# CMA Interim Report: Response from BFLG-UK, December 2024

**Executive Summary**

To address the high prices of infant formulas, acknowledging the drivers as identified by the CMA and upholding the protection of breastfeeding and safe and appropriate formula feeding where needed, we recommend the following four priority measures for urgent and simultaneous implementation. We believe these policy options are proportionate and impactful, as well as feasible:

1. Price controls (price or profit margin caps)
2. Pre-authorisation (which will ensure enforcement of labelling regulations)
3. Standardised labelling and packaging in healthcare settings
4. Improved provision of DHSC-approved information to parents (via health care professionals and in retail settings)

We *do not* support publicisation of price reductions, which we believe would not be effective or proportionate and could cause harm.

We recommend two medium-term policy actions to be initiated as soon as possible, given the time it will take for their realisation:

5. Strengthen formula marketing restrictions (in line with the Code, all subsequent resolutions and WHO guidance on digital marketing)
6. Fix the enforcement process (removing conflicts of interest and ensuring independent monitoring)

We suggest that the following policy solutions are considered backstop options to be implemented only if the above actions are found to be ineffective:

- Standardised labelling and packaging in all settings
- State-backed infant formula provision

**Baby Feeding Law Group UK Members:**
Association of Breastfeeding Mothers (ABM), Association for Improvements in the Maternity Services (AIMS), Baby Milk Action, Best Beginnings, the Breastfeeding Network (BfN), Breastival, Breastfeeding Twins & Triplets UK, Code Monitoring Northern Ireland, the Community Practitioners' and Health Visitors' Association (CPHVA), Doula UK, The Fatherhood Institute, First Steps Nutrition Trust, GP Infant Feeding Network (GPIFN), HENRY, Hospital Infant Feeding Network (HIFN), the Human Milk Foundation, Institute of Health Visiting, Lactation Consultants of Great Britain (LCGB), La Leche League GB (LLLGB), Leicester Mammas, Centre for Lactation, Infant Feeding and Translational research (LIFT), Local Infant Feeding Information Board (LIFIB), Midwives Information and Resource Service (MIDIRS), National Breastfeeding Helpline, NCT (National Childbirth Trust), Royal College of Midwives (RCM), Save the Children, UK Association of Milk Banking (UKAMB), Unicef UK Baby Friendly Initiative, Unison, Women's Environmental Network (WEN), World Breastfeeding Trends Initiative (WBTi) UK. Independent members: Dr Robert Boyle, Natasha Day, Dr Clare Patton, Dr Ernestine Gheyoh Ndzi, Prof Amandine Garde, Dr Andrea Gideon

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## 1. Introduction

We acknowledge and welcome the publication, on 8 November 2024, of the Competition and Market Authority (CMA) interim report on the infant formula and follow-on formula market study[1] setting out provisional findings and possible options to address emerging concerns. We commend the approach the CMA has taken in engaging with stakeholders, including civil society and experts.

The following response is from the Baby Feeding Law Group UK (BFLG-UK)[2], coordinated by First Steps Nutrition Trust[3], in our capacity as the current Secretariat for the BFLG-UK. For 27 years, the BFLG-UK, which now comprises 38 key organisations (including the Royal College of Midwives, the Institute of Health Visiting and NCT) and independent expert members, has been advocating for government and policy-makers to take action to prevent inappropriate marketing of infant formula and other breastmilk substitutes which not only undermines breastfeeding, but also safe and appropriate formula feeding.

Acknowledging Section 9 of the Interim report "*Responding to the interim report and next steps*"[4], our response takes the form of a general submission and below we provide feedback on all possible measures proposed by the CMA in section 8 of the interim report[5], in order of our perceived priority.

Before addressing the possible measures, it is important to frame the context in which the CMA is conducting this market study.

### *1.1 The priority should be infant health*

Infant formula is an essential food for many UK infants under 12 months of age, the only recommended substitute for breastmilk in the first 6 months of life, and the recommended substitute from 6-12 months. It is a safe and suitable breastmilk substitute (when prepared appropriately) to support adequate growth and development, but does not impart the health benefits of breastmilk, hence the need to protect breastfeeding.

The priority in addressing high infant formula prices and concerns in the market needs to be the health and well-being of infants and young children and their mothers, and pregnant and breastfeeding women, focusing on the most vulnerable (see 1.2). Any measures suggested by the CMA must be aligned with public health imperatives and principles. We acknowledge the purpose of the CMA[6], to "*help people, businesses and the UK economy by promoting competitive markets and tackling unfair behaviour*" and that the CMA's remit is market competition. We therefore recognise that the CMA has limitations in what it can investigate, request and propose. However, it is vital to acknowledge that infant formula is unique and different from other products the CMA may investigate, and the use of commercial milk formulas can have irreversible negative effects on infant and maternal health. Further, others have argued that competition authorities should consider multiple goals in addition to regulating market power, including the protection and promotion of public health[7]. It is our view that any consideration about the proportionality of interventions needs to put public health implications first.

