

Response to the CMA interim report on marketing of infant formula in UK

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Thank you for the opportunity to respond to this important report.

Some of my responses are general thoughts and others to specific points in the report.

1. Feeding a newborn baby is an entirely unique form of nutrition and there are no similar periods in the life course. Breast milk has been developed over millennia to provide the optimal and sole form of nutrition for around the first 6 months of life. In addition, as it occurs so early any effects either beneficial or otherwise have the potential for amplification during the life span. These effects may be very small and of little significance, but they can also potentially be life changing.
2. Any substitutes for breast milk used in the UK follow guidelines whereby they need to contain all the nutrients proven scientifically to be essential to nourish a baby successfully. This in effect reduces any differences between products to those components which are wrongly implied to be necessary or to other attributes such as appearance or cost. In effect one product could provide all a baby needs, appearance, etc not being relevant.
3. It concerns me that infant formula manufacturers are driven by profit when marketing their products for feeding this highly vulnerable population. I have had numerous experiences of how this has biased company reps when trying to persuade colleagues to use their products over my 30+ years in the NHS.
4. [REDACTED]
[REDACTED]
[REDACTED] You mention DHA as a component now required to be added to infant formula, most of that work was done independent of formula companies and the actual necessity of DHA is still contested by many.
5. For many years many professionals working in paediatric nutrition have discussed the benefit of a single national infant formula. I realise that this would be an extremely long term goal but looking at the evidence logically it would seem the optimal way to ensure a consistent, appropriately priced and nutritionally adequate alternative for all babies who cannot be breast fed. It may also help support breast feeding.
6. The approach of Scandinavian countries to promotion and support of breast feeding shows that large scale improvements in breast feeding rates can be made by motivated governments. This in turn would reduce the amount of infant formula needed within a population.
7. Putting aside the proposal above and looking at what needs to be addressed in the short term to ensure that marketing of formula in the UK is equitable and that

the public are equipped to make informed decisions there are some proposals I agree with but would elaborate on.

8. Firstly I agree with proposals to use unbranded formula within hospitals and other health care establishments. But there are possible issues with parents then wanting to carry on with the formula their baby started on which would need to be addressed (a national formula would be an advantage in this respect)
9. I also agree that there needs to be more unbiased information for families from dietitians, health visitors GPs, paediatricians, neonatologists etc. This would require co-ordinated education of these health care professionals (HCPs)(not all are aware of the issues around breast feeding vs infant formula and some themselves have biases) and sufficient resourcing to allow them, once suitably trained, to inform pregnant women and those with new babies and their families about infant formulas. One of the biggest issues being a belief that stage 2 and follow on formulas are necessary. It would be very useful to have a government led report around this issue which could inform HCPs and interested members of the public. It would be important that the HCPs do not discuss individual formula products as bias might come into play, but keep the discussion to the general principle that all formula have to comply with best practice for optimal nutrition for babies and that there is no need for any formula other than the stage 1 or first formulas.
10. On a different note I would point out that not all families are affected by the cost of formula equally. At 6 months of age a baby could weight 10.5kg if they are on the 99th centile for weight, 8kg if they are on the 50th and only 6.4kg if they are on the 2nd centile. Babies take in on average 150ml/kg meaning that the largest babies are taking around 20% more milk than the average size babies and 40% more than the smallest babies. This incurs very different costs for families.
11. Re advertising price reductions – this doesn't sit well with me, I assume it is a previously untried approach and there may be unintended consequences. If seriously considered some kind of formal evaluation of parents feeding practices would be good to establish before it is put in place.

I have kept my responses as short as possible but am very happy to contribute further to the development of the report by commenting on any further drafts if that is helpful.