There is good effort made by the Australian Breastfeeding Association with their telephone hotline and so on,

but that does not replace the need for on-the-spot advice. The better-off mothers can afford a private lactation consultant, but the problem is with the lower socioeconomic groups.

The other thing that needs to be considered is the provision of workplace support. Certainly later in that period—four, five, six months—one of the most common reasons given by mothers for stopping breastfeeding is a return to work and the inability to find care that will allow them to continue to breastfeed. Some places are exemplary: departments of health. My own university has childcare facilities which allow the mothers to visit and breastfeed during the day. Other places are not so generous.

CHAIR—Do you think new mothers in general are aware of the health benefits of breastfeeding? Some people can breastfeed and some people cannot breastfeed. Some people can and will not. It is a conscious decision. Is enough being done to train our health workers to pass on that information? We have had private briefings from the association, which has suggested that some of the nursing staff in hospitals are so busy that they take short cuts; it is easier not to breastfeed than breastfeed—consequently, you do not have the outcomes.

Prof. Binns—I will make a couple of points. Physiologically, almost all women can breastfeed so, in terms of mothers who cannot breastfeed, you are talking of one, two, three per cent.

Mr ENTSCHE—What about being able to produce sufficient volume? That is one of the reasons that women give: ‘I am just not able to produce enough milk to feed a child.’

Prof. Binns—The breast is a remarkable organ. I have the greatest admiration for the mothers of Australia who are very good at producing breastmilk. That is rarely a problem if properly managed. There are all sorts of pressures and tensions that obviously impact on the ability of a mother to breastfeed but, with correct advice and management, almost all mothers can produce adequate amounts of milk. We obviously need to monitor babies to ensure that they are growing properly and so on, but that is not a limitation.

In answer to a question that you asked, one of the difficulties is that mothers are now only having one or two babies. So the actual number of births in hospital either has declined or is relatively static. There is a turnover of staff. The staff need to be constantly re-educated about the importance of breastfeeding and so do mothers. So you have to provide a lot more information now than you did, say, 30 or 40 years ago, when families were larger, when young mothers always had friends or relatives who were breastfeeding. We do not have that now so, yes, we require a lot more effort.

Ms KING—Thank you for your submission. Just for the record, it would be great if you could outline some of the health consequences, overall in our population, of not breastfeeding that the study has shown.

Prof. Binns—I am the guy who actually wrote the book here, so you have a whole pile of information there. One of the really interesting things about breastfeeding is the evidence that is accumulating on the role of breastfeeding and obesity. At a meeting I attended in Europe last year, the chair of the European committee, which I guess is similar to your committee, Professor Cattaneo, reviewed all of the evidence linking obesity and breastfeeding. I think there were 30 or

40 studies. The consensus is that babies who are breastfed for at least three months, and preferably for six months, have a lower rate of obesity during childhood. That translates to a lower rate of obesity during adulthood, probably because the number of obesity cells, adiposities, is decreased and that has all kinds of health benefits. So, while we can spend a lot of money later in life combating the obesity problem, it would be great to promote breastfeeding as a way of preventing it in the future.

The other area that is of interest to me is the influence of breastfeeding on IQ. Again, with all these studies a word of caution: we cannot do control trials with breastfeeding as we would with a drug, because it would be simply immoral to stop some mothers breastfeeding so we could use them for comparison purposes. But, gradually, evidence is accumulating, and it appears that babies who are breastfed are slightly more intelligent than those who are not—and that is an important thing for a modern society. There are all sorts of health benefits and societal benefits. We can talk about that all day.

Ms KING—I wanted to get some of that on the record; thank you. At the other end of the scale, you talked very briefly about some of the barriers that women face while continuing to breastfeed for six months. Can you elucidate on those a little more? Can you tell us whether any studies have been done—we will probably hear from the next witness—about how some of those barriers may be alleviated?

Prof. Binns—There have not been that many studies done in Australia. It has been very difficult to get funding for applied breastfeeding research in Australia.

Ms KING—Is there any reason for that, do you think?

Prof. Binns—It is not sexy and cutting edge, like genetics and things like that. It is rather mundane, but it is still extremely important. I guess that is another issue. There is the Cochran review, which is kind of the gold standard of what should be applied in evidence in medicine, which shows that postnatal support once people get home from hospital is very good at encouraging duration of breastfeeding. Our own studies have shown the importance of the support of the father, the importance of educating mothers as early as possible during pregnancy or preferably just before they become pregnant. The longer they have been thinking about it and adjusting their lifestyles, the longer they will continue to breastfeed after the baby is born. So prenatal education, even before pregnancy, is really important. Classes for fathers to help them to support the breastfeeding process are important, as is support after the mother goes home from hospital. I am strongly in favour of expanding the current telephone counselling services so that there is always somebody there to answer the phone. Also important is the ability of mothers to access support through the various community health nursing services. Finally, societal support through maternity leave provisions would be fantastic.

Ms KING—You gave an example before of where, if the support is not available and someone develops sore breasts, they will go to the pharmacist and just pick up infant formula. Are there any programs that actually operate through pharmacies or at point of sale of infant formula that would let women know there are other places to call for help?

Prof. Binns—Pharmacists obviously have a conflict of interest. Many of them are interested in the health of people and do their best to help. But, in the end, they make a profit from selling

formula. I might give you an anecdotal experience. I do some general practice in a very poor area because I want to keep in touch with mothers. A month or two ago a mother came to me and, when I asked her how she was feeding her baby, she said, 'I am bottle feeding.' I said, 'Why?' and she said, 'Well, I didn't have enough milk.' I said, 'How did you know you didn't have enough milk?' 'Well, I didn't know what to do so I went to the pharmacist and he hired a breast pump to me so that I could measure the amount of milk. I gave that to the baby in a bottle and then I went back and told him how much and he said, "That's not enough, so now you've got to buy this formula.'" So I guess he made a double profit; he hired the breast pump and he sold the formula. It was, to me, a very sad case. It is an example of technology gone completely wrong. If not for the lack of sympathetic support from a person with experience in lactation counselling, that mother would still be breastfeeding.

Mr GEORGANAS—You spoke earlier about the variation between the socioeconomic groups in terms of acceptance of breastfeeding and the maintenance of breastfeeding. What are some of the factors that contribute to this? I suppose you just touched on one.

Prof. Binns—We know that less healthy habits cluster in certain groups in the community. For example, our research has shown a link between breastfeeding duration and alcohol consumption and smoking. Groups in the community who smoke, who drink and who do not exercise are less likely to breastfeed. They are the lower socioeconomic groups among the Aboriginal community, the younger mothers there. Why that is is the great challenge to public health that we have all been searching for the answer to.

