Tasmanian Joint Select Committee Inquiry into Preventative Health Care

Submitted by **Ros Escott**

Co-Convenor, Tasmanian Breastfeeding Coalition

03 6223 6396

On behalf of

Tasmanian Breastfeeding Coalition
GPO Box 217
South Hobart
Tasmania 7004

Summary

Breastfeeding is a key preventative health strategy. Not breastfeeding contributes to numerous adverse health outcomes for mothers and babies. This cost individuals emotionally and physically and escalates life-long health care costs.

Breastfeeding initiation rates are reasonable, but there is a rapid decline in the first weeks and months, and low exclusive breastfeeding rates. Of huge concern in Tasmania is the strong social gradient in relation to breastfeeding and the high rate of formula feeding from birth in some sectors.

There are various blue-prints for action such as the National Breastfeeding Strategy but what is missing is investment in long-term strategies to close the gap in breastfeeding rates.

Recommendations for priorities to reduce the equity gap in breastfeeding:

- **Investment in local action on breastfeeding** as an intervention trial (including studying communities with low breastfeeding rates as well as learning from those communities where breastfeeding rates are good). We need community based social marketing mixed with community identified solutions to improving breastfeeding rates in specific communities. We also need this to be a partnership with the research sector.
- **Investment in stronger community support for breastfeeding.** This includes good antenatal and postnatal services, supporting community organisations such as the Australian Breastfeeding Association and investing in strategies that create more supportive environments for breastfeeding (such as workplaces across all sectors – policies, lactation breaks, facilities (breastfeeding/expressing room), family friendly working conditions; and local communities – public facilities, local businesses, parenting rooms.
- **Baby Friendly Health Initiative (Community)** for health and community services (especially in targeted areas where breastfeeding rates are low). Because we have seen how BFHI (Hospital) has improved initiation rates we should be applying this strategy to achieve improvements in duration rates.
- **Greater protection of breastfeeding from inappropriate marketing** of infant formula using regulatory measures (such as strengthening or adding to the Marketing in Australia of Infant Formula (MAIF) agreement). This will require us working closely with the Commonwealth, and probably will require advocacy from community and other sector partners.
- **Improving breastfeeding monitoring and surveillance and qualitative research** at a local level. While we have better data available now, there continues to be great limitations with the data we are relying upon and also we need better social research to identify community driven solutions.

COMMENTS ON TERMS OF REFERENCE

1. The Committee will inquire into and report on the current impact of inequalities in the major social determinants of health on the health outcomes, including mental health outcomes of Tasmanians and including current evidence describing social gradients in health, and the capacity for health and community services to meet the needs of populations adversely affected by the social determinants of health;

Breastfeeding is important to a range of health outcomes.

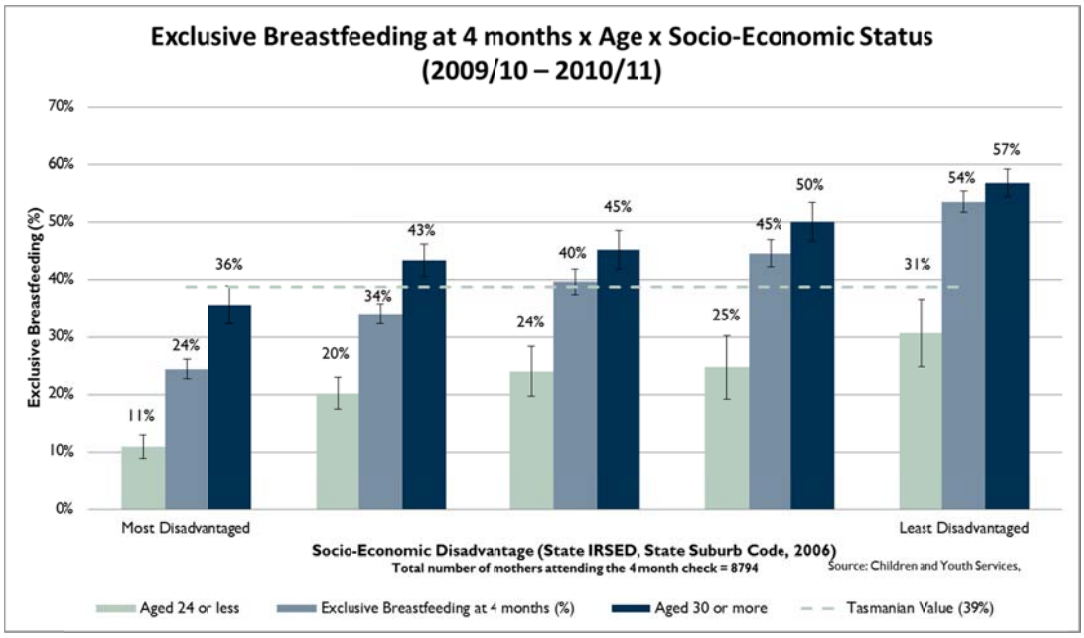
- Breastmilk is the normal food for babies. Nothing else can fully provide for and adapt to a baby's needs from beginning to end of a feed, or from day to day. Breastfeeding is protective against a number of illnesses and diseases for both mother and baby; exclusive breastfeeding is even more protective. These include but are not limited to, gastrointestinal illness, respiratory illness, ear infections, eczema and necrotising enterocolitis for babies, and premenopausal breast cancer, ovarian cancer and osteoporosis for women. Breastfeeding is also protective against chronic conditions such as obesity and multiple sclerosis.
- Breastfeeding is important for communities in relation to reducing the burden of health, in relation to improved education outcomes and in relation to social inclusiveness.

