COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# HOUSE OF REPRESENTATIVES

## STANDING COMMITTEE ON HEALTH AND AGEING

**Reference: Health benefits of breastfeeding**

WEDNESDAY, 23 MAY 2007

CANBERRA

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**HOUSE OF REPRESENTATIVES**

**STANDING COMMITTEE ON HEALTH AND AGEING**

**Wednesday, 23 May 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:** Mr Cadman, Mr Georganas, Ms Hall, Mr Johnson, Ms King and Mr Somlyay

**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.

## WITNESSES

**MALONE, Ms Geri, Executive Director, Australian Rural Nurses and Midwives ..................................... 1**

**Committee met at 9.20 am**

**MALONE, Ms Geri, Executive Director, Australian Rural Nurses and Midwives**

**CHAIR (Mr Somlyay)**—I declare open this public hearing into the health benefits of breastfeeding, and I welcome the Australian Rural Nurses and Midwives to the hearing today. I apologise for your not being able to give evidence at the last public hearing, when we simply ran out of time. Because you were Canberra based, you were kind enough to come in today.

These proceedings are formal proceedings of the parliament. The giving of false or misleading evidence is a serious matter and may be regarded as contempt of parliament. I now invite you to make an opening statement to the committee.

**Ms Malone**—Thank you very much for inviting me; I was pleased to be able to come back again. The Australian Rural Nurses and Midwives is the peak national body representing the nurses and midwives who work in rural Australia. That is quite a broad scope of practice, as you would imagine: it is in acute care as well as community and primary care practices. The aim of our association is to promote quality health care to rural communities through excellence in nursing and midwifery.

The main thrust of our submission, which I want to re-emphasise, is that, while we support a lot of the other areas around breastfeeding and certainly acknowledge the importance of breastfeeding, our main concern as an organisation representing part of the workforce is that there are critical shortages—we have got them and they are going to get worse. We are also concerned about the impact of the reduction of services for people who live in rural and remote areas. We think this has quite a significant impact on this particular topic because the support services that are taken for granted in urban areas are just not there for women in rural areas.

One of the implications has been the reduction in birthing services in rural Australia. I think the figure we cited was that about 130 services have been closed down in the last decade in rural areas—and that has flow-on impacts. It has an impact in that women are not able to access services where they live, and therefore the care that they receive through their pregnancy, birthing and postbirthing is very fragmented. There is a lack of continuity of care, which people acknowledge is very important in building up good, solid relationships for women particularly—supportive relationships in terms of the support they need for breastfeeding.

The other impact of the reduction in birthing services, particularly on the midwifery profession, is that their ability to practise across their broad scope of practice is very limited in rural areas, so we know we are losing them from the profession. That has implications.

While we believe that the role of supporting people in breastfeeding is across all professions and community support groups—we are not saying it is the sole domain of midwives and nurses—we do believe that midwives are best placed in lots of situations to provide this support, because they have the opportunity throughout pregnancy to have really good relationships with women which are sustainable in these situations when they need that support.

Those are our main issues: it is about the workforce, the reduction of services and the inability of rural services to provide the services that women might require to help them through this period of time.

**CHAIR**—You heard us say last time that we had been up to Kowanyama and Pormpuraaw. Do you also cover Indigenous communities?

**Ms Malone**—We do to a certain extent, although perhaps not as much. They are more, as you would know, in the remote areas of Australia. They are not so much in the rural areas, although there are Indigenous communities within rural Australia too.

**CHAIR**—Depending on the remoteness up in the Cape, they bring them in at 36 weeks to Cairns. They stay there for four weeks and then for four weeks after the baby is born and then they go back to the communities. How different is that in the more remote areas—not in Indigenous communities but in remote areas where people are out on properties et cetera? Do they still mainly use hospitals to give birth?

**Ms Malone**—Yes, they do, and the same situation applies, which is one of the challenges of the system. It has been my experience in another life; I worked a lot in remote areas and for the Flying Doctor Service, and it was very much the same situation. Women were required to come into town, wherever town might be, for extended periods of time before birthing, which has enormous implications in terms of the social disruption to their lives, as well as the economic factor. That certainly still applies. Women who you might not think of as being in a remote area but who are in a rural area where they are not able to birth anymore and who have to go to a metropolitan area to birth are still theoretically required to go to that location four weeks before the birth, which a lot of people will acknowledge is quite ridiculous for lots of situations. It has those enormous implications. Women are being taken from their social supports for extended periods of time.

