**ETHICAL ISSUES IN PAYING FOR BREASTMILK**

George Kent[[1]](#footnote-1)\*

University of Hawai'i (Emeritus)

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Women, breastmilk, and breastfeeding have been consistently undervalued, not given the recognition they deserve for their contribution to human well-being. Several people have argued that the value of breastmilk should be fully recognized in national accounts such as the gross national product, and women should be recognized for its production (Aguayo and Ross 2002; Berg 1973; Hatløy and Oshaug 1997; Oshaug and Botten 1993; Palmer 2009, 319-344; Rohde 1982). In Australia, for example, human milk production is estimated to be worth more than $3 billion a year (Smith 2013). In low-income countries breastmilk production can account for a substantial shared of the gross national product. Some have argued that women should actually be paid for this and other services they normally provide without compensation (Solveig et al, 2002). Here it is argued that at the very least women should be offered payment when they provide breastmilk for infants not their own. Women who wish to donate their milk should be allowed to do that, and women who wish to sell it should be allowed to do that—under well-managed conditions.

Women have offered their breastmilk to other women’s infants since time immemorial. Currently, “commerce free” sharing of breastmilk is underway and growing in many countries (Akre 2012; Akre, Gribble, and Minchin 2011). Arrangements for doing this have become more systematic, raising many different kinds of issues (Arnold 2006; Aunpalmquist 2014; Dutton 2011; Fentiman 2009; FDA 2015; Gribble and Hausman 2012; Heise 2014; Palmquist and Doehler 2014). The issues are very different from those raised in dealing with breastmilk substitutes such as commercial infant formula (Brady 2012).

It is generally agreed that the buying and selling of breastmilk should be regulated, but details of how that should be done are yet to be worked out and widely accepted. In that context the focus here is specifically on concerns that arise when transactions relating to breastmilk involve the exchange of money. *Is there any good reason why women should not be compensated for breastmilk they provide to milk banks or directly to other families through milk sharing arrangements?*

The objective here is to stimulate further discussion, with no expectation that the debates will soon be settled.

Several issues were raised when the *New York Times* ran an article about Medolac, an Oregon-based company that worked with the local branch of Mothers Milk Cooperative, paying members for their milk, processing it, and then selling it to hospitals (Allers 2014). The responses to the article raised ethical concerns such as . . .

It's true, not all women produce excess milk, but those who do will welcome the opportunity to send it to a company who not only pays you for it (extremely rare), but is ultimately sending the excess milk to babies in need.

“Bribing women of color or paying them to breastfeed implies that they care more for money than their babies.”

Even when my daughter was eating 40+oz/day (most babies eat 25oz/day) I was still freezing an extra 1,000oz EVERY MONTH. Can you tell me $1,000 every month wouldn't make a difference for many women?

“It sounds to me that Medolac's business model is poor women = dairy cows.”

“This seems to harken back to a time when wealthy white women employed poor women, both black and white, to nurse their babies.”

There are milk banks all over the country that want the milk for free, turn around and charge an arm and a leg for sick babies that need it (Allers 2014).

A few days after the *New York Times* article was published the Human Milk Banking Association of North America challenged the Medolac model. HMBANA said it “takes the position that accepting milk donations from volunteer donors is the most ethical way to ensure that milk donations will be shared with the most critically ill of infants.” They argue, “Through following the nonprofit model of milk banking, HMBANA milk banks prioritize infant health when distributing donor milk to fragile infants. When donors contribute their milk to a for-profit breast milk operation, they do not always have the level of certainty about the destination of their donation (PRWeb 2014).” (Also see Hayes 2015).

HMBNA said, “By donating their milk with a nonprofit milk bank, mothers can be sure that their milk will be allocated to the sickest babies in their area.” What does non-profit status have to do with the fact that breastmilk providers are not compensated? What does non-profit status have to do with credibility of their assurances regarding which infants will get the breastmilk? For-profit organizations could offer similar assurances.