What do we know about influences on breastfeeding rates?

Unfortunately not all communities in Tasmania experience the same level of support to enable mothers to continue to breastfeed their babies.

In Tasmania, around 80% of Tasmanian women leave hospital intending to breastfeed falling a bit short of the National target of 90%. However, there is a substantial decline in breastfeeding rates in the first weeks and months after birth, and low exclusive breastfeeding rates. It is estimated that only 50% of Tasmanian infants are still (at least partially) breastfed at 6 months, well below the National target of 80%. This data is drawn from statistics collected by the Child Health and Parenting Service (CHAPS). The limitations of this data include the fact that only two-thirds to three-quarters of babies attend a six month visit with CHAPS. These state-wide breastfeeding rates have remained fairly static over the last ten years.

Of concern are recent findings that the CHAPS collected breastfeeding rates vary substantially between local government areas. For example in the years 2009–10 to 2010–11, an average of 39% of mothers attending the four-month Child Health Assessment were exclusively breastfeeding their babies. Exclusive breastfeeding rates at the LGA level ranged between a high of 62% and a low of 19% and have not significantly changed at a state-wide level over the past three years[i]. See Graph 1 from the Kids Come First Report.



Graph 1 – Exclusive Breastfeeding at 4 months by age and Socio-economic status

Notes
Attendance at Child Health Assessments is voluntary. Only 72% of babies attend a four-month Child Health Assessment between 2009-10 and 2010-11 and non-breastfeeding mothers may be less likely to attend routine checks.

Source: Unpublished data, Children and Youth Services, DHHS

Table 1: Exclusive breastfeeding at 4 months x age x socio-economic status (2009/10–2010/11)

Socio-Economic Disadvantage Quintiles	Exclusive Breastfeeding at 4 months	Exclusive Breastfeeding at 4 months aged 24 or less	Exclusive Breastfeeding at 4 months aged 30 or more
Most Disadvantaged	24% (±1)	11% (±2)	36% (±3)
	34% (±1)	20% (±3)	43% (±3)
	40% (±2)	24% (±4)	45% (±3)
	45% (±2)	25% (±6)	50% (±3)
Least Disadvantaged	54% (±1)	31% (±6)	57% (±2)
Lowest LGA[1]	19% (±3)	-	-
Highest LGA[1]	62% (±3)	-	-
State-wide	39%	19%	48%

Source: Unpublished data, Children and Youth Services, DHHS

[1] References to LGAs exclude Flinders Island, King Island and Central Highlands due to low numbers.

Social determinants underpin whether or not women choose to breastfeed. National research has found that some population priority groups are less likely to breastfeed than others[2]

• Aboriginal and Torres Strait Islander mothers:

• Less educated women of low socio-economic status:

• Young mothers.