Mr ENTSCH—Do you have any ideas on what could be done to encourage a lesser drop of participation in breastfeeding for that critical three- to six-month period? Is there anything that you could tell us that we should be considering to minimise that reduction or to maximise participation?

Prof. Binns—Starting right at the top, at the policy level, some years ago the Australian Department of Health and Ageing had the National Breastfeeding Strategy. It was there for everybody to see; I think they still have a page on their website. But for the government to formally endorse breastfeeding as a policy would be a substantial step forward. I would suggest continued funding of organisations such as the ABA to provide their telephone service. You need to continually provide health professionals with information about the benefits so that they are all giving the correct information. In the practice where I work, we have a number of overseas trained doctors who have not had the benefit of the education that we have had in Australia, and for them the normal way to feed infants is to give out formula. We need to make sure that when they come to this country they learn of the benefits of these things. We need to continually strengthen, through the states, the provision of services for community health nursing, where mothers can get access to advice and assistance on breastfeeding when they need it, not the next week or two weeks later. By then their breasts are sore or their milk is having problems and they have stopped.

CHAIR—It is important that this committee comes up with some recommendations to government. We are already finding out that there is an enormous amount of information, but the information is not being disseminated in such a way that women can make informed decisions about breastfeeding. I said before that the states are cooperating with us. I think everyone recognises the benefits of breastfeeding, but how do we implement something? What do we

recommend? How do we make a recommendation that will give effect to all your work at NHMRC and the initiatives of the health department?

Prof. Binns—I have to say that my contribution in the past have been, and I hope will be in the future, to continue to provide the scientific basis for what we are doing. I am not an expert in communicating to working-class mothers. I recognise how important that is and I hope the committee will have other witnesses who can expand on that. I know what needs to be done but I am not an expert on how to do that.

Mr ENTSCHE—One issue I raised with the earlier witnesses was labelling. Do you think there is any merit in that?

Prof. Binns—All infant formula in Australia is labelled. All the materials that the companies circulate are required to have a statement which says that breastfeeding is best and that once you stop breastfeeding you may not be able to start again et cetera. The wording varies a little bit from company to company, but all material that is distributed to health professionals contains those labels. On the side of an infant formula can there is a label which basically says breastfeeding is best; that is already a requirement. The difficulty is that there is no requirement about the size of the font, so it is in tiny print on the back of the label. It may be interesting for the committee to actually have a look at some cans. You will see that it is there but it is very small.

CHAIR—I suppose you will keep an eye on the inquiry as it progresses.

Prof. Binns—I hope so.

CHAIR—As I said earlier, we are going up to Cairns next week and out to Doomadgee and other communities. We will see what we find. At the coalface of delivery of what current knowledge is, putting it into a practical effect—which is the desirable outcome—is really the task that this committee is looking at. Do you want to add anything to what you have said?

Prof. Binns—As far as the communities are concerned, breastfeeding amongst Aboriginal mothers is higher than it is amongst non-Aboriginal mothers except for two groups. The first is very young mothers, teenage mothers. That is a problem all over Australia, but since there are more Aboriginal teenage mothers than non-Aboriginal mothers it is more of a problem there. The second group where it is a problem is mothers who have already had seven or eight children and who simply say, 'I am too tired to breastfeed again.' One thing the committee might like to know—I am not sure whether it is in your brief or not—is that there are a range of infant formula available in Australia. In my personal submission I have pointed out that about 50 per cent of the formula which are sold in Australia are of the cheap varieties which are not supplemented with things like long chain polyunsaturated fatty acids. Particularly in Aboriginal communities, the use of the cheaper formula is universal. I think that if a baby is not going to be breastfed then that is sad, but if they are not going to be breastfed they should at least have the highest quality infant formula that is available, rather than the cheaper varieties.

CHAIR—Thank you for appearing before us today.

[11.38 am]

SMITH, Dr Julie Patricia, Australian Research Council Fellow, Australian Centre for Economic Research on Health, Australian National University

CHAIR—I need a motion to authorise the submission from Dr Julie Smith for publication on the parliamentary database.

Mr ENTSCH—So moved.

Ms KING—I second that.

CHAIR—If there is no objection, it is carried. Welcome, Dr Smith. The committee does not require you to speak under oath, but you should understand that these hearings are a formal proceeding of the Commonwealth parliament and that the giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. Could I invite you to give us an introductory statement, please.

Dr Smith—I have provided some notes, which will provide a bit of a visual trigger for—

CHAIR—Might you run us through that?

Dr Smith—I will run you through that, yes. I want to say at the outset, first of all: thank you for holding this inquiry. Women of Australia have waited for this for many, many decades. I also want to say at the outset that my submission was specifically on the economic aspects of breastfeeding. I am also a breastfeeding counsellor with the ABA. I would like to emphasise that breastfeeding cannot be reduced to the economic aspects alone. It is a complex physiological, emotional and social relationship between the mother and the baby and it is very much embedded in society as a whole. It is understandable that some women actually feel quite affronted by the idea of looking at it in dollar terms. That is not the thrust of what I am saying. I am saying, however, that it is useful to take an economic approach for a number of reasons. One is to show the economic and social value of the work that women do and to make visible that contribution that is made to the economic wellbeing of the nation.

Secondly, it also helps to give public policy a broader perspective on the economy, other than just the market part of the economy, so that governments can avoid unintended adverse effects and get a better perspective on the importance of breastfeeding in the whole economy. I would also like to point out that we know, whether we like it or not, that market forces and financial incentives affect peoples' decisions, including on breastfeeding. If we want to improve breastfeeding rates we also need to understand how those financial and economic forces do affect decisions.

The final argument I would also make for looking at this from an economic perspective is that it highlights the fact that when you look it from an economic viewpoint you look at the costs and the benefits. You realise that just because breastfeeding and breastmilk is free to the consumer—

that is, the baby—it does not mean it is actually free in terms of getting it there. It requires skill, effort, time and so on. I will talk a bit about the research I have been doing there.

I have given you a summary of the research that I have been doing on the valuation of breastfeeding and two aspects of that: firstly, the economic gains from the milk that is made, how you value that, and, secondly, the health cost savings. I have also done research analysing breastfeeding as part of a market. I think this is a really important point: breastfeeding, breastmilk, is in a market, competing against commercial products. It is in a labour market, competing with the paid economy for mothers' time. When you view the world from that perspective it gives you new ways for looking at the problem.