**CHAIR**—Fewer GPs are delivering babies?

**Ms Malone**—Yes, that is correct. The GPs who do obstetric procedures are, like a lot of us out in the bush, getting older; the average age is pretty high. GPs are choosing not to do that anymore, for lots of reasons. That has implications in terms of the very medical model of the birthing practices that are around in this country.

**CHAIR**—During the early seventies there was a tendency not to breastfeed. Has breastfeeding fallen away? That was when GPs used to deliver babies—more so than they do now. Hopefully now there will be an increase in the breastfeeding rates. How different is it for somebody in a rural area to get good breastfeeding advice compared with what is available in metropolitan areas?

**Ms Malone**—For the reasons I have already stated there is a great deal of difficulty. There are important groups there, and other groups will have spoken of this much more and more knowingly than I can, I am sure. Of the other supports that are available for women, lactation consultants are a good example. This is a group that has emerged over the years and that has a very significant role in supporting women. Again, like any other specialised area, they are few and far between in rural areas. We struggle in rural areas to just get what we consider basic

services in terms of GP services and nursing and midwifery support services, but allied health and specialist medical services are few and far between. So in comparison to the metropolitan areas there is not a diversity of support networks.

It is also indicative that—although this was not the thrust of our submission—the social fabrics of rural communities have changed. They are not the extended networks anymore of the auntie and grandmother and those sorts of things, so people are also quite socially isolated, whereas they might have traditionally had a lot of that support. That support is not there, and if you cannot supplement it with professional support then they miss out all round.

**Mr GEORGANAS**—Obviously you would not have the figures on hand—if there are figures for that. Would you say that women in rural areas are less likely to continue breastfeeding for a period of time than women in city centres or larger metropolitan areas?

**Ms Malone**—I certainly do not have any figures around that, and I do not think that there are any. It would depend on the different groups of people. I know that there is a lot of concern around Indigenous communities, certainly in terms of not continuing breastfeeding.

**CHAIR**—What about workplace pressures?

**Ms Malone**—Workplace pressures for the women?

**Mr GEORGANAS**—Working on properties.

**Ms Malone**—A lot of women would say—and this goes back to my experiences of when I worked in those areas—that it is a lot easier to breastfeed. If it is well established and supported and they are confident in it, a lot of them acknowledge that it is a much easier option, certainly in terms of access to the basic things that we all take for granted. People on properties cannot just go down to the shop and get those sorts of things. Looking back on my experience, I would say that those that felt confident and well supported would continue in that. It is difficult to know.

**CHAIR**—That is women on properties. What about women in rural towns?

**Ms Malone**—It would be fairly indicative of the general trend but, again, I do not have any evidence around that. I do not think that anything has ever really been looked at. I understand that, in terms of the statistics, there are good statistics for women who leave hospital breastfeeding, but there have not been any really good studies about how long it is sustained for, the impacts and what influences why they stop.

**Ms HALL**—Do you think there needs to be a more longitudinal study than has been conducted?

**Ms Malone**—I guess longitudinal studies are always difficult, aren't they. From my reading and my understanding and from talking to people—and I am not specifically into the midwifery or breastfeeding areas—I would say that, if you really want to understand the things that influence why women do not continue to breastfeed, there is probably a place to have some more meaningful studies around that.

**CHAIR**—This inquiry came about because the ABA put in a submission to our health funding inquiry. Their evidence was that there are benefits to the health budget in the long term from breastfeeding: there is a lower incidence of complications later relating to disease and immunities. So we are looking at it from that point of view; but you cannot look at something if there is no data.

**Ms Malone**—No. That is exactly right.

**CHAIR**—We cannot differentiate between metropolitan and rural if there is no data, so that may be our recommendation: that this data be gathered.

**Ms Malone**—There is a concern particularly with Indigenous communities, and I know this came out when I was here last time. It was represented in our submission, particularly by nurses and midwives who work in those Indigenous communities. The concern is that Indigenous communities are already marginalised in terms of health status, and ideally they should be the group that are breastfeeding to get all those benefits to their children. But there are a lot of reasons why they are not able to, including the lack of support services.

