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Uniting Church in Australia
SYNOD OF VICTORIA AND TASMANIA

Justice and International Mission Unit
130 Little Collins Street
Melbourne Victoria 3000
Telephone: (03) 9251 5271
Facsimile: (03) 9251 5241
jim@victas.uca.org.au

Submission to the

Standing Committee on Health and Ageing

Inquiry into the health benefits of breastfeeding

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Dr Mark Zirnsak
Director
Justice and International Mission Unit
Synod of Victoria and Tasmania
Uniting Church in Australia
130 Little Collins St
Melbourne, Victoria, 3000
Phone: (03) 9251 5265
Fax: (03) 9251 5241
E-mail: mark.zirnsak@vic.uca.org.au

Executive Summary

The Justice and International Mission Unit of the Synod of Victoria and Tasmania welcomes the opportunity to make a submission to the Standing Committee on Health and Ageing 'Inquiry into the health benefits of breastfeeding'. In Australia, the sophisticated marketing of breastmilk substitutes threatens a woman's right to an informed choice about breastfeeding and also undermines the rights of the infant to the best food and nutrition possible.

It is a well recognised fact that breastfeeding is the best start in life for a baby, where breastfeeding is possible. This view is held by the World Health Organisation (WHO) and UNICEF and continues to be confirmed by medical research. The World Health Organisation recommends exclusive breastfeeding for the first six months of life, the introduction of local, nutrient rich complementary foods thereafter with continued breastfeeding to two years of age and beyond.[1] In reaching this conclusion the WHO Expert Consultation reviewed more than 3,000 references.[2]

The Justice and International Mission (JIM) Unit is concerned that the marketing activities of the manufacturers of breastmilk substitutes undermine breastfeeding rates and the effectiveness of the money spent by Federal, State and Territory Governments in promoting breastfeeding in the Australian community. Marketing of breastmilk substitutes is covered by the voluntary *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement* (MAIF). Coverage is not comprehensive and only applies to six major baby food companies: Heinz Watties, Nestlé, Nutricia, Wyeth, Abbott and Snow Brand.

MAIF falls well short of the standards set by the World Health Organisation *International Code of Marketing of Breastmilk Substitutes* (WHO Code) and subsequent World Health Assembly (WHA) resolutions on the marketing of breastmilk substitutes. These standards are seen as the minimum required in order to protect breastfeeding rates. MAIF does not cover all breastmilk substitutes, but only infant formula. Thus, baby cereals, drinks and any other breastmilk substitutes marketed to infants below six months are not subject to MAIF. The MAIF Agreement also does not cover marketing of bottles and teats, which are within the scope of the WHO Code. The failure of the MAIF Agreement requires an immediate change in legislation and/or regulation to protect current breastfeeding rates in Australia.

Samples of advertising observed by the JIM Unit reveal that baby food companies use marketing strategies which breach the MAIF Agreement, WHO Code and WHA Resolutions such as the distribution of free samples, the promotion of breastmilk substitutes in health care facilities, and the use of pictures idealising artificial feeding. Such advertising of breastmilk substitutes can falsely lead new mothers to make decisions about breastfeeding that are ill-informed and may be detrimental to their baby's health. It is well documented that advertising and attitudes of health care workers and obstetricians also influence women's choice of infant feeding methods[3].

The JIM Unit does not believe that current measures to promote breastfeeding are either adequate or effective. According to the Australian Bureau of Statistics, only 32% of all infants aged 6 months

[1] World Health Assembly Resolution 54.2, 2001.
[2] Colin Binns, 'Encourage and Support Breastfeeding', in National Health and Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia*, 10 April 2003, p. 1.
[3] Howard, C et al, 'Office prenatal formula advertising and its effect on breast-feeding patterns', *Obstetrics & Gynecology*, vol.95, no.2, February 2000, pp296-303

or less were fully breastfed. This is well below the recommended target of the National Health and Medical Research Council (NHMRC) of 80% and also below the world breastfeeding standard of 34%.

Although infant mortality rates in Aboriginal and Torres Strait Islander children have decreased dramatically, they still remain to be two or three times greater that the national average. Evidence suggests that there is a close relationship "between the introduction of bottle feeding and a depression in the weight gain velocity of Aboriginal children"[4]. Significant problems have resulted from bottle-feeding Indigenous children including the use of "inappropriate modified cow's milk... and inadequate sterilisation of bottle-feeding equipment in conditions where this is difficult to achieve"[5]. It is well documented that low socio-economic status women and women from disadvantaged groups, as well as women who become ill in the post natal period are at higher risk for shortened breastfeeding duration.

There is an economic burden on the health system associated with the use of breastmilk substitutes and early cessation of breastfeeding. A decrease in the rate of breastfeeding presents a number of significant problems including the hospitalisation and medical costs associated with an increased rate of illness for both mother and infant. The current costs to the health system nationally of not increasing breastfeeding rates are estimated at $780 million annually. Thus, investments to increase breastfeeding rates have the benfits of increasing public health and decreasing demand on the health system.

The Unit acknowledges that increasing breastfeeding rates would impact on Australia's milk industry. However, the costs to the health system are far greater. The Unit also believes the moral imperative should be to provide infants with the best food and nutrition available so that they have the best possible start in life.

Final Recommendations

The Justice and International Mission Unit recommends the Australian Government adopt the following measures:

1) Replace the existing voluntary, self-regulatory MAIF agreement with implementation of the *WHO International Code of Marketing of Breastmilk Substitutes* and subsequent World Health Assembly resolutions via either legislation and regulation or a mandatory code in the *Trade Practices Act*;
2) Reintroduce funding to support the implementation of Baby Friendly Health Initiatives;
3) Develop culturally-appropriate health services targeted at Indigenous and disadvantaged women with consideration for local customs, languages and traditions;
4) Appoint a national breastfeeding coordinator of appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations and health professional associations as recommended in the *Innocenti Declaration 2005 on Infant and Young Child Feeding;* and
5) Enact imaginative legislation protecting the breastfeeding rights of working women and establish a means for its enforcement[6].

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[4]Howard, C et al, op cit.
[5]Ibid
[6] International Code Documentation Centre 1990, *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.*

Introduction

The Justice and International Mission Unit, Synod of Victoria and Tasmania (JIM) welcomes this opportunity to make a submission to the Standing Committee on Health and Ageing 'Inquiry into the health benefits of breastfeeding'.

The JIM Unit exists to engage with the church and society about issues of social justice. This work is guided by the statements and resolutions of the Uniting Church in Australia and a belief that Christian theology calls us advocate on behalf of those who are poor or marginalised. Our position is guided by basic Christian values and principles such as, "*the importance of every human being, the need for integrity in public life, the proclamation of truth and justice, ... personal dignity, and a concern for the welfare of the whole human race.*"[7]

The church believes life is a gift from God and all human beings are important to God. Health depends on all dimensions of an individual's life - physical, emotional, mental, cultural, social and spiritual. Therefore, in assessing the health benefits of breastfeeding, JIM believes it is also necessary to assess if there are policies and practices that are preventing all people access to these benefits.

Health is internationally recognised as a human right under Article 12 of the *International Covenant on Economic, Social and Cultural Rights* which states the right of everyone to, "the enjoyment of the highest attainable standard of physical and mental health"[8]. In Australia, the sophisticated marketing of breastmilk substitutes threatens a woman's right to choose whether or not to breastfeed, and also undermines the rights of the infant to the best food and nutrition possible. Where breastfeeding is not possible, a mother should still be supported to seek out accurate and independent information about her choices.