For example (from Kids Come First) mothers aged 24 years or younger are less than half as likely to exclusively breastfeed as mothers aged 30 years or more (19% compared to 48%). Additionally, mothers who live in the most disadvantaged communities are half as likely to exclusively breastfeed compared to mothers in the least disadvantaged communities (24% compared to 54%). There is an association between age and socio-economic status, with the average age of mothers in the most disadvantaged communities significantly lower than in the least disadvantaged communities.

In Tasmania there are differences in community social norms, where in some communities it is more usual and accepted to *not* breastfeed. Women having babies are choosing not to breastfeed, or giving up quickly, because they have had little or no exposure to positive breastfeeding experiences around them (that is, they weren't breastfed, none of their family breastfed, their friends don't breastfeed, their partner wasn't breastfed). They also believe that there is an acceptable alternative available (in infant formula).

There are also many different barriers to breastfeeding which play out unevenly in different communities within Tasmania. These include:

- Inadequate measures to protect breastfeeding from inappropriate marketing of its main competitor – infant formula.
- Unhelpful attitudes and inadequate knowledge levels of some health professionals.
- Lack of appropriate education and ongoing support and advice on techniques for successful breastfeeding establishment in the first six weeks postpartum.
- Lack of adequate and consistent advice on breastfeeding maintenance, and on factors that are likely to limit breastfeeding success of common breastfeeding problems by some health practitioners.
- Media representations and cultural perceptions of the breast as sexual and cultural attitudes to breastfeeding in public.
- Inadequate maternity leave and workplace legislation and lack of appropriate workplace facilities for breastfeeding.

[2] AIHW. A Picture of Australia's Children 2012.

What has been achieved and what more is needed?

Tasmania has achieved Baby Friendly Health Initiative (BFHI) accreditation for all of its public and private maternity services. This is a very positive achievement resulting in initiation rates that are quite good. Within communities, CHAPS actively supports and monitors breastfeeding. The NHMRC has just released Infant Feeding Guidelines for health workers in line with its recent review of the evidence.

The formation of the Tasmanian Breastfeeding Coalition (TBC) was initiated over 15 years ago and has been supported by Population Health in order to put some cross sector mechanism in place in order to maximise efficiencies when working with limited investment in breastfeeding. The TBC is an inter-sectoral coalition that provides an opportunity for open and transparent communication between private, community, government and research sectors and to identify opportunities for intervention and maximising effort through collaboration.

Some important achievements of the TBC include:

- Better, more meaningful breastfeeding data is now collected in Tasmania. It was only because of TBC advocacy efforts that there is data published for Tasmania.
- We have created a culture of working together in relation to breastfeeding. This cross sector partnership can be built upon in order to strength commitment and investment from other sectors in relation to improving breastfeeding.
- Identification of a number of key practices occurring that clearly show Australia's response to the WHO International Code of Marketing of Breast milk Substitutes needs to be strengthened. This will form evidence to support this section of work in the National Breastfeeding Strategy (and probably needs advocacy to ensure it can't be ignored).

When the TBC first formed its main focus was to apply for (usually one-off) funding to conduct various breastfeeding projects. These included: a couple of small social marketing campaigns, various breastfeeding promotional events, a peer education program on the North West coast, a project to engage businesses in providing supportive breastfeeding environments and a range of small scale research projects. We learned that this approach was not effective. Small amounts of one-off investment in breastfeeding strategies in Tasmania has not achieved any impact on the decline in breastfeeding duration rates.

In relation to social marketing we learned there is no impact at all on breastfeeding with small scale investment and broad messages. While the peer education program was showing some positive process evaluation (and there is international evidence to support this approach) our program was not able to be sustained beyond the funding period. The Australian Breastfeeding Association now has a short course to train peer Community Breastfeeding Mentors that has been successful interstate for communities with low breastfeeding rates, but peer group mentors do need ongoing support if they are to be effective.

In the community more needs to be done to protect breastfeeding from competing commercial pressures. This could be achieved through regulatory approaches (such as adopting all aspects of the WHO Code (International Code of Marketing of Breast milk Substitutes) including strengthening our ability to influence retailer practices in relation to marketing Breast Milk Substitutes and including toddler milks in the regulatory framework.

Building on the success of the Baby Friendly Health Initiative in hospitals, more support is needed to achieve BFHI (Community) accreditation for a range of health and community services.