I have also done historical research looking at the trends—what is behind the trends historically in breastfeeding in Australia and around the world. That really identifies poor hospital and health provider policies and practices, marketing and distribution of commercial breastmilk substitutes. The issue of maternity leave is central and really highlights the time intensity of caring for infants and breastfeeding.

I have also got some information in the submission about the supportive national policies in northern Europe which mean that nearly all mothers are still breastfeeding at six months, compared to less than half in Australia. If you look specifically at Norway, for example, you see that 99 per cent of mothers initiate breastfeeding; 80 per cent are still breastfeeding at six months; and 40 per cent are still breastfeeding at 12 months. Their bodies are the same as ours. There is nothing particularly different about Australian women, but what is different in Norway is the policy settings. I have got some ideas that I think are a key focus for that. I recently spent some time in Europe talking to people in Sweden, Norway and the World Health Organisation—

Mr ENTSCHE—What percentage did you say it was at six months?

Dr Smith—Eighty per cent are breastfeeding at six months. Just briefly, in terms of how to value mothers' milk, it seems a bit bizarre but it is actually very simple. One of the tables that you have in front of you—which you probably cannot read; I certainly cannot because it is too small—illustrates the spreadsheet where you work out how much milk mothers make. If we know how many babies there are and we know how much milk each baby takes approximately per day, we can work out that around 33 million litres a year is produced by Australian women at present breastfeeding rates.

How do you value that? Traditionally people have said, 'The value of breastfeeding is the formula you don't have to buy,' but that is actually a very incomplete way of looking at the problem because the cost of formula is not just the retail cost; it is actually the health costs that go with that, to the mother, the family and society as a whole. Part of the issue in a market analysis of breastfeeding is that those costs and benefits do not necessarily fall on the person who makes the decision. For a market to work effectively, if the person who takes the decision to breastfeed, not to breastfeed or not to support that mother to breastfeed is not the person who bears the health costs down the track or the benefits then you will get an undersupply of that effort and so on.

In terms of looking at the right way to value mothers milk, there are three approaches that the Bureau of Statistics is comfortable with, but the best one is essentially to take the donor milk

bank price. There is actually a market in breastfeeding. If you read last January's *Washington Post*, breastmilk is now a hot commodity that is bought and sold on the internet. The going rate for wet nurses is around \$US1,000 a week. In China there is a growing market in wet nursing and also a huge growing market in formula feeding. The wealthy employ wet nurses. I know that in the US recently a company began marketing human milk especially processed for premature babies. They are selling that at \$US650 a litre. I have not used that for my estimates. That is really a pharmaceutical product. But it highlights what informed opinion will pay for mothers milk. It is actually a valuable product and there is a market for it.

It is very common in Europe, the UK, Germany and Austria as well as in Scandinavian countries for milk banking to occur. Hospitals buy and sell milk. I have used the milk bank price in Europe to value that 33 million litres of mothers milk. At the 1992 breastfeeding levels, which are pretty much the same as breastfeeding levels now, nothing has changed—it is around \$2 billion a year. There are other different methods that you can use to look at that, but they have come up with pretty much the same result.

What is extraordinary, though, is that there is no acknowledgement of that. There is no social acknowledgement in our national product. If you look at the national accountants guidelines, the standard system of national accounts on what should be in the national accounts, what should be measured in GDP and what should not, products and commodities that can be stored, exchanged and traded should be in the national accounts and should be measured in GDP if they are significant enough. Breastmilk can be stored and traded and is exchanged, and it is not in there. It is significant enough. It is more significant, in fact, than things that are already in there such as home-produced and consumed eggs on farms. The milk that the cow provides for the farmer, given to the baby, is estimated by the Bureau of Statistics. If the farmer breastfeeds the baby, because the farmer is a woman, that does not get counted.

I put a little cartoon in the submission just to reflect one of the newspaper perspectives at the time this research was released. The title on the story was 'Breastfeeding is the mother of all cash cows'. There is a mother feeding a baby with the sound of the cash register in the background. Some mothers can be offended by that, but I think it puts a different perspective on it when you see the magnitude of the effect. At \$2 billion, that is about six per cent of national food consumption or national food sales. It is large. It is not something that you can ignore. That is why it is important for policy to understand that what you do in various dimensions actually affects the economy in the broad sense, not necessarily just the market but in a broad sense.

The second aspect is the hospital cost and health cost issues. I have done a study at Canberra Hospital which is also available to you and which has been extrapolated nationally. I am doing further research on the chronic disease impact. That shows that, for just four conditions, the attributable costs of formula feeding are between \$60 million and \$120 million just for four common illnesses.

I have been doing calculations recently about the attributable costs of chronic disease. The research is accumulating on that; there has been an immense growth even in the last three years since the NHMRC study. There have been a number of meta-analyses that show there is a clear link between lack of breastfeeding in infancy and obesity, heart disease, diabetes, some childhood cancers, coeliac disease and various digestive illnesses. You can again work out the attributable proportion of that.

These are preliminary figures and it depends on how you measure breastfeeding. Colin Binns said that you have to be careful about how you measure breastfeeding. We do not actually know how much breastmilk actually makes the difference to some of these things, so it actually becomes hard to work out what the important breastfeeding rate is. But as much perhaps as about 30 per cent and between perhaps four per cent and 20 per cent of chronic disease could be statistically attributable to lack of breastfeeding in infancy, which means a fair chunk of national health costs could ultimately be found in that direction.

I have provided some of the numbers. The point was made about whether mothers know this and I think part of the problem is communicating that message. The people who best know how to communicate that message are the mothers. That is why the Breastfeeding Association has been so successful. The message that mothers get is the health benefits of breastfeeding. We do not talk about the health benefits of not smoking; we talk about the health risks of smoking. For people to engage with this issue we have to talk about the health risks of formula feeding. When you talk to a mother about benefits it is, 'Oh, I would love to do that really well but I am not a perfect mother and I will just do what I can,' but she will not expose her baby to risks. She will admit that she is not the perfect mother—as she has to; as every mother has to—but she will not expose her baby to risks. So you have got to start talking in the proper language. This is the only field of epidemiology where we talk about the health benefits of health behaviour rather than the health risks of a risk exposure.

The other thing about that is that it affects the child's capacity to learn down the track. Hearing loss and ear infections and so on affect the child's ability to learn as well as the IQ impact that we talked about. Also, there are the chronic disease impacts down the track on economic productivity. Labour force participation is also something that the committee probably would like to look into.