(a) <u>The extent of the health benefits of breastfeeding</u>

It is a well recognised fact that breastfeeding is the best start in life for a baby, where breastfeeding is possible. This view is held by the World Health Organisation and UNICEF and continues to be confirmed by medical research. The World Health Organisation recommends exclusive breastfeeding for the first six months of life, the introduction of local, nutrient rich complementary foods thereafter with continued breastfeeding to two years of age and beyond.[9] In reaching this conclusion the WHO Expert Consultation reviewed more than 3,000 references.[10]

Attached to this submission is a paper by INFACT Canada on *Risks of Formula Feeding. A Brief Annotated Bibliography.*[11] The paper provides a bibliography of research showing that babies feed on breastmilk substitutes rather than exclusive breastfeeding have:

- Increased risk of asthma;
- Increased risk of allergy;
- Reduced cognitive development;

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[7] Uniting Church in Australia, *Statement to the Nation*, 1977

[8] Officer of the High Commission for Human Rights, International Covenant on Economic, Social and Cultural Rights, http://www.unhchr.ch/html/menu3/b/a_cescr.htm

[9] World Health Assembly Resolution 54.2, 2001.

[10] Colin Binns, 'Encourage and Support Breastfeeding', in National Health and Medical Research Council, *Dietary Guidelines for Children and Adolescents in Australia*, 10 April 2003, p. 1.

[11] Elisabeth Sterken, 'Risks of Formula Feeding. A brief annotated bibliography', INFACT Canada, Second revision, July 2006

- Increased risk of acute respiratory disease;
- Increased altered occlusion;
- Increased risk for infection, from contaminated formula with deaths reported as a result of *Enterobacter sakazakii* contaminating infant formula;
- Increased risk of nutrient deficiencies;
- Increased risk of childhood cancers;
- Increased risk of chronic diseases;
- Increased risk of diabetes;
- Increased risk of cardiovascular disease;
- Increased risk of obesity;
- Increased risk of gastrointestinal infections;
- Increased risk of mortality (with one study finding this was the case in the US and not just developing countries);
- Increased risk of otitis media and ear infections; and
- Increased risk of side effects of environmental contaminants.

In addition, not breastfeeding after birth increases a number of health risks for mothers. The INFACT Canada paper presents a list of papers finding the following increased risks for mothers in developed countries such as Australia:

- Breast cancer;
- Being overweight;
- Ovarian cancer and endometrial cancer;
- Osteoporosis;
- Rheumatoid arthritis;
- Stress and anxiety; and
- Maternal diabetes.

(b) Evaluate the impact of marketing of breast milk substitutes on breastfeeding rates and, in particular, in disadvantaged, Indigenous and remote communities

The JIM Unit is concerned that the marketing activities of the manufacturers of breastmilk substitutes undermine breastfeeding rates and the effectiveness of the money spent by Federal, State and Territory Governments in promoting breastfeeding in the Australian community.

The Marketing of breastmilk substitutes in Australia is covered by the *Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement* (MAIF), which was established in May 1992. This is a voluntary agreement between the Australian Government and six major baby food companies:

- H J Heinz Company Australia Ltd
- Nestle Australia Limited
- Nutricia Australia Pty Ltd
- Wyeth Australia Pty Ltd
- Snow Brand (Australia) Pty Ltd and
- Abbott Australasia Pty Ltd

The limitations of MAIF

MAIF falls well short of the standards set by the World Health Organisation *International Code of Marketing of Breastmilk Substitutes* (WHO Code) and subsequent World Health Assembly (WHA) resolutions on marketing of breastmilk substitutes, which are suggested as a minimum international standard. It does not cover all breastmilk substitutes, but only infant formula. Thus, baby cereals, drinks and any other breastmilk substitutes marketed to infants below six months are not subject to MAIF. The MAIF Agreement also does not cover marketing of bottles and teats, which are within the scope of the WHO Code.

The Advisory Panel on the Marketing of Infant Formula (APMAIF) was established to "monitor compliance with and advise the Government on the Marketing in Australia of Infant Formula".[12] To fulfil this purpose the APMAIF monitors the marketing actions of the companies that are bound to the MAIF-agreement by receiving and assessing private complaints. Thus, the panel is not actively monitoring the marketing behaviour of its subscribed members, but is dependent on complaints being made.

Furthermore, the complaints received by the APMAIF are rarely determined as breaches of the MAIF Agreement. Between 2001 and 2004, a total of 279 complaints reached the APMAIF, but only three were found to be breaches. This may be attributed to the fact that the MAIF Agreement itself contains very broad and ambiguous language, which would limit the number of breaches found.

Of the breaches that were found however, there are further questions surrounding the effectiveness of MAIF. The Annual report (2001-2002) details a breach by Heinz that their advertising neglected to meet the information requirements of Clause 4(a) in the MAIF Agreement. However in the annual report (2002-2003) a repeated violation of the same regulation is also listed. The consequences to companies who are caught in breach of the MAIF Agreement therefore appear to be ineffective in preventing further breaches. The enforcement of the MAIF Agreement is also completely lacking in public transparency. The APMAIF reports contain no detail for the complaints that are dismissed.

Another concern is a perception that there is a potential lack of independence from the industry in the APMAIF. Currently, 70% of the APMAIF is sponsored by the infant formula industry, and the industry have a representative on the panel of four people.[13] A total of 170 complaints in 2002 resulted in only one breach. The following year 60 complaints were made, again resulting in one breach. The JIM Unit has been informed that both complaints were submitted by a competing company in the infant formula industry who is also a member of APMAIF. The effective breakdown of the MAIF Agreement requires an immediate change in legislation and/or regulation to protect current breastfeeding rates in Australia.

The following table compares the violations covered under the MAIF Agreement, World Health Organisation (WHO) Code and subsequent World Health Assembly (WHA) resolutions and also lists other ethical considerations. The table further illustrates the limitations of MAIF Agreement in providing an adequate level of protection against the marketing practises of infant formula companies.

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[12]http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-strateg-foodpolicy-apmaif.htm

[13]APMAIF 'Annual Report 2003/2004', p. 34.

COMPARISON OF LEGAL INSTRUMENTS AGAINST SOME VIOLATIONS	
Types of violations	**Legal instruments**
Samples provided to mothers and health providers	**MAIF:** 6(e) Allows certain free supplies as it is based on the 1981 Code Article 6.6 which is superseded by the WHA resolution 47.5.. **WHO Code:** Article 6.6 *Donations or low-price sales to institutions or organizations of supplies of infant formula or other products within the scope of this Code, whether for use in the institutions or for distribution outside them, may be made. Such supplies should only be used or distributed for infants who have to be fed on breastmilk substitutes. If these supplies are distributed for use outside the institutions, this should be done only by the institutions or organizations concerned. Such donations or low-price sales should not be used by manufacturers or distributors as a sales inducement.* **WHA Resolutions:** Free or subsidised supplies are banned in any part of the health care system (WHA resolution 47.5 [1994]) **Generally unethical:** The provision of samples of any breastmilk substitute or information materials which may influence a mother's decision to breastfeed or not , is considered by the JIM Unit as unethical.
Use of pictures and text that idealise the use of breastmilk substitutes	**MAIF:** 4(b) *When such materials contain information about the use of infant formulas, they should not use any pictures or text that idealise the use of infant formula.* **WHO Code:** Article 9: *Neither the container nor the label should have pictures of infants, nor should they have other pictures or text which may idealize the use of infant formula.* **WHA Resolutions:** No superseding resolution on the use of pictures and text. **Generally unethical:** Any information, material or labelling that wrongly informs and influences mothers by idealising the use of products is unethical and indecent.
Advertising that implies that bottle feeding is equivalent or superior to breastfeeding	**MAIF:** It is mandatory for companies to give information to health care professionals. **WHO Code:** Article 7.2 *Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breastfeeding.* **WHA Resolutions:** No superseding resolution has been adopted.
Gifts provided to mothers and health workers advertising breastmilk substitutes	**MAIF:** 5c of the MAIF agreement is based on article 5.4 of WHO Code **WHO Code:** Article 5.4 *Manufacturers or distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils which may promote the use of breastmilk substitutes or bottle-feeding.* **WHA Resolutions:** No superseding resolution on the provision of gifts. **Generally unethical:** To advertise certain products and brands through the provision of gifts seeks to promote breastmilk substitutes.
Brand recognition through the use of educational and information materials	**MAIF:** No existing regulation on brand recognition. **WHO Code:** No specific article on brand recognition. **WHA Resolutions:** No superseding resolution exists. **Generally unethical:** Information materials that promote the use of breastmilk substitutes and encourage brand recognition as a marketing strategy is impinging upon a woman's freedom of choice to breastfeed or not. An example of this manner of unethical practise is when toddler formula is advertised with the same logos and colours also found on infant formula.

