The Breastfeeding Committee for Canada
The National Authority for the WHO/UNICEF
Baby-Friendly™ Hospital Initiative in Canada

Affordable Health Care Begins with Breastfeeding Support and the Use of Human Milk

Introduction:

The Breastfeeding Committee for Canada (BCC), with supporting documentation from Health Canada, is pleased to provide the Commission with an overview of the current situation in which Canadian women who give birth in hospital experience the need for improved protection of and support for their breastfeeding decision. This overview includes:

- barriers and inequities in the heath care system experienced by women who chose to breastfeed
- identified economic costs to the health care system resulting from health problems of infants and children related to lack of breastfeeding and/or short breastfeeding duration
- the need to restructure health policies in accordance with international evidenced based standards as outlined by the World Health Organization (WHO) / United Nations Children's Fund (UNICEF) Baby Friendly ™ Hospital Initiative (BFHI) (1992).

Evidenced based, internationally set **minimum** standards for professional breastfeeding knowledge and care have recently been incorporated in the *Family-Centred Maternity and Newborn Care National Guidelines* (Health Canada 2000). Standards for quality care have been developed for community health care services as well. The Breastfeeding Committee for Canada document *Baby Friendly™ Initiative in Community Health Services: A Canadian Implementation Guide* (BCC 2002) was released this spring. However there is an urgent need for a comprehensive infrastructure to raise professional education standards and practices to this level in the public health care system in Canada.

The Background:

Until a half-century ago, when the manufacturers of infant formula started the highly successful marketing of their product, it was taken for granted that a mother would breastfeed her child. It is one of marketing's greatest success stories that hundreds of millions of mothers switched to bottle-feeding their babies. Marketing integration into the health care system convinced health professionals that formula is nutritionally equivalent to breastfeeding. Direct advertising techniques convinced the public that formula feeding was "convenient" and "liberating". However, manufactured products **cannot** replace mother's milk (BCC 2002). There is a steadily growing body of evidence demonstrating the failure of manufactured products to provide infants with adequate protection from infections and allergies in the first year of life. This failure also results in episodes of malnutrition that affect the quality of health of many children; it can affect the IQ potential and learning readiness of children and can even cause death. (Anderson EW, Johnstone BM, Remax DT. 1999) (Cunningham AS, Jelliffe DB, & Jelliffe EFP.1991). This failure, which has been named "commerciogenic malnutrition", results in a needlessly heavy burden on the health care system extending into the education system and beyond to the work place.

Mothers want what is best for their babies and this is evidenced by the high rates of breastfeeding initiation across Canada. The breastfeeding initiation rate is about 75% as an average across Canada, with marked variations in prevalence from east to west. Breastfeeding rates in Quebec and Atlantic Canada much lower than in the rest of Canada. (Health Canada 1999). Rates of exclusive breastfeeding in the first six months and duration rates of breastfeeding into the second year of life have not been adequately documented.

A decade ago, the World Health Organization (WHO) identified supporting women to exclusive breastfeeding to six months and to sustain breastfeeding to two years and beyond as a primary health care goal for maternal and child health (Innocenti Declaration 1991).

Health Canada has identified healthy child development as a determinant of health, identifying the prenatal, infancy and early childhood experiences as critical to healthy child development and to the health and well-being of individuals. The positive effects of breastfeeding on the health of infants, which is now shown to extend to childhood and beyond, are increasingly recognized as major contributors to healthy child development and to the prevention of chronic health problems such as obesity and diabetes (American Academy of Pediatrics 1997); (BCC 2002).

Health Canada has promoted breastfeeding nationally since 1978. The focus has largely been on the promotion of breastfeeding as a lifestyle choice – 'Breastfeeding Anytime, Anywhere' rather than a health decision that is protected, promoted and supported by the health care system. The WHO/UNICEF Ten Steps to Successful Breastfeeding and the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes are policies developed to promote exclusive and sustained breastfeeding as a health choice and to protect and support women in making informed infant feeding decisions. These policies are evidence-based and are the basis for the Baby Friendly™ Initiative (Vallenas C, Savage F.1998).

The Problem: Barriers and Inequities in Health Care System faced by Women Who Choose to Breastfeeding.

The legacy of aggressive formula marketing since the 1940's is false assumptions about formula feeding as nutritionally equivalent, labour saving and necessary for a progressive lifestyle choice for working parents. The provision of free formula in hospital, free educational materials for new parents and educational donations for staff has been taken for granted as a convenient way to provide patient and staff education. Strains on health care budgets have led health care facilities to depend on formula company donations as though there are no alternatives.

