NEW ZEALAND COLLEGE OF MIDWIVES (INC)

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Dear Anthony

Submission from the New Zealand College of Midwives

Thank you for providing the opportunity for feedback on the request to the Commerce Commission, from the Infant Nutrition Council (INC), seeking authorisation of a restrictive trade practice.

The College of Midwives would like it noted that the timing of this sector consultation in relation to the INC authorisation request is not ideal given that interested parties, like the rest of New Zealand, are working with less staff due to annual leave over Christmas and the summer. We would therefore suggest that this time frame has potentially reduced the submission rate by those named as interested parties in the INC document.

EXECUTIVE SUMMARY

1. The College strongly supports the regulation of all breast-milk substitutes, as per the International Code and subsequent, relevant WHA resolutions.

2. The College considers that if the INC self-regulated and voluntary code of practice was to be disestablished, by being deemed anti-competitive, then there would be an urgent need for Government intervention to implement these regulatory measures.

3. The College strongly recommends the Commerce Commission seek advice from the Ministry of Health in this matter as the history and process of the International Code in New Zealand and the marketing of infant formula is not just a commercial decision but rather it relates to both public and population health outcomes for New Zealanders and the accompanying economic burden of these diseases increasing.

4. In regards to the Commerce Act, the College notes that consideration of public benefit is covered in s61:7. The College would like to draw attention to the recommendation (No 4) in light of the public benefit point.

5. Breastfeeding is economically beneficial in regards to population health protection.

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6. Benefits that derive from better outcomes for children must be given the highest priority, as suggested by Sir Peter Gluckman, "*Social Investment in New Zealand should take more account of the growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over that life course than do strategies applied later.*" [1]

7. Despite any perceived barriers to regulation of the practices of the formula industry, that may be framed within the context of restricting trade practices, it is critical to note a statement within the International Code of Marketing of Breast-milk Substitutes that highlights why industry regulation is paramount.

   "In view of the vulnerability of infants in the early months of life and the risks involved in inappropriate *feeding practices, including the unnecessary and improper use of breast-milk substitutes, the marketing of breast-milk substitutes requires special treatment, which makes the usual marketing practices unsuitable for these products."* (p. 7) [2]

8. The INC voluntary and self-regulated code, whilst containing a diluted set of principles, provides at least some small protection for our most vulnerable consumers.

9. The College supports that the INC code be retained in the absence of other marketing protections and whilst we would prefer that the New Zealand government met their international obligations and strengthened and aligned the marketing of infant formula to reflect the original intent of the Global Strategy (see Appendix), we recognise the current INC Code gives some degree of protection in the absence of this.

10. The College would therefore be supportive of the application for authorisation on this basis, and in the health and economic interests of both individual women and their babies, and due to our concern about the wider health and economic implications of not supporting the limitation of the marketing of infant formula.

11. The College notes that the New Zealand Commerce Commission equivalent in Australia has granted authorisation for this very purpose. If authorisation is granted this would create a level playing field amongst manufacturers, while at the same time, ensuring New Zealand practice aligns with international guidance. We recognise that authorisations are infrequently granted by the Commission but in this case we would like consideration for all the reasons noted in this submission.

INTRODUCTION

The New Zealand College of Midwives (the College) is the professional organisation for midwifery. Our members are employed and self-employed and collectively represent 90% of the practising midwives in this country. There are around 2,900 midwives who hold an Annual Practising Certificate (APC). These midwives provide maternity care to on average 60,000 women and babies each year. New Zealand has a unique and efficient maternity service model which centres care around the needs of the woman and her baby. It provides women with the opportunity to have continuity of care from a chosen maternity carer (known as a Lead Maternity Carer or LMC) throughout pregnancy and for up to 6 weeks after the birth of the baby. Over 85% of women choose a midwife to be their LMC. Primary maternity services provided by LMC midwives are integrated within the wider primary care and

maternity services of their region or locality. The College offers information, education and advice to women, midwives, district health boards, health and social service agencies and the Ministry of Health regarding midwifery and maternity issues.

