Date: 21st January 2015

To: The Commerce Commission New Zealand

Regarding: The request to the Commerce Commission, from the Infant Nutrition Council (INC), seeking authorisation of a restrictive trade practice.

From: Carol Bartle & Dr Alison Barrett

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

INTRODUCTION – THE SIGNIFICANCE OF BREASTFEEDING PROTECTION

Breastfeeding protection includes the control of breast-milk substitutes advertising as this has the potential to create a negative impact on breastfeeding. The NZ Ministry of Health affirm the significance 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.[1]

Breastfeeding makes a significant positive impact on infant and young child development, women's health and population health. There is a growing body of robust evidence to support not only the significance of breastfeeding but the issues with insufficient or weak regulation of breast-milk substitutes advertising. There is also a growing body of evidence showing the disastrous effects and economic costs to countries, including New Zealand, of a lack of protection and support for breastfeeding with dramatic increases in the rates of non-communicable diseases (NCDs) being observed. The burden of obesity, diabetes and heart disease continues to increase and this places significant stresses on already underfunded and overworked health systems.

The World Health Organisation and UNICEF developed a Global Strategy for Infant and Young Child Feeding (GSIYCF) in 2003, and this document provides guidance on all aspects of infant and young child feeding. [2] The International Code of Marketing of Breast-milk Substitutes is a key foundation document for the strategy. [3] (See appendix 1) Therefore, an

identified 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 Resolutions (WHA) in their entirety. 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. As discussed by Smith, Galtry and Salmon, the International Code is not a treaty but an intergovernmental resolution that, although not legally binding, sets out specific recommendations to guide the regulation of baby foods. [4] This is in light of the importance of breastfeeding and the need to protect immature infants and young children during a time of critical development.

The GSIYCF recommendations are for infants to be exclusively breastfed for the first six months of life to achieve optimal growth, development and health. Then, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years and beyond. The New Zealand Ministry of health recommendations are for breastfeeding for one year and beyond.

A study was commissioned by UNICEF UK Baby Friendly to look at the potential economic impacts of increasing breastfeeding rates in the UK. The impacts of low breastfeeding rates were found to be substantial.[5] [6] Alongside the costs of treatment for four acute diseases in childhood, associated with not breastfeeding (at least £89 million annually) were the substantial costs of breast cancer. The 2009-2010 value of lifetime costs of treating breast cancer was estimated at £959 million. Breastfeeding provides more protection against breast cancer when breastfeeding is protected and women are supported to breastfeed for a longer duration. In the US the yearly economic cost savings associated with increasing exclusive breastfeeding rates were estimated to be US$13 billion by Bartick & Reinhold. [7]

In a recent study by Yan et al, breastfeeding was associated with a significantly reduced risk of obesity in children. Analysis of seventeen studies revealed a dose-response effect between breastfeeding duration and a reduced risk of childhood obesity. [8] The Growing Up in Ireland study showed that children who have been breastfed for three to six months are 38% less likely to be obese at nine years of age compared to exclusively formula fed children. Those breastfed for six months or more are 51% less likely. These results adjust for a large number of factors including parental weight status. [9] A Japanese study of 43,000 infants, followed from birth to eight years, found exclusive breastfeeding for six to seven months

was associated with a decreased risk of overweight and obesity compared with formula feeding. The risk of obesity at seven and eight years was reduced by nearly half. [10]

The costs of hospitalisation of infants and young children are substantial and the emotional impact of this on families is also significant. Ajetunmobi et al, using a birth cohort of 502,948 infants, found that breastfeeding was associated with reduced hospitalisation in childhood. In 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. A greater relative risk of hospitalisation was observed for formula fed infants, in the first year of life and beyond, for a range of illnesses including gastrointestinal, respiratory, urinary tract infections, otitis media, fever, asthma, diabetes and dental caries.[11]

The NZ 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.[12] It was recognised by this committee that the interpretation and implementation of the International Code in New Zealand, did not meet the minimum standards envisaged by the International Code (p. 9).

Key stakeholder consultation to complete the evaluation of the effectiveness of the WHO International Code of Marketing of Breast-milk Substitutes in New Zealand was undertaken in 2012. [13] The report recommended that the Ministry of Health progress ideas with the Infant Nutrition Council related to the inclusion of follow-on formula within the INC code and also 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 differs from the practice in New Zealand.

Smith, Galtry and Salmon, (2014), examine the issues involved in any discussion about infant and young child health, breastfeeding protection and the formula and baby food market, when they point out that, “the growing market dominance of commercial baby food producers in children’s diets, in the face of the ongoing accumulation of evidence on breastfeeding’s importance, reflects imperfections in the infant food ‘market’ which skew choices about IYCF.” [14] Smith et al, also highlight the unrecognised social costs of unequal

power relationships implicated in the loss of breastfeeding, which alongside commercial incentives for aggressive marketing, result "in economically inefficient (and unfair) outcomes for society." (p. 135). The marketing of formula products has a significant effect on breastfeeding decisions, rates and durations and therefore a direct effect on public and population health outcomes in New Zealand.