One of the other big issues in Indigenous communities is the breakdown of the social structure, where that does not happen. There is a breakdown in the society, whereas, traditionally, breastfeeding would have been supported.

**CHAIR**—We heard evidence in Cairns that alcohol was a problem with breastfeeding. Do you find that?

**Ms Malone**—It is well acknowledged by people who work in remote communities that alcohol is a problem. I think it is just generally indicative of the breakdown of the societies in the remote communities, unfortunately.

**Ms HALL**—What about rural areas generally? I think there is data that suggests that there is higher alcohol consumption in rural communities generally than there is in other areas.

**Ms Malone**—Yes, I think there is. I think that the data supports that in terms of the incidence of alcoholism, but I do not know whether that has had any impact here, specifically. I would not have thought so. But I guess that is true anyway of the indicative data that says that the health status of all rural and remote communities is far lower than that of their urban counterparts—and I think there are lots of factors around that. But yes, the data supports that.

**Ms KING**—What is the main factor in the closure of rural maternity units?

**Ms Malone**—A lot of that is around workforce, I think. As I alluded to before, a lot of it also came about as a result of the very medical model of birthing services in Australia.

**Ms KING**—Are you saying that obstetricians are not available?

**Ms Malone**—Yes. Obstetricians are not available, GPs are not available and it became a risk issue for health services. I think there was a fear factor that you had to have a whole array of medical specialists in order to allow women to birth, which is a very natural process. A lot of that

has been debunked. There have been some papers that support the idea that it is very safe to birth in small rural places; it is a matter of risk management and carrying out a proper analysis of the risk factors of the woman. It is not necessarily about having to have a whole myriad of specialists to support it. In Australia, certainly, midwives are not utilised to the extent to which they are educated to provide birthing services.

**Ms KING**—Obviously, the issue of medical indemnity has driven some of that.

**Ms Malone**—And I think it is the lack of GPs in the country, generally. There are a lot of pressures on them, and they just do not want to work extended hours and after hours and provide those sorts of services. They have a lot of demands on their time. So, unfortunately for women, it is the birthing services that get knocked off.

**Ms KING**—I have absolutely no evidence for this but I am hearing around the traps in some of the communities I work with that, in some rural areas, breastfeeding is in fact higher. Part of this is an economic issue, because formula is so expensive and they are on fairly low incomes, so breastfeeding is the solution for those families. We do not have the data to say this but I am asking you to speculate: if it were the case in rural areas that breastfeeding rates were higher, how would that accord with your argument that a lack of services is making breastfeeding lower?

**Ms Malone**—Yes, you are right. If that were actually the data, it would not support it, would it. As I said, I am not aware of any data that supports that, but I think that, as you say, there is some validity in that. Formulas are very expensive, certainly for people in the lower socioeconomic group. Unfortunately, it has been my experience that that does not always equate. Whilst you might think it would equate to the fact that breastfeeding is the best option in lower socioeconomic groups, it is not always the situation.

**Ms KING**—They can be specifically targeted by companies as well.

**CHAIR**—In those two communities that I mentioned before, it was 100 per cent breastfeeding. We had a look in the stores and spoke to the store owner, who said they sell about two tins of formula a month. That raises the question: either they are being breastfed or they are using something else.

**Ms Malone**—Yes—Sunshine milk. That is the anecdotal—

**CHAIR**—Carnation milk, which was—

**Ms Malone**—Yes, Carnation milk or Sunshine milk. It is well known in Indigenous communities that it is the one of choice. I guess it is the cost factor and what is available. That has been around for years, and I was interested that, when I canvassed our membership about this, it still happens.

**Mr CADMAN**—I have a quick question about the withdrawal of the bush nurses. It is some years since I lived in the bush, but my wife was absolutely dependent on the bush nurse for our children, because it was motherly advice, and practical. My impression is that the bush nursing service no longer exists around Australia.

**Ms Malone**—No, I would say that it still does exist. Of course, we would say that nurses and midwives are the backbone of health services in rural and remote Australia.