HMBNA seems to suggest that non-profit organizations are inherently more ethical than for-profit organizations, but offered no argument or evidence to support that idea. An organization that is nominally non-profit can be exploitative, charging hospitals high prices for milk they receive from women who are not compensated at all. It can be just as exploitative as organizations that are organized on a for-profit basis.

Gabrielle Palmer argues that women should not be paid for their breastmilk because “altruisim is important to maintain quality”:

Breastmilk donation requires trust between donor and receiver. If a mother expresses her milk for money, then she may be tempted not to tell the milk bank that, for example, she occasionally smokes or that she has had a course of antibiotics. Just as with blood or organ donation, financial incentives can do harm (Palmer 2009, 330).

Similarly, paid providers might be tempted to increase the volume of their offerings by adding cow’s milk or something else to their breastmilk to increase the volume and thus increase the payments they receive.

There are these risks, but relying on altruism though non-payment might not be the best way to deal with them. The risks can be reduced to some extent with appropriate monitoring and regulations, including screening of providers. Rather than simply excluding the option of paying for breastmilk, it is important to weigh the potential benefits against the risk of harm. No one asks farmers or infant formula manufacturers to offer their products for free as a way of ensuring their integrity. Why should women who offer breastmilk for sale be treated differently?

There is a milk sharing organization called Human Milk 4 Human Babies Global Network (hm4hb 2014). It promotes sharing of breastmilk freely, with no compensation to the providers. Their mission is “to promote the nourishment of babies and children around the world with human milk.”

The network called Eats on Feets is devoted to community breastmilk sharing:

Community breastmilk sharing works because mothers, fathers, professionals, communities, caring citizens and people just like YOU are joining together to help ensure that babies have access to commerce-free breastmilk. Babies need breastmilk to maintain optimum health. Parents and professionals know this! Every day, women from around the world selflessly donate thousands of ounces of breastmilk directly to babies. With Eats On Feets, these donations are commerce-free, just as nature intended, and they are making a huge difference in the lives of babies and their families (Eats on Feets 2015).

Their system for sharing breastmilk revives and extends the practice of wet nursing. But why insist that the sharing must be “commerce-free, just as nature intended”? What does that mean? It is wonderful that the network has been able to deliver thousands of ounces, but maybe it could deliver millions of ounces if the providers were compensated.

Human Milk 4 Human Babies and Eats on Feets have some good procedures, and some questionable ones. They key point there is that they might be able to reach far more families if they provided compensation to breastmilk providers, especially those with low incomes. Milk sharing organizations could encourage a few of their branches to experiment with compensation systems and then make well-informed judgments about whether the benefits outweigh the risks. There could be two types, some that compensate and some that do not.

An organization called Only the Breast functions as “A community for moms to buy, sell, & donate natural breast milk (Only the Breast 2015)” It operates primarily by hosting classified advertisements to connect sellers or donors to buyers. It exercises little control over the transactions.

The Mothers Milk Cooperative was mentioned earlier in relation to its connection with Medolac (Mothers Milk Cooperative 2015). In contrast with Human Milk 4 Human Babies and Eats on Feets, the organization pays the women who provide their breastmilk, even though it calls them “donors”. Its use of the term “cooperative” is unusual as well. It calls all its “donors” members of the “cooperative” even though they do not have an active role in the management of the organization (Sears 2014).

In designing appropriate regulations, a clear distinction should be made between formal hospital-based banking operations and less formal milk-sharing schemes (Akre 2012). They may need to be regulated in different ways. Women could be compensated for the milk they provide in both types of arrangements.

There are important issues related to providing *breastmilk* as a commodity. Consideration should also be given to the alternative of providing *breastfeeding* as a service. In some circumstances, the two could be close to being functionally equivalent.

Throughout history women have served as wet nurses and many have been paid for their service (Baumslag and Michels 1995; Golden 2001; Palmer 2009, 182-190). Some live with wealthy families, nursing their children, possibly one after the other. Some are called in to substitute for women who are suddenly unable to nurse their own children. The practice has declined sharply with the advent of infant formula, but it continues in some form in many places. In some cultures, women will casually nurse any young child who comes along, giving different meaning to the thought that “it takes a village to raise a child”.