Observed breaches of the MAIF Agreement

The Justice and International Mission (JIM) Unit have collected substantial evidence of breaches of the MAIF Agreement. This illustrates that the current voluntary system of regulation is ineffective.

Furthermore, this evidence illustrates the way in which companies are currently able to market their products in Australia, but still be in breach of the WHO Code and subsequent WHA resolutions. The WHO Code is recommended as a minimum for Governments in order to protect breastfeeding and thus reveals the further inadequacies of MAIF in protecting breastfeeding rates in Australia.

Sample packages

The MAIF Agreement (6e) allows manufacturers and importers of infant formulas to:

> *make donations, or low-priced sales, of infant formulas to institutions or organisations, whether for use in the institutions or distribution outside them. Such provisions should only be used or distributed for infants who have to be fed on breast milk substitutes. If these provisions are distributed for use outside the institutions, this should be done only by the institutions or organisations concerned. Manufacturers or importers should not use such donations or low-price sales as a sales inducement.*

Bounty bags are supplied by the Commonwealth Family Assistance Office as a gift to new mothers including 'Mother to Be' Bag, 'New Mother' bag and 'Mother and Baby Gift Pack'. Infant formula companies in Australia use this avenue as an effective marketing tool to provide samples and advertising materials to new mothers. The JIM Unit has witnessed a large variety of advertising materials provided by Baby Food companies in the bounty bags including NUK, Heinz, Dr Browns, Nutricia, Wyeth and Pigeon.

A sample of Nutricia Karicare 1 Gold (newborn formula) was found by the JIM Unit in the 'New Mother' bag which is clearly a breach of MAIF.

The JIM Unit also found a sample of Heinz Nurture 3 Gold (toddler formula) in a 'Mother and Baby gift pack' and was offered free samples of Wyeth S26 toddler formula at the Pregnancy, Babies and Children's Expo 2006. This would be a breach under the WHO Code (Articles 5.2 and 6.6) and subsequent WHA Resolution 47.5 which bans all free or subsidised supplies from the entire health system. However, it does not formally constitute a breach under MAIF because the scope of MAIF is limited to infants under 6 months.

On request, doctors and health workers are sent samples of infant formula. It appears the companies make no enquiries about whether the samples are being used for professional evaluation or research[14]. This is a breach of the MAIF Agreement 7 d) and the WHO Code Article 7.4 which states:

> *Manufacturers and importers of infant formulas should not provide samples of infant formulas, or of equipment or utensils for their preparation or use, to health care professionals except when necessary for the purpose of professional evaluation or research at the institutional level. (WHO Code Article 7.4)*

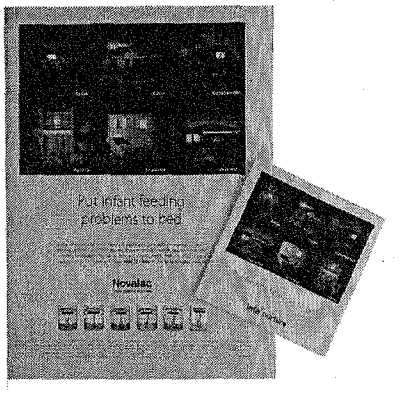
The JIM Unit has also been provided with a 29 g Heinz Nurture 1 Gold Starter sample infant formula given to a mother. Even if Heinz did not intend this sample to end up with a mother, production of these sample packages invites violation of MAIF. Similarly, sample sized bottles of Karicare infant formula were provided to the Intensive Infant Care Unit of Westmead Hospital. These samples may have been intended for the care of sick infants in serious need of breastmilk substitutes but the production of sample sized, well packaged and accessible bottles of infant formula invites a violation without adequate regulation.

Advertising that implies bottle-feeding is equivalent or superior to breastfeeding

Clause 7(a) of the MAIF Agreement states:

> *Information provided by manufacturers and distributors to health professionals regarding products within the scope of this Code should be restricted to scientific and factual matters, and such information should not imply or create a belief that bottle-feeding is equivalent or superior to breastfeeding.*

The JIM Unit has collected samples of a Nutricia advertisement which suggests that their infant formula is equal to breastmilk by stating "Breast milk and infant formula have the right balance of nutrients for infants under 12 months"[15]. This is a breach of MAIF.



A further limitation of the MAIF Agreement is that it only covers six companies. Therefore advertising that would otherwise be banned under MAIF clause 5(a) restricting advertising to the general public is currently allowed by companies who have not signed on. In the September 2006 edition of the Australian Family Physician magazine is a Novolac advertisement. Novalac is a product of Bayer Health Care and therefore not covered under MAIF. The advertisement is for their entire range of infant formula products titled "Put infant feeding problems to bed". The problems identified in this advertisement include the baby being "hungry" and "growing" with the implication that infant formula is needed to deal with these "problems". This advertisement was also observed in the Aug/Sept 06 edition of the *Mother and Baby* parenting magazine and pamphlets are freely available in pharmacies.

[14]International Baby Food Action Network 2007, 'A Survey of the State of the International Code of Marketing of Breastmilk Substitutes and Subsequent WHA Resolutions'.

[15] Nutricia Advisory Service, Information pamphlet 'Choosing the right milk for your baby'

Pictures and text that idealise the use of infant formula

Another limitation of the MAIF Agreement is that it does not adequately protect against the use of pictures and text that idealise the use of infant formula. The only requirement of baby food companies in Australia is that they must conform to Australian Food Standard R7 which minimally states, "The label on a package of food for infants must not include a recommendation, whether express or implied, that the food is suitable for infants less than four months old".