**Mr CADMAN**—I would agree with that.

**Ms Malone**—I think it still does happen, and I think one of the things that you get concerned about—

**Mr CADMAN**—Are you not sure about the number of bush nurses who are employed by the state governments and where they are sited? Have they been drawn back to main centres or do they still service remote centres?

**Ms Malone**—It varies across the states. For example, in Victoria, there was the Bush Nursing Association, which still exists, and they certainly were employed in small communities throughout Victoria. They are still there. So there are certainly pockets of it.

**Mr CADMAN**—I think we need to find out what is going on there, Mr Chairman.

**Ms Malone**—If you go to Western Australia, there is a group, Silver Chain, who provide what you would call 'remote' services involving nurses working in isolated rural and remote communities. They very much provide support for the whole community.

**CHAIR**—Nurses also travel with the flying doctors when they visit the communities.

**Mr CADMAN**—I am aware of that service, but the bush nurse would have a large area based around a central, provincial city and would cover remote areas. They would spend one day a week in a number of centres.

**Ms Malone**—Some of them are perhaps not operating exactly as they were previously. Now they might cover a region in terms of being community health nurses, but it is very different in every state.

**Mr CADMAN**—Mothers now have to drive a lot further. If they do not have cars or money for petrol, then they have a problem.

**Ms Malone**—In terms of costing, a lot of those services are often cut back because of the requirement to travel out. The expectation that people will travel in means that some people become quite isolated, if they do not have the means for that.

**CHAIR**—In rural areas, is there a large take-up by GPs of practice nurses?

**Ms Malone**—Yes, increasingly so. That is certainly a burgeoning area. There is no doubt about that; it is certainly starting to take up.

The other interesting point that I probably need to make is that nurses, because of their scope of practice and their education, do not have any education and training in providing services to pregnant women. That is the role of the midwife. What happens in country areas is what happens with a lot of things: if there is a reduction in the extent of the specialisation of the workforce, it

comes back to nurses doing a lot of things. Midwives are the best-placed people to provide those services, because that is exactly what they are educated and trained to do. Nurses, however, do not have that experience. They do often pick up the gaps but they are not the best-placed health professionals to provide that information.

**CHAIR**—Are lactation studies part of a midwife's training?

**Ms Malone**—To a certain extent, but now lactation consultation is a specialty area in itself, as a build-on to midwifery. Certainly, midwives, in the normal course of their education, cover that.

**CHAIR**—What about nurses?

**Ms Malone**—No.

**CHAIR**—Not at all?

**Ms Malone**—No. It is an area that nurses just do not—

**CHAIR**—What about GPs?

**Ms Malone**—No. I would tend to say not, unless they have a particular interest in it, but not as a general rule. It is really the role of midwives. That is a bit of a misunderstanding which is quite general—the differences between what nurses do and what midwives do.

**Mr JOHNSON**—My brother is a doctor and my sister is about to become a doctor. My brother is a neurosurgeon, and he is quite often called to look after patients from rural and remote areas of the country. You mentioned earlier that, sometimes, women are called to go into town three to four weeks ahead of the birth. Can you give me a flavour of how often that would be?

**Ms Malone**—How often that would occur?

**Mr JOHNSON**—Yes. I would like to know the percentages.

**Mr CADMAN**—Every time they have a baby.

**Mr JOHNSON**—How often would it occur that women are required to go into town three or four weeks before the birth and incur all the costs and the emotional issues that go with that?

**Ms Malone**—How many women does that affect?

**Mr JOHNSON**—Yes, how many women would that constitute? There might be complications that arise; and they go back to their homes and then come in again.

**Ms Malone**—Yes, I think that is one of the points: it is now very fragmented care because of that situation. If they are fortunate, they are able to get some of their antenatal care where they live—if there is a GP and/or midwife shared care, which we would like to see a lot more of, with

midwives being able to provide that. Unfortunately, because of item numbers and all those complicated issues, that does not happen. But, if they are lucky enough, they might be able to get some of their antenatal care where they live.

However, for a lot of them, if their birthing is going to be under an obstetrician, for example, in a metropolitan centre, they are required to go down and have visits with them periodically. So, over the period of their pregnancy, they have to travel to visit their specialist obstetrician, as an example. This does happen a lot and, because there is the reduction in birthing services in rural areas, it is happening more and more. The recommendation is that, yes, they really should be located close to where the women are going to birth, from 36 weeks on. I do not know if that answers the gist of your question.