While the CMA suggests the need to accept potential trade-offs, we maintain that any recommendations from the CMA market study cannot have any risk of negative consequences for infant health. Any such trade-

[1] www.gov.uk/cma-cases/infant-formula-and-follow-on-formula-market-study
[2] Baby Feeding Law Group (BFLG)-UK. www.bflg-uk.org/about-us/#who-we-are
[3] First Steps Nutrition Trust. www.firststepsnutrition.org/
[4] assets.publishing.service.gov.uk/media/672cce6ceee595f5288bdc10/_Interim_report_.pdf
[5] a) Information and supply in healthcare settings; b) Information and price promotion in retail settings; c) Clarifying, monitoring and enforcing the existing regulations; d) Strengthening labelling and advertising rules; e) Price controls; f) Public provision
[6] www.gov.uk/government/organisations/competition-and-markets-authority/about
[7] Wood B, Karouzakis C, Sievert K. et al. 2024. Protecting whose welfare? A document analysis of competition regulatory decisions in four jurisdictions across three harmful consumer product industries. *Global Health* 20, 70. doi.org/10.1186/s12992-024-01076-2

offs would be inappropriate and an unacceptable violation of child rights due to the vulnerability of infants and the potential life course consequences.

Existing human rights treaties place obligations on governments to achieve the progressive realisation of human rights. This includes the right that every infant and young child has to the highest attainable standard of health and best possible nutrition[8]. The UK should ensure that the health and rights of children are duly protected and one way of doing this is to regulate infant formula manufacturers and retailers and prevent them from using their market power in ways that do not uphold the best interests of children. In June 2023, the United Nations Committee on the Rights of the Child shared "Concluding Observations" from its periodic report of the UK and a recommendation was full implementation of the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly resolutions ('the Code')[9] and strengthening relevant legislation[10].

### *1.2 Policy solutions to high infant formula prices need to work for those most affected by high prices*

We strongly recommend that an inequalities lens be applied to inform final policy recommendations because there is a socioeconomic gradient in infant feeding, whereby those least able to afford formula are more likely to be reliant on it[11] and their babies have more to lose out on if they are not breastfed, breastfeeding is non-exclusive or short duration. This is partly due to the formula industry undermining women's efforts to breastfeed through inappropriate marketing[12,13].

High infant formula prices are an acute problem for some low socio-economic and disadvantaged families who use it, therefore the solutions need to work best for these families. As per section 1.1, the solutions should ensure breastfeeding is protected[14] (this being the ideal solution to high infant formula prices, as well as optimal for population health), as well as ensuring safe and appropriate formula feeding where needed.

### *1.3 A robust regulatory framework for formula marketing already exists*

'The Code' is an international health policy framework to regulate the marketing of breastmilk substitutes, protect parents' rights to make informed decisions about infant and young child feeding free from commercial influence, and ultimately to protect breastfeeding and safe and appropriate formula feeding[15]. Breastmilk substitutes are defined as including all formula milks marketed for use to 3 years of age, and bottles and teats[16]. While the Code was adopted by the WHA in 1981, it has been strengthened and updated to reflect new marketing practices through 20 subsequent relevant WHA resolutions including recent

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[8] Baker P, Smith JP, Garde A, et al. 2023. The political economy of infant and young child feeding: confronting corporate power, overcoming structural barriers, and accelerating progress. *Lancet*. 401(10375):503-524. doi.org/10.1016/s0140-6736(22)01933-x

[9] www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/code-and-subsequent-resolutions

[10] digitallibrary.un.org/record/4013807?ln=en&v=pdf

[11] McAndrew AF, Thompson J, Fellows L, Large A, Speed M, & Renfrew MJ. 2012. Infant feeding survey 2010. The Health and Social Care Information Centre. sp.ukdataservice.ac.uk/doc/7281/mrdoc/pdf/7281_ifs-uk-2010_report.pdf

[12] WHO & UNICEF. 2022. How the marketing of formula milk influences our decisions on infant feeding. www.who.int/publications/i/item/9789240044609

[13] Rollins N, Piwoz E, Baker P, et al. 2023. Marketing of commercial milk formula: a system to capture parents, communities, science, and policy. *Lancet.* 11; 401 (10375): 486-502. doi.org/10.1016/s0140-6736(22)01931-6

[14] It is vital to acknowledge that most women in the UK want to breastfeed, but also that 8 out of 10 do not meet their breastfeeding goals (McAndrew, 2012). This means that many families are not using formula because they wanted to but because they had to, in the face of factors undermining continued breastfeeding, including inappropriate marketing of commercial milk formulas (this is relevant to but not made clear in interim report paragraph 5.4). It is also globally recognised that there is insufficient investment into breastfeeding support, including in the UK, where much breastfeeding support is provided on a voluntary basis. If universal, quality breastfeeding support together with maternity protection and restrictions on inappropriate marketing were guaranteed, fewer families would be reliant on infant formula.

[15] www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing-breastmilk-substitutes-resources/the-code/

[16] www.who.int/publications/i/item/WHO-NMH-NHD-18.11

resolutions on digital marketing[17]. These resolutions have the same legal status as the Code and must be read together with it. As per section 1.1, the obligation of State parties to implement the Code and companies' obligations to comply with it has since been clarified under international human rights law. The Independent Review Panel of the UN Secretary-General's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) recommends developing a global human rights framework to address harmful marketing of foods for and to children[18].

For the reasons described above, we highlight an important section of the **Preamble to the Code**:

*"Believing that, in the light of the foregoing considerations, and 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 usual marketing practices unsuitable for these products****;"*

We propose that since the Code (in its entirety, including all subsequent resolutions) is an evidence-based, global public health policy framework for infant feeding, it is vital that the final policy recommendations from the CMA market study are situated in this context. Any regulatory changes to address formula marketing that are less stringent or narrower in scope will create further loopholes for exploitation, and a reduced chance of meeting the public health objective of protecting breastfeeding, informed decision making and safe and appropriate formula feeding. Our long-held view is that strengthened regulations are needed governing the marketing of formula milks and other breastmilk substitutes in line with the Code, with adequate monitoring and enforcement. This should not be compromised by any regulatory reform intending to improve market outcomes, and on the contrary reforms which make the law more aligned would be beneficial[19]. This could be achieved through adopting the 2022 WHO European Model Law "*Effective regulatory frameworks for ending inappropriate marketing of breast-milk substitutes and foods for infants and young children in the WHO European Region*"[20] and implementing the 2023 WHO "*Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes"*[21].