Pictures of cute babies are used frequently on the advertising and packaging of breastmilk substitutes in Australia which would be a direct violation of Article 9 of the WHO Code which states:

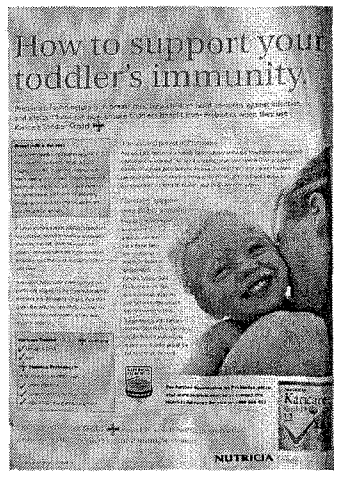
> *Neither the container nor the label should have pictures of infants, nor should they have other pictures or text which may idealize the use of infant formula.*

and Article 4.2 of the WHO Code:

> *Such materials should not use pictures or text, which may idealise the use of breastmilk substitutes.*

The JIM Unit has collected the following examples of this form of advertising:

1) Nutricia distributes material such as 'Choosing the right milk for your Baby' with pictures of healthy, happy babies
2) Melbourne's Child magazine advertises breastmilk substitutes such as infant formula, follow on formula, toddler formula, bottles and teats. The February 2007 edition includes two full page advertisements for toddler formula products: Nutricia Karicare Gold and Nestle Neslac Gold. Both advertisements use smiling, happy faces of babies and misleading text that implies infant formula will protect their immune system as adequately as breastfeeding. The April 2006 edition of Melbourne's Child magazine also includes a full page for Wyeth S26 Toddler Gold with a picture of a beautiful little girl stating "one day she'll change the world". Similarly, the February 2006 edition includes another Wyeth advertisement for toddler formula with the statement "one day he'll make his mark" inferring that this product will create clever, extraordinary people.
3) Heinz advertises their infant formula with the text "Nurture your child's potential"
4) Nutricia advertises their Karicare Gold range with the slogan "Essential nutrition for toddlers reaching their full potential...with a little help from Karicare".



Gifts to Mothers or Health Workers

Clause 5(c) of the MAIF Agreement is based on Article 5.4 of the WHO Code which states:

> *Manufacturers and distributors should not distribute to pregnant women or mothers of infants and young children any gifts of articles or utensils, which may promote the use of breastmilk substitutes or bottle feeding*

The JIM Unit has observed the following breaches of the MAIF Agreement:

1) Heinz baby growth charts with a large picture of the characteristic giraffe given to mothers in Bounty Bags;
2) Wyeth baby sipping cups with the label 'S26 Toddler Gold' given out at the 2006 Pregnancy, Babies and Children's Expo in Melbourne;
3) Dr Brown's natural flow baby bottle also handed out in the Expo; and
4) Wyeth 'The yummy scrummy in your tummy' cookbook for babies.

Use of colours and logos to market breastmilk substitutes

The JIM Unit is also concerned about advertising practices that further contribute to undermining breastfeeding which are not covered by either MAIF or the WHO Code or subsequent WHA regulations. The same colours and logos as used on infant formula are used to actively market toddler formula (those targeted at babies over 12 months of age). This is a brand recognition strategy that unethically coerces consumers to recognise particular companies and make future purchases based on recognition of those logos, colours and symbols. The JIM Unit have noted the following examples:

- Heinz Nurture Range uses the same giraffe logo and colour scheme on its starter formula (targeted at babies from birth to 12 months), its follow-on formula (for babies from six months) and toddler formula (for babies from 12 months of age);
- Nestle Nan Range of infant formula uses a colourful picture of a mother bird protectively standing over a nest of baby birds to market their products and this is used across each age range;
- Wyeth use a logo of two happy, healthy babies and the S26 logo across their full range of baby formula products (targeted for babies from birth through to 2 years of age) and;
- Nestle advise customers to look for the Bifidus BL symbol found on their full range of infant and toddler formula.

The need to replace MAIF

The Justice and International Mission Unit believes that there is a need to replace MAIF. In dialogue the Unit has had with infant formula companies, it has been argued that the World Health Organisation *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA Resolutions cannot be implemented into Australian legislation and regulation due to the *Trades Practices Act 1974*. Legal advice from Clayton Utz (attached as Appendix A) indicates that this view is legally incorrect. The advice obtained states:

The *Trade Practices Act 1974* (Cth) (**"TPA"**) does not prevent the introduction of the WHO Code, provided the instrument introducing the WHO Code complies with the National Competition Principles Agreement ("CPA"). The CPA provides that Governments may enact legislation or regulations which may have the effect of restricting competition, provided that the proposal for the new legislation is accompanied by evidence that:

(a) the benefits of the restrictions to the community as a whole outweigh the costs; and

(b) the objectives of the instrument can only be achieved by restricting competition.

The Justice and International Mission Unit is of the view that the benefits to the community and public health of implementing the World Health Organisation *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA Resolutions to restrict the marketing activities of the baby food companies outweigh the costs. Further, the marketing activities of the companies, as outlined above, demonstrate that further attempts at a voluntary code are highly likely to fail to achieve compliance with the standards of the *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA Resolutions. Simply, the existing marketing culture of the companies collectively makes voluntary measures inadequate as a means to protect and promote public health.

Mandatory Mechanisms for Implementing the WHO *International Code of Marketing of Breastmilk Substitutes*

There are two main forms in which the WHO *International* Code of Marketing of Breastmilk Substitutes and subsequent WHA Resolutions could be introduced into Australian law. These are:

(a) Commonwealth legislation; or

(b) a prescribed mandatory industry code of conduct under the *Trade Practices Act* 1974 (Cth) ("TPA").

1. Commonwealth Legislation

The Commonwealth Parliament may enact legislation to give the WHO International Code legal effect in Australia.

Some of the benefits of introducing the WHO Code in legislative form include:

a) The creation of a specific agency to monitor and enforce the legislation via the imposition of enforceable penalties; and

b) Breaches of legislation are generally regarded seriously. Publicity and financial penalties providing incentive for manufacturers and distributors to comply with their legislative obligations.

The current method of identifying non-compliant companies in reports by the Advisory Panel on the Marketing in Australia of Infant Formula ("APMAIF") tabled in Parliament is ineffective, a significant reason for which is the lack of publicity given to such Reports.

The JIM Unit notes that if the WHO International Code were to be implemented by legislation there would be the need to identify a relevant regulator and the resources necessary to monitor and enforce compliance with the legislation. The Unit does not favour APMAIF becoming the regulator, as the regulator should be completely free from any industry representation.

2. Industry Codes of Conduct

An alternative method of giving legal effect to the WHO International Code and subsequent WHA Resolutions would be to develop an industry code under Part IVB of the TPA Section 51ACA of the TPA provides that an industry code is a code regulating the conduct of participants in an industry in their dealings with other participants or consumers in the industry. There are three types of industry codes under the TPA are:

(a) prescribed mandatory industry codes of conduct;
(b) prescribed voluntary industry codes of conduct; and
(c) voluntary industry codes of conduct.

As outlined above, the JIM Unit lacks confidence that a voluntary code could achieve the necessary objective of protecting infant and women's health from unethical marketing practices of baby food companies promoting breastmilk substitutes. Further:

(a) Voluntary codes are not legally enforceable; and
(b) While prescribed voluntary codes are enforceable against signatories, they are not enforceable against industry participants who have not agreed to sign the code. Bayer Health Care has given a clear example of the type of unethical behaviour that might be expected from companies that refuse to be signatories of a voluntary code with its advertising of its Novalac range of infant formula.

Prescribed mandatory codes of conduct are introduced by regulations pursuant to s.51AE of the TPA and are binding on all industry participants pursuant to s.51AD. The Australian Competition and Consumer Commission (ACCC) is responsible for administering and enforcing such codes. Examples of current prescribed mandatory codes of conduct include the Franchising Code of Conduct, the Oil Code and the Horticulture Code.

Introducing the WHO International Code as a mandatory code would make the international provisions (or something equivalent to the international provisions) binding on all participants in the Australian industry of breastmilk substitutes, including manufacturers and importers of baby food.