In their practice, midwives interface with a multitude of other health professionals and agencies to support women to achieve the optimum outcome for their pregnancies, health and well-being. One of the key issues concerning midwives, along with other parties interested in public health and short and long-term population health, is the protection and support for women who breastfeed.

There are many issues that require consideration when it comes to infant feeding. The College does not intend to present a full statement about breastfeeding and appropriate infant and young child feeding in this submission, as there are many policy documents, research evidence-based articles, and global strategies that contain this information but this submission requires some background reference to breastfeeding and the costs to the economy of not breastfeeding to inform the Commerce Commission in relation to the importance of the request from INC seeking authorisation to restrict their infant formula marketing activities, as described in bullet point 8 in the Executive Summary of their application.

1.0 HEALTH AND ECONOMIC ADVANTAGES OF BREASTFEEDING

1.1 Breastfeeding is economically beneficial in regards to population health protection. This is a significant evidence-based statement. The New Zealand Ministry of Health highlight the significant contribution of breastfeeding to optimal nutrition, and protection from a wide range of diseases and infections including positive contributions to the reduction of obesity, the incidence and impact of cancer, cardiovascular disease and diabetes.[3]

1.2 A recent report from the 2014 Gravida Strategic Summit emphasises the urgent need to address the issues of overweight and obesity that are imposing large burdens on public health systems, the economy and society. [4]

1.3 A recent study from Japan found that exclusive breastfeeding for six to seven months was associated with a decreased risk of overweight and obesity compared with formula feeding. 43,000 infants were followed from birth up until the age of eight and the risk of obesity at seven and eight years was reduced by nearly half. [5] This shows that exclusive breastfeeding represents an intervention of huge impact.

1.4 Sir Peter Gluckman, the Prime Minister's Chief Science Advisor, in a paper about reducing the burden of chronic disease in the next generation, states that "epigenetic development can be influenced by how the infant is fed and perhaps how its gut is colonized with commensal bacteria". [6]

1.5 Gluckman also highlights the enormous economic and humanitarian costs of non-communicable diseases (NCDs) and the importance of breastfeeding for promoting optimal growth, resistance to infection, cardiovascular health and neurocognitive development. [7] In another paper by Hanson, Gluckman et al., a call for interventions to reduce the health burden of diabetes and NCDs, focusing on nutrition, breastfeeding and infant feeding practices is made.[8]

1.6 Pokhrel et al, looked at the potential economic impacts from improving breastfeeding rates in the UK and found that the impacts of low breastfeeding rates are substantial.[9] Treating four acute diseases in childhood associated with not breastfeeding was estimated to cost at least £89 million annually while the 2009-2010 value of lifetime costs of treating maternal breast cancer was estimated at £959 million. Breastfeeding is protective against breast cancer in a dose response manner which means that support for a longer duration of breastfeeding is important.

1.7 Breastfeeding protection includes maternity protection, broad policy documents that recognise and take account of breastfeeding and the regulation of breast-milk substitute marketing. Smith and Ingham (2001) discuss the negative economic repercussions of a failure to take account of breastfeeding and breast milk value and the adverse effects of formula feeding, and draw attention to the incomplete and biased estimates of economic progress and well-being that this produces in national accounts. [10]

1.8 A US study by Bartick and Reinhold in 2007 found the yearly economic cost savings associated with increasing exclusive breastfeeding rates to be US$13 billion. This was considered to be an underestimate by the researchers. [11]

1.9 Recent research from Scotland by Ajetunmobi et al, shows that breastfeeding is associated with reduced hospitalisation in childhood. This evidence comes from a birth cohort of 502,948 infants. Within the first six months of life there was a greater hazard ratio of hospitalisation for common childhood illnesses among formula fed infants and mixed fed infants. Within the first year of life and beyond, a greater relative risk of hospitalisation was observed for formula fed infants for a range of illnesses including gastrointestinal, respiratory, urinary tract infections, otitis media, fever, asthma, diabetes and dental caries.[12] As explained by Stuebe, the significant health differences between breastfed and formula fed infants can be explained, in part, by specific and innate immune factors present in human milk.[13] These cannot be reproduced in formula.