## 2. Outcomes

In the questions posed by the CMA in section 9 (Responding to the interim report) there is a focus on three "*outcomes for parents who need or choose to use infant formula*"; namely, price, product differentiation and choice.

Our view is that the primary outcome that needs to be improved for parents, is price. The unique characteristics of infant formula described above makes it unnecessary and potentially harmful to actively encourage further product differentiation and choice while marketing remains uncontrolled. We acknowledge these are important outcomes for competition purposes, but the CMA report highlights how the industry is misusing differentiating features for marketing purposes in the context of inadequate regulation of marketing.

[17] www.who.int/teams/nutrition-and-food-safety/food-and-nutrition-actions-in-health-systems/code-and-subsequent-resolutions
[18] data.unicef.org/resources/global-strategy-womens-childrens-adolescents-health/
[19] The 'Marketing of Breastmilk Substitutes: National Implementation of the International Code Status report 2024' www.who.int/publications/i/item/9789240094482 shows that several high income countries and some upper middle income countries, some with high levels of formula feeding, have implemented stringent breastmilk substitute marketing restrictions substantially aligned with the Code: Saudia Arabia 77/100, UAE 79/100, Bahrain 80/100, Armenia 90/100, Brazil 83/100. We are not aware of any concerns about formula shortages or inaccessibility as a result.
[20] www.who.int/europe/publications/i/item/WHO-EURO-2022-4885-44648-63367
[21] www.who.int/publications/i/item/9789240084490

### *2.1 Product differentiation is misused for marketing*

As described in section 1.1, infant formula is an essential, non-substitutable product for some babies[22]. It is also universally manufactured in accordance with international standards for quality set by the Codex Alimentarius Commission, *"…to satisfy the normal nutritional requirements of infants up to… six months of age and adapted to their physiological characteristics*."[23]. This implies a globally guaranteed high baseline quality and nutritional equivalence across all infant formula products that all manufacturers are obliged to comply with, including in the UK where legislation sets specific compositional requirements. Inferences in the CMA report that quality can vary between products (e.g. interim report paras 4.83 and 8.42) show this has not been fully understood, likely because the formula industry state otherwise. Manufacturers use various strategies to differentiate commercial milk formula products for marketing purposes, with features that do not genuinely provide products of different quality. These differentiating features have no demonstrable health, safety, environmental or other advantages, but are used to achieve higher product prices and these risks obscuring the principal fact that all infant formula are nutritionally comparable.

Some of the features used in marketing to differentiate products are verifiable, for example to appeal to environmentally conscious consumers (organic, British made) or regarding sources of ingredients (halal, vegetarian), but this does not mean they confer environmental or health benefits. Other marketing claims used to differentiate products are not valid or verifiable, sometimes relating to source of ingredients or addition of non-mandatory ingredients. Manufacturers also mis-categorise some infant milks regulated as foods for special medical purposes (FSMPs) as a marketing strategy to encourage wider use, despite the potential for harm. Annex 1 provides further detail. In short, although product differentiation may be valid and required for competition, it should not be encouraged in the context of uncontrolled and inappropriate marketing, because, in this context, product differentiation contributes to increased prices, as well as misuse of products.

### *2.2 Consumer choice is different in a food category where products are nutritionally equivalent*

We understand that in traditional markets, choice is an important characteristic that is necessary for competition. However, in the infant formula product category, this is different, since as described previously, all infant formula is nutritionally equivalent, due to Codex standards. We have seen that companies use choice as a strategy for marketing, but choice should be based on valid features, which in the infant formula category are limited to characteristics like 'halal' and 'vegetarian'.

For example, providing a wide range of infant formula in maternity units (alluded to in 8.30 *"… this measure would go further by asking healthcare settings to actively maintain a wider range of infant formula brands in their inventories.*") would suggest that different brands may offer something different when we are communicating to consumers that products are nutritionally equivalent. This may also place additional burden on the NHS to stock a wider variety of products (as described by the CMA in 8.33(c)).

Therefore, our response focuses on the implications of the possible measures for influencing the outcome of infant formula **price**, in the context of public health (protecting breastfeeding and safe and appropriate formula feeding) and next, we address the effectiveness and proportionality (on formula price, for formula feeding families) of the six categories of possible measures proposed by the CMA:

[22] It is the only formula milk that is necessary for healthy babies; follow on formula and growing up milks are differentiated products created only for the purposes of generating profit. Interim report paragraph 6.26 fails to acknowledge this, or the fact that 'stage numbers' are marketing a ploy.