According to the ACCC publication "Guidelines for developing effective mandatory industry codes of conduct", the Government has stated that a code of conduct will only be prescribed if:

(a) the code would remedy an identified market failure or promote a social policy objective;
(b) the code would be the most effective means for remedying that market failure or promoting that policy objective;
(c) the benefits of the code to the community as a whole would outweigh any costs;
(d) there are significant and irremediable deficiencies in any existing self-regulatory regime—for example, the code scheme has inadequate industry coverage or the code itself fails to address industry problems;
(e) a systemic enforcement issue exists because there is a history of breaches of any voluntary industry codes;
(f) a range of self-regulatory options and 'light-handed' quasi regulatory options have been examined and demonstrated to be ineffective; and
(g) there is a need for national application as state and territory fair trading authorities in Australia also have the options of making codes mandatory in their own jurisdiction.

In the view of the JIM Unit a mandatory code would promote the social policy objective of promoting and protecting the use of breastfeeding given that a light-handed regulatory option was trialled via the MAIF Agreement and has been demonstrated to have failed. The evidence of breaches of the MAIF that go unaddressed and the failure of some manufacturers to sign the MAIF Agreement has indicated that the voluntary MAIF Agreement is not sufficient.

Some of the benefits of introducing the WHO International Code as a mandatory code include:

(a) The use of a regulation to introduce the mandatory code into Australian law. Regulations are made by Government (not the Parliament). In contrast, passing legislation involves a rigorous process in parliament which may be quite time-consuming; and
(b) Regulations are typically more flexible and easy to update than legislation.

Precedents for implementing the WHO International Code as a Mandatory Code

Precedents for implementing the WHO *International Code of Marketing of Breastmilk Substitutes* and subsequent WHA Resolutions already exist in Australia. The *Therapeutic Goods Act (1989)* regulates the advertising and promotion of prescription only medicines. The following codes also apply:

- Therapeutic Goods Advertising Code 2006;
- Medicines Australia Code of Conduct Edition 15 ("**MA Code**");
- Australian Self Medication Industry Code of Practice;
- Complementary Healthcare Council of Australia Code of Practice for the Marketing of Complementary Healthcare and Healthfood Products; and
- Medical Industry Association of Australia and Medical Industry Association of New Zealand Code of Practice.

This method of regulating the promotion of prescription only medicine demonstrates a mandatory system can function effectively. Furthermore it is not something new or untested in Australia.

The advertising of prescription only medications to the general public is prohibited by section 42DL(1)(f) of the Act. Further, advertising and promotion of prescription only medications must be in accordance with the MA Code. Importantly, the MA Code is *mandatory* and regulates the

conduct of both members and non-members of Medicines Australia. This is because the Therapeutic Goods Administration's letter of marketing approval specifically *requires* the promotion of all prescription products to comply with requirements of the MA Code. In other words, compliance with the MA Code is mandatory insofar as promotion of prescription products is concerned.

Examples of restrictions on the advertising and promotion of prescription only medications to healthcare professionals in the MA Code include:

- A prohibition on making claims for products which have not been approved for registration in Australia by the TGA or for indications of approved products which themselves have not been approved;

- The requirement that all information, claims and graphical representations be current, accurate, balanced and not misleading either directly, by implication, or by omission (there is particular emphasis on comparison of products being factual, fair, capable of substantiation and not disparaging);

- Certain information must be included in or accompany promotional material. For example, for products that have a "boxed warning" in their TGA approved Product Information (a "boxed warning" is a mechanism adopted by the TGA for highlighting special warning statements in Product Information), all promotional material must include the boxed warning or a prominent statement drawing attention to the boxed warning. By way of further example, an advertisement for a new chemical entity or new indication of an existing chemical entity for the period of 24 months from the first advertising in medical publications must contain the following information within the body of the advertisement: the brand name of the product; the Australian Approved Name of the ingredients; the name of the supplier and the city, town or locality of the registered office; all PBS listings including restrictions; either the Product Information, Abridged Product Information or Minimum Product Information; a clear and unambiguous statement for prescribers to review the Product Information before prescribing; and for products listed on the PBS, the current PBS dispensed price;

- A restriction on the provision of items or services (gifts) to healthcare professionals with some limited exceptions. For example, it is acceptable to provide medical educational material to healthcare professionals or to offer hospitality as an adjunct to (and secondary to) education (for example, at a symposium);

- Starter packs of prescription only medications may only be supplied at the request of healthcare practitioners when required for one of the following reasons: for immediate use in the surgery for relief of symptoms; for the use of alternative treatments, prior to a prescription being written; for after hours use; or for gaining familiarisation with products. There are also specific restrictions on the content of Starter packs; and

- Any post marketing surveillance studies must have scientific or medical merit and objectivity and not be designed for, or conducted as, promotional exercises. Similarly, market research activities must have as their sole purpose the collection of data and not the promotion to and/or reward of healthcare professionals.

The MA Code further confirms the prohibition of the promotion of prescription only medications to the general public while allowing the provision of educational material to the public. It also prescribes certain requirements for patient support programs.

Similarities with the WHO Code

As can be seen from the above there are a number of similarities between the restrictions on promoting prescription only medicine and the restrictions contained in the *World Health Organisation International Code of Marketing of Breast Milk Substitutes* (**"WHO Code"**) including:

- **Provision of promotional information by companies to the general public**: Both codes prohibit the promotion of relevant products to members of the general public (refer article 5.1 of the WHO Code, section 42DL(1)(f) of the Act and clause 9.4 of the MA Code);

- **Provision of information to healthcare professionals**: Both codes regulate the information that may be provided to healthcare professionals about relevant products. Under the WHO Code, information provided by companies to healthcare professionals about breast milk substitutes is restricted to "scientific and factual matters" (article 7.2). Under the MA Code, all information must be current, accurate, balanced and must not mislead (clause 1.3) and the use of quotations from medical literature or personal communications must be accurately reflect the meaning of the author and significance of the study (clause 10.5.2);

- **Provision of information to the general public**: Both codes contain strict criteria on what must be contained in "educational material" to be provided to members of the general public. Article 4.2 of the WHO Code provides that all informational educational material dealing with the feeding of infants and intended to reach pregnant women and mothers of infants and young children is required to include information on the benefits and superiority of breastfeeding, maternal nutrition, the negative effect on breastfeeding of introducing partial bottle feeding, the difficulty of reversing the decision not to breastfeed and where needed, the proper use of infant formula, whether manufactured industrially or home prepared. Similarly, clause 9.5 of the MA Code has strict requirements on what material is to be classified as 'educational material';

- **Provision of benefits (financial and otherwise) to healthcare professionals:** Both codes prohibit the provision of financial or material benefits to healthcare professionals to promote or influence the prescription of relevant products (see article 7.3 WHO Code and clause 10.1 MA Code.) In addition, clause 10 of the MA Code permits companies to provide healthcare professionals with hospitality that is modest, secondary to the educational content and provided in an environment that enhances education and learning. Interactions between companies and healthcare professionals must not include entertainment (clause 10.1). Article 7.5 of the WHO Code makes provision for the disclosure of contributions to health workers for fellowships, study tours, research grants, attendance at professional conferences or the like; and

- **Provision of samples:** The WHO Code (article 7.4) only allows provision of samples to health workers where necessary for the purpose of professional evaluation or research at the institutional level. In a similar vein, the MA Code restricts the circumstances in which

starter packs may be provided to healthcare professionals (clause 5.1.2, refer above for a list of the circumstances) and stresses that such supply may only be at the request of the healthcare professional.