Recommendations for priorities to reduce the equity gap in breastfeeding:

- Investment in local action on breastfeeding as an intervention trial (including studying communities with low breastfeeding rates as well as learning from those communities where breastfeeding is working well). We need community based social marketing mixed with community identified solutions to improving breastfeeding rates in specific communities. We also need this to be a partnership with research sector.
- Investment in stronger community support for breastfeeding. This includes good antenatal and postnatal services, supporting community organisations such as the Australian Breastfeeding Association and investing in strategies that create more supportive environments for breastfeeding (such as workplaces – policies, lactation breaks, facilities (breastfeeding/expressing room), family friendly working conditions; and local communities – public facilities, local businesses, parenting rooms.
- Implementation on Baby Friendly Health Initiative (Community) for health and community services (especially in targeted areas where breastfeeding rates are low). Because we have seen how BFHI has improved initiation rates we should be applying this strategy to achieve improvements in duration rates.
- Greater protection of breastfeeding from inappropriate marketing of infant formula using regulatory measures (such as strengthening or adding to the MAIF agreement). This will require us working closely with the Commonwealth, and probably will require advocacy from community and other sector partners.
- Improving breastfeeding monitoring and surveillance and qualitative research at a local level. While we have improved data available now, there continues to be great limitations with the data we are relying upon and also we need better social research to identify community driven solutions.

2. The Committee will inquire into and report on the need for an integrated and collaborative preventative health care model which focuses on the prevention, early detection and early intervention for chronic disease;

The National Breastfeeding strategy[3] has examined and documented the evidence of effectiveness of various breastfeeding promotion and protection strategies. Much of the evidence comes from overseas. It appears that multi-strategic approaches will be most effective. Most of the other states are developing breastfeeding strategies to guide

[3] Commonwealth of Australia, 2009 on behalf of the Australian Health Ministers Conference. *Australian National Breastfeeding Strategy 2010-2015.* *http://www.health.gov.au/internet/main/publishing.nsf/Content/aust-breastfeeding-strategy-2010-2015*

investment in this area. In Tasmania, the breastfeeding focus area in the Tasmanian Food and Nutrition Policy[4] remains a relevant framework to guide action and investment.

There are some good blueprints to guide collaborative action on this important issue but what is missing is investment. There is a need to reduce the current inequity in breastfeeding rates across communities in Tasmania by increasing rates in more disadvantaged communities. There is a need for much more targeted activity and investment.

Cross sector action on breastfeeding (that is, strengthening the TBC partnership to get greater buy in and commitment from a range of sectors) is needed. This could greatly influence our ability to get greater action on breastfeeding in education, workplace relations, economic development etc). For example, a whole of government policy to support the continuation of breastfeeding by mothers when they return to work (in all sectors of the workforce) would not only improve the health outcomes of the mother and child, there would be important benefits for the workplace in relation to a reduction in sick leave and in relation to important workforce issues such as retention of skilled staff. NSW, QLD and WA all have whole of government Breastfeeding policies. Tasmania has yet to initiate such a policy.

3. The Committee will inquire into and report on the need for structural and economic reform that promotes the integration to health and wellbeing, including the consideration of funding models;

Breastfeeding contributes significantly to the Tasmanian economy both through the production of a valuable commodity and through the reduction in health cost costs in the short and long term.

The value of breastfeeding and its economic contribution to the community needs to be recognised. In 2010, with financial support from the Tasmanian Early Years Foundation, the Tasmanian Breastfeeding Coalition hosted an event called *Breastfeeding, Every Drop Counts.* The TBC worked with Health Economist Dr Julie Smith to calculate a dollar value on breast milk (approx $100/litre) emphasising its value to the community and the economy[5].

Breastfeeding is designed for normal human health, nutrition, physical development (including immune system development) and psychological development. Breast milk is more than food. It should be thought of as a 'broad-spectrum medicine' providing antibodies, living cells, enzymes and hormones, which can't be replicated. Breastfeeding is protective against a number of illnesses and diseases for both mother and baby.