[23] iris.who.int/bitstream/handle/10665/40382/9241541601.pdf?sequence=1

## 3. Possible measures we agree with, in order of priority:

**We acknowledge, as the CMA has indicated, that a package of interventions will be required and for certain possible measures, there will need to be concurrent, simultaneous actions.**

**We further acknowledge that recommendations need to be feasible and affordable, and so if a stepwise approach is recommended, we motivate the priority of certain measures.**

### *3.1 Price controls (price or profit margin caps)*

Even though price controls are "*not actively recommended at this stage*", we advise they are both warranted and proportionate. The commercial milk formula industry has maintained high profit margins, despite a cost-of-living crisis), persistent infant food insecurity[24,25] and minimal market improvements since November 2023[26]. Urgent regulatory intervention is needed to reduce and stabilise infant formula prices equitably and sustainably[27]. Price volatility, as described by the CMA on follow-on formula products (which are legally allowed to have publicised price reductions), is harmful for families.

Government-mandated price controls would effectively lower prices for all, including the most vulnerable, and are proportionate given industry's control over pricing. We acknowledge that price controls require legislative change but are of the view that alternative measures would not achieve comparable impact. There are alternative measures (prohibition of abuse of dominance or excessive pricing) that would be more labour intensive and costly, as well as detrimental to companies' images.

As a precedent, Greece implemented a 7% profit cap on infant formula from March 2024[28] and has already fined a company for profiteering[29]. It may be too early to observe consequences for infant feeding practices, but infant formula prices decreased overnight[30] on the date for implementation. We suggest that a profit margin cap, though more resource-intensive to implement, is preferable to a price cap as it allows competition and minimises market interference. We suggest the UK Government liaises with Greek counterparts for practical support and lessons learned in implementation.

Other possible related measures could include:

- Mandated sharing of profit margins. In the UK, the recently published Economic Crime and Corporate Transparency Act of October 2024, which requires all companies to file profit and loss accounts[31]. For the commercial milk formula industry, there could be a requirement to also publish profit margins.

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[24] Independent Food Aid Network. 2024. Reducing infant and maternal food insecurity in the UK. www.foodaidnetwork.org.uk/_files/ugd/95a515_e28c4ccc767a41b287f1b62f39796369.pdf

[25] Trussel Trust. 2024. The Cost of Hunger and Hardship: Interim Report. www.trussell.org.uk/news-and-research/publications/report/the-cost-of-hunger-and-hardship

[26] I.e. mostly static prices for existing products, or very small price reductions relative to the price increases during the cost-of-living crisis infantmilkinfo.org/wp-content/uploads/2024/11/Summary_of_trends_November-2024.pdf . One retailer (Lidl) has recently made a new own-brand infant formula available (Lupilu) which is promising, but the extent of accessibility of this product is unknown. Kendal Nutricare has introduced a new branded product (Bonya), but there are still other lower-cost products available on the market.

[27] In November 2016, a Joint statement by UN Special Rapporteurs on the Right to Food, Right to Health, the Working Group on Discrimination against Women in law and in practice, and the Committee on the Rights of the Child recommended that: *"… in cases where a woman cannot breastfeed or is not willing to do so, even after having been duly informed about the benefits of breastfeeding, access to good quality breast milk substitutes should be regulated and affordable. In addition, in helping women make informed choices about breastfeeding, States and others should be careful not to condemn or judge women who do not want or who cannot breastfeed."* www.ohchr.org/en/statements/2016/11/joint-statement-un-special-rapporteurs-right-food-right-health-working-group?LangID=E&NewsID=20871

[28] kglawfirm.gr/wp-content/uploads/2024/01/New-measures-to-combat-high-prices-of-consumer-goods_consolidated_25.01.2024_final-B-2.pdf

[29] www.ot.gr/2024/01/23/english-editon/greek-authorites-slap-baby-formula-company-with-e561000-fne-for-profteering/

[30] www.ekathimerini.com/economy/1233065/price-cuts-have-taken-effect/

[31] www.gov.uk/government/publications/economic-crime-and-corporate-transparency-act-outline-transition-plan-for-companies-house/economic-crime-and-corporate-transparency-act-outline-transition-plan-for-companies-house

- Tax profiteering or excess profits relating to infant formula sales. Profiteering[32] has not been adequately addressed in the CMA report and that this option could be proportionate since there are currently insufficient deterrents to companies on unfair business practices.
- The CMA should more vigorously enforce exploitative abuses of dominance in the commercial milk formula sector, as has been suggested previously[33].

We note that the CMA present some potential negative implications of price controls, in 8.96: *"… firms may have less incentive to compete by innovating, investing and offering genuine benefits which parents value if there is a fixed price ceiling."* We believe competition through innovation is unnecessary in infant formula, as its nutritional composition is tightly regulated. The Singapore Market Inquiry into the Formula Milk Supply revealed innovation, including large investment into research, development and marketing, to be a main strategy that manufacturers use to compete with competitors[34]. Manufacturers' "innovations," such as adding DHA, have often failed to show verified benefits in independent studies[35]. Infant formula is a food designed to support adequate growth and development, and innovation will not replicate the biological properties of breastmilk.

We also note in 8.96 that the CMA is concerned that "*This could result in less choice for parents and greater risk of product shortages if some manufacturers scale back or exit the market*." While choice is necessary for competition, it should be based on valid features and not be misused for marketing, especially in the category of infant formula when products are nutritionally equivalent (see section 2.1). We believe it is unlikely that manufacturers would exit such a lucrative market, even with reduced profits. Notably, there is no evidence of manufacturers leaving the Greek market after the introduction of a profit margin cap. In the UK lower priced products (Lidl's own-label Lupilu brand and Bonya by Kendamil) have both recently entered the market. We request the CMA to provide any evidence to support that their concerns could be realised.