After the birth, if there is a local hospital in their area which has midwives, the women can go there—but, again, if women are not birthing there, often the midwives do not choose to stay in that area, because they are not able to practise across their scope of practice. The women might be able to have some of their postbirthing period in their local town or else go home—but, as birthing services are no longer in the local towns, a lot of them tend to go straight home from the hospital in the regional area, and they have not built up good relationships in the community.

**Mr JOHNSON**—That was the point that I was trying to get to: what is the percentage of women who would not go to follow-up care, compared to their city or urban counterparts, simply because of the distance factor, when maybe they should?

**Ms Malone**—Yes, exactly. I do not have any data on that, but I would think that that would not be insignificant.

**Mr JOHNSON**—It would not be uncommon?

**Ms Malone**—No, it would not be uncommon, because they have to travel back to see the obstetrician in the metropolitan area. Six weeks later is the general recommendation, as long as there are no complications; that is in a normal situation. That is a significant impost on rural people. It also comes into that whole patient assistance travel scheme issue, which is fairly current at the moment, in terms of the burden of cost and those sorts of things.

Sometimes it is a choice, and that is good too: they do need to have that choice. That is, they might choose to go to a particular specialist in a particular metropolitan area: it is a choice not a necessity. But for more and more women it is absolutely a necessity, because there is nothing more local than that.

**CHAIR**—It is more complicated when there are two or three kids still at home.

**Ms Malone**—Exactly.

**Ms HALL**—I am interested in the network of midwives that are in rural areas. Is there a significant network? Is there potential for midwife-led deliveries for cases that indicate low risk—and, associated with that, the antenatal and postnatal care that could be provided by those midwives?

**Ms Malone**—Absolutely; I would say yes to all of that. There are some very good models that already exist in metropolitan areas, and some that are starting up in rural and regional areas—that is, midwifery-led models of care, where midwives are providing the bulk of the care, including the birthing services.

However, in country areas it is a little bit different, and again it comes down to the actual numbers. It has been a bit of a contentious issue in rural areas. Traditionally, in rural areas, the role has been a nurse-midwife role. I am a classic example. If you were a registered nurse, you went off and did your midwifery course afterwards—it was a separate course—and you came back and you worked in a rural situation as a nurse and a midwife. That has traditionally been the role in rural areas, and it continues to be. That is out of necessity and the fact that rural health services cannot really afford to provide both services, because of the lower numbers: you might be having birthing, but there is not a birth every day or even once a week. So people have to be very general in their approach; they have to be able to provide a multitude of services. It is much more viable for small health services to employ someone like me, who is a nurse and a midwife and can do both roles. So that has an implication in itself.

In Australia we are now back to direct-entry midwifery, where you become just a midwife: you do not have to be a nurse to be a midwife. This has been a great advantage for people who want to specifically practise midwifery as their sole career, because it is a role within itself. In rural areas, though, there is not quite that option because you do not have the higher numbers of births. However, if you are in a regional area with high birthing numbers, there are opportunities to do that—and there are some regional areas that have high birthing numbers. There are some very innovative, smaller rural places that are trying to do that as well. There are midwives who are really committed to it, trying to work with their local GPs to provide that continuum of care.

**Ms HALL**—Could you give us some examples of those innovative models in rural areas; maybe you might like to send that in.

**Ms Malone**—There is a small area that I am trying to think of in Queensland—Goondiwindi, maybe. That is a small rural community, but there is a passionate group of people who are really keen to progress that and to work very closely with the GPs in their town. Yes, I will send you some information on that.

**Ms HALL**—My follow-up question relates to postnatal issues such as the support that mothers get with breastfeeding and ongoing advice as to the various stages, linking into immunisation—the whole gambit of what it is like if you are in a rural area, maybe a little bit away from a provincial centre, and how that support is delivered.