1.10 Benefits that derive from better outcomes for children must be given the highest priority, as suggested by Sir Peter Gluckman, "*Social Investment in New Zealand should take more account of the growing evidence that prevention and intervention strategies applied early in life are more effective in altering outcomes and reap more economic returns over that life course than do strategies applied later.*" [14]

2.0 POLICY DIRECTION – NATIONAL AND INTERNATIONAL

2.1 The New Zealand National Strategic Plan of Action for Breastfeeding was developed by the National Breastfeeding Advisory Committee as advice for the Director-General of Health in 2009.[15] It was recognised by the committee that New Zealand's interpretation and implementation of the International Code did not meet the minimum standards envisaged by the International Code (p. 9). Issues with marketing violations have accelerated since this statement was made until now, in 2015, New Zealand has many more competitors in the marketplace who are not members of INC and therefore not following the principles in the INC code of practice.

2.2 The 2003 World Health Organisation and UNICEF's Global Strategy for Infant and Young Child Feeding (GSIYCF) highlights the public health recommendation for infants to be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. The World Health Organisation states that a review of evidence has shown that, on a population basis, exclusive breastfeeding for six months is the optimal way of feeding infants. Thereafter infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years and beyond. [1] The recommendations also state that exclusive breastfeeding from birth is possible except for a few medical conditions and that unrestricted breastfeeding results in ample breast milk production.[16] The New Zealand Ministry of Health recommends exclusive breastfeeding for around six months and a continuation of breastfeeding, after the introduction of suitable complementary foods, for one year and beyond.[17] It is also important to note, in the context of this submission, that the New Zealand Ministry of Health define an infant as a child in the first twelve months of life.

2.3 Despite any perceived barriers to regulation of the practices of the formula industry, that may be framed within the context of restricting trade practices, it is critical to note a statement within the International Code of Marketing of Breast-milk Substitutes that highlights why industry regulation is paramount.

"In view of the vulnerability of infants in the early months of life and the risks involved in inappropriate feeding practices, including the unnecessary and improper use of breast-milk substitutes, the marketing of breast-*milk substitutes requires special treatment, which makes the usual marketing practices unsuitable for these products."* (p. 7)

2.4 Kevin Frick, an American health economist, discusses frameworks for infant and young child nutrition strategies and suggests that there are times when a government should not leave decisions to individuals and organisations in a private market. Frick also points out that breastfeeding is part of the process of producing child health.[18]

2.5 The College feels strongly that this point about producing child health is critical, alongside the importance of breastfeeding to women's health and overall population health. The sustainable health and well-being of citizens requires recognition that even in times when GDP may be increased, this may not signify any increase in societal well-being but may in fact be linked with a decrease in well-being.

2.6 The INC voluntary and self-regulated code, whilst containing a diluted set of principles, provides at least some small protection for our most vulnerable consumers.

2.7 The College would prefer to see the International Code of Marketing Breast-milk Substitutes and subsequent, relevant, World Health Assembly (WHA) resolutions enacted into regulation and legislation under some urgency to protect breastfeeding and the safe and appropriate use of breast-milk substitutes where necessary.

[1] http://who.int/nutrition/topics/exclusive_breastfeeding/en/

2.8 The College supports that the INC code be retained in the absence of other marketing protections and whilst we would prefer that the New Zealand government met their international obligations and strengthened and aligned the marketing of infant formula to reflect the original intent of the Global Strategy (see Appendix), we recognise the current INC code gives some degree of protection in the absence of this.

2.9 The College would therefore be supportive of the application for authorisation on this basis and in the health and economic interests of both individual women and their babies but also due to concerns about the wider health and economic implications of not supporting the limitation of the marketing of infant formula. If authorisation is granted this would create a level playing field in the market and better align New Zealand with international guidelines.

2.10 We note that the New Zealand Commerce Commission equivalent in Australia has granted authorisation for this very purpose.