The ability of parents to make informed decisions about exclusive and sustained breastfeeding for their child is often limited by the level of knowledge of their health care providers' about the hazards associated with not breastfeeding, and the risks associated with infant formula and their level of skill in providing support for lactation management. Institutions do not routinely require breastfeeding education as mandatory when hiring staff to support prenatal and postnatal mothers; for example maternity or public health nurses, nutritionists, dietitians and pharmacists. They do not require breastfeeding expertise when extending hospital privileges to obstetricians or pediatricians. Institutions do not routinely hire professional lactation consultants to provide services for mothers or to service the educational needs of staff. **Free formula and company sponsored educational materials are too often substitutes for a contingency of well-educated health professionals with the time to support mothers.**

Mothers feel very vulnerable after giving birth. Younger mothers, under 25 years of age, are particularly vulnerable to stopping breastfeeding within the first week. This same group has indicated that they were two to three times more likely to be influenced by health professionals (Health Canada 1999 p32). As mothers work to establish breastfeeding they experience:

- the undermining of their confidence to breastfeed when formula is used to deal with breastfeeding management problems
- lack of complete information about how formula use will effect breastfeeding initiation and its risks to the health of their baby
- frustration with conflicting information and advice across the continuum of care from health workers who have minimal or inadequate breastfeeding knowledge and skills
- inadequacies and gaps in the continuum of prenatal and postnatal support between the hospital in which they deliver and community health
- inequities in their ability to find the support needed to establish and sustain breastfeed in the postpartum period as they had intended when initiating breastfeeding after delivery

- interpretation of breastfeeding problems or failure to breastfeed as failure on the part of the mother rather than as a deficit in health care support

Variations in the breastfeeding initiation and duration rates across the country reflect problems with breastfeeding support in the system. These problems are evident in the low rates of both exclusive and sustained breastfeeding. The rate of exclusive breastfeeding (providing breastmilk as the only food or drink for the first 6 months) is not presently being monitored but is known to be low. Well- educated women and older mothers are more likely to decide to breastfeed and to breastfeed longer. These women also have higher incomes and the means to access private lactation consultant care in the community or the La Leche League to help them with breastfeeding management problems. These mothers are able to sustain breastfeeding longer with support from their families, their peers, their employers and in their community. Younger women, single women, women with social or economic challenges, aboriginal mothers, immigrant women or women whose infants are born with health problems receive inadequate support and are more likely to wean prematurely, before breastfeeding is established (Health Canada 1999 p.32).

The Implications: Unnecessary Cost to the Public Health Care System

Breastfeeding and the use of human milk have major implications for the health of infants and children and for the prevention of infant and childhood illness that require physician care, the use of antibiotics and, often, hospitalization (Cunningham AS, Jelliffe DB, & Jelliffe EFP.1991). Lack of breastfeeding support directly affects infant health. Children carry the burden of unnecessary ill health in infancy and into childhood. This failure is directly affecting the health of children and this is the main reason they are hospitalized during the first year. This costs the public health care system untold dollars:

- Exclusive use of formula is associated with substantial costs to the health care system solely in terms of the three most common illness outcomes in the first year of life: gastrointestinal illness, otitis media, and lower respiratory infections. For each 1000 infants never breastfed, there is in excess of 2033 office visits, greater

than 200 days of hospitalization and greater than 600 prescriptions compared to infants breastfed exclusively for at least 3 months. Differences between mothers who breastfed and those who did not are unlikely to account for this excess use of health care services, because figures have been adjusted for maternal education and smoking. This excess use of health care services attributable to inadequate breastfeeding costs between US $331 and $475 per infant never breastfed (Ball TM & Wright AL. 1999).

- Canadian evidence has verified the importance of breastfeeding to decreasing the rate of hospitalization for infants. In 1995 Dr. Micheline Beaudry reported in the Journal of Pediatrics a retrospective study carried out in New Brunswick which traced incidences of respiratory and gastrointestinal illnesses for 776 full term infants to six months according to feeding practices. Those that were breastfed had 47% fewer gastrointestinal episodes, 34% fewer respiratory illness and 56% less ear infections. The rate of hospitalization was 55 times greater for the bottle-fed than for the breastfed infant (Beaudry M. 1995).
- Internationally, these findings were largely confirmed by the PROBIT study conducted in Belarus by a team, including Dr. Michael Kramer and Dr. Beverley Chalmers of Canada, which was the largest randomized control trial study ever undertaken of the affects of breastfeeding on infant health (Kramer MK, Chalmers B et al. 2001).
- In 1997, Riordan calculated the health care costs for the USA for infant illness: diarrhea, respiratory syncytial virus, otitis media, and insulin dependent diabetes. She estimated this cost for these four illnesses alone to be one billion dollars US annually (Riordan J. 1997).
- USA Dept. of Agriculture, in March 2001, concluded that a minimum of $3.6 billion dollars would be saved on ear infections, gastroenteritis, and necrotizing enterocolitis if breastfeeding were increased from current levels (64 percent in hospital, 29 percent at 6 months) to those recommended by the Surgeon General (75 and 50 percent) (Weimer L. 2001).
- A framework for calculating the impact of the economic value of breastfeeding to the Canadian health care system was developed in 1998 by INFACT Canada.