The point was made by the health department this morning that 33 per cent of Australian mothers were breastfeeding at six months. That is actually not true. The figures are that 33 per cent of infants fewer than six months old are exclusively breastfeeding; by six months of age, only five per cent are. Those are the figures from the Queensland Child Health Survey and the New South Wales Health Survey.

CHAIR—Can you explain the difference again?

Dr Smith—Of the population of infants, which is about 100,000 infants who are less than six months old, 33 per cent of them are breastfed. That includes ones that a just born and exclusively breastfed.

CHAIR—Okay.

Dr Smith—That is on average, so it is a prevalence measure. The percentage who are exclusively breastfeeding at six months, which is the more commonly used measure, is five per cent. Five per cent are exclusively breastfed. I have been involved with this survey in the ACT where we have measured this, and it corresponds to New South Wales and Queensland as well.

Mr ENTSCHE—As opposed to 80 per cent?

Dr Smith—In Norway? There are two sets of figures. Any breastfeeding at six months in Norway is 80 per cent and in Australia it is about 40 per cent to 50 per cent. In Australia, exclusive breastfeeding at six months is around five per cent and in Norway it is about 20 per cent to 25 per cent. I have looked closely at the National Health Survey data on this question of why there is a decline after three months. Fundamentally, it seems to be due to middle-class mothers introducing solids too early. They are getting the wrong messages about when they should be introducing solids. These are breastfeeding mothers.

CHAIR—Who are they getting that message from?

Dr Smith—From the supermarket, on the sides of the packets. There has been a procedure in place to change the labelling on baby formula and solid food for I think the last three or four years. I have lost track of where that process has gone.

Ms HALL—What messages do they receive from their GP or health professional? Is that impacting or impacting on their decisions to maintain breastfeeding?

Dr Smith—If you look at the submissions that are on the website, there is a very clear answer to that.

Ms HALL—Okay. Would you like to tell us so as to get it onto the *Hansard* record?

Dr Smith—Women take a lot of notice of the health professionals when they do go to see them, but the decisions they are making are based on, quite often, what they hear from other mothers, which is the blind leading the blind given our historical culture of bottle-feeding and they are looking at the labels on the stuff in the supermarkets and saying, ‘Four months is when you introduce solids, isn’t it?’ Why would they know that the National Health and Medical Research Council three or four years ago said that six months of exclusive breastfeeding is best? They do not know that.

Ms HALL—Do you think that needs to be advertised a little bit better? Should there be a campaign to actually address that with health professionals leading the way?

Dr Smith—I am not necessarily sure it is health professionals. Can I hold off on responding to that? I have a list.

Ms HALL—Okay. I will not interfere with your list!

Dr Smith—In front of you there are some graphs. This is part of the historical research I have been doing which shows the product market competition in the form of advertising from the 1950s onwards. What you can see is that there is a very large increase in advertising of baby foods. This is actually on baby milks.

What you can see is that there is a very dramatic rise—a fivefold increase—in the marketing and advertising of breastmilk substitutes from the 1950s. That has declined to some extent, but what that symbolises is that, at that time, there was a very close collaboration between health providers and industry in terms of supplying and promoting breastmilk substitutes through the health system. On my analysis that was the main factor in reducing breastfeeding over that time.

The main factor bringing it back up again was the establishment of the various nursing mothers type groups from about 1964. You had the women's advocacy, which actually brought breastfeeding rates up. One of the graphs that you can see there shows that very dramatic drop in breastfeeding during the 1950s and 1960s that recovered from around the late 1960s. That was the advocacy of women's groups that was doing that.

The other point about that graph is that this is not about individuals' behaviour: this is not a mass, coordinated refusal to breastfeed by Australian women. This is a systemic issue. Lactation failure was induced, in a sense, by our society and by what was happening to them in hospital.

If you also look at one of the graphs showing the results of market competition in terms of rising sales of commercial milk formula, you can see that there was a very rapid increase in the sale per capita of infant formula from the fifties. But, despite the rise in breastfeeding, those sales have continued to rise. That reflects the very low duration of breastfeeding in Australia. There is a number of examples which have been before the committee of the type of advertising that does happen in Australia. We have the MAIF but it is very narrow, very weak, and unenforceable. It is a voluntary agreement.

You see, for example, these advertisements for breastmilk substitutes from birth for hungry and sleepless infants. Well, that is a pretty large market share. What infant is not hungry and sleepless, I would like to know? It is similar with the toddler formulas. These are reinforcing mothers' anxieties—culturally induced anxieties—and hooking into those. I am not saying that marketing is the only issue, but there is plenty of evidence—and I think historical evidence—that it is contemporaneous with the decline in breastfeeding. If you look at the history of what was going on, that marketing and promotion through the health system was behind that decline in breastfeeding.

You had practices in the fifties and sixties, and in some places still, where the baby was taken away from their mother after birth—in the fifties and sixties it was for two days sometimes—and they wondered why they could not breastfeed them when they got them back. The babies were given formula while they were away from their mother. When they were in the nursery, they were given formula or a dummy and so on. There was a whole heap of practices that make you wonder why any mother has managed to breastfeed at all. This comes to the issue of guilt. There is a generation of women in Australia who feel guilty about not having breastfed. But they really should feel quite angry at what was done to them in terms of getting in the way of what they would have done as mammals.

I have looked at the extent to which time competition—which is the other market that competes with breastfeeding—impacts on breastfeeding. I would argue that that was not the major factor in the sixties. It was possibly a small factor, but it cannot account arithmetically for the extent of the decline in breastfeeding. It is more likely to be important since the mid-80s in affecting the duration of breastfeeding. The Bureau of Statistics survey shows that one in 10 mothers wean before six months onto formula because they return to work and that corresponds pretty well with the United States literature.

I did a time use survey. You have a picture in front of you of this little device that we gave mothers for a week to carry around; 167 of them did this. This showed that mothers of infants worked—so they were not sleeping, in the shower or eating and they were not involved in

leisure—for between 71 and 75 hours a week, either paid or unpaid. Most of it was unpaid work. They were responsible for infant care for around 160 hours a week. In other words, they only got about eight hours a week off. They were on call—because the question was asked of them: how often are you not responsible for the infant? One hour a day on average those mothers had a break. So this is really very time-intensive. Caring for infants is very time-intensive.

If you actually replace that mother care at current minimum wage rates, around \$15 an hour with an on-call loading of 25 per cent for the other hours that she is on call, that is about \$18 billion a year of mother care that we are getting free, but it requires the effort and commitment of mothers. What is the cost of maternity leave by comparison? It is a very small offset to the costs that mothers face in terms of the time they give to their infants.