3.0 COMMENTS SPECIFIC TO THE INC AUTHORISATION REQUEST

3.1 INC state in the executive summary (6) that member's marketing activities are restricted in relation to infant formula. As these restrictions only apply to members of INC this enables current and future competitors to continue inappropriate marketing practices to the serious detriment of breastfeeding. Granting of an authorisation by the Commerce Commission would be more equitable in this current environment and would inform all companies marketing infant formula in New Zealand to follow these marketing restrictions.

3.2 INC reference the Food Standards Code, in regards to a statement about infant formula as a breast-milk substitute being suitable from birth up to around four to six months (7). Current recommendations for exclusive breastfeeding remain at six months and the College would like the Commerce Commission to note that Standard 2.9.1 – 'Infant Formula Products and other standards in the Code that regulate infant formula products' is under the process of review currently (from September 2014) in order to "ensure that the regulation of infant formula is clear and reflects the latest scientific evidence." It is also under consideration in terms of "harmonising the Code with international regulations." FSANZ also state, "We have decided to focus only on issues relating to infant formula (0-<12 months) and this work is expected to take three years to complete. A consultation paper is scheduled for release in late 2014 or early 2015." [2]

3.3 INC submission 7/124. The UNICEF UK report [19] was clear that the calculations made of about £40 million per year, were an underestimate of the potential cost savings of supporting more women to breastfeed for longer in the UK. Professor Mike Kelly, Director of the Centre for Public Health Excellence, The National Institute for Health and Clinical Excellence (NICE) highlights in the foreword that the authors *"confine their analyses to health service costs. They do not consider broader costs to society. Nor do they deal in detail with the many other health problems that have been linked over the years to not breastfeeding such as type 2 diabetes, cardiovascular disease, asthma and adult obesity. They do, however, note that if costs beyond the health sector were to*

[2] http://www.foodstandards.govt.nz/code/infant/pages/default.aspx

be included, and if these conditions could be built into the analyses, then the cost savings would be very significant indeed."

The current definition of an infant as six months of age and under is not a valid definition but it has been utilised as a definition, by the formula industry, to market products after this age. As noted earlier the College would like to see broader restrictions but note the resistance to this, so once again reinforce the need to at least protect babies six months and under, in the absence of endorsing the International Code in its entirety. The College is concerned about the marketing of follow-on (follow-up) formula. It is currently marketed in such a way that may cause confusion and have a negative impact on breastfeeding. Studies strongly suggest a direct correlation between marketing strategies for follow-on (follow-up) formulae and perception and subsequent use of these products as breast-milk substitutes. [20]

The issue of lack of regulation of breast-milk substitutes is of greater concern since the arrival of more companies into the market. The College notes an increase in International Code violations, and violations covered by the principles within the INC code, and note with alarm the increase in misleading health and nutrition claims particularly via the internet. For example a formula company website recently suggested a formula product could alleviate symptoms of asthma. These issues require action for consumer protection.

The College is grateful to have been given the opportunity to make a submission on this authorisation request, as the implications of the marketing of breast-milk substitutes is of critical importance to infant and young child health and well-being, the health of women and the population in general.

If further information is required in regards to this submission please do not hesitate to contact the College.

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Appendix Key documents, statements and comments

1.0 The Global Strategy for Infant and Young Child Feeding

1.1 The imperative for placing improved infant and young child feeding high on the public health agenda was one of the principles determinants for the policy framework underpinning the Global Strategy for Infant and Young Child Feeding (GSIYCF) in 2003.

1.2 The GSIYCF is intended as a guide to action for a revitalisation of the global commitment to, "appropriate infant and young child nutrition, and in particular breastfeeding and complementary feeding" (p. 1) and the International Code of Marketing of Breast-milk Substitutes is a key foundation document for the strategy.

1.3 Therefore an identified urgent strategy objective of the GSIYCF was to give effect to the principles and aims of the International Code of Marketing of Breast-milk Substitutes and subsequent, relevant World Health Assembly (WHA) Resolutions in their entirety.