This framework estimates that the number of pediatric admissions to a hospital can be multiplied by the average length of stay of 6.61 days at a cost of $1609.97 per day (INFACT 1998).

- These figures are likely an underestimation of the total savings because they represent cost savings from the treatment of only a few childhood illnesses and do not include the costs of illness associated with women who do not breastfeed, including an increased risk of developing premenopausal breast cancer, ovarian cancer, osteoporosis etc. .

Full cost accounting would identify the economic value of breastfeeding to the sustainability of the services provided at the hospital level and to the health care system in Canada including:

- the full burden of ill health for children and women that comes with the routine use of infant formula in hospital
- the cost savings in pediatric admissions when exclusive breastfeeding and the use of human milk is fully supported across the continuum of care
- the cost savings that come with staff education and support for informed decision making for parents
- the importance of institutional, financial and staffing policies to support combined care (mother and infant rooming in) to facilitate the initiation of successful breastfeeding and attachment parenting in hospital
- the economic value of human milk banking
- the cost savings that come with peer support outreach programs

The Need: To Improve the Quality of Care for Mothers and Babies in Canada

There have been major efforts by federal/provincial/territorial governments and stakeholder groups in promoting breastfeeding in Canada since 1978 when Health Canada began actively promoting breastfeeding. However, much more must be done to protect and support women's decisions to breastfeed. Improving the quality of care during the prenatal and postnatal periods to international standards is the basis of successful breastfeeding.

Comprehensive breastfeeding education for staff, including the use of human milk, is needed to overcome barriers and inequities in the system. The WHO/UNICEF Ten Steps to Successful Breastfeeding and the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes are international standards for institutional care of women who breastfeed. These standards are evidence-based and form the basis for the Baby Friendly™ Initiative. The principles of this initiative are:

- to promote exclusive and sustained breastfeeding as a health choice for both the child and the mother
- to provide support for client-centered informed decision making
- to protect and support women's decision to breastfeed through staff education and institutional policies.

To date there is only one hospital in Canada that has met the standards for successful breastfeeding support and has been designated as a Baby Friendly™ hospital. World wide there are over 15,000 Baby Friendly™ hospitals. There is only one hospital in Canada that provides a human milk bank to support infants' access to human milk. The number of milk banks in the United Sates, Australia, the United Kingdom and other countries is increasing yearly.

Breastfeeding is the foundation of health for individuals. Breastfeeding support has a major contribution to make to an affordable health care system for Canadian citizens. This vision is supported by:

- recognition of children's biological need for breastfeeding as critical to the determination of health of the individual and as a basic human right
- leadership and commitment by the Federal and Provincial Governments, Health Canada and the Provincial Health Departments to the WHO/UNICEF Baby Friendly™ Initiative and the WHO/UNICEF International Code of Marketing of Breastmilk Substitutes as the minimum standard for quality care for pregnant women, new mothers and children

- enhanced support for integrating the standards of Health Canada's *Family-Centred Maternity and Newborn Care National Guidelines* and the BCC document *Baby Friendly™ Initiative in Community Health Services: A Canadian Implementation Guide*
- integration of the 18 hours of the WHO/UNICEF Baby Friendly™ Initiative breastfeeding education into training curriculums as standard education for health care professionals.
- staffing support for combined mother and child care in hospital as the basis for successful initiation of breastfeeding and attachment parenting
- support for breastfeeding promotion as a health decision with access to a provincially funded network of Human Milk Banks
- support for health care facilities to provide breastfeeding support services for their employees per WHO/UNICEF Mother Friendly work places.

Conclusion:

The benefits of exclusive and sustained breastfeeding are not presently accessible to the majority of children in Canada. This is a quality-of-life issue for children and for individuals. It is a quality-of -care issue for women who have no choice but to deliver in hospital.

Protection of the decision to breastfeed as a health choice and support for those who decide to breastfeed affects mothers' ability to establish exclusive breastfeeding and their ability to sustain breastfeeding. There is strong evidence that this support directly affects the quality of health for infants and children and quality of life for individuals. Comprehensive infrastructure support to the level of the WHO/UNICEF international standards is needed to provide quality of care for breastfeeding mothers and children during the prenatal and postnatal period. Improved breastfeeding outcomes are dependent on quality care. Quality of breastfeeding care during the prenatal and postnatal period is the foundation for an affordable health care system for all Canadians.

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