Infant Nutrition Council

Industry supporting both Breastfeeding & Infant Formula

AUSTRALIA & NEW ZEALAND

COMMERCE ACT 1986: RESTRICTIVE TRADE PRACTICES

SECTION 58: NOTICE SEEKING AUTHORISATION (STREAMLINED PROCESS)

The Registrar
Mergers and Authorisations
Commerce Commission
PO Box 2351
WELLINGTON
registrar@comcom.govt.nz

Pursuant to section 58 of the Commerce Act 1986 notice is hereby given seeking authorisation of a restrictive trade practice.

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INTRODUCTION AND EXECUTIVE SUMMARY

1. This is an application under section 58(1) of the Commerce Act 1986 by Infant Nutrition Council Limited for authorisation for the Infant Nutrition Council and its members to enter into, and give effect to, an arrangement to which section 27 may apply.

2. In 1981, the 34th session of the World Health Assembly adopted the International Code of Marketing of Breast Milk Substitutes (**WHO Code**). The WHO Code is attached as Appendix 1. Although it is not obvious from its title, the WHO Code aims to protect and promote breastfeeding, and to restrict the marketing of breast milk substitutes in ways that would undermine this aim.

3. Article 11.1 of the WHO Code states (in part):

> *"Governments should take action to give effect to the principles and aim of this Code, as appropriate to their social and legislative framework, including the adoption of national legislation, regulations or other suitable measures."*

4. The WHO urged all member states to take action to give effect to the principles and aim of the WHO Code, and subsequent relevant World Health Assembly resolutions, as appropriate to each member state's social and legislative framework.

5. The WHO Code was adopted on a voluntary basis by New Zealand in 1983. The government of the day directed that the WHO Code was to be implemented and monitored through consensus and discussion, not through legislation. Consistent with this, the Ministry of Health is committed to giving effect to the WHO Code in New Zealand. The Ministry of Health document *Implementing and monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand* attached as Appendix 2 explains that the WHO Code is given effect through four Codes:

   (a) Code of Practice for Health Workers (published by the Ministry of Health);

   (b) Advertising Standards Authority Code for Advertising of Food (2010);[1]

   (c) Australia New Zealand Food Standards Code (2014); and

   (d) Infant Nutrition Council Code of Practice for the Marketing of Infant Formula (2012).

6. The Infant Nutrition Council Code of Practice for the Marketing of Infant Formula in New Zealand (the **INC Code of Practice**) is published by the Infant Nutrition Council. The INC Code of Practice is attached as Appendix 3. Under the INC Code of Practice, members' marketing activities are restricted in relation to infant formula. The INC Code of Practice is part of facilitating New Zealand's compliance with the WHO Code and subsequent relevant World Health Assembly resolutions.

7. Members of the Infant Nutrition Council are manufacturers, marketers and importers of infant formula in New Zealand and/or Australia. The Australia New Zealand Food Standards Code states

[1] The Code for Advertising of Food states that advertisements should comply with appropriate industry codes. The ASA explicitly recognises the INC Code of Practice as an appropriate industry code.

that infant formula is a product represented as a breast milk substitute for infants and which satisfies the nutritional requirements of infants aged from birth up to around four to six months.[2]

8. The Infant Nutrition Council seeks authorisation for an arrangement under which the members would restrict their infant formula marketing activities in relation to the following:

    - advertising infant formula to the general public;
    - distributing free samples to pregnant women, mother of infants, or their families and caregivers of infants;
    - distributing free samples to healthcare professionals as a sales inducement;
    - marketing personnel seeking direct or indirect contact with pregnant women or with parents of infants and young children;
    - distributing bulk quantities of free infant formula product to the health system as an inducement;
    - distributing gifts of utensils or other articles that may discourage breastfeeding, to pregnant women, mothers of infants and caregivers of infants; and
    - offering inducements to health workers, health practitioners, or their families, to promote infant formula.

9. These restrictions lessen competition by depriving manufacturers and marketers of infant formula the opportunity to consider methods of marketing and communication that would typically be considered part of the optimal mix of methods adopted for the purpose of competing to sell products.

10. The Ministry of Health actively promotes breastfeeding and New Zealand's compliance with the WHO Code which is given effect in New Zealand under the four codes as outlined above. Breastfeeding is widely recognised as a way to improve the health and nutrition of infants, young children, and their mothers.[3] The Ministry of Health states that implementing the WHO Code is an important part of creating an overall environment that enables mothers to make the best possible feeding choice, based on impartial information free of commercial influence, and to be fully supported in doing so.[4] The Ministry of Health recommends that babies are exclusively breastfed until they are around six months old.[5]

11. In light of this, absent the authorisation sought by this application, as New Zealand has an obligation to ensure the WHO Code (to the extent that it is appropriate for New Zealand) is implemented and monitored appropriately within the context of New Zealand's legal and economic

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2 Standard 2.9.1

3 See for example the Ministry of Health's Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0-2): A background paper (4th ed) – Partially revised December 2012, available at http://www.health.govt.nz/publication/food-and-nutrition-guidelines-healthy-infants-and-toddlers-aged-0-2-background-paper-partially

4 http://www.health.govt.nz/publication/implementing-and-monitoring-international-code-marketing-breast milk-substitutes-nz-code-nz

5 http://www.health.govt.nz/your-health/healthy-living/babies-and-toddlers/breastfeeding?icn=yh-breastfeeding&ici=readmore.

environment, the Ministry of Health would likely take steps to impose analogous restrictions through regulation or by engaging with each marketer and manufacturer on a bilateral basis.

12. However, for a period of time before the Ministry of Health is able to impose the restrictions, it would be clear to all members of the Infant Nutrition Council that they would not, and could not, be bound by relevant restrictions in the INC Code of Practice. Non-members, perceiving the potential for more active marketing, may be incentivised to increase their own marketing with the overall effect of a reduction in the rate of breastfeeding of infants.

13. While INC members have been committed to restrictions of the type embodied in the INC Code of Practice and its predecessor (the NZIFMA Code of Practice) for some time, in the event that there was any increase, however small, in marketing by an industry participant, each INC member would have to reassess its position. For example, while members would not expect there to be a massive increase in advertising to the general public, a number of the other restrictions present less of a clear distinction between actions that would be consistent or inconsistent with the INC Code of Practice or WHO Code.

14. While the potential increase in competition would be for a period of two to three years, the potential public health detriments would be more lasting: once an infant switches to infant formula, it is very difficult to re-establish breastfeeding and, accordingly, breastfeeding that may have been able to be maintained past six months is also affected.

15. In addition to public health detriments, the WHO Code and other literature state that the financial and social impacts of maintaining an infant on formula can be significant.