1.4 As the International Code was developed and written in 1981 the purpose of the WHA resolutions is to keep the Code current and regularly updated to take account of contemporary industry marketing practices.

2.0 The International Code of Marketing of Breast-milk Substitutes [21]

2.1 The aim of the International Code is to contribute to the safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution (Article 1, p. 8).

2.2 The scope of the International Code encompasses all marketing and related practices of products – breast-milk substitutes including infant formula, other milk products, food and beverages, including bottle fed complementary foods, when marked or otherwise represented to be suitable, with or without modification, for use as a partial or total replacement of breast milk. This includes quality, availability and information concerning their use. It also applies to feeding bottles and teats (Article 2, p. 8).

2.3 No advertising or other form of promotion to the general public of products within the scope of the International Code is allowed. This includes point of sale advertising, or any promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums and special sales (Article 5.1 & 5.3 p. 10-11).

2.4 Governments should take action to give effect to the principles and aim of the International Code as appropriate to their social and legislative framework, including the enactment of national legislation, regulations and other suitable measures (Article 11.1, p. 14).

2.5 Manufacturers and primary distributors of products within the scope of the International Code should regard themselves as responsible for monitoring their marketing practices according to the principles and aims of the International Code, and for taking steps to ensure that their conduct at every level conforms to them (Article 11.3, p. 14).

2.6 Manufacturers and primary distributors of products within the scope of the International Code should appraise each member of their marketing personnel of the International Code and their responsibilities under it (Article 11.5, p. 14).

2.7 It is recognised that there is a legitimate market for infant formula for women who are either not breastfeeding or breastfeeding partially, but products should not be marketed or distributed in ways that may interfere with the protection and promotion of breastfeeding (p. 6).

3.0 WHO Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition. [22]

3.1 By 2025 increase the rate of exclusive breastfeeding up to at least 50% (p. 9).

3.2 Create a supportive environment for the implementation of comprehensive food and nutrition policies (Action 1, p. 10).

3.3 Provide support to Member States, on request, in their efforts to develop, or where necessary strengthen and monitor legislative, regulatory and other effective measures to control marketing of breast-milk substitutes (Action 2d, p. 13).

3.4 To stimulate development policies and programmes outside the health sector that recognise and include nutrition. Many sectors should be engaged including agriculture, food processing, trade and social protection. These matters could be considered in the development and implementation of a framework akin to the WHO Framework Convention on Tobacco Control which has provided substantial impetus to the control of tobacco use (Action 3, p. 13).

3.5 World Health Assembly resolution 2014/65.6 – urges the development or strengthening of legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes (p. 20).

4.0 Key stakeholder consultation to complete the evaluation of the effectiveness of the WHO International Code of Marketing of Breast-milk Substitutes in New Zealand. [23]

4.1 The report recommended that the Ministry of Health progress ideas with INC related to the inclusion of follow-on formula within the INC code.

4.2 The report recommended seeking the position of the Commerce Commission as to whether or not an agreement among INC members not to market follow-on formula would be viewed as anti-competitive, and whether a decision like the Australian Competition and Consumer (ACCC) authorisation would be possible in New Zealand. It also suggested seeking information about how the MAIF agreement was reached as in Australia the marketing of follow-on is treated differently to NZ.