---

[4] Tasmanian Government, 2004. *Tasmanian Food and Nutrition Policy.* http://www.dhhs.tas.gov.au/__data/assets/pdf_file/0004/.../TFNP_final.pdf

[5] **How are we calculating the economic contribution of breastfeeding?**
In 1992 breastmilk was worth $67 per litre (Smith 1999). Based solely on inflation and not on any increases in value due to its recognised importance, the cost of breast milk in 2009 was approximately $101. The average first year breast milk production rate is 670ml per day (Oshaug and Botten 1994). This equates to 20.4 litres of breast milk per month. The average second year breast milk production rate is 309ml per day (Oshaug and Botten 1994). This equates to 9.4 litres of breast milk per month. This means that breast milk in the first year of feeding is worth $2064 per month in 2009 and that breast milk in the second year of feeding is worth $951 per month in 2009. These calculations will be used today to come up with an approximate figure in today's monetary terms that represents the contribution to the Tasmanian economy by the breastfeeding women present.

Not breastfeeding contributes to illnesses for mothers and babies. Artificial feeding is associated with increased health risks during infancy, childhood and adulthood. In developed countries it is estimated that babies not breastfed have twice the likelihood of illness than breastfed babies. Affordable health care begins with breastfeeding. Breastfeeding makes a significant difference to the Tasmanian community through reduced short and long-term health care costs[6].

The value of breastfeeding should be recognised and protected by a greater investment into research and breastfeeding promotion in Tasmania. Around $30–$50 million annually is spent on marketing infant formula in Australia[7]. This compares with only $2 million spent on a National Breastfeeding Strategy. Women cannot make an informed choice about infant feeding in such a market place.

4. The Committee will inquire into and report on the extent to which experience and expertise in the social determinants of health is appropriately represented on whole of government committees or advisory groups;

All too often, decisions and policies are made by government (at all levels) which do not consider potential implications for the social determinants of health and health inequities. Asking all government departments to conduct a health impact assessment prior to setting policy and programs, would be an important strategy to ensure equity in health improves in Tasmania.

5. The Committee will inquire into and report on the level of government and other funding for research addressing social determinants of health.

In Tasmania there has been no investment into research which aims to understand the influences of social and cultural norms in relation to breastfeeding in different communities.

It is important to understand the different set of circumstances and barriers that exist for women in different communities in relation to breastfeeding. Because the factors affecting a woman's decision to breastfeed are multifactoral and vary for different communities there needs to be greater investment in research to inform local level long term strategies to make both initiation and longer duration of exclusive breastfeeding an easier and more common choice by women. One of the key barriers to breastfeeding is a lack of exposure to positive experiences by women to breastfeeding. For example, if they were not breastfed as a child, if they haven't been around women in their family and community who breastfeed and if they do not have a supportive partner, then they are highly unlikely to successfully breastfeed themselves.
The Tasmanian Breastfeeding Coalition is made up of a number of groups and organisations which work together to improve breastfeeding rates in Tasmania. Initially formed in 1996 the Coalition now extends across the state of Tasmania.

[6] Smith, J, Thompson, J & Ellwood, D. 2002. Hospital system costs of artificial feeding: estimates for the Australian Capital Territory. Australian and New Zealand Journal of Public Health. 26(6), 543-551.

[7] Smith, J. 4B: Mothers Milk, Money and Markets. 1-11.

Currently the following are members of the Tasmanian Breastfeeding Coalition:

- Australian Breastfeeding Association
- Australian College of Midwives Inc. Tas Branch
- Baby Friendly Hospital Initiative, Tas Committee
- Calvary HealthCare Hospitals
    - St Lukes Campus
    - Lenah Valley Campus
- Department of Health and Human Services
    - Physical Activity and Community Nutrition Unit
    - Child Health and Parenting Service
    - Maternity Services, Royal Hobart Hospital
    - Maternity Services Launceston General Hospital
    - Oral Health Services Tasmania
    - Women's Health
- Healthscope
    - Hobart Private Hospital, Maternity Services
    - St Helens Private Hospital
- Ramsay Health Care
    - North West Private Hospital
- Birth Centre, Launceston
- National Association of Childbirth Educators
- Pharmaceutical Society of Australia (Tasmanian Branch)
- Tasmanian Lactation College Inc.
- Eat Well Tasmania
- Child Health Association Tasmania Inc
- Good Beginnings Australia
- Tasmanian Early Years Foundation
- Diabetes Australia – Tasmania
- Australian Medical Association, Tasmanian Branch
- Glenorchy City Council
- Menzies Research Institute
- Tasmanian Aboriginal Centre