16. Further, authorisation would lead to avoidance of transaction costs arising from establishing the relevant regulation or bilateral arrangements and the steps required by members to ensure compliance with slightly modified requirements.

17. In light of the above, the public benefit to be gained from the arrangement outweighs the lessening in competition, and the Commerce Commission should authorise the arrangement.

PART 1: DETAILS OF APPLICANT AND OTHER PARTIES

The applicant

18. This notice is given by Infant Nutrition Council Limited

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19. The contact person at the Infant Nutrition Council is:

Jan Carey, CEO

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Email:	jancarey@infantnutritioncouncil.com.au

20. Correspondence and enquires should in the first instance be addressed to:

Buddle Findlay
PO Box 2694
Wellington 6140

Attention:	Susie Kilty / Tom Georg
Telephone:	498 7356 / 498 7338
Facsimile:	462 0856 / 462 0498
Email:	susie.kilty@buddlefindlay.com / tom.georg@buddlefindlay.com

21. Infant Nutrition Council Limited is a company limited by guarantee, incorporated in Australia. It is owned by manufacturers and marketers of infant formula in Australia and New Zealand. Those manufacturer and marketer owners are the Ordinary members and Associate members listed in Appendix 4.

22. There are currently eight directors of the Infant Nutrition Council. Each of the Ordinary members of the Infant Nutrition Council has one representative on the board. Associate members may elect up to two members to the board between them. The current directors are:

    (a) Reece Prewett – Chairman;

    (b) Nigel King;

    (c) Klaus Wachsmuth;

    (d) Michael Stein;

    (e) Kelly Sowden;

    (f) Corine Tap;

    (g) Michael Teen;

    (h) Stephen Voordouw; and

    (i) Guy Wills.

23. The Infant Nutrition Council's constitution requires its members to comply with a code of conduct published by the Infant Nutrition Council pursuant to its constitution. The code of conduct requires Infant Nutrition Council members to comply with the INC Code of Practice. The Infant Nutrition Council's constitution and code of conduct are attached as Appendix 5.

24. The directors of the Infant Nutrition Council have the power to terminate or suspend the membership of a member if they refuse or neglect to comply with the constitution which, indirectly, means that a failure to comply with the INC Code of Practice may lead to expulsion from the Infant Nutrition Council.

25. The INC Code of Practice has a complaints process that is administered by the Ministry of Health. This process facilitates the New Zealand implementation and monitoring of its obligations under the WHO Code. The complaints process has three parts: initial written complaint, reference to the Compliance Panel, and appeal to the Adjudicator. The Compliance Panel and Adjudicator have no power to sanction market participants that are in breach. However, they do make findings that can have significant reputational impact.

Other parties

26. The other relevant parties to the arrangement are the members of the Infant Nutrition Council that market infant formula in New Zealand. A table of those members and their relevant details is provided in Appendix 4.

27. Membership of the Infant Nutrition Council is voluntary. Ordinary membership is open to manufacturers and marketers of infant formula in Australia and New Zealand. Associate membership is open to manufacturers, marketers of infant formula with < 2% market share in either Australia or New Zealand, or other interested parties that are neither manufacturers or marketers.

Persons with control of the parties

28. The Applicant would be happy to provide shareholding information for members of the Infant Nutrition Council if the Commission considers such information to be necessary to its assessment of the application.

Description of practice

29. The 34th session of the World Health Assembly adopted the WHO Code in 1981 as a minimum requirement to protect and promote appropriate infant and young child feeding.

30. New Zealand is a signatory of the WHO Code, which commits New Zealand to progressing the aims of the WHO Code, and is committed to working towards its aims. The WHO urged all member states to take action to give effect to the WHO Code's principles and aim, and subsequent relevant World Health Assembly resolutions, as appropriate to their social and legislative framework.

31. The WHO Code was adopted on a voluntary basis by New Zealand in 1983. The government of the day directed that the WHO Code was to be implemented and monitored through consensus and discussion, not through legislation. Consistent with this, the Ministry of Health is committed to giving effect to the WHO Code in New Zealand.

32. The Ministry of Health document *Implementing and monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand* is attached as Appendix 2. The WHO Code is given effect in New Zealand under four New Zealand codes. They are:

    (a) Code of Practice for Health Workers (published by the Ministry of Health);

    (b) Advertising Standards Authority Code for Advertising of Food (2010)[6];

    (c) Australia New Zealand Food Standards Code (2014); and

    (d) Infant Nutrition Council Code of Practice for the Marketing of Infant Formula (2012).

33. For clarity, the Infant Nutrition Council notes that the Ministry of Health website refers to a document called the New Zealand Infant Formula Marketers' Association Code of Practice (NZIFMA Code of Practice). The NZIFMA has been incorporated into the Infant Nutrition Council, and the INC Code of Practice supersedes the NZIFMA Code of Practice.

34. This application relates to an arrangement under which members of the Infant Nutrition Council agree to restrict their marketing (but not pricing) activities. The restrictions are embodied in the INC Code of Practice which was developed in consultation with the Ministry of Health.

35. Article 1 of the INC Code of Practice (which mirrors the aim of the WHO Code) states that:

> "*The aim of the Code is to contribute to the provision of safe and adequate nutrition for infants by the protection and promotion of breastfeeding and by ensuring the properties of breast milk substitutes, when they are necessary, on the basis of adequate information and through appropriate marketing and distribution.*"

[6] The Code for Advertising of Food states that advertisements should comply with appropriate industry codes. The ASA explicitly recognises the INC Code of Practice as an appropriate industry code.

36. Relevantly to this application, the INC Code of Practice includes the following:

    (a) Article 5.1: *The advertising of infant formula to the general public, prepared by or under the local control of INC companies through mass media, including television, national or local newspapers, magazines, radio, the electronic media or at point of purchase should be avoided*;

    (b) Article 5.3: *INC companies should not distribute samples of infant formula to pregnant women, mothers of infants, or their families and caregivers of infants*;

    (c) Article 5.4: *Gifts of utensils or other articles that may discourage a mother from breastfeeding her infant should not be distributed to pregnant women, mothers of infants and caregivers of infants;*

    (d) Article 5.5: *Marketing personnel, in their business capacity, should not seek direct or indirect contact with pregnant women or with parents of infants and young children*;

    (e) Article 6.5: *Quantities of infant formula can be purchased by health care organisations at wholesale prices. However, the distribution of bulk quantities of free product to the health care system should be avoided*;

    (f) Article 7.2: *No financial or material inducement to promote infant formula should be offered to health workers, health practitioners or members of their families; and*

    (g) Article 7.3: *Samples of infant formula, or of equipment or utensils for the preparation or use of infant formula, may be provided at the request of a health practitioner on the completion of a "Samples Request Form" consistent with the Infant Nutrition Council approved form and only for the purposes of professional evaluation and research, or for the education of mothers and carers who have made the informed decision to provide infant formula to their infants.*

37. The restrictions broadly fall into two categories:

    (a) restricting the usual ways by which INC members communicate with end consumers (ie buyers of infant formula); and

    (b) restricting the use of samples, gifts, or donations as an inducement.