**Ms Malone**—Again, it depends upon what service is available. In our submission, there was an example of a small area in South Australia where they are still able to do the birthing. The midwives that are there are able to get involved in, for example, antenatal care with a GP. That does not happen a lot: often antenatal care has been taken away from midwives and is the sole domain of GPs, which is another topic in itself. Women in that community are able to birth in their local hospital and they have the support of midwives that they know. The midwives provide postnatal care; they are committed to having a community follow-up service, where the midwife goes and visits the women once they leave hospital. That is a very supportive network, and I

would suggest that, while there is not data around it, it would be a very conducive and supportive environment to support women through all of that period.

**Ms HALL**—If that does not exist, are they just sent home with some sheets of paper?

**Ms Malone**—They might be; the service that they get is so fractured nowadays. They might have birthed in a regional centre, for example, and they might bypass the local health service completely when they come home. That does happen. They go directly from that regional centre, so they do not get support when they leave that hospital. They would have had support from the midwife team and support with their breastfeeding, but then they are sent home. They may be 200 to 300 kilometres away. The first time that they need to come back and access services, unless they seek them out actively, is when they have to do their visit to the GP at six weeks. Postnatal services in terms of that check-up do happen, but there is not an item number around it. There is a lot of opportunity for midwives to get much more engaged in that. Depending on where you live, you might be fortunate enough, down the track, to go on to the maternal and child health services in that area who offer that support. That service varies enormously in terms of the experience and specifically supporting breastfeeding.

**Ms HALL**—So what are the options for a woman who, say, has engorged breasts or mastitis or is having some sort of problem with attachment?

**Ms Malone**—One of the nice things about country areas is that people are very familiar, so people feel quite comfortable in ringing up the local hospital. They will know that so and so is a midwife. There is that advantage in a rural area—it is not all bad. It is very optimistic in some ways, because they know the people and they usually find their own networks, so they might seek that out themselves. Generally, most of them will go back to their GP, because that is the main link that they have. That, too, will vary enormously according to their experience. In a community where there are good professional networks, the GP would refer them on to somebody else if it is not their area of expertise. The midwives might be there, but the concern is that we are losing our midwifery workforce in rural areas because they are choosing not to practise in that area: nurses who are midwives are choosing not to renew their midwifery certificate, because they are not getting the opportunity to practise in that area.

**Ms HALL**—How do we solve the problem?

**Ms Malone**—I think there are opportunities. There needs to be a really serious look at models of care. I know that different states are doing things in terms of different models of care, to encourage and promote birthing services safely staying in rural areas. They are utilising midwifery and shared care responsibilities and generally working together. Unfortunately, in our health system, we work in silos a lot, which I am sure you have heard about previously. There are silos between the public system and the private system, where everyone is doing their own little thing. Particularly when we have limited resources, we cannot afford to continue to do that. We have to be much more together in that.

There really are opportunities for state health services to look at different models of care. We need to support the midwifery workforce. That is one of our concerns. Particularly in rural areas, where we have that group who perform the nurse-midwife role, we need to provide professional development and support for them in their roles. Work needs to occur around some of the

postnatal services and—although it is not my area of expertise—some of the areas around item numbers availability, so that professionals other than doctors can provide some of those important services for women. For example, midwives might be able to provide postnatal care or other services like that. I think there are different funding models that are options. I know that is the ‘big picture’ thing, but I think there are things that we can do.

**Ms HALL**—Looking at item numbers is one role for the Commonwealth. Do you see any other role for the Commonwealth in this?

**Ms Malone**—I think that predominantly for the Commonwealth it is in terms of item numbers, but I would also like to see acknowledgement of, recognition of, and support for that workforce, including opportunities for professional development. We do have a serious situation impending across all of rural Australia in terms of our medical workforce, so it is important to provide incentives and professional development support. The Commonwealth already does some good things, in terms of the scholarships that are available, to support rural and remote nurses and midwives in their practice, but I think there needs to be more of that, and greater recognition. Certainly in the bush—and I am sure you have heard this before—we cannot rely on one health professional: it is a multidisciplinary team, and everybody should be treated equitably in terms of the role that they play in supporting people in rural areas.