References

[1] Gluckman, P. D. (2011). *Improving the Transition, Reducing Social and Psychological Morbidity During Adolescence,* A Report from the Prime Minister's Chief Science Advisor, Wellington, p. 15.
[2] World Health Organisation. (1981). *The International Code of Marketing of Breast-milk Substitutes*. Geneva, WHO
[3] Ministry of Health. (2007). *Implementing and Monitoring the International Code of Marketing of Breast-milk Substitutes in New Zealand: The Code in New Zealand*. Wellington, MOH.
[4] Macaulay, E. C., Donovan, E. L., Leask, M. P., Bloomfield, F. H., Vickers, M. H., Dearden, P. K., & Baker, P. N. (2014). The importance of early life in childhood obesity and related diseases: a report from the 2014 Gravida Strategic Summit. *Journal of Developmental Origins of Health and Disease*, 5(6):398-407.
[5] Yamakawa, M., Yorifuji, T., Inoue, S., Kata, T., & Doi, H. (2013). Breastfeeding and Obesity Among Schoolchildren: A Nationwide Longitudinal Survey in Japan. *JAMA Paediatrics*, 167(10):919-925.
[6] Gluckman, P. D., Hanson, M. A., & Mitchell, M. D. (2010). Developmental origins of health and disease: reducing the burden of chronic disease in the next generation. *Genome Medicine*, 2(14):p. 1.
[7] Gluckman, P. D., Hanson, M. A., & Mitchell, M. D. (2010). Developmental origins of health and disease: reducing the burden of chronic disease in the next generation. *Genome Medicine*, 2(14):p. 3.
[8] Hanson, M. A., Gluckman, P. D., Ma, R. C. W., Matzen, P., & Biesma, R. G. (2012). Early life opportunities for prevention of diabetes in low and middle income countries. *BMC Public Health*, 12(1025).
[9] Pokhrel, S., Quigley, M. A., Fox-Rushby, J., McCormick, F., Williams, A., Trueman, P., Dodds, R., & Renfrew, M. J. (2014). Potential economic impacts from improving breastfeeding rates in the UK. *Arch Dis Child*, doi:10.1136/archdischild-2014-306701.
[10] Smith, J. P., & Ingham, L. H. (2001). Breastfeeding and the measure of economic progress. *Journal of Australian Political Economy*,47:51-72.
[11] Bartick, M., & Reinhold, A., (2010). The burden of suboptimal breastfeeding in the United States: A pediatric cost analysis. *Pediatrics*, 125(5):e1048-e1056.
[12] Ajetunmobi, O. M., Whyte, B., Chalmers, J., Tappin, D. M., Wolfson, L., Fleming, M., MacDonald, A., Wood, R., & Stockton, D. L. (2015). Breastfeeding is Associated with Reduced Childhood Hospitalization: Evidence from a Scottish Birth Cohort (1997-2009). *The Journal of Pediatrics*. Article in press.
[13] Stuebe, A. (2009). The risks of not breastfeeding for mothers and infants: management review. *Reviews in Obstetrics and Gynecology*, 2(4):222-228.
[14] Gluckman, P. D. (2011). *Improving the Transition, Reducing Social and Psychological Morbidity During Adolescence,* A Report from the Prime Minister's Chief Science Advisor, Wellington, p. 15.
[15] National Breastfeeding Advisory Committee of New Zealand. (2009). *National Strategic Plan of Action for Breastfeeding, 2008-2012*. Wellington, MOH.
[16] World Health Organisation/UNICEF. (2003). *Global Strategy for Infant and Young Child Feeding*. Geneva, WHO.
[17] Ministry of Health New Zealand. (2008). *Food and Nutrition Guidelines for Healthy Infants and Toddlers (Aged 0-2): A background paper*. Partially revised December 2012. Wellington, MOH.
[18] Frick, K. D. (2009). Use of Economics to Analyse Policies to Promote Breastfeeding. In F. Dykes & V. Hall-Moran, (eds) *Infant and Young Child Feeding: Challenges to Implementing a Global Strategy,* Chapter 10, pp. 189-196, Oxford, Wiley-Blackwell.
[19] Renfrew, M. K., Pokhrel, S., Quigley, M., McCormick, F., Fox-Rushby, J., Dodds, R., Duffy, S., Trueman, P., & Williams A. (2012). *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK*. UNICEF UK commissioned report.
[20] World Health Organisation. (2013). *Information concerning the use and marketing of follow-up formula*. Geneva, WHO>
[21] World Health Organisation. (1981). *The International Code of Marketing of Breast-milk Substitutes*. Geneva, WHO.
[22] World Health Organisation. (2014). *Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition.* Geneva, WHO.
[23] Quigley & Watts. (2012). *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.