38. In the main, however, the articles of the INC Code of Practice place emphasis on information and education, not only about the benefits and superiority of breastfeeding, but also on other matters that would not be typical in the context of marketing a consumer product. For example, article 4.3 states that information and education materials should include the social and financial implications of the use of infant formula.

39. The restriction on advertising in the INC Code is designed to support the public health goal of improving breastfeeding rates. Advertising/marketing is designed to increase demand for a firm's products and allows firms to seek to differentiate products (as well as provide useful information). It is therefore an important part of the competitive process. Greater advertising/marketing would be expected to lead to more competitive outcomes in relation to the sale of infant formula through

greater rivalry between manufacturers/marketers of such formula. However, increased rivalry and more competitive outcomes undermine the public health goal.

40. In relation to the restrictions on free samples and bulk free quantities, the Infant Nutrition Council has considered the relevance of *Commerce Commission v Caltex New Zealand Ltd* (1999) 9 TCLR 305. In that case, the High Court held that free car washes operated as an integral part of the petrol pricing or was a discount in relation to petrol. The High Court drew a similar conclusion in relation to car wash pricing. Therefore, agreeing to discontinue free car washes constituted price fixing.

41. The Infant Nutrition Council does not consider that an arrangement between Infant Nutrition Council members under which those members agree that they should not provide free samples, gifts or bulk free quantities (in a health sector context) could be viewed as similar to the petrol companies' free car wash agreement.

42. In contrast to the facts of *Commerce Commission v Caltex New Zealand Ltd* neither samples, gifts, nor bulk free quantities to hospitals could be regarded as an integral part of the price of infant formula, or as a discount in relation to infant formula.

43. As a starting point, single serve infant formula product is available for purchase through retailers and retailers are not restricted in any way by the INC Code of Practice. Further, samples are provided only when requested by health practitioners, in conjunction with information about not only the health benefits of breastfeeding, but the suitability of a particular product for feeding a particular baby. In that context, samples are only provided to healthcare practitioners for the purpose of professional evaluation or research, or for the education of mothers who have made an informed decision to use infant formula. The Infant Nutrition Council's Samples Policy and template Samples Request Form are attached as Appendix 6.

44. In relation to article 5.4, the restriction on gifts of utensils or other articles to the general public (such as bottles and teats) is aimed at preventing what may be seen as an inducement regarding the use of infant formula, where that consumer may otherwise breastfeed, by lowering the barriers to adopting formula.

45. Further, article 6.5 is aimed at avoiding incentivising or encouraging (through distribution of large quantities of free product within the health system as a sales-related inducement) use of formula divorced from a discussion and assessment of the features of any particular infant formula, its suitability, and the health benefits of breastfeeding. It is preferable for such a discussion to occur on a case by case basis between a healthcare professional and the patient.

46. However, the Infant Nutrition Council recognises that undertaking advertising and promotion (that may include giving out free samples direct to consumers) of the type restricted under the INC Code of Practice would ordinarily be expected to be part of the competitive process. To state the obvious, the restrictions on marketing embodied in the INC Code of Practice therefore mean that competition in the infant formula industry is lessened.

PART 2: THE INDUSTRY

Description of relevant goods supplied by the parties

47. The members of the Infant Nutrition Council manufacture and/or market infant formula. The WHO Code defines infant formula as:

> "*[A] breast milk substitute formulated industrially in accordance with applicable Codex Alimentarius standards, to satisfy the normal nutritional requirements of infants up to between four and six months of age, and adapted to their physiological characteristics. Infant formula may also be prepared at home in which case it is described as 'home-prepared'.*"

48. More relevantly, the INC Code of Practice defines infant formula as:

> "*A product represented as a breast milk substitute for infants and which satisfies the nutritional requirements of infants aged from birth up to four to six months.*"

49. The definition adopted by the INC Code of Practice is taken from Australia New Zealand Food Standards Code – Infant Formula Standard 2.9.1.

Industry affected

50. This application affects the infant formula industry in New Zealand and, in particular, marketers of infant formula. The table in Part 5 (existing competitors) sets out the current marketers who participate in the industry. Some of those marketers manufacture in New Zealand, others import infant formula from overseas.

51. Infant formula products available in New Zealand are made to stringent quality and compositional standards to meet the regulatory requirements for food supply in Australia and New Zealand, which is set by Food Standards Australia New Zealand. The raw materials used in the manufacture of infant formula and the final product itself must meet very strict specifications. The highest standards throughout the manufacturing process involve thorough heat treatment which ensures the microbiological safety of the product. Quality control procedures are very strict and stringent standards of hygiene are in force throughout the manufacturing process with a view to ensuring the risk of potential contamination is kept to an absolute minimum.

52. The sale of infant formula to consumers is dominated by the two large supermarket chains, Progressive Enterprises Limited and the Foodstuffs group (Foodstuffs North Island Limited and Foodstuffs South Island Limited). A much smaller portion of sales are made through alternative channels, such as pharmacies, online retailers and mass channels such as The Warehouse. While the INC Code of Practice does not apply to retailers, retailers are generally aware of the requirements of the INC Code of Practice, and the Infant Nutrition Council has published a document entitled "Information for Retailers". That document sets out the key features of the INC Code of Practice that are relevant for retailers, and is attached as Appendix 7.

53. In addition, marketers compete to supply public hospitals (although the volume of product sold to hospitals is very small). The products supplied are pre-mixed liquid infant formula (mainly for pre-

term babies) and a small amount of infant formula powder. Hospitals tend to rotate suppliers to ensure that one brand is not favoured over another.

54. Further, hospitals are also encouraged to take part in the Baby-Friendly Hospital Initiative, and the vast majority in New Zealand are "Baby-Friendly" accredited.[7] The Baby-Friendly Hospital Initiative is an international programme launched in 1991 by UNICEF and the World Health Organization to ensure that all maternity services become centers of breastfeeding support. Hospital staff are also required to comply with the Code of Practice for Heath Workers (see paragraph 32 above).

55. The Ministry of Health is an important stakeholder. The Ministry of Health is directly relevant to this application because it promotes the principles and aims of the WHO Code in New Zealand and administers a process for handling complaints under the INC Code of Practice.

56. The Infant Nutrition Council understands that the Ministry occasionally independently takes steps to engage with non-member manufacturers and marketers of infant formula to raise awareness of the content of the INC Code of Practice. For example, the Ministry will occasionally contact non-members in response to a complaint, or on its own initiative, about conduct that may be regarded as contrary to the INC Code of Practice. However, at present, the Ministry has less than one FTE available to do this.