If you look at the breastfeeding time specifically, it is around 20 hours a week just on breastfeeding in the early months. For a baby to be exclusively breastfed, whether it be three months old or six months old, takes around 20 hours a week of just breastfeeding. Mothers who are breastfeeding and mothers generally also spend a lot of time in soothing, holding and settling the baby. What I found in my research—and one of the graphs there shows it; the one with the box plots—is that the more exclusively the baby was breastfed, the more time the mother spent in that soothing, holding and settling emotional care. What the research from psychology literature tells us is that this is really important human capital investment. This responsive, sensitive, maternal care is really important to that child's mental and emotional health. That graph suggests that it is really important for us to make that time for mothers to have with their babies, whether that be through maternity leave or through making sure that they have flexible workplaces and accommodating workplaces.

If you look at the final graph there you can see that Norway experienced the same declines in breastfeeding as Australia did. As in Australia also, that turned around in the late fifties and early sixties when the mothers groups arose. That was what turned it around. The big difference in Norway was that, in the early 1970s, the governments of Norway and the Scandinavian countries engaged with these groups to promote breastfeeding.

CHAIR—You have just lost me. Which graph are we looking at?

Dr Smith—This one here. You can see that that is a very familiar pattern compared to the Australian one. Theirs recovered earlier.

Mr ENTSCHE—You have half a dozen here.

Dr Smith—I am afraid it is in Norwegian. The one at the top is the initiation rates. The next one down is breastfeeding at three months.

Mr ENTSCHE—This is all in Norway, is it?

Dr Smith—Yes.

Mr ENTSCHE—Okay. Now I understand it. I was not quite sure. So this is just the Norwegian one?

Dr Smith—Yes. It has a similar pattern, but theirs recovered earlier than ours and it went up a lot higher. Fundamentally, that is because government engaged with the breastfeeding advocacy groups early—in the seventies. By the late 1980s, every hospital in Norway was baby-friendly. It had met the baby-friendly hospital criteria which got rid of all of those practices that get in the way of breastfeeding. Finally, in the 1990s, they increased their maternity leave weeks from eight weeks, which it had been at during the sixties, and about 20 weeks from the seventies. It is now 40 weeks. So you can see that made a difference.

The final point I would make here is about obesity in those countries. This is not just in Norway but also Switzerland and Austria. They have very high initiation rates as well—they have about 92 per cent or 98 per cent initiation. Those high breastfeeding initiation rate countries typically have youth obesity of around one to two per cent. In the low breastfeeding initiation countries, which are the Anglo-Saxon countries such as the US and the UK, initiation is around 70 per cent in those countries and typically the rate of obesity among youth in those countries is around four to five per cent. So it is several times higher. Norwegians also recognise mothers milk by including it in their food production statistics. I have a reference if you would like to go and have a look at that, but it is in Norwegian.

Finally, the thing that I suppose you are most interested in really is what I think we should do next. I would urge you to focus your recommendations in five areas. The first area is funding incentives to encourage breastfeeding-friendly health services. The Commonwealth does not actually run health services, but it has enormous influence on how health services are run through the health agreements with the states. I think that one way to go would be to have health agreements with the states requiring baby-friendly hospital status for all maternity care facilities. That could be part of the next health agreement.

There should be policies and regulations to facilitate and encourage milk banking and perhaps wet nursing, and requiring health insurance funds to encourage and support breastfeeding. A lot of money goes into supporting the health insurance funds in Australia and some of that should go to encouraging and supporting breastfeeding. It is in their own interest, actually.

Secondly, the issue of health professional training and education comes up all of the time in those submissions. Health professionals, even GPs, get maybe 10 minutes on breastfeeding in their training. They learn that, basically, you make milk in breasts. That is about it—in 10 minutes.

Ms HALL—So there is no learning included in that—no information on the benefits of it?

Dr Smith—Within that 10 minutes, it would include the physiology of lactation and the health benefits of it. But there has been a massive outpouring of research even in the last five years which would not be encompassed in health professional education. It takes a long time. A really important area is that health professional training and education. In the case of vaccination, we have incentives in place for doctors to improve their practices. Why can't we do that for breastfeeding? I would also suggest that the other aspect of their education is in terms of the professional ethical obligations. It is well known that some health providers provide samples to mothers under the table, which is extremely unethical and contrary to everything the WHO code stands for.

The third thing is the marketing and social marketing aspects and the mother-to-mother support—the cultural area. I would suggest that, unless we have an effective implementation and enforcement of the WHO code in Australia—and the MAIF is a long way from it—on the marketing and promotion, we need to match the marketing and promotion spend of the industry. I estimate that that would be, based on about 15 per cent of turnover, which is what businesses often spend—and that ignores any R&D—around \$15 million to \$30 million a year at a minimum. That is only what is spent on marketing to the consumer.

We had a discussion earlier on about food labelling. Those labels have been out there since 2003, when the National Health and Medical Research Council made those recommendations for six months. It is now 2006, and that process has stalled. The response we got from the department—I made a submission to that inquiry—was that it basically was not given priority; it was not a priority.

Mr ENTSCHE—So you have a different view on labelling?

Dr Smith—I think it matters enormously. If you go into the supermarket, what do mothers pick up about when it is appropriate to introduce solids? Four months. Some of the stuff has, in big letters, ‘for all ages’ and then, in small letters, ‘four months’, ‘six months’ or ‘nine months’. Women often do not go to their health providers for information. They either cannot get hold of them or it is not seen as a major enough issue. Their mother introduced solids at six weeks on the advice of her health nurse.

Thinking about the history of breastfeeding and why it is so low in Australia, I would also suggest that we do a thought experiment and say, ‘What if the health system collaborated with mothers milk incorporated in the same way that it collaborated with Nestle, Wyeth, Mead Johnson and Abbott Ross during the fifties and sixties in referral and setting up facilities to make sure that the product was promoted properly?’ If we had that sort of collaboration with mothers milk incorporated, we could do a lot more in Australia because mothers milk incorporated knows the market. They are women who are talking to other women with young babies. They know exactly what is on their minds. They know how to talk to them and communicate.

The fourth area is employment. I talked about maternity leave and breastfeeding-friendly workplace practices. Very few women benefit from those in Australia. Only about one in four women get paid maternity leave of any kind—that was the same in my survey—and very few women have breastfeeding-friendly workplaces. Is Parliament House breastfeeding-friendly? There are many women who work here. That would obviously be the leadership role for the Commonwealth parliament to play.

