

## Invitation to comment responses

### General questions

- Do you agree with our proposed scope (both the product and geographic scope) and themes for this market study, as set out in paragraphs 40 to 54. If not, what other areas should we focus on and why?

*We are largely in agreement with the proposed scope of the study, with two exceptions.*

*We disagree with the proposed exclusion of infant formulas as prescribed by healthcare professionals. This specific market segment is one that suffers from significant over-diagnosis of certain conditions, primarily cows' milk protein allergy ('CMPA'), a condition which recent published research demonstrated that up to 14% of all UK families believe (or are led to believe) their child has, despite only approximately 1% of UK infants actually suffering from the condition<sup>1</sup>.*

*Resultingly, this market suffers from chronic over-diagnosis and in our opinion, remains a segment that is more concentrated, opaque and questionable than the mainstream formula market. The prices charged for these products, typically supplied in smaller packaging formats (400g) versus mainstream products, are generally sold at a significant price premium per 100g. We find the pricing of such products, including to the NHS and healthcare channels, difficult to justify and we suspect, represents a significant driver of excess profits for multinationals while increasing the financial burden upon the NHS and UK taxpayers. Open prescribing data recorded the total cost to the NHS (April 2021 - Jul 2022) for specialised formulations was over £11m.*

***More distressing still, specialist formula prescriptions for infants with cows' milk allergy increased by 500% between 2006 and 2016<sup>2</sup>.*** *We would support an investigation of this category to protect consumers. This over-diagnosis of CMPA not only increases the cost-per-feed of infant formulas versus non-prescribed formula, but based on customer feedback, is generally considered less palatable in taste and smell (due to extensive protein hydrolysis) which may impact infant willingness to consume. To exclude these formulas from the study – as a large and over-diagnosed segment of the UK formula market – would set a dangerous precedent and open the door for potential future market manipulation by dominant multinational brands.*

*Another area in which we would call for greater focus as part of this investigation relates to the NHS channel. As data first reported by the CMA in their initial findings made clear, a significant proportion of feeding decisions are taken at or around periods in which parents are in hospital and / or in contact with midwives and healthcare professionals. In one consumer survey, a sample of UK parents confirmed that 38% of families who*

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<sup>1</sup> Munblit D, Perkin MR, Palmer DJ, Allen KJ, Boyle RJ. Assessment of Evidence About Common Infant Symptoms and Cow's Milk Allergy. *JAMA Pediatr.* 2020;174(6):599–608.

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<sup>2</sup> <https://www.bmj.com/content/363/bmj.k5056>

*had chosen to bottle-feed (in full or in part) had selected an infant formula brand to use during the third trimester and prior to their baby completing one month of life, a period closely associated with healthcare professional and midwife engagement. For newcomer brands, the largest barrier to entry and opportunity to compete on an even playing field is the narrow and selective offering of infant formula brands in UK hospitals.*

*We wish to see this critical segment of the formula decision journey explored in a much more thorough way as part of this investigation as it represents the key barrier to newcomer brands being able to compete on an even playing field against dominant multinationals whose historic influence over the hospital channel, despite the good recent work of the Baby Friendly Initiative (BFI), continues to reap dividends for incumbent brands and as such reinforces the status quo. It is our view that consumers who make the decision to bottle feed would stand to benefit from greater transparency and equality of offerings within the hospital channel, resulting in higher quality, greater choice and ultimately, lower consumer prices.*

## **Consumer behaviour**

- Are there any ways in which consumers could be provided with more or better information on infant formula and follow-on formula?

*In our opinion, the incomplete and subjective offerings of infant formula stocked at NHS hospitals, for parents who choose not to breastfeed or combination feed, serves to inhibit consumer awareness, choice and fair market competition. The majority of UK maternity wards stock only a fraction of all infant formulas available nationally (and are overwhelmingly confined to legacy multinational brands). This is despite some of these brands being supplied to the NHS (via public tender) at higher prices than alternative brands.*

*We believe in a parent's right to choose formula based on transparent information around product characteristics and cost. Given that data confirms that for many parents this decision is made within the hospital, we would recommend that every NHS hospital offers parents a range that presents equal, objective representation of brands, so parents can make their own informed decisions. We would be supportive of healthcare professionals sharing with parents seeking to bottle-feed the average price of each formula in UK retail and the expected cost of using each product over a typical infant feeding journey, at the point of decision in hospital, so families can understand and budget appropriately.*

## **Supply-side features of the market**

- How far does manufacturer innovation lead to better infant formula products? Does the regulatory framework provide the right incentives and support for such innovation?

*We believe that the significant global research and development efforts - conducted across the academic and industry community - to better understand the composition of breastmilk can unlock positive outcomes for children. Sixty years ago, it was not uncommon for children in developed Western countries to be fed condensed milk as the closest substitute to breastmilk. Today, the research conducted by the academic community (together with industry in many cases) into areas such as prebiotics, probiotics, HMOs and MFGM is helping uncover new components within breastmilk, observe their function and benefits, isolating such ingredients for inclusion in formula and demonstrating through clinical studies their impact on healthy growth in infants.*

*While consumers report commonly hearing the phrase ‘all formulas are nutritionally equal’, we should not forget that it is the research efforts of the global academic and industry community that has led regulations to adapt to developing trends and the latest scientific understanding of breastmilk, the very regulations that aim to ensure all formulas are ‘nutritionally complete’. For example, it was the strong scientific evidence underpinning the benefits of DHA, a fatty acid identified as occurring within breastmilk, that led the European Union to advocate for the high mandated levels of DHA within all infant formula by law, based on new scientific understanding of its benefits. This should not be taken for granted – to this day, such insights have not yet been incorporated within the legislation of many developed countries such – and in our opinion is a positive externality of the research conducted by academia and industry alike.*