57. Nevertheless, the Ministry of Health can be considered the natural regulator for this industry. This point is further addressed in the counterfactual discussed in part 4 below.

Current industry trends and developments

58. The infant formula industry has a significant history of technical innovation through research and development. A primary focus of research and development is on producing infant formula that contains ingredients found in breast milk that more closely matches the outcomes for breastfed infants. There is also a focus on producing infant formula for specific medical requirements.

59. Technical innovation typically occurs over a long time frame because of the rigorous testing required to ensure the safety and benefits of infant formula.

60. Members of the Infant Nutrition Council recognise the importance of the promotion of breastfeeding as providing the best possible nutrition for infants. This is reflected in the requirement set out in the INC Code of Conduct for each member of Infant Nutrition Council to display a statement along the lines of the following, on their websites:

> "*Breast milk is the normal way to feed a baby and is important for baby's health. Professional advice should be followed before using an infant formula. Introducing partial bottle feeding could negatively affect breastfeeding. Good maternal nutrition is preferred for breastfeeding and reversing a decision not to breastfeed may be difficult. Infant formula should be used as directed. Proper use of an infant formula is important to the health of the infant. Social and financial implications should be considered when selecting a method of feeding.*"

[7] See http://www.babyfriendly.org.nz/

61. Recognition of the importance of the promotion of breastfeeding as providing the best possible nutrition for infants is further reflected by the Infant Nutrition Council's desire to have the arrangement between its members to restrict certain marketing activities authorised by the Commission.

Relevant mergers and acquisitions

62. In 2012, Nestlé, a member of the Infant Nutrition Council, acquired the infant nutrition business of Pfizer. Clearance was not sought for this acquisition in New Zealand as the level of aggregation was *de minimus* (given Nestlé had a market share at the time of less than 1%).

63. In May 2014 it was announced that Nutricia proposes to acquire the Sutton Group and Gardians. Sutton Group is an Auckland-based blending, packing and can-forming company. Gardians operates a spray dryer in Balclutha.

Relevant reports, surveys, published papers

64. There are many reports on the benefits of breastfeeding. Breastfeeding is widely recognised as a way to improve the health and nutrition of infants and young children.[8] The importance in New Zealand is highlighted by the Ministry of Health on a dedicated part of its website,[9] which includes a range of resources.

65. The Ministry of Health has published a paper which links with its specific health indicator of increasing the proportion of infants being exclusively and fully breastfed in the first six months of life: "*The Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper*" (Ministry of Health, Wellington, partially revised December 2012).[10]

66. Further, and relevantly to this application, a 2011 paper explicitly addressed the WHO Code as implemented in New Zealand: "*Effectiveness, Implementation and Monitoring of the International Code of Breast milk Substitutes in New Zealand: A Literature and Interview-Based Review*" (Report for the Ministry of Health, Matt Burgess and Neil Quigley, Victoria University of Wellington, July 2011).[11]

67. That paper highlights the steps taken not only in New Zealand but in many other jurisdictions in order to give effect to the WHO Code.

68. In 2012, a report was prepared for the Ministry of Health on consultations that took place regarding the effectiveness of the WHO Code in New Zealand: *"Key Stakeholder Consultation to Complete the Evaluation of the Effectiveness of the WHO International Code of Marketing of Breast-Milk Substitutes in New Zealand*" (Report prepared for the Ministry of Health by Quigley and Watts Ltd, September 2012).

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8 See for example the National Strategic Plan of Action for Breastfeeding 2008 – 2012,and related Background Report, published by the National Breastfeeding Advisory Committee, available at http://www.health.govt.nz/publication/national-strategic-plan-action-breastfeeding-2008-2012

9 See http://www.health.govt.nz/your-health/healthy-living/babies-and-toddlers/breastfeeding

10 See http://www.health.govt.nz/system/files/documents/publications/food-and-nutrition-guidelines-healthy-infants-and-toddlers-revised-dec12.pdf

12 The complaints process relates to breaches of the INC Code, if the relevant provisions are not enforceable, the complaints process cannot apply.

69. A 2013 report of the Health Committee discussed the nutritional and psychological importance of breastfeeding: "*Inquiry into improving child health outcomes and preventing child abuse with a focus on pre-conception until three years of age*" (Report of the Health Committee, Fiftieth Parliament (Dr Paul Hutchinson, Chairperson, November 2013)).

PART 3: MARKET DEFINITION

Markets relevant to the proposed practice

70. The Infant Nutrition Council submits that the appropriate product market is infant formula, being infant formula for babies from birth six months old. The relevant functional market relates to:

    (a) the supply and distribution of infant formula to retailers; and

    (b) the supply and distribution of infant formula to hospitals.

71. The Infant Nutrition Council submits that supply and distribution to hospitals is a different market from supply and distribution to retailers, because liquid formula is not supplied in any other context, and formula is used within the hospital setting. Further, staff at hospitals are governed by the Code of Practice for Health Workers and, where applicable, the Baby Friendly Hospital Initiative.

72. The purpose of the Code of Practice for Health Workers mirrors that of the WHO Code, and is to protect and promote breastfeeding, and to ensure the proper use of breast milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution. In addition, almost all hospitals are Baby-Friendly accredited, as mentioned above.

73. The Infant Nutrition Council considers that there is a separate retail market (ie the retail sale of infant formula to consumers). However, no member company currently sells directly to consumers, and the arrangement to which this application relates applies only to the supply and distribution to those retailers (and hospitals). Further, the INC Code of Practice is not binding on retailers (although retailers are encouraged to comply with its aims). In light of this, the Infant Nutrition Council does not consider that the retail market is relevant to this application.

74. Finally, the Infant Nutrition Council submits that the geographic extent of the market is national in relation to the supply and distribution of infant formula to retailers. Each marketer supplies and distributes products nationally. In relation to supply and distribution to hospitals, there is an argument that each district health board region constitutes a separate geographic market. However, as with the supply and distribution to retailers, supply and distribution to hospitals occurs on a national basis.

75. In summary, the relevant markets are:

    (a) the national market for supply and distribution of infant formula to retailers (the **retail distribution market**); and

    (b) the national market for the supply and distribution of infant formula to hospitals (the **hospital distribution market**).

How are products differentiated?

76. Product formulation is a key differentiating factor. Technological innovation that seeks to replicate ingredients found in breast milk and seeks outcomes closer to breastfed infants is pursued by market participants. There are also special formulations for various medical conditions. For example, for infants who are dairy intolerant, there are soy-based infant formula alternatives. There

are also special formulations for babies with allergies (extensively hydrolysed and elemental formulas) and premature babies which are available via hospitals or prescription only.