The Twenty-seventh World Health Assembly, in 1974, after noting a general decline in breastfeeding globally, due to factors including the promotion of breast-milk substitutes, urged *"Member countries to review sales promotion activities on baby foods to introduce appropriate remedial measures, including advertisement codes and legislation where necessary*".[15]

A statement within the introduction of the 1981 International Code of Marketing of Breast-milk Substitutes, highlights why industry regulation is necessary for these products:

"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)** [16]

KEY POINTS

1. Ideally there should be regulation of all breast-milk substitutes, as per the International Code of Marketing of Breast-milk Substitutes, and subsequent, relevant WHA resolutions, and this would apply to all manufacturers, marketers and distributors.

2. Failing any impending regulatory measures being implemented by the government, support for the application for authorisation made by INC is necessary, as it is in health and economic interests to protect breastfeeding in any way possible by limiting the marketing of formula products. The INC voluntary and self-regulated code, whilst containing a weak set of principles, provides at least some small protection for New Zealand's vulnerable infants.

3. The current definition of an infant as six months of age and under is not a valid definition but it has been used, by the formula industry, to market products aimed at

the six months to one year infant age group. It is important to note that the New Zealand Ministry of Health define an infant as a child in the first twelve months of life. The marketing of follow-on (follow-up) formula in New Zealand is of concern. 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 other products, and the perception and subsequent use of these products as breast-milk substitutes. [17] [18] [19] [20] A 2014 study by Cattaneo et al, examining advertisements of follow-on formula and their perception by pregnant women and mothers in Italy, found that follow-on formula advertisements are perceived by pregnant women and mothers as promoting infant formula. When participants were asked whether they had ever come across advertisements of infant formula, 81% of mothers reported that they had, despite the legal inexistence of such advertisements in Italy, and 65% thought that it was for a product to be used from birth.[21]

4. The economist, Kevin Frick (2009) [22] considers the formula market is an example of monopolistic competition rather than perfect competition, as a market characterised by perfect competition would result in a uniformly nutritious formula product being produced at minimum cost and sold to consumers at a similar cost regardless of the manufacturer. Frick suggests that the monopolistic competitive market has led to formula manufacturers using substantial resources to differentiate themselves from other manufacturers (via marketing) leading to competition based on quality rather than price. As a result, the market does not operate efficiently. The value of different products/alternatives, available for women who do not breastfeed, or partially breastfeed, is far from clear. Basically the added functional ingredients are advertised using inappropriate/confusing health and nutrition claims and parents purchase them because they think these more expensive products are a signifier of quality. It should be noted here that we consider that all babies fed on breast-milk substitutes require a quality product that is affordable to their parents, nutritionally adequate and as safe as possible. The World Health Assembly added a resolution to the International Code in 2010 stating there must be an 'end to all forms of inappropriate promotion of foods for infants and young children and that nutrition and health claims should not be permitted on these foods' (WHA63.23).

5. The issue of lack of regulation of breast-milk substitutes is of greater concern since the arrival of more companies into the market.

6. Protecting infant and child health is an investment for New Zealand and as breastfeeding is a significant producer of infant and child health it requires protection.

RECOMMENDATIONS

- Strongly support the regulation of all breast-milk substitutes, as per the International Code of Marketing of Breast-milk Substitutes and subsequent, relevant WHA resolutions.

- Support the authorisation request by the Infant Nutrition Council, (failing government regulation of the International Code and subsequent, relevant World Health Assembly resolutions), but strongly support the inclusion of all manufacturers, marketers and distributors in a code of practice.

- Consider that the inclusion of follow-on (follow-up) formula in regulatory measures would be a step in the right direction for New Zealand to protect all infants one year of age and under. To this end recommend that (failing government regulation of the International Code and subsequent, relevant World Health Assembly resolutions), the INC authorisation be granted, but that urgent consideration of increasing the scope of the INC code to cover infants up to one year be undertaken. Follow-on (follow-up) formula is covered by the International Code, is clearly a breast-milk substitute and falls well within the scope of the International Code.

- Consider the issue of public benefit, as per the Commerce Act, s61:7, to be a key issue, as recommendation (No 4) applies significantly in regards to the population health and overall economic benefits of protecting breastfeeding outlined in this submission.

Thank you for the opportunity to present this submission

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Appendix 1

Key points from The International Code of Marketing of Breast-milk Substitutes

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).

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).

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).

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 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).