CHAIR—Some people behind me are shaking their heads, but I am told the House of Representatives is.

Ms KING—It would help if you had somewhere you could leave your children—that would be a start.

Dr Smith—Finally, there is the issue of social recognition. The Norwegians have done this very well. It is right there in their official statistics. There are seven million litres of mothers milk made each year. That counts alongside fish production and bread production. It is part of

the food supply. It is part of the food security of the country. If you have a food safety scare, the breastfed babies are fine. We need to acknowledge that in our national statistics and we need to give priority to getting a decent set of national breastfeeding figures together.

We have had a very good guide map of how to put these statistics together since 2001. This national monitoring system was mentioned this morning, but it has not been implemented. The latest that I have heard is that the National Health Survey next time around is not even going to include breastfeeding, because they are relying on the states to do it. Unless you have a coordinated system for collecting good information, how can we evaluate programs and how can we do research on breastfeeding and what matters? Thank you for your patience. That went a bit longer than I expected.

CHAIR—Thank you for your comprehensive submission. It is a great help to the committee. You pretty well covered everything I wanted to ask.

Ms KING—Can you tell me what the lack of breastfeeding costs the Australian economy?

Dr Smith—If all Australian mothers were to breastfeed as the World Health Organisation recommended, there would be an increase in economic output in the form of milk of around \$3 billion.

Ms KING—And what is the converse of that?

Dr Smith—The converse of that in terms of health costs? If I get my next AIC funding I will be able to tell you in three years time. Just for those four illnesses that I have identified in the Canberra study—gastro, respiratory illness, eczema and necrotising enterocolitis, which is the premie baby—that is about between \$60 and \$120 million just for hospital costs. That does not include GP costs; it does not include the lost productivity of the parent who has the sick child and so on. It does not include out-of-hospital pharmaceutical costs for babies that are not hospitalised. So it is in the hundreds of millions and perhaps billions of dollars.

Ms KING—Alright, so there is no short answer?

Dr Smith—Ask me again in three years time.

Ms KING—It will be too late by then. The reason I asked you that is that I know, having worked on issues such as falls prevention, that one of the things that attracted great attention and got money into falls prevention for older Australians was a statement that was able to be backed up that falls cost more to the Australian economy than motor cycle and car accidents. There were all of the stats behind that to prove that. There was a very clear, sharp statement about what it cost the economy and that is what got people initially interested in falls prevention as a health promotion or area to actually put federal funding in. I leave that out there for you to consider—the short, sharp statement about what it costs the economy.

Dr Smith—The IQ effects of not breastfeeding are comparable to lead, except the exposure is much higher.

Ms KING—So the IQ effects are comparable to lead in terms of that. That is from scientific studies that bring all of that together. I was asking the health department at the start, and I think you were present, some questions about the amount of Commonwealth funding that goes into this whole area. Have you had any look at comparative levels of funding?

Dr Smith—Not at comparative levels of funding. I have looked to try to see how much there is. The ABA gets \$100,000 a year over three years; there is research funding, the NHMRC says, of around \$3 million. But a lot of that is actually research into the components of breastmilk. It is not about breastfeeding promotion. It is actually about giving the formula industry more information on how to make formula better. It is not actually focussed on addressing the breastfeeding problem. There are programs in terms of Aboriginal health, but I have not been able to track that down. It is often buried and it is not given a very high profile within that. It is seen as an add-on.

Ms KING—Yes. Obviously, the health department is going to provide us with some information, but if you do have any data about the amount of Commonwealth funding or any comparative data with other countries, or if there is anything that you have that compares it with other areas of population health, that would certainly be useful to us.

Dr Smith—The relevant comparison was what the industry spent against it.

Ms KING—Sure; we could do that on a number of issues. The tobacco industry would be an example of that too. But I think that is not quite what we want. Thank you.

Mr GEORGANAS—I was pleased that you touched on the Northern Europeans and Norway. One of the things you said was that one of the major differences was policy setting. You touched on the workplace policies. Is there anything else that stands out that makes a difference? They are huge figures when we work out the three months, six months and 12 months differences.

Dr Smith—Yes—baby-friendly hospitals universally, all of the health professionals, and engagement with the volunteer advocacy groups. They actually have almost like a marketing department within government but it is a partnership with the local nursing mothers association, really, which does the PR and promotion for that. They have very strong health professional training and education which is run by that same centre and they have the paid maternity leave. So I think it is those four things.

Ms HALL—Would you mind saying again what amount of money was put into research?

Dr Smith—The NHMRC submission said it is around \$3 million over three or four years, so it is a very small amount. As an academic I am, of course, in favour of much more of it.

Ms HALL—For academics that are interested in this area, that means that there is a very limited amount of money that is available there. What about money that is available for research through the companies that are promoting or selling?

Dr Smith—I do not know. I have looked at this to try and work out the research and development spend of the industry. If it is comparable with the pharmaceutical industry generally, the combined marketing promotion plus research and development totals about 40 per cent of their

turnover, so you would approximately double the figure I mentioned before for marketing. I would say probably around \$10 million to \$30 million or maybe more. That is just a very loose rule of thumb from the pharmaceutical industry generally.

Ms HALL—Therefore, anyone who was interested in research in the area would probably—

Dr Smith—Go and work for the industry—that is right.

Ms HALL—That was the point I was getting to.

Dr Smith—Yes, I just twigged! My grant is a fixed term grant. so as of June I am finished.

Ms HALL—Therefore, it is all slanted towards the formula industry than it is towards research that does not have any vested interest.

Dr Smith—Even further forward than that, if you look at the projects that the NHMRC has funded, it has a very strong medical orientation. The problem is actually not medical problems. As Colin Binns said, most women can breastfeed. We know that. They are built to breastfeed. The problem is not a medical one. It is a social, cultural and structural one. But I think there are only two studies that have been funded by the NHMRC that are addressing the social, anthropological and cultural sorts of issues that are the real barriers, or the health professional education and training, which are also real barriers. So it is quite distorted in the nature of it.

CHAIR—Thank you very much for appearing before us today. It was a very comprehensive submission and evidence. Because you are in Canberra, we may ask you to come back again. Please keep an eye on the public hearings in the *Hansard*. I think we would like to hear from you again.

Dr Smith—I would be happy to.

CHAIR—Thank you.

[12.21 pm]

PILE, Mrs Charndra, Private capacity

CHAIR—Welcome. The committee does not require you to speak under oath, but you should understand that these hearings are a formal proceedings of the Commonwealth parliament and the giving of false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. I invite you to make an opening statement.