Safeguards may be needed to prevent unintended consequences from price controls on infant formula. While affordability and accessibility are key, other formulas in a brand range must be price-matched to infant formula. If follow-on or growing-up milks are cheaper, parents might use them inappropriately, risking harm, as follow-on formulas may contain more iron and free sugars than infant formula (see Annex 3 and our response to the CMA question on the value of follow-on formula on Pg 16) and growing up milks are not subject to any compositional standards and are not suitable at all[36]. Conversely, if they are more expensive, parents might wrongly perceive them as higher quality. Therefore, infant formula should be price matched to brand equivalent follow-on formula and growing up milks.

### *3.2 Pre-authorisation of product packaging*

We strongly agree with the need for strengthening of the competent authority role (described in paras 8.55-8.63) and concur that there are limitations with the current notification process (described in paras 8.57-

[32] Profiteering refers to "the act of making excessive profits by exploiting a shortage or crisis situation" and "taking advantage of consumers by selling goods or services at a much higher price than their normal market value. www.benmunro.co.uk/profit-without-principle-understanding-profiteering-in-the-uk/

[33] assets.publishing.service.gov.uk/media/672cca8421fd56bd96b1a331/_Professors_Amandine_Garde_and_Andrea_Gideon__University_of_Liverpool_.pdf

[34] Competition Commission of Singapore. 2017. Market Inquiry into the supply of formula milk in Singapore. www.cccs.gov.sg/-/media/custom/ccs/files/media-and-publications/media-releases/infant-formula-milk/formula-milk-market-study-for-publication-9-may-1630-hrs.ashx

[35] Baby Feeding Law Group (BFLG)-UK. 2024. CMA Infant formula and follow-on formula market study: Invitation to comment. Comments complied by First Steps Nutrition Trust on behalf of the BFLG-UK. www.bflg-uk.org/s/CMA_IF-and-FoF-Market-Study-Invitation-to-comment_FINALFSNTBFLGresponse_13Mar2024.pdf

[36] This is not acknowledged in the interim report, eg. paragraph 4.13 where is it suggested, inappropriately, that the absence of own brand growing up milks is problematic. See more on growing up milks here: https://static1.squarespace.com/static/59f75004f09ca48694070f3b/t/670e7948fdc9d2356f7d6603/1729001803078/Drinks%2Bmarketed%2Bas%2Btoddler%2Band%2Bgrowing%2Bup%2Bmilks%2Bin%2Bthe%2Bdiets%2Bof%2B1-4%2Byear%2Bolds_FINAL2.pdf

8.59). We endorse the proposal for pre-authorisation of new products (described in paras 8.61-8.63) (including infant formula, follow-on formula and FSMPs[37]) as an urgent priority alongside price control regulations. This measure is feasible and proportionate, building on the existing notification process.

Pre-authorisation should ensure that new labelling and packaging comply with legislation and clearly distinguish infant formula from other types of formula[29]. This measure would improve consumer protection, allow oversight of regulatory adherence and provide a feasible way to strengthen compliance despite resource constraints faced by trading standards and environmental health teams. Oversight from the relevant Department of Health and Social Care (DHSC) expert advisory committee e.g. SMCN (the Scientific Advisory Committee on Nutrition, SACN's Subgroup on Maternal and Child Nutrition) would be essential, similar to the function of the United States Food and Drug Administration (FDA) infant formula division[38]. If products do not comply with legislation on composition, labelling and packaging, they should not be placed on the market. Effective implementation could over time address widespread violations in UK product labels and packaging.

It should be noted that there is an additional need to consider how to rectify existing widespread, non-compliant labelling, as described in our March 2024 submission to the CMA Invitation to comment[39].

### *3.3 Standardised labelling and packaging in healthcare settings*

We (and many health professionals we have spoken to) strongly endorse the suggestion in 8.25 "*to require infant formula to be presented in standardised packaging in healthcare settings, to reduce the influence of brands on decisions over what formula to use*". This measure would enable the provision of impartial information while reducing marketing influence and support the message that all infant formula is nutritionally equivalent. This measure is also feasible to implement and could be effected through internal policy change.

The CMA state "*We also consider that there is a risk that these measures affecting labelling could also stigmatise parents who use infant formula*." We are not aware of any evidence that standardised packaging of infant formula has been evaluated and found to be stigmatising. There is precedent of plain packaging for tobacco, but its evaluation is not generalisable to formula as it was purposefully designed to make the packaging unattractive and thus dissuade use from adult smokers and children, including using the most unattractive colour and large pictures of smoking related disease[40].

In Mexico, while marketing agencies and manufacturers argued against front of pack warning labelling on commercial milk formula and baby foods, parents approved possible implementation, suggesting utility to quickly identify components of and choose products. Health professionals and civil society organisations in Mexico were supportive of clear labelling aligned with the Code, including plain packaging, without images, or health and nutrition claims[41].

We recommend that standardised labelling and packaging for infant formula, compliant with the Code, UK law and guidance notes, and general food law be designed to be neutral, rather than unattractive (see for example that developed by First Steps Nutrition Trust for NHS supply chain), and be tested prior to use to ensure acceptability by parents and health workers.

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[37] All regulations need to be extended to include growing up and toddler milks, which are currently not subject to any specific regulations, see section 5.1.