In the modern world it is often more convenient to purchase a commodity than to hire someone to provide a service. But in some circumstances both alternatives should be considered. Is there any reason why a hospital’s neonatal intensive care unit should not maintain a list of screened and certified women who could be called on to breastfeed its patients? With the Internet and smart phones, on-demand services can now be managed in very sophisticated ways (The Economist 2015).

Hospitals now pay a high rate for breastmilk obtained through milk banks. At those rates, many women would be glad to deliver the product in person, on demand, in a form that is safe and nutritionally superior to any infant formula that could be offered.

Breastmilk is valuable, but usually the producers are not compensated for it (Palmer 2009, 331-339; Smith, Galtry, and Salmon 2014). Women who provide their breastmilk to other families could be compensated, regardless of whether the milk is destined for infants who are critically ill or healthy and safe. They could be compensated whether the organization handling it was as a for-profit or a non-profit organization. Both types should be closely regulated and monitored by government and also by relevant professional associations.

The ethical imperative for compensating women for the breastmilk they provide is strong because it would benefit both women and children:

1. It would be fair to compensate women who provide breastmilk for others’ infants,
2. With compensation, there would likely be a larger supply, so more infants would be able to receive breastmilk rather than breastmilk substitutes.
3. With a larger supply, the cost for breastmilk would be lower.
4. With more children getting breastmilk rather than infant formula or other breastmilk substitutes, the health and well-being of both women and children would be substantially improved.
5. Many people would agree that the money that now goes to infant formula manufacturers would be better spent if it went to women, especially women with low incomes.

The extent to which these effects would occur is uncertain and would vary in different circumstances. The advantages and disadvantages of compensating women for their breastmilk under various arrangements should be carefully studied.

Milk banking organizations that wish to operate solely with voluntary donors should be free to continue that way. At the same time, other organizations should be allowed to compensate women who provide their breastmilk. The providers don’t all have to be donors.

Laws in the United States relating to breastfeeding are summarized in a website of the National Conference of State Legislatures, accessible at <http://www.ncsl.org/research/health/breastfeeding-state-laws.aspx> Apparently there is no place in the U.S. where the selling of breastmilk is illegal. In some contexts people interpret certain laws as meaning that the selling of breastmilk is illegal while others interpret the same law differently. There is a need for new, clearer, wiser law relating to the buying and selling of breastmilk under various conditions (Dawson 2011), not just in the U.S., but everywhere.

The buying and selling of breastmilk can be done badly but it also can be done well. It is possible to learn from successes and failures in current practices to establish appropriate guidelines and rules to govern the buying and selling process. If women were paid for their breastmilk, more infants whose mothers were unable or chose not to breastfeed would have a good alternative to infant formula.

One serious concern is that making it easy to obtain others’ breastmilk might lead some mothers to be more reluctant to breastfeed on their own, an option that would be better for the health of their infants. The extent to which this negative impact actually occurs is an empirical question that should be studied. It must be balanced against the likelihood that easy to obtain breastmilk deters mothers from choosing worse alternatives. There is now a huge global effort underway by the manufacturers to promote the use of infant formula, especially in “emerging” economies with a growing middle class (Kent 2015). Making safe breastmilk more readily available could be an effective method for pushing back against that pressure.

For people with low incomes, infant formula remains out of reach and may be difficult to use because of sanitation and other issues. In those cases it is especially important to promote improved breastfeeding practices so that mothers can feed their own children more effectively. Where that fails, increasing the supply of breastmilk from other women could do a great deal to improve children’s health status (Patel 2014). It could sharply improve their survival prospects. Some countries focus on creating milk banks for the benefit of premature infants (UNICEF 2013), but with a larger supply far more children could benefit.

Policymakers should facilitate vigorous open discussion and research on the issues raised here. The stakes are high.

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