Mrs Pile—I am very proud that I have breastfed my son for two years so far in line with the World Health Organisation's guidelines. Feeding him has certainly aided my transition to being a mum. It is not always easy and I have overcome various obstacles in this time. I surrounded myself with people supportive and educated about breastfeeding and I avoided negativity as best I could. With this support, any barriers that I came across just became obstacles to be overcome with the support.

I found that the ABA has been the only consistent source of support that I have had and this support network is already out there and really only needs to be more actively promoted by the government so that the ABA can simply get on with helping mums like me who want to breastfeed. It is really reassuring to know that there are mums who have been or are going through the same thing and can help. Lots of mums that I talk to have never actually heard of the ABA. I feel very sad for mothers who have not found the support that I have and did not feed as long as they had planned. Breastfeeding is very important.

As we have heard, new mothers want to breastfeed. Unfortunately, not enough women are receiving the information and ongoing help that they deserve to feed their babies breastmilk. Then there is ongoing emotional grief when it does not work out. This is not really right in Australia and should not happen here because we have got the information.

There are four main concerns I would like to highlight today from my experience. Firstly, having done it, I feel that antenatal education for breastfeeding is crucial. I did the breastfeeding education class run by the ABA when I was about six months pregnant. It gave me confidence, I got an accurate understanding about what normal breastfeeding was like and I knew how to avoid lots of the common problems that people tell you always happen but do not. It enabled me to recognise poor advice when I heard it and to access any help I needed. I knew about all of the different services that were available.

The ongoing support as a result of the class—the local meetings, the breastfeeding help line and the forum—has also buoyed my confidence in a society that is largely ignorant about how to support breastfeeding mothers. I think that the government could take an active role in publicising these ABA classes to expecting mothers and the community. In fact, actually sponsoring these classes would be an awesome investment as mums automatically receive a year of ongoing support with the class, as part of it.

Secondly, I have noticed a lack or inconsistency of knowledge in some healthcare providers and I can only attempt to express how reassuring it is to have a healthcare provider who

obviously knows about breastfeeding and how demoralising it is to be undermined by another. I have actually been told all sorts of rubbish, but luckily I knew when the information was wrong. Just imagine the impact on another mum, who took that advice and then their breastfeeding relationship ended as a result.

To address this, I suggest that the government needs to ensure that all healthcare providers receive a consistent level of breastfeeding knowledge. Even an ABA class would be great. I have had precisely one healthcare provider mention the ABA to me, yet they are the primary reason I am still breastfeeding today. It is actually a really simple thing to say, 'Have you contacted the ABA, because it is a network out there of mums.'

Thirdly, I feel strongly that the marketing of substitutes is undermining women's confidence and promoting a culture that does not support women to breastfeed their babies and young children. I would suggest that the government needs to protect mums by strengthening the systemic protection in that area, by tightening up the MAIF agreement and adding in more of the WHO code, so in particular restricting the retailers who are constantly promoting substitutes. It is very discouraging and it reinforces myths about breastfeeding.

I see a weekly parade of ads delivered for free to my letterbox. The ads are in many parenting magazines, on the internet and in glossy brochures in most chemists I visit. I have even seen TV ads featuring infant formula. There is one running at the moment. This is not supposed to happen, but retailers are exempt from any of the restrictions, so they do whatever they like. As I see it everywhere, it raises doubts in me and I have all the support I need to see through various marketing tricks. Imagine if I didn't? What irks me about it is that normal infant behaviours are often identified as a problem that needs to be solved with a particular formula rather than getting breastfeeding support. I have even seen on some of the websites damaging breastfeeding information given as help because they usually have a section about helping with breastfeeding. I feel that this constant promotion creates a feeling that breastfeeding must be really darn near impossible if so many substitutes are marketed all the time. It was actually one of the reasons that I made sure that I got prepared and went to the ABA class because I really wanted to breastfeed and all the ads sort of made me scared that maybe it is really impossible these days because lots of people tell me, 'You probably won't be able to. Lots of people can't.'

Following on from that, I feel a bit cross that we were not told anything about the increased risks of not breastfeeding in hospital antenatal classes. It makes no sense that we weren't. As parents we deserve the information about risks, otherwise the idea that breastfeeding is just lifestyle choice is perpetuated. Lastly an area of personal interest to me is the need to re-establish a national system of milk banks. I feel that if we had lots of milk banks again in Australia to support babies and mothers through stressful times of various types, it would emphasise to the wider community the importance of human milk.

I can see Australia could become a world leader in this area of health. We need to strive for what nature intended and what most mothers want: to breastfeed our young. It is mum and baby friendly and also friendly to the budget and the environment and it makes having a baby and now a toddler very pleasant. It would take time of course but if we keep trying to do good things as a community, those good things will keep happening. I think it is fantastic that the government is taking an active interest in improving support for mothers with this inquiry. I

heard a new baby is actually born two minutes in Australia, so there are lots of mums to reach every single day.

CHAIR—Thank you very much for your statement and your submission. As a new mum, when did you make up your mind you were going to breastfeed or have you always wanted to?

Mrs Pile—Always. I remember reading a textbook at school that talked about the importance of breastfeeding and the effects of colostrum in particular. I remember reading a section about that and then I sort of did a bit more research about it before I became pregnant and I thought I am definitely going to go that way. I started looking into finding out more information and I found out about the ABA class and booked in straightaway.

CHAIR—You have heard from the evidence given today that the best advocates for breastfeeding are mums. Are you in the same position yourself? Did you seek advice from other mothers or your own mother?

Mrs Pile—Yes, my mum breastfed my sister and pumped milk for me because I was just not interested in milk banks because I was born three months prem, so she pumped milk for me for nine months, and my grandma breastfed and my great grandma, so it was just what you did; you breastfeed your babies. I had that background.

CHAIR—Did you have the opportunity to provide advice to other friends having babies? Was that advice accepted?

Mrs Pile—I sort of stay in ABA circles at the moment, so we all basically have the same information. I am new to Canberra so that is my peer group at the moment.

Mr ENTSCHE—I have to say it is interesting to hear the myths that others have told you. I think it is rather frightening to hear what you were told by healthcare professionals and I think it seriously highlights the need for further education, no nutritional value past six months, frequent feeds make your milk go sour and gives your baby belly-ache.

Mrs Pile—I was told that.

Mr ENTSCHE—This is bizarre. It is seriously bizarre.

Mrs Pile—This is happening now. It happened to me last year and the year before.