77. Despite the restrictions in the INC Code of Practice, there is vigorous price competition in the retail distribution market, on a constant basis, as marketers are not restricted from offering promotional prices/price support to retailers.

78. In the hospital distribution market, hospitals tend to simply rotate from one supplier to another. At present, only the three largest infant formula marketers supply hospitals: Nestlé, Nutricia, and Heinz Watties. A typical rotation is four to six months, although this varies. Some hospitals will stock all the major brands simultaneously. Consecutive rotations may occur if competing manufacturers do not have sufficient stock or give poor service. Some hospitals have made a decision based on a clinical basis or experience with a product to have an exclusive supply or extend a rotation.

PART 4: COUNTERFACTUAL

79. As outlined above, and as a signatory of the WHO Code, New Zealand is committed to meeting the aims of the WHO Code in New Zealand.

80. Given New Zealand's commitment to the WHO Code, the Infant Nutritional Council submits that no counterfactual would involve unrestricted marketing of infant formula.

81. If the Commerce Commission declines to authorise the arrangement under which members of the Infant Nutrition Council agree to restrictions as embodied in the INC Code of Practice, the Infant Nutrition Council will either have to amend the INC Code of Practice to omit the relevant restrictions, or otherwise take steps to ensure that it is clear that the relevant restrictions are not binding.

82. Whilst the Ministry would be likely to continue its current practice of contacting manufacturers and marketers of infant formula that act inconsistently with the restrictions embodied in the INC Code of Practice/WHO Code, this is unlikely to be effective in the long-term. It will also likely be less effective in the short-term: at present the Ministry is able to say with certainty that all INC members give effect to the restrictions in the INC Code of Practice, and submit to the jurisdiction of the Ministry's complaints procedure, so as to encourage non-members to give effect to and comply with the INC Code of Practice. The Ministry's leverage would be severely diminished during the interim period.

83. The Infant Nutrition Council considers the counterfactual will involve the Ministry of Health seeking to give effect to similar (or potentially more restrictive) marketing restrictions to those that currently operate. The Ministry will of course be guided by the Minister of Health and the government, but the Infant Nutrition Council is not aware of any current proposals that would suggest a move away from New Zealand's previous commitment to, and support of, the WHO Code. Any such move would not be consistent with a high level of consumer and social expectation based on New Zealand's support for the WHO Code that there will be appropriate regulation of some form in this area.

84. While the INC Code of Practice would be an obvious basis for concluding binding arrangements, there is the potential for the Ministry to seek greater restrictions than currently operate. For example, while the WHO Code states that it applies in relation to infants aged 0-6 months old, the Health Workers Code of Practice developed by the Ministry applies in relation to infants aged 0-12 months old. Further, the WHO Code applies to a wider range of industry participants, such as distributors and retailers. If the Ministry sought greater restrictions, negotiations could take some time.

85. The Ministry has also indicated to the Infant Nutrition Council that this option may be unrealistic. In particular, the bilateral contracting approach would be resource intensive and would not be likely to be an efficient use of its limited resources to have individual conversations with the potentially 70+ industry participants (there are 30 members of INC, and the Ministry has noted that there are 40+ non-INC companies it would potentially need to engage).

86. Alternatively, the Ministry of Health may seek an amendment to an Act under its administration (for example, the New Zealand Public Health and Disability Act 2000), to provide for regulations, or other measures, to restrict the marketing of infant formula products through the infant nutrition industry.

87. The process to implement such restrictions would be unlikely to be swift. It is likely that a complete solution could not be put in place for at least 12 months (two or more years would be a more realistic time frame for legislative change).

88. Further, when the Ministry of Health preferred course of action was finalised, the restrictions they impose would likely be similar or potentially more restrictive, and covering more participants. This is because the WHO Code is more restrictive than the INC Code of Practice, and, if regulated, non-member marketers and importers would be required to comply with restrictions, as well as potentially a range of other industry participants, such as manufacturers, retailers and distributors.

89. The WHO Code is more restrictive than the INC Code of Practice in that it seeks to restrict all advertising and promotion of breast milk substitutes, including pricing/discounting – see article 5.3 of the WHO Code.

90. In the medium term, it would be clear to participants that the INC Code of Practice is not enforceable and it would create pressure for participants to act in a way inconsistent with the INC Code of Practice and the WHO Code.

91. Although members have been committed to restrictions in the INC Code of Practice and its predecessor (the NZIFMA Code of Practice) for some time, absent the restrictions in the INC Code of Practice, a good degree of uncertainty would be introduced as to how each market participant would behave. It is uncertain, for example, how participants would react to pressure from third parties to undertake conduct that would have been restricted by the INC Code of Practice.

PART 5: EXISTING COMPETITORS

Existing competitors

92. The major competitors in the relevant markets are members of the Infant Nutrition Council. Competitors who are not members of the Infant Nutrition Council comprise less than 1% of the market, measured by value and/or volume.

93. A list of competitors is included in the table in paragraph 99 below. In addition, as explained further below, a number of new competitors have entered the retail distribution market, including small companies that market products in New Zealand, but are principally producing products for the Asian export market. Some of these companies are members of the Infant Nutrition Council, and some are not.

How competitors compete

94. Although there are regulatory constraints on the composition, labelling and marketing of infant formula, within those constraints the market is dynamic and innovative.

95. In particular, market participants compete on the following non-price factors:

    (a) Participants may use specific approved ingredients to improve growth and development outcomes in infants. Participants compete by using varying ingredients in order to better mimic the composition or developmental outcomes of breast milk;

    (b) Competitors in the market for infant formula in New Zealand compete with each other on the reputation of their brand;

    (c) Many participants have an economy and premium infant formula product. Some competitors market goat milk or soy-based infant formula;

    (d) Packaging innovation is another key area of competition between participants. Examples include pre-measured portions, and containers that have a scoop stored in the lid for ease of use; and

    (e) Participants who are not members of the Infant Nutrition Council may compete in the market by advertising to the general public, providing free samples, and by directly approaching consumers. For example, Fernbaby is a sponsor of the New Zealand Warriors. Nutri Care has recently run a gift with purchase promotion where consumers are offered a free training toothbrush set with any purchase of Nuenfant infant formula.

96. Marketers compete on price in both relevant markets. In addition to having to ensure competitive wholesale prices, marketers of infant formula are asked, from time to time, to support in-store shelf price promotion of their products.

97. As outlined above at paragraph 78, competition in the hospital distribution market is significantly different to the retail distribution market.