Oversight of implementing the WHO Code

The Unit believes that oversight of the WHO Code should be independent of vested interests and conducted in an open and transparent manner. The Unit therefore does not support the continuation of APMAIF because of its links to the infant formula industry. Clause 11.3 of the MA Code currently contains provisions for disclosing conflict of interest. The JIM Unit recommends such a clause also be included in the new regulations or Mandatory Code.

Breastfeeding of Aboriginal and Torres Strait Islander Infants

A review recently conducted by the Commonwealth Department of Health and Family Services strongly endorses a greater commitment to promoting and supporting breastfeeding and infant nutrition practises in Aboriginal and Torres Strait Islander communities. The report recommends a combination of strategies to significantly improve breastfeeding rates in Indigenous communities in Australia including:

- Implement the World Health Organization (WHO) *Code of Marketing for Breastmilk Substitutes;*
- Improve health care practices, for example accreditation by the *WHO/UNICEF Baby Friendly Hospital Initative*;
- Provide breastfeeding education programs in undergraduate and post-graduate health care provider courses;
- Encourage the work of community support groups;
- Routinely report and record breastfeeding statistics;
- Improve the conditions associated with paid employment, e.g. maternity leave and nursing breaks; and
- Promote breastfeeding education programs to the community[16].

Several Indigenous forums held recently in Australia have prioritised the support and promotion of breastfeeding amongst Aboriginal and Torres Strait Islander communities including:

- National Aboriginal Health Strategy;
- Queensland Aboriginal and Torres Strait Islander Food and Nutrition Strategy;
- Aboriginal and Torres Strait Islander Health Policy, Meriba Zageth for Diabetes (Torres Strait Island diabetes strategy);
- Apunipma Cape York Health Council 1996 Women's Conference;
- Northern Territory Breastfeeding Policy and Strategic Plan.

According to the Australian Bureau of Statistics, only 32% of all infants aged 6 months or less were fully breastfed.[17] This is well below the recommended target of the National Health and Medical Research Council (NHMRC) of 80% and also below the world breastfeeding standard of 34%. Although Infant mortality rates in Aboriginal and Torres Strait Islander children have decreased dramatically, they still remain to be two or three times greater that the national average. Evidence suggests that there is a close relationship "between the introduction of bottle feeding and a

[16]Commonwealth Department of Health & Family Services, 1998 'Review of Current Interventions and Identification of Best Practise currently used', Commonwealth of Australia.

[17] Australian Bureau of Statistics, 'Breastfeeding in Australia' 4810.0.55.001, 2001.

depression in the weight gain velocity of Aboriginal children"[18]. Significant problems have resulted from bottle-feeding Indigenous children including the use of "inappropriate modified cow's milk... and inadequate sterilisation of bottle-feeding equipment in conditions where this is difficult to achieve"[19]. It is well documented that low socio-economic status women and women from disadvantaged groups, as well as women who become ill in the post natal period are at higher risk for shortened breastfeeding duration.

The JIM Unit recognises the well founded belief that information made available during the antenatal and early postnatal period make a significant impact on a mother's decision to breastfeed. Furthermore, continued support and availability of appropriate information is crucial for the effective establishment and continuation of breastfeeding. To effectively impact the rates of breastfeeding in Indigenous communities it is imperative that culturally-appropriate health services and information are provided with consideration for local customs, languages and traditions. It is evident that the majority of Aboriginal and Torres Strait Islander women receive their antenatal, birthing and postnatal care in mainstream health settings[20]. The Commonwealth review demonstrated that there is a significant need to improve the education and baby friendly initiatives in hospitals.

Inadequate, inappropriate and misleading information leads to poor rates of breastfeeding in disadvantaged, Indigenous and remote communities

The advertising information observed by the JIM Unit as evidence of breaches of the MAIF agreement, WHO Code and subsequent WHA Resolutions indicates that the information provided to new mothers, whether Indigenous or non-Indigenous, is inadequate, inappropriate and misleading. Sophisticated advertising of breastmilk substitutes falsely leads new mothers to make decisions about breastfeeding that are ill-informed and may be detrimental to their infant children. Infant formula companies use clever marketing strategies such as the distribution of free samples, the promotion of breastmilk substitutes in health care facilities, and the use of pictures idealizing artificial feeding. It is well documented that advertising and attitudes of health care workers and obstetricians also influence women's choice of infant-feeding methods[21]. Studies have also demonstrated that the distribution of infant formula materials in the postnatal period has a negative impact on breastfeeding duration.

A mother's right to make an informed decision about the initiation and duration of breastfeeding is being undermined by the marketing practises of infant formula companies. The World Health Organisation postulate that "trying to prove the precise effect of advertising, however, misses the point that there are inherent dangers in encouraging uninformed decision-making and the bypassing of the mother's physician or other health worker. Those who suggest that direct advertising has no negative effect on breastfeeding should be asked to demonstrate that such advertising fails to influence a mother's decision about how to feed her infant"[22].

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[18]Commonwealth Department of Health & Family Services, op. cit

[19]Ibid

[20] Howard, C et al, 'Office prenatal formula advertising and its effect on breast-feeding patterns', *Obstetrics & Gynecology*, vol.95, no.2, February 2000, pp296-303

[21] Ibid.

[22] Document WHA45/1992/REC/1, Annex 9, paragraphs 120–123

(c) The potential short and long term impact on the health of Australians of increasing the rate of breastfeeding

The immediate and long term impact of increasing the breastfeeding rate on the health of Australians is discussed in section (a) of this submission.

(d) Initiatives to encourage breastfeeding

The Australian Government has in the past had a number of programs aimed at promoting breastfeeding, including the Perth Infant Feeding Study II which monitored breastfeeding behaviour and the National Child Nutrition Program which provided funding for 109 community based projects. Fifteen of these projects featured breastfeeding as a key component. The Australian Government also promoted the National Health and Medical Research Council (NHMRC) Guidelines which recommend babies be exclusively breastfed until 6 months of age. Funding for these programs ceased in 2004.

Between 2002 and 2004 the Australian Government provided funding for The Baby Friendly Hospital Initiative now Baby Friendly Health Initiative. This international initiative was developed by the World Health Organisiation (WHO) and UNICEF to ensure breastfeeding is established and supported and seen as the normal way to feed a baby. A maternity facility can be designated 'baby-friendly' when it does not accept free or low-cost breastmilk substitutes, feeding bottles or teats, and has implemented the '10 specific steps' to support successful breastfeeding.

The 10 specific steps are:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff;
2. Train all health care staff in skills necessary to implement this policy;
3. Inform all pregnant women about the benefits and management of breastfeeding;
4. Help mothers initiate breastfeeding within one half-hour of birth;
5. Show mothers how to breastfeed and maintain lactation, even if they should be separated from their infants;
6. Give newborn infants no food or drink other than breastmilk, unless medically indicated;
7. Practice rooming in - that is, allow mothers and infants to remain together 24 hours a day;
8. Encourage breastfeeding on demand;
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants; and
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.[23]

Currently, the only means of promoting breastfeeding by the Australian Government is through funding to the Australian Breastfeeding Association (ABA). The ABA has received $610,000 in funding since 1998 and a further $300,000 has been committed through the current funding agreement (2005-2008).