Mr ENTSCHE—It certainly highlights the need for education and training for health professionals. How long do you hope to continue to breastfeed?

Mrs Pile—I would like to feed him until he is at least three. That is my goal. Two was my absolute minimum and he has just turned two now, so we are just cruising along and he will stop feeding whenever he feels like it. Some time between three and four possibly.

Ms HALL—I wonder whether if there is anything about your decision to breastfeed that could be used by mothers generally. Could we take your experiences and use them to promote the virtues and the benefits of breastfeeding?

Mrs Pile—There is the fact that I knew about antenatal breastfeeding education.

Ms HALL—A lot of mothers do not know about antenatal breastfeeding, so you believe that that is something that should be promoted.

Mrs Pile—Absolutely.

Ms HALL—What did you think when the previous witness was talking about COAG? Maybe including that in all antenatal courses could be part of the COAG agreement.

Mrs Pile—Yes, definitely, because I did a hospital antenatal course as well. It was over three weeks and we did breastfeeding for part of it, about an hour I think. I had already done the ABA one, so I thought it was a bit lacking.

Ms HALL—What was involved in that?

Mrs Pile—Which one?

Ms HALL—The hospital one.

Mrs Pile—We looked at a video on attachment in the first week the baby was born.

CHAIR—Where was that?

Mrs Pile—In South Australia, actually.

Mr GEORGANAS—Which hospital?

Mrs Pile—Flinders. It is actually a baby friendly hospital, so that was good. We brainstormed as a group the reasons for breastfeeding and that was it really. It was have a go; it will save you some money. In retrospect, in comparison I think it was not very much information really.

Ms HALL—What type of information would you like to see included if you were to draft a program for antenatal courses?

Mrs Pile—I would say look at what the ABA does. My friend and I did it at the same time and we are both still breastfeeding. We watched a young mum who breastfed for us, so we had a role model to have a look at, showing us what to do and the various positions. We looked at all the common problems and how they are caused and how to overcome them—or avoid them in the first place. And the sort of early things to avoid that can impact on breastfeeding. We had Mavin in a baby friendly hospital, so he stayed with me and he was put on the breast straightaway after he was born, he was not taken away, he was not given a dummy and they have policies to support that sort of thing.

Ms HALL—What do you think the psychosocial impact is of current advertising and marketing of non-breast products?

Mrs Pile—What do you mean by psychosocial?

Ms HALL—How it affects people psychologically and socially?

Mrs Pile—It affects me—I think it just gives the impression that breastfeeding must be really, really hard if all the images that we see in the media are about bottle feeding or buying formula and that sort of thing. There are shows on TV that always have a baby on a bottle rather than having a baby on the breast and that sort of thing.

Mr ENTSCHE—I think your point (f) here, companies marketing breastmilk substitutes should not be allowed to give breastfeeding advice on their websites is a very good point because they are not doing it in the public good. They are doing it to angle in on their own.

Mrs Pile—It will say things like if your baby is feeding every two hours, it is probably hungry, whereas that is actually perfectly normal.

Ms HALL—Does your child go to day care?

Mrs Pile—No, I look after him at home.

CHAIR—Do you have much contact with people who are having their first children in their mid-30s as the tendency is, and do they have a different attitude to breastfeeding from somebody who is having babies in their early 20s or teens?

Mrs Pile—I do not know. I guess my peer group is in their 30s I suppose, but my peer group here in Canberra is the ABA, so everyone is breastfeeding.

Mr ENTSCHE—A lot of your recommendations are quite modest and they are quite doable, things that could be done quite quickly. You have put a lot of effort into this. I congratulate you for that. It is very useful to have somebody that is actually doing it now. Thank you very much indeed.

Ms HALL—Do many of your peer group in the ABA work?

Mrs Pile—Lots of them do.

Ms HALL—And have their children in child care.

Mrs Pile—Yes, there are all sorts of combinations; some people are working full time, some are working part time and some are not working for money.

Ms HALL—How does it work for them?

Mrs Pile—With the support it works okay because, through the ABA, you learn all the different ways of integrating breastfeeding into the workplace and how you can express milk and use that for the baby during the day rather than having to wean because you are going back to work. You do not have to stop. You can breastfeed morning and night, the days you are off, on the weekends.

Ms HALL—You are saying the ABA is the key to success?

Mrs Pile—Absolutely.

Mr ENTSCHE—I notice another thing too obviously very crucial in relation to your own capacity to be able to meet your son's needs which is the support of dad hovering around in the background. I assume that is absolutely critical.

Mrs Pile—Absolutely, he has been my support model and has taken the day off work today. He has been great all the way through and I would say, 'I can't get the baby on.' He'd say, 'Got to have you up horizontal' and he would get me water and say 'You look after the baby and I will do the cooking.'

Mr ENTSCHE—That is good.

Mrs Pile—It makes a big difference. There is a really high percentage of increased breastfeeding if people's partners are educated about it. Chris says: 'Anything that is closer to what is natural, that is what you want to do. Stay away from processed things.'

Ms KING—How is infant formula being promoted to you? I noticed you mentioned in your submission that you were getting stuff through your letterbox about it as well; is that unsolicited?

Mrs Pile—Just the supermarket catalogues.

Ms KING—So it has not specifically been targeted at you? I had a thought that they might have some database of people having babies which would just be extraordinary.

Mrs Pile—No, it is just images coming through all the time. Buy this. This is an everyday product, essential needs. I have seen lists like that in a toy shop it is—

Mr ENTSCHE—Makes you feel guilty if you do not do it.

Ms KING—Are you saying in a toyshop there is a list?

Mrs Pile—Yes, one of the toy shops here in Canberra there is a list for everything a new mum needs—bottles, formula, right there.

Ms HALL—When your baby was young, did you give your baby any water or you just exclusively breastfed?

Mrs Pile—He was exclusively breastfed. He does not need water if he has got access to the boob.

Ms HALL—What about now?

Mrs Pile—He has breastmilk, water and all sorts of stuff now.

Mr ENTSCHE—Solids?

Mrs Pile—Yes, he is into it now.

CHAIR—Thank you very much for appearing before us. I know it is not easy to sit before a parliamentary committee. You have done very well and we appreciate your input. It is important for us to hear the views of a current mum. Thank you very much. I need a member of the committee to move that the committee authorise the publication of the evidence given before it at the public hearing today, including publication on the parliamentary electronic database of the proof transcript.

Mr GEORGANAS—So moved.

CHAIR—There being no objection, it is so resolved. Thank you.

Committee adjourned at 12.41 pm