Market shares – retail distribution market

98. The value of stage 1 infant formula sales by retailers (which is a proxy for the value of sales to retailers) has ranged from approximately $18 million (in 2009) to $38 million (in 2012), reflecting significant increases to sales/export to China. These fluctuations can be partly explained by the high volume of 'grey trade' export to China, where product was being purchased for unofficial export to China. Towards the end of 2012 the Ministry of Primary Industries engaged with retailers to clamp down on this 'grey trade'. The Infant Nutrition Council understands that retailers voluntarily imposed restrictions on the number of cans that can be purchased. In 2013, sales dropped to $23 million and it is unlikely the market will change significantly given relatively flat birth rates and improving breastfeeding rates.

99. The table below contains relevant market share data for wholesale supply of infant formula to supermarkets in New Zealand. The data covers the 12 months ending on 30 December 2013.

Rank	Competitors	Estimated revenue	Estimated % of market share by revenue	Estimated volume (kg)	Estimated % of market share by volume
1	Nutricia	$12,789,803	54.7%	459,710	49.9%
2	Nestlé	$5,867,879	25.1%	244,236	26.5%
3	Heinz Watties	$4,552,024	19.5%	212,212	23%
4	Other: A2 Nutrition Bayer Australia Bellamys Fernbaby NZ New Image International Nuztri Purelea The Kiwifood Company	$163,559	0.7%	5,100	0.6%

100. Appendix 8 includes market share data for 2009-2013 (approximate calendar years), and the moving annual total to May 2014. Market share data provided in this application is sourced from AC Nielsen.

101. As is clear from the data in Appendix 8, other small competitors have entered and exited the market over the preceding five years. The Infant Nutrition Council is aware of the following small competitors that have been active over the past five years:

(a) Biolife New Zealand;

(b) Carrickmore;

(c) Fresco Nutrition;

(d) Green Monkey;

(e) New Zealand Goldmax Health;

(f) New Zealand Dairy Products;

(g) Nutria care;

(h) Silver Fern Branding; and

(i) Vitagermine.

Market shares – distribution to hospitals

102. As mentioned above, Nestlé, Nutricia, and Heinz Watties supply hospitals. The value of sales to hospitals is dwarfed by retail distribution sales. However, as a rough estimate by volume share, it is likely to be less than 1% of all distribution sales.

PART 6: POTENTIAL COMPETITION

Significant new entry and exit in the past five years

103. In the past five years the following participants have entered the market for wholesale supply of infant formula into supermarkets:

    (a) Bayer Australia Ltd (2010);

    (b) Bellamys (2010);

    (c) Fernbaby NZ (2012);

    (d) Purelea (2012) ;

    (e) A2 Nutrition (2013);

    (f) Nuztri (2013);

    (g) New Image International (2013); and

    (h) The Kiwifood Company (2013).

104. In the past five years the following participants have exited the market for wholesale supply of infant formula into supermarkets:

    (a) Pfizer (acquired by Nestlé in 2012);

    (b) Vitagermine (2012); and

    (c) Bayer Australia Ltd (2012).

105. In addition to the significant new entries and exits listed above, there are a number of very small market participants that have been active in the previous five years. Those that the Infant Nutrition Council is aware of are listed at paragraph 101.

Potential for new entry/expansion within next two years

106. The potential for new entry or expansion in the market for wholesale supply of infant formula in New Zealand is strongly linked to the export market in Asia, particularly China. This is because New Zealand is a very small market and any new entry or expansion would likely be supported primarily by expansion into the growing Asian market.

PART 7: PUBLIC BENEFITS AND DETRIMENTS

Detriment

107. In our analysis in Part 4 above, there is no long-term counterfactual involving less restriction on competition than the factual. This means that over the long- term there is no public detriment, in competition terms, arising from the arrangement or, more specifically, the restrictions embodied in the INC Code of Practice.

108. However, for a transition period before the Ministry of Health implements new measures to give effect to the WHO Code, there would be less competition in the factual than the counterfactual.

109. As noted above, the Infant Nutrition Council anticipates a transition period without explicit restrictions on marketing activities that are typically, and frequently, used by marketers and manufacturers of consumer products to advertise, market and promote those products.

110. The Infant Nutrition Council submits that members and non-members alike would be pressured to undertake more aggressive marketing during this transition period as a result of a perception that if they did not do so, they would lose market share to competitors that did.

111. Non-members of the Infant Nutritional Council may perceive there will be greater competition in the areas of marketing that are currently restricted, and increase their marketing of infant formula in response.

112. While INC members have been committed to restrictions in the INC Code of Practice and its predecessor (the NZIFMA Code of Practice) for some time, in the event that there was any increase, however small, in marketing by an industry participant, INC members would have to reassess their position.

113. For example, while members would not expect there to be a massive increase in advertising to the general public, a number of the other restrictions present less of a clear distinction between actions that would be consistent or inconsistent with the WHO Code. Any uncertainty would be exacerbated as there would be no complaints process as currently administered by the Ministry of Health to assess those actions.[12]

114. INC submits that, for a transitional period (which could extend to a couple of years), if members were asked to advertise a product at the request of a retailer, or to provide free samples, it would be hard to commercially justify not acquiescing to that request.

115. Therefore, as a result of the restrictions in the INC Code of Practice, there is a reduction in (and therefore detriment to) competition by depriving manufacturers and marketers of infant formula the opportunity to consider methods of marketing and communication that would typically be considered part of the optimal mix of methods adopted for the purpose of competing to sell products.

[12] The complaints process relates to breaches of the INC Code, if the relevant provisions are not enforceable, the complaints process cannot apply.

Public benefits – health of infants and wider community, and avoidance of financial costs

116. Public health benefits will be supported as a result of the authorisation of the arrangement. Restrictions on advertising/marketing of the type embodied in the INC Code of Practice facilitate a focus on appropriate, scientific and neutral information about infant formula, disseminated through a healthcare professional on a one on one basis. This approach facilitates a focus on education (for both health professionals and consumers) in order to protect and promote breastfeeding, and safe and adequate infant nutrition.

117. It is widely accepted that human breast milk is the best form of infant nutrition.

118. The Ministry of Health summarises the health and community benefits of breastfeeding as follows:[13]

Breastfeeding is important for infants because it:

- provides optimum nutrition for infants;
- assists the physical and emotional development of infants;
- decreases the incidence and severity of childhood infectious disease;
- is associated with decreased infant mortality and hospitalisation; and
- is associated with the decreased risk of chronic disease for infants.

Breastfeeding is important for mothers because it:

- may help the mother return to her pre-pregnancy weight;
- helps to protect a mother's iron status by minimising postpartum maternal blood loss;
- reduces the risk of postpartum haemorrhaging (this effect relates to immediate post birth breastfeeding);
- encourages contraction of the uterus after birth;
- has a 98 percent contraceptive effect in the first six months after the infant's birth, provided the infant is exclusively breastfed in response to their hunger cues and the mother does not resume menstruation;
- reduces the risk of pre-menopausal breast cancer;
- may reduce the risk of ovarian cancer;
- may reduce the risk of osteoporosis and hip fracture in later life; and
- may inspire healthier choices such as ceasing smoking, quitting recreational drugs or improving nutrition, which can be emotionally and physically satisfying and enhance self-esteem in the maternal role.