The Australian Breastfeeding Association's Leadership Plan recommends a number of strategies to encourage breastfeeding. These include:

- Appointment of a National Breastfeeding Advocate as recommended in the Innocenti Declaration;

[23] UNICEF, Baby friendly Hospital Initiative, http://www.unicef.org/programme/breastfeeding/baby.htm#10

- Set breastfeeding targets and establish benchmarks for each state and territory;
- Implement the *World Health Organisation Code of Marketing of Breastmilk Substitutes* through enforceable legislation;
- Raise the health policy priority of breastfeeding;
- Remove financial disincetives to breastfeeding such as GST on breast pumps and remove the GST free status of follow on and toddler formulas;
- Provide funding for maternity leave for all mothers to enable breastfeeding to be established.
- Support and extend the Baby Friendly Health Initiative;
- Enhance health professionals breastfeeding knowledge and breastfeeding management skills;
- Recognise and value acquisition of breastfeeding knowledge skills and qualifications;
- Develop a human milk bank network in Australia;
- Promote and provide information for employees and employers on breastfeeding friendly workplaces;
- Incorporate breastfeeding friendly criteria into childcare accreditation;
- Support programs offering peer support for breastfeeding;
- Encourage participation by indigenous, young, English as a second language and other disadvantaged groups;
- Educate future parents on breastfeeding;
- Promote breastfeeding as acceptable in public; and
- Improve amenities for breastfeeding in public.[24]

The Public Health Association of Australia recommends that Australia's breastfeeding rate would be enhanced by the following:

- All maternity hospitals working towards becoming accredited Baby Friendly hospitals;
- Workplace provision supporting breastfeeding times and location, so that women can return to paid work and maintain breastfeeding;
- Enhanced education of health service providers such as GPs, paediatricians, pharmacists and maternal and child health nurses about effective breastfeeding practice;
- Greater community awareness about the benefits of breastfeeding and acceptance of public breastfeeding anywhere; and,
- The establishment of human milk banks in Australia to support the babies of women who have difficulty establishing or maintaining breastfeeding.

The World Health Organisation's Global Strategy for Infant and Young Child Feeding builds on the *Innocenti Declaration on the Protection, Promotion and Support for Breastfeeding*[25]. This declaration was endorsed by 139 governments at the 1990 World Summit for Children and recommends that all governments should develop national breastfeeding policies and targets, and monitor their progress. The strategy also builds on the Baby friendly Hospital initiative.

The strategy addresses the needs of all children including those living in difficult circumstances, such as infants of mothers living with HIV, low-birth-weight infants and infants in emergency situations and calls for action in the following areas:

- All governments should develop and implement a comprehensive policy on infant and young child

[24] Australian Breastfeeding Association, 'Leadership Plan 2004', http://www.breastfeeding.asn.au/advocacy/030804abastrategy.pdf

[25] UNICEF, http://www.unicef.org/programme/breastfeeding/innocenti.htm

feeding, in the context of national policies for nutrition, child and reproductive health, and poverty reduction;

- All mothers should have access to skilled support to initiate and sustain exclusive breastfeeding for 6 months and ensure the timely introduction of adequate and safe complementary foods with continued breastfeeding up to two years or beyond;
- Health workers should be empowered to provide effective feeding counselling, and their services be extended in the community by trained lay or peer counselors;
- Governments should review progress in national implementation of the *International Code of Marketing of Breastmilk Substitutes*, and consider new legislation or additional measures as needed to protect families from adverse commercial influences; and

Governments should enact imaginative legislation protecting the breastfeeding rights of working women and establishing means for its enforcement in accordance with international labour standards.

(e) Examine the effectiveness of current measures to promote breastfeeding

As mentioned earlier, currently the Australian Government's only measure to promote breastfeeding is to support the Australian Breastfeeding Association (ABA). Whilst the JIM Unit supports the work of the ABA, it does not believe this is an adequate measure on its own to promote breastfeeding.

The Australian Bureau of Statistics conducted Health surveys in 1995 and 2001. The statistics reveal that on discharge from hospital 83% of babies were breastfed. However, of all infants 3 months or less in age only 54% were *fully breastfed* and only 32% infants aged 6 months or less were *fully* breastfed. This is well below the recommended target of 80% as recommended by the National Health and Medical Research Council (NHMRC).

The surveys also show that the most common reason for discontinuing breastfeeding of children aged 0-3 years old was problems in producing adequate milk (30%). The factors which can influence milk production and supply include not enough, or too short feeds, poor positioning or sucking, changing sides too soon, or introduction of solids too early.[26] A mother's perception that she isn't producing enough milk and therefore not providing adequately for her baby can be very stressful and leave her feeling vulnerable. This emphasises the need for accurate and adequate information to be given about breastfeeding in order to avoid any unnecessary introduction of infant formula. Once breastmilk substitutes have been introduced it makes it more difficult to ensure an adequate supply of breastmilk.

The UNICEF breastfeeding initiatives concentrated on the proper initiation of breastfeeding in maternities and hospitals, and supportive legislation. These efforts were not designed to directly address exclusive breastfeeding to 6 months nor continued breastfeeding, nonetheless, there was an 8% increase in exclusive breastfeeding. Additionally, global levels of continued breastfeeding have increased and are relatively high at one year of age (79%), and around half of infants are still breastfeeding at two years of age. Although not as yet at optimal levels, much progress has been made in the last decade.[27]

[26] Australian Breastfeeding Association
[27] http://www.unicef.org/programme/breastfeeding/facts.htm

Success stories

- In Cuba, where 49 of the country's 56 hospitals and maternity facilities are baby friendly, the rate of exclusive breastfeeding at four months almost tripled in six years from 25 per cent in 1990 to 72 per cent in 1996.
- In China, which now has more than 6,000 Baby-Friendly Hospitals, exclusive breastfeeding in rural areas rose from 29 per cent in 1992 to 68 per cent in 1994; in urban areas, the increase was from 10 per cent to 48 per cent.
- The Catholic University of Chile, Santiago, initiated one of the first baby-friendly hospitals. As a result, initiation of breastfeeding within the first two hours increased. With a strong Step 10, a monthly clinic, exclusive breastfeeding at 6 months increased from approximately 20% to over 60%.[28]

(f) The impact of breastfeeding on the long term sustainability of Australia's health system

It is well documented that breastfeeding can prevent disease and illness by providing the best hygienic security possible for infants. Research indicates that there is a strong correlation between breastfeeding and short/long term health effects.

> *Breastfeeding is the normal and most appropriate method for feeding infants and is closely related to immediate and long-term health outcomes*[29]

Marketing strategies such as the distribution of free samples, the promotion of breastmilk substitutes in health care facilities, and the use of pictures idealizing artificial feeding, influence a new mother's ability to make an intelligent, informed choice about the initiation and duration of breastfeeding based on the best medical knowledge available. The typical rules of consumer sovereignty such as informed, rational choice, and the consumer bears all costs and benefits, do not apply in the marketing of breastmilk substitutes.[30] There are external costs to society associated with a mother's decision not to breastfeed which impact on the resources of Australia's health system.

Breastfeeding rates are stagnant or declining in Australia with an increase in feeding of breastmilk substitutes to infants under the age of six months[31]. The economic burden associated with a rise in the use of breastmilk substitutes and early cessation of breastfeeding will only worsen without appropriate health interventions to promote and support breastfeeding. The financial strain on resources produced by a decrease in the rate of breastfeeding presents a number of significant problems.