[38] www.fda.gov/food/infant-formula-guidance-documents-regulatory-information/regulations-and-information-manufacture-and-distribution-infant-formula

[39] www.bflg-uk.org/s/CMA_IF-and-FoF-Market-Study-Invitation-to-comment_FINALFSNTBFLGresponse_13Mar2024.pdf

[40] McNeill A, Gravely S, Hitchman SC, Bauld L, Hammond D, Hartmann-Boyce J. 2017. Tobacco packaging design for reducing tobacco use. *Cochrane Database Syst Rev.* 27;4(4): CD011244. doi.org/10.1002/14651858.CD011244.pub2

[41] Mota-Castillo PJ, Unar-Munguía M, Santos-Guzmán A. et al. 2023. Digital marketing of commercial breastmilk substitutes & baby foods: strategies, and recommendations for its regulation in Mexico. *Global Health* 19, 8. doi.org/10.1186/s12992-023-00908-x

### *3.4 Improved information provision to parents and caregivers through health care professionals and in retail settings*

Providing information on formula feeding, including on the nutritional sufficiency of all infant formulas at key decision points in **healthcare settings** is reasonable (8.18).

The NHS (Better Health/Start For Life) websites hwww.nhs.uk/start-for-life/baby/feeding-your-baby/bottle-feeding/ and www.nhs.uk/start-for-life/baby/feeding-your-baby/bottle-feeding/how-to-make-up-a-feed/how-to-use-formula/ currently state: *"By law, all infant formula sold in the UK must meet the same standards, which means they are all suitable for your baby's growth and development."* From the findings presented by the CMA, it appears that there are misperceptions - driven by marketing[42] - that product quality differs because of ingredient differences (such as higher levels of non-mandatory ingredients, or different sources of ingredients). We therefore recommend DHSC revise the message on the NHS website to state *"All infant formulas will meet your baby's nutritional needs, regardless of brand or price. Extra or special ingredients make no difference to product quality. By law, all infant formula sold in the UK must meet the same standards which cannot be exceeded. This means they are all equally suitable for your baby's growth and development".*

The recommendation that the key message from the NHS be accompanied by information on the range and prices of infant formula may be time-consuming and resource-intensive for health professionals to provide. Health professionals could answer questions on price by accessing information from First Steps Nutrition Trust's data on the Infant Milk Info website[43], as long as we are able to provide this. We agree that a message about follow-on formula being 'unnecessary' (as opposed to 'optional', to align with NHS messaging) be shared more routinely (as suggested in para 8.20), but this would be best provided by health visitors given timing as this message becomes most relevant just before 6 months of age.

Regarding balanced procurement, we agree with the suggestion that brands could be rotated (para 8.27).

For **retail settings,** we agree with the suggestions that infant formula should be displayed separately from other formula milks (described in para 8.39-8.41) on retail shelves, although we caution against giving prominence (nb. this was advised in a previous version of the DHSC Guidance Notes). All standard infant formulas across brands should be displayed with equivalent prominence, to mitigate the effects of brands buying premium shelf space. We would advise the CMA to investigate retail practices that push own brands onto lower shelves or completely off the shelf, including how manufacturers negotiate buying shelf space at retail outlets and how this affects own brand availability and retail placing.

We agree with part of the wording in the 8.35 stating *"We consider that parents would be more supported in making well-informed decisions regarding what infant formula to purchase, and be more confident that cheaper products are suitable for meeting the nutritional needs of their baby, if they were given clear, accurate and impartial information on the nutritional sufficiency of infant formula in retail settings".* We think this information should contain standardised messaging using updated NHS wording[44]. The suggestion that "*on retail shelf-edges next to infant formula products"* might be a short-term solution while labelling and packaging regulations are updated. While self-signage is theoretically a good idea, we understand it may be hard to operationalise in store and is usually temporary as layout and shelf displays change regularly. If shelf edge messaging is used, we agree with that *"In addition, official information from trusted sources (eg the NHS) could be provided to parents on shelves in retail settings that the use of follow-on formula is not*

[42] We have supplied examples of company marketing which challenges the current NHS message, suggesting that the standards are minimum, added ingredients are beneficial, that quality differs etc, and would be able to supply more if useful.
[43] infantmilkinfo.org/
[44] We caution against allowing retailers or manufacturers to provide this 'information' and disagree with interim report paragraphs 5.33 and 5.34 that suggests marketing from companies is useful to guide parent's decision making. Due to the inherent conflict of interest, it is not. All public health messaging whether provided in health settings or retail settings must be provided and approved by DHSC.

*necessary. … Your baby can continue to have first infant formula as their main drink until they are 1 year old."* (para 8.38). However, the best place for such messaging would be on product packaging (as recommended in para 8.36), being compliant with labelling and packaging provisions of the Code.

While we agree with the first part of para 8.37 stating *"The main message for parents would be that all infant formula products (irrespective of the price and brand) will meet a baby's nutritional needs (as noted above330,331)",* we disagree with the second part stating *"It could be supplemented with a clear and factual assessment of some of the health and nutrition claims made by manufacturers on their packaging…".* No claim should be permitted, consistent with current UK legislation and the Code. Most claims are not science-based. Ensuring that infant formula packaging does not contain claims requires a functional, independent monitoring enforcement system (a recommendation we make in section 5.2) and effective pre-authorisation process (as alluded to in para 8.61).

We agree with the last part of para 8.37 stating that information should be available on *"…and/or a comparison of unit prices. We consider that this information could be made available online, and can be kept up to date, accessible via a QR code at the point of sale."* For prices, we strongly recommend price per 100ml made up formula is displayed alongside unit cost at the point of sale. Since products are sold in varying formats and sizes, providing parents and consumers with a price that is comparable and in the unit of consumption (such as per 100ml made up formula) is essential to allow parents to compare accurately. This needs to be in the context of controlled marketing, otherwise it is unlikely to change purchasing behaviours.