[13] Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (Ministry of Health, Wellington, partially revised December 2012 - available at http://www.health.govt.nz/publication/food-and-nutrition-guidelines-healthy-infants-and-toddlers-aged-0-2-background-paper-partially

119. Even though that transition period would exist for a relatively short period, the ramifications could be far-reaching. For example, mothers who discontinue breastfeeding because of marketing pressure (or as a result of insufficient information/advice) may be unable or unwilling to switch back to breastfeeding. It is widely accepted that once bottle feeding is established, it is extremely difficult to revert to breastfeeding, and the resulting health, financial and social implications would likely continue.

120. In relation to financial costs (and the consequent benefits arising through the avoidance of such costs), INC notes that the cost of infant formula, if used as the exclusive source of nutrition for an infant from birth to the age of six months, based on recommended quantities and timing, would be several hundred dollars. There are also the related costs of equipment, such as bottles, teats, and sterilisation equipment.

121. INC submits that it is difficult, if not impossible, to quantify the cumulative benefits that arise specifically from giving effect to the marketing restrictions in the INC Code of Practice. The Ministry of Health acknowledges that the "barriers to breastfeeding are interlinked, and demonstrate the need for a comprehensive approach if breastfeeding rates in New Zealand are to be improved".[14]

122. In order to quantify, it would be necessary to identify infants who were switched to formula feeding when it was not necessary to do so. Identifying when it is or is not necessary to bottle feed is a very complex and controversial task. The 2011 report for the Ministry of Health by Burgess and Quigley identified the lack of quality literature on understanding, enforcement or compliance with the WHO Code across countries (the WHO Code is implemented in New Zealand in part via the INC Code of Practice). That report noted that the literature that is available is largely qualitative, and unreliable.[15]

123. Even so, a US report published in 2010 assessed the economic benefit of breastfeeding, and estimated that around US$13 billion would be saved annually if breastfeeding were increased from current levels to 90% of women breastfeeding exclusively for six months in the US.[16]

124. More recently, an October 2012 report commissioned by UNICEF UK noted difficulties in studying health outcomes in this area, such as ethical and feasibility issues in conducting randomised controlled trials, and lack of a clear line between "breastfeeding" and "not breastfeeding".[17] For example, some infants will be both breastfed and formula fed for a period of time.

125. However, the literature consistently points to a range of benefits to breastfeeding. These benefits arise for each infant and mother where breastfeeding is continued in a scenario where it would have

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[14] Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0–2): A background paper (Ministry of Health, Wellington, partially revised December 2012 - available at http://www.health.govt.nz/publication/food-and-nutrition-guidelines-healthy-infants-and-toddlers-aged-0-2-background-paper-partially

[15] "*Effectiveness, Implementation and Monitoring of the International Code of Breast milk Substitutes in New Zealand: A Literature and Interview-Based Review*" (Report for the Ministry of Health, Matt Burgess and Neil Quigley, Victoria University of Wellington, July 2011).

[16] M. Bartlick and A Reinhold, 'The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis', *Pediatrics* volume 125, number 5, May 2010, p 1048.

[17] "*Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*" (Report commissioned by UNICEF UK, Renfrew et al, October 2012).

otherwise been stopped as a result of being influenced by the marketing, communications and other activities restricted by the INC Code of Practice.

126. While there is no corresponding literature in New Zealand, the UNICEF UK analysis suggests that a moderate increase in breastfeeding rates would lead to fewer cases of gastrointestinal infection, respiratory tract infection, acute otitis media, and necrotising enterocolitis, and lower associated healthcare costs.

127. Because the public health benefits are self-evident, INC submits that it is open to the Commission to make a qualitative assessment of the public benefits arising from the restrictions in the INC Code of Practice, and that these benefits will arise if the rate of breastfeeding is maintained at even a marginal level compared to the counterfactual.

Public benefits – avoidance of regulatory costs

128. The counterfactual identified includes similar or more restrictive regulation, implemented potentially via legislation or through bilateral arrangements between the Ministry of Health and market participants.

129. In order for the Ministry to directly regulate the marketing of infant formula, the Infant Nutrition Council expects that the Ministry would, at a minimum, need to allocate additional/new resources to enable it to enter into binding arrangements with each manufacturer and marketer on a bilateral basis. The Ministry currently has less than one FTE responsible for matters relating to implementing and monitoring the WHO Code in New Zealand. If the Ministry were potentially required to negotiate and contract with each of the 70+ industry participants on a bilateral basis, significant new resources would be required. The legislative options also gives rise to costs in terms of establishing legislation and continual monitoring and enforcement.[18]

130. We are not in a position to quantify with any certainty the costs that may be incurred by the Ministry of Health or any other Government department in implementing legislative change or hiring new staff.

131. The public benefit arising from authorisation of restrictions embodied in the INC Code of Practice derive from the efficiencies gained by using self-regulation to give effect to the WHO Code in New Zealand.

132. Self-regulation can have significant benefits to government regulation. Self-regulation is relatively low cost, and the costs are internalised in the industry, resulting in strong incentives for cost efficiency. These lower costs permit a greater scope for effective regulation than would otherwise be possible given financial constraints.

133. Self-regulation has been successfully implemented in Australia since 1992, when industry participants (many of whom are INC members) sought authorisation of the MAIF (Marketing in Australia of Infant Formula) agreement. Authorisation was granted by the ACCC. The MAIF

[18] A research report recently published in the Bulletin of the World Health Organization estimated the cost of each page in an act or regulation, in New Zealand, to be US$32,434 (N. Wilson et al, 'Estimating the cost of new public health legislation', *Bulletin of the World Health Organization,* volume 90, 2012, p 532).

agreement features on the INC website, reflecting that the INC is a trans-Tasman organisation, accordingly there are operational and management efficiencies that can be maintained if INC remains responsible for the parts of the Code for which authorisation is sought.

134. Further, despite lacking coercive powers, self-regulation can result in significant costs for non-compliance because of loss of business and reputation that result from an adverse finding. This is enhanced by the key role that brand reputation plays in the infant formula industry.