**CHAIR**—You mentioned that the advertising of all breastmilk substitutes should be outlawed in Australia.

**Ms Malone**—Did we say that, did we?

**CHAIR**—Yes.

**Ms Malone**—They sound like very strong words.

**CHAIR**—It is a bit strong.

**Ms Malone**—It is, isn’t it. I think that was as a recommendation.

**CHAIR**—We will put that before the manufacturers when they appear before us in Sydney on 4 June.

**Ms HALL**—I am sure you will get a lot of support there!

**CHAIR**—This is not a witch-hunt against the manufacturers, because they do provide a service and a product that some people want. If the advertising is to create product differentiation between competitors, that is a different thing from trying to convince people that they should have their product instead of breastfeeding.

**Ms Malone**—Yes, that is the difference. One of the important things—I think this came out last time I was here, and the Australian College of Midwives made this point—is that there is a bit of concern that sometimes women who choose, for lots of good reasons, not to breastfeed do not get very good support. This, again, comes from my personal experience of seeing it. That is sometimes potentially damaging, too, if you think about the situations.

**CHAIR**—How do they not get support?

**Ms Malone**—In terms of support in working through that period of time. It is a continuation of what you were saying: who do women go to if they have problems with breastfeeding? If the breastfeeding is not going well and they choose to give it up and go on to use formula, they might not have been given any education in relation to the proper use of formula, particularly if they are young. If formula is not prepared properly in terms of adequate sterilisation and cleanliness, it puts infants at risk, particularly in groups who are already marginalised.

The Australian College of Midwives say—and this is in the midwives code of ethics—that midwives still need to continue to support people who are not breastfeeding. Again, they are very well placed to provide all that sort of information. In my career, I have seen many situations where women and families choose to use formula, but it is very dangerous if it is not done properly. There must be sterilisation and the right amounts; if not, the implications for the health of the child are quite significant. That is another area. Whilst we may not support the fact that formula is used, if it is—and often it is the only option—then we cannot pretend it is not happening. Whilst we all acknowledge, support and encourage breastfeeding as the ideal way, you have to also cater for other people.

**CHAIR**—As a professional, do you see high levels of complications when people who use formula to feed babies are not sterilising properly?

**Ms Malone**—No, I have not personally seen that. I can take you back to when I did my midwifery in Scotland. Going into the poorer areas of Scotland was a real eye-opener for me. I suppose you can make some analogies between lower socioeconomic groups who should have been choosing to breastfeed but were not doing so. As community midwives, we used to go around the communities, and there was very much no sterilisation. Scotland at that time was well known for its high infant morbidity rate.

There are certainly implications for our already marginalised Aboriginal communities in the overuse and underuse of formula. That they are not getting the nutrition they need is a significant factor, and the opportunity for infection and gastroenteritis from the lack of sterilisation is significantly high for the very vulnerable age of the baby. Again, I do not have any real evidence around that, but it is something we need to be aware of: that we should support people well when they choose, for a lot of good reasons perhaps, to not go down the breastfeeding path.

**CHAIR**—I think that is outside our terms of reference.

**Ms Malone**—Yes, I know it is, but it is a point.

**CHAIR**—It is a very valid point. If you could make a recommendation to us that specifically covers your area of rural and remote Australia, what would it be? I know we have your submission—

**Ms Malone**—It would be around supporting the workforce that we have in rural and remote Australia, particularly in midwifery because midwives are the group best placed to provide this professional support. We need to acknowledge the specific role of midwives in rural communities and support them in their professional development and in the continuation of their

services through the maintenance of birthing services in rural communities—obviously with the adjunct that it is around safety and quality and it always will be. We know that you can provide safe, quality birthing services in rural communities, but it is about supporting the workforce.

**CHAIR**—We are very keen as a committee to make sure that parents—not only mothers—have the opportunity to make an informed choice regarding breastfeeding. We want to put on the table the known data in favour of breastfeeding, so that people can be aware and make an informed choice. That is what we are trying to do.

**Ms Malone**—As nurses and midwives are the most widely distributed workforce out there, they are a good group to promote that information. I certainly consider that it is the responsibility of their role to do that health promotion in terms of breastfeeding.

**CHAIR**—Thank you very much for appearing today and making the effort to come in twice. You obviously follow this inquiry. If anything further comes up later and you want to make a comment either in writing or verbally, we would be only too happy to receive it.

**Ms Malone**—I will provide some information on those birthing models.

Resolved (on motion by **Mr Georganas**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

**Committee adjourned at 9.59 am**