It is the responsibility of healthcare settings to "*include a clear and factual assessment of some of the claims made by manufacturers on their packaging*" (8.18), especially since most claims are not permitted and/or unnecessary and this would effectively require healthcare settings to "debunk" manufacturer marketing claims. Further, in para 8.21, the suggestion that "*This measure [health professionals providing price information] could potentially be expanded further by accompanying pricing information with factual independent information about the benefits or otherwise of ingredients added by manufacturers to infant formula*" is unhelpful and inappropriate, since manufacturers add many non-mandatory ingredients for marketing purposes. Healthcare settings do not have the resources for this, and a more feasible and appropriate action would be to strengthen and enforce marketing restrictions.

For the measures suggested in paras 8.19 and 8.21, we disagree that health professionals have a role in supporting parents' purchasing decisions beyond informing them that all infant formula are nutritionally equivalent, as per the updated NHS wording, and providing information aligned with NHS webpages. It is important that health professionals have access to information about infant formula and formula feeding from independent, evidenced-based sources to avoid relying on companies, given the inherent conflict of interest. Currently First Steps Nutrition Trust fills this gap, but we believe DHSC should do this. We previously recommended that there be improved coverage of Unicef Baby Friendly Initiative (BFI) accreditation which would help to support availability of independent, evidence-based information on formula and formula feeding to parents and support for health care providers. There should be more and clearer information on the Better Health Start for Life and NHS websites, including reconciling the description of unnecessary products as 'suitable'.

We do not think it would be helpful "*that parents are given a wider choice of brands where possible"* in hospitals (8.27). We also disagree with "*asking healthcare settings to actively maintain a wider range of infant formula brands in their inventories"* (8.30). Instead, we think that standardised labelling and packaging would be more effective, by avoiding creation of brand loyalty, which underlies inflated formula prices.

We note that the CMA states that measures that would significantly reduce or eliminate consumer exposure to branding and cross promotion might "*make it more difficult for firms wishing to enter and/or expand in the market to build brand awareness and attract customers, which could over time lead to a reduction in choice for parents*" (paras 8.80-8.81). We do not believe this will be a problem, because we maintain that all products have nutritional equivalence and therefore increased choice is not a priority (as per Section 2.2).

## 4. Possible measures that we disagree with

### *4.1 Publicised prices and price reductions*

We strongly disagree with the suggestions in paragraphs 8.45 and 8.46 to potentially allow **publicised prices and price reductions**. While feasible, it is our view that this would not meet the objective of reducing infant formula prices universally, sustainably or sufficiently (given companies have been shown to protect their high margins) and will pose a risk to infant health. Prices would fluctuate[45], and publicity would draw attention to inappropriate marketing until this is controlled. This is therefore not an effective, proportionate or equitable measure[46]. For essential products like infant formula, parents need stable, long-term affordability[47].

Furthermore, since most consumers do not switch brands, price competition would not have as much impact as other forms of competition. In the rare occasions where brand switching could happen, price reductions could incentivise new mothers to use a product with a temporarily reduced price. These new mothers may not yet have settled on a feeding method, and this could thereby undermine breastfeeding. Companies could also use price reductions as an exclusionary strategy against potential competitors to capture new mothers and then raise prices again when a competitor has exited the market. Families are then "stuck" with a brand that is too expensive for them. More generally, companies may then regain missed profits from reductions afterwards by raising prices. It seems unlikely that companies would sustain lower profits voluntarily.

The potential risks of allowing publicised price reductions outweigh any benefits. Our overall view on price reductions is that these should be implemented through price controls, and government-mandated price or profit margin caps (see Section 3.1).

The Code clearly views publicity on price as promotional:

> *"Article 5.3 of the Code: In conformity with paragraphs 1 and 2 of this Article, there should be no point-of-sale advertising, giving of samples, or any other promotion device to induce sales directly to the consumer at the retail level, such as special displays, discount coupons, premiums, special sales, loss leaders and tie-in sales, for products within the scope of this Code. This provision should not restrict the establishment of pricing policies and practices intended to provide products at lower prices on a long-term basis."*

The Code states that usual marketing practices are unsuitable for breastmilk substitutes because of the vulnerability of the infants. Any marketing of formula, including price promotions, can induce the use of formula in place of breastfeeding: promotions are proven to drive sales. This is NOT just about safeguarding breastfeeding, but also ensuring safe formula feeding. Dangerous feeding practices when parents cannot access formula (as may be the case for low-income families facing fluctuating prices) include over-diluting or restricting feed volumes, substituting with a product other than formula or breast milk (e.g., cows' milk) or attempting to make formula at home, as described during the 2022 US infant formula shortages[48].

We disagree with the rationale presented in paragraph 8.47, as "*publicising of lower prices could lead some consumers to buy the same brand at a different retailer; this in turn would provide some incentives for retailers*

[45] Price competition would not lead to permanent reductions of cost for parents. The price will go down until the initiator of the price competition reaches its objectives (e.g., increased market share, positioning in the retail system, better brand image), then it will go up led by the need to recover and increase the profit margins. A permanent price war would be deleterious for the industry and there is a risk that cartels would be formed to stop it.