135. The Burgess/Quigley report referred to in paragraph 66 above, discusses the circumstances where self-regulation is most likely to be effective. Those circumstances, relating to the infant formula industry, are:

    (a) Relatively few industry players (low monitoring costs and large reputational costs for non-compliance);

    (b) Firms are multi-product (reputational costs can impact across multiple markets);

    (c) Firms can observe rivals' behaviour (firms have incentive to monitor compliance of competitors);

    (d) High industry exit costs/industry-specific human capital (high exit costs increase maximum effective punishment);

    (e) Industry marked by innovation or technology;

    (f) Industry not dominated by a single large firm;

    (g) The industry is not hazardous (in contrast to, for example, industries such as construction). In hazardous industries, self-regulation may lead to under-supply of compliance on health and safety matters;

    (h) Appropriate behaviour hard to codify in legislation (greater tolerance for imprecise rules in a non-adversarial regulating environment); and

    (i) Self-regulation compatible with ethical behaviour (if regulated behaviour is consistent with social norms, deviation from regulation is more easily identified.

136. We submit that the characteristics of the infant formula industry are such that there are significant benefits to self-regulation as proposed in the factual.

PART 8: IDENTIFICATION OF INTERESTED PARTIES

137. The contact details of likely interested parties are set out below. Information has been obtained from the interested parties' publicly available information.

	Entity name	Contact details	Relevant contact person
Competitors	Bellamy's	PO Box 96 Launceston 7250 Tasmania Australia +61 3 6332 9200 export@bellamysorganic.com.au	
	Purelea	Unit 2 710 Great South Road Penrose Auckland 1061 New Zealand +64 9 579 8800 advisory@purelea.co.nz	
	Fernbaby	PO Box 105-982 Auckland 1143 New Zealand +64 9 525 2222 info@fernbaby.co.nz	
	The Kiwifood Company	98 Grassmere Road Henderson Valley Auckland 0612 New Zealand +64 9 836 4288	
	Carrickmore	PO Box 1626 Paraparaumu 5252 New Zealand 0800 3676852	

	Nutria Care	20T Cain Road Penrose Auckland 1061 New Zealand +64 9 525 1111 info@nutriacare.co.nz	
	Silver Fern Branding	Unit 5 1 Tony Street Henderson Auckland 0610 New Zealand +64 9 836 0330 cassinfmgc@xtra.co.nz	
	Vitagermine	Parc d'Activités du Courneau Rue du Pré Meunier - Canéjan – CS 60003 – 33612 CESTAS Cedex France +33 5 57 96 56 82 info@vitagermine.com	
Government/public sector	Ministry of Health	04 496 2137 phil_knipe@moh.govt.nz 04 816 4335 elizabeth_aitken@moh.govt.nz	Phil Knipe, Chief Legal Adviser Elizabeth Aitken, Team Leader & Senior Advisor (Nutrition)
	Auckland DHB	PO Box 92-189 Auckland Mail Centre Auckland 1142 09 638 9909	Ailsa Claire, Chief Executive Officer
	Bay of Plenty DHB	Private Bag 12-024 Tauranga 3143 07 579 8000	Phil Cammish, Chief Executive Officer
	Canterbury DHB	PO Box 1600 Christchurch 8140	David Meates, Chief Executive Officer

		03 364 4106	
	Capital and Coast DHB	Private Bag 7902 Wellington South 6242 04 385 5999	Debbie Chin, Interim Chief Executive Officer
	Counties Manukau DHB	Private Bag 94-052 South Auckland Mail Centre Manukau City 2241 09 262 9500	Geraint Martin, Chief Executive Officer
	Hawkes Bay DHB	Private Bag 9041 Hastings 4156 06 878 8109	Kevin Snee, Chief Executive Officer
	Hutt Valley DHB	Private Bag 31-907 Lower Hutt 5040 04 566 6999	Graham Dyer, Chief Executive Officer
	Lakes DHB	Private Bag 3023 Rotorua 3046 07 348 1199	Ron Dunham, Chief Executive Officer
	MidCentral DHB	PO Box 2056 Palmerston North 4440 06 350 8061	Murray Georgel, Chief Executive Officer
	Nelson Marlborough DHB	Private Bag 18 Nelson 7042 03 546 1800	Chris Fleming, Chief Executive Officer
	Northland DHB	Private Bag 9742 Whangarei 0148 09 470 0000	Nick Chamberlain, Chief Executive Officer
	South Canterbury DHB	Private Bag 911 Timaru 7940 03 687 2100	Nigel Trainor, Chief Executive Officer
	Southern DHB	Private Bag 1921 Dunedin 9054 03 474 0999	Carole Heatly, Chief Executive Officer
	Tairawhiti DHB	Private Bag 7001 Gisborne 4640 06 869 0500	Jim Green, Chief Executive Officer

	Taranaki DHB	Private Bag 2016 New Plymouth 4342 06 753 6139	Tony Foulkes, Chief Executive Officer
	Waikato DHB	PO Box 934 Hamilton 3204 07 839 8899	Nigel Murray, Chief Executive Officer
	Wairarapa DHB	PO Box 96 Masterton 5810 06 946 9800	Graham Dyer, Chief Executive Officer
	Waitemata DHB	Private Bag 93503 Takapuna Auckland 0740 09 486 8900	Dale Bramley, Chief Executive Officer
	West Coast DHB	PO Box 387 Greymouth 7840 03 768 0499	David Meates, Chief Executive Officer
	Whanganui DHB	Private Bag 3003 Whanganui 4540 06 348 3216	Julie Patterson, Chief Executive Officer
Customers	Progressive Enterprises Limited	media@countdown.co.nz	Dave Chambers, Managing Director
	Foodstuffs North Island Limited	PO Box 38-896 Wellington Mail Centre 04 527 2510	Murray Jordan, Managing Director
	Foodstuffs South Island Limited	Private Bag 4705 Christchurch 03 353 8700	Steve Anderson, Chief Executive Officer
Other	Women's Health Action Trust	PO Box 9947 Newmarket Auckland 1149 09 520 5295	Julie Radford-Poupard, Director
	New Zealand Breast Feeding Authority	P O Box 20-454 First Floor, Unit One 16 Sheffield Crescent Bishopdale 03 3572 072	Julie Stufkens – Executive Officer

	Royal New Zealand Plunket Society	PO Box 5474 Wellington 6145 04 471 0177	Jenny Prince, Chief Executive Officer
	New Zealand College of Midwives	PO Box 21-106 Edgeware 8143 Christchurch 03 377 2732	Karen Guilliland, Chief Executive
	La Leche League	PO Box 50780 Porirua 5240 04 471 0690	Alison Standon, Director

PART 9: CONFIDENTIALITY

138. Nothing in this application is confidential.

Appendices

Appendix 1: WHO Code

Appendix 2: Implementing and monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand

Appendix 3: INC Code of Practice

Appendix 4: INC members including contact details

Appendix 5: INC constitution and code of conduct

Appendix 6: INC's Samples Policy and template Samples Request Form

Appendix 7: Guidance for Retailers

Appendix 8: Market shares 2009-2014