1) **Hospitalisation and medical costs associated with an increased rate of illness and disease among infants:**

   Even in affluent conditions, breastfeeding works as a protective agent against a whole range of infant diseases and illnesses. A long list of risks and health problems associated with not breastfeeding is described in section (a) of this submission. The costs associated with these infant health problems are not only borne by the mother, but are shared amongst present

[28] http://www.unicef.org/programme/breastfeeding/baby.htm#10

[29] Binns, C (2003), 'Encourage and support breastfeeding', *Food for health-dietary guidelines for children and adolescents in Australia*, Commonwealth Department of Health and Ageing, NHMRC.

[30] Smith, Julie 2004, 'Mothers' Milk and Markets', *Australian Feminist Studies*, Vol.19, No.45, November 2004.

[31] Smith, Julie *Ibid*

and future taxpayers, other consumers and/or the child. For example, a study produced in the Australian Capital Territory indicated that the hospitalisation costs associated with five infant illnesses due to early weaning could be estimated at $60-100million annually.[32]

2) **Health risks for mothers who do not breastfeed**
The risks of not breastfeeding may be significant and long term with financial costs to the Australian health system. The increased risks for mothers in developed countries who do not breastfeed include: breast cancer, being overweight, ovarian cancer and endometrial cancer, osteoporosis, rheumatoid arthritis, stress and anxiety, and maternal diabetes. See section (a) of this submission for more information.

3) **Financial viability of human milk banking is threatened**
The recommended alternative where a mother cannot breastfeed is expressed breastmilk or another mother's milk, not articificial formula. There are many successful human milk banks around the world based in hospitals and other milk banking facilities. The availability and affordability of breastmilk substitutes may lower the true economic value of breastmilk, and threaten the financial viability of human milk banking in Australia. In the long-term, this undermines a highly effective solution to feed Australian infants of mothers who cannot breastfeed. This also leads to an increase in infant health problems associated with a decline in breastfeeding.

4) **Costs associated with breastmilk as an unmarketed product**
The potential economic value of breastfeeding is substantial when taking into account the economic cost avoided by not using breastmilk substitutes and the assoicated costs where breastfeeding is displaced. It has been estimated in Australia that $5.7billion could be saved if babies were exclusively breastfed to six months of age.[33]

5) **Cost of buying breastmilk substitutes**
It is estimated that households spend over $105.5 million on purchasing infant formula. Reducing the consumption of infant formula through interventions to prolong the duration of breastfeeding would have a significant impact on the family budget.[34]

6) **Financial disincentives to breastfeeding produce long-term costs**
The Australian Breastfeeding Association reports on the financial disincentives to breastfeeding in Australia, highlighting the long term costs to the Australian health system should breastfeeding rates continue to decrease. Current breastfeeding disincentives include:
   - Existing State and Territory Government agreements currently charge a goods and services tax GST on breastpumps and other lactation devices; and
   - Follow on and toddler formulas as well as manufactured baby foods receive GST free status.[35]

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[32] Smith, Thompson & Ellwood 2002, 'Hospital system costs of artificial infant feeding: Estimates for the Australian Capital Territory.' *Australian and New Zealand Journal of Public Health;* 26 (6): 543-551.
[33] Smith, Julie, Opcit
[34] http://www.breastfeeding.asn.au/advocacy/matleave.html
[35] Australian Breastfeeding Association, August 2004, *Australian Breastfeeding Leadership Plan.*

7) **Lack of paid maternity leave increases public health costs and family expenses**
Countries with paid maternity leave have achieved higher rates and duration of breastfeeding than in Australia. Norway have developed workplace practises that support breastfeeding resulting in "nearly universal breastfeeding among babies up to 3 months old". Complementing an investment in the physical and emotional health of families and recognition of women's unpaid work, this initiative also reduces public health costs and family expenses.[36]

A denial of opportunity to initiate and maintain successful breastfeeding can significantly increase the incidence of ill health among mothers and babies as outlined in section (a). As a result, preventable illnesses are funded through Medicare payments, the Pharmaceutical Benefits Scheme and the public hospital system, representing a public and community health cost. The Australian Breastfeeding Association purports that by "increasing the rate and duration of breastfeeding in Australia from 60% to 80% at three months has the potential to save over $11.5 million per year in Government health expenditure for just on 4 illnesses"[37].

The total annual cost of not breastfeeding is estimated at $1.2 to $1.3 billiion[38]. Research indicates that increasing breastfeeding in Australia could result in the following cost savings to the Australian health system:

- Reduction in childhood cancer save $10 million;
- Reduction in childhood diarrhea $100 million;
- Reduction in ear infections $500 million;
- Reduction in tympanostomies $500 million;
- Reduction in juvenile onset diabetes $2.6 billion;
- Reduction in hospitalization for Respiratory Syncytial Virus $225 million; and

The total conservative cost savings nationally for one year is ($780 million).[39]

The JIM Unit recognises the impact of an increase in breastfeeding rates on Australia's milk industry. Of the total volume of milk production in Australia approximately 12% is used for whole milk powder, and 20% of whole milk powder produced is infant formula.[40] In 2004/2005, the Milk Industry in Australia produced 37,651 tonnes of infant formula, with an estimated value of $120 million per year.[41] This is significantly less than the total cost to the health system of approximately $780 million per year. In reality, the health costs resulting from a decline in breastfeeding rates is far greater than the cost to the milk industry of a loss in sales of infant formula.

From an ethcial and moral standpoint, it would be fundamentally wrong to prop up the milk industry at the expense of the health of infants. The overarching priority should be to provide infants with the best food and nutrition possible in order to give them the best start in life.

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[36] http://www.breastfeeding.asn.au/advocacy/matleave.html
[37] Australian Breastfeeding Association 2002, 'Valuing parenthood: options for paid maternity leave- Interim paper' *Submission to the Sex Discrimination Commisioner,* July 2002
[38] http://www.childbirthsolutions.com/articles/postpartum/costbenefits/index.php
[39] Ibid.
[40] Dairy Australia 2007, email, 21 February.
[41] Dairy Australia 2007, email, 21 February.

CONCLUSION

The health benefits of breastfeeding to both women and infants is scientifically proven. Access to these benefits is a matter of public health, community well-being and human rights. This submission has demonstrated that one of the factors affecting breastfeeding rates is the marketing practises of infant formula companies. Enforced regulation of the marketing practises of infant formula companies would increase breastfeeding rates in Australia.

The MAIF agreement falls well short of the *WHO International Code for the Marketing of Breastmilk Substitutes*. MAIF is an ineffective self regulatory system and should be replaced by enforceable regulation through implementation of the *WHO International Code for the Marketing of Breastmilk Substitutes* and subsequent WHA resolutions. The WHA resolution 34.22 highlights the importance of adherence by all governments to the WHO International Code as a **minimum** requirement.

Final Recommendations

The Justice and International Mission Unit recommends the Australian Government adopt the following measures:

1) Replace the existing voluntary, self-regulatory MAIF agreement with implementation of the *World Health Organisation International Code of Marketing of Breastmilk Substitutes* and subsequent World Health Assembly resolutions via either legislation and regulation or a mandatory code in the Trade Practices Act;
2) Reintroduce funding to support the implementation of Baby Friendly Health Initiatives;
3) Develop culturally-appropriate health services targeted at Indigenous and disadvantaged women with consideration for local customs, languages and traditions;
4) Appoint a national breastfeeding coordinator of appropriate authority, and establish a multisectoral national breastfeeding committee composed of representatives from relevant government departments, non-governmental organizations and health professional associations as recommended in the *Innocenti Declaration 2005 on Infant and Young Child Feeding;* and
5) Enact imaginative legislation protecting the breastfeeding rights of working women and establish a means for its enforcement.[42]

[42] International Code Documentation Centre 1990, *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding.*