[46] United Nations Children's Fund (UNICEF). 2024. Countering Industry Arguments against Code Implementation: Evidence and Rights-Based Responses. www.globalbreastfeedingcollective.org/reports/countering-industry-arguments-against-code-implementation-evidence-and-rights-based

[47] There is a difference between short term price reductions, and 'reduced retail price of infant formula for a sustained period' (as described in paragraph 8.44) which can be permissible, but a "sustained period" would need to be defined, and would require monitoring and enforcement. We also recommend consistent pricing across all store types and locations, as the Food Foundation has noted that online prices for formula are sometimes higher than in-store.

[48] Kalaitzandonakes M, Ellison B, Coppess J. 2023. Coping with the 2022 infant formula shortage. *Prev Med Rep.* 30;32: 102123. doi.org/10.1016/j.pmedr.2023.102123

*to offer more competitive pricing on a given brand*" places the burden on parents and families to "shop around" to find the lowest-priced product. We know that low-income households are often unable to do this as families may choose retailers based on accessibility and transport costs and are likely to be buying more than formula during a shop. Furthermore, this could entice consumers to bulk buy when there is a price reduction which disadvantages low-income families that cannot do so and could lead to product shortages. Contrary to the CMA's view (paragraph 4.18), we see prices between retailers to be significant and changeable[49]. What might seem like small cost differences are significant to low-income families struggling to afford infant formula. The First Steps Nutrition Trust cost reports show examples of supermarkets lowering and then raising the cost of a product (in this case ready to feed 'starter packs' of infant formula), whilst the cost of a product remains stable for other retailers. It is not fair or equitable for families that short-term cost savings are highlighted in this way.

In Annex 2 we provide an evidence summary on price reductions. We would like to challenge advertisers, manufacturers and retailers to provide evidence to demonstrate that publicised price reductions will NOT have a negative impact on infant feeding practices; including by reducing the duration of exclusive breastfeeding, causing parents to over-dilute or restrict feed volumes when price-promotions are not available, encouraging parents to purchase 'premium' products that are more expensive and have no demonstrable benefits over less costly products, leaving less in their budgets for other essentials. We respectfully suggest that the CMA would need to provide an impact assessment for the implementation of publicising price and price reductions, consulting with health economists and competition lawyers.

## *5.* Medium term policy actions *(need to be actioned soon, will take time to effect change)*

### *5.1 Strengthening labelling and advertising rules*

We firmly agree with extending advertising prohibitions beyond infant and follow-on formulas to include growing-up milks and FSMPs and ensuring distinct packaging and labelling for all formula types to avoid cross-promotion. We reiterate that pre-authorisation of claims on formula products would ensure transparency and reduce the influence of marketing on parental decisions. Strengthening UK legislation to comply fully with international guidelines (the Code) is a priority, including adopting WHO guidance on regulatory measures to restrict digital marketing of commercial milk formula. Manufacturers could reinvest funds saved from reduced marketing into lowering product prices. We believe that strengthening labelling and advertising rules using the strategies described in this section would be proportionate and impactful.

We strongly agree that *"…extending the prohibition on advertising of infant formula to follow-on formula, or going even further, prohibiting all brand-related advertising, would reduce the influence of branding on parents' decision-making and, in turn, potentially increase downwards pressure on prices."* (paragraph 8.85). Extending advertising prohibitions from infant formula to follow-on formula would align with the Code, and we recommend that advertising prohibitions are further extended to growing up milks and FSMPs. Breastmilk substitutes are defined as including all formula milks marketed for use to 3 years of age, and bottles and teats[50]. When certain product categories are exempt, companies exploit loopholes, as has been evidenced time and again, including in the CMA interim report (Executive Summary, paragraph 44[51]). These measures would be proportionate and impactful.

[49] https://foodfoundation.org.uk/initiatives/kids-food-guarantee-dashboard#tabs/%E2%91%A1-Staples-Guarantee/Tracking---formula

[50] www.who.int/publications/i/item/WHO-NMH-NHD-18.11

[51] "We found that promotional and marketing spend on follow-on formula and growing-up milks appears to be high, particularly if its main purpose is to support sales of just these product categories. For two manufacturers, promotional and marketing spend amounted to [20-30%] and [10-20%] as a share of follow-on formula and growing-up milk revenues in the UK. We therefore consider that this level of spend is likely to support infant formula sales through brand awareness and reputation, as well as sales of those products being directly advertised."

We agree that infant formula should have entirely different labelling and packaging, including brand names and logos, compared to follow-on formula (paragraphs 8.68-8.72). This completely aligns with the recommendations to end cross-promotion but needs to extend beyond follow-on formula to include growing up milks and FSMPs too.

We strongly agree that *"Governments could intervene in the market by setting stricter thresholds for such certain types of claims, or to prohibit the use of phrases/claims which are difficult for parents to meaningfully assess."* (paragraph 8.78). However, the preferred approach to this is pre-authorisation (as described in Section 3.2), including scrutiny of any claims and associated language, already in place in DHSC for other foods, via the UK Nutrition and Health Claims Committee expert advisory committee. If this is burdensome, then it may be necessary to charge industry for assessment of products for potential pre-authorisation and use these funds to support the work of the relevant committee. Other than the brand name and any required compositional, safety or preparation information, we do not think terms such as 'palm-oil free' or 'UK made' are helpful since these are claims. Despite being technically factual, these claims make it more difficult for parents to meaningfully evaluate products. Essential consumer information such as formula type (e.g. 'thickened', 'for low birth weight or preterm babies' etc on FSMPs) or other consumer-relevant information such as 'halal' and 'vegetarian' can be included.

The UK legislation currently scores 40 out of a possible 100 on the 'Marketing of Breastmilk Substitutes: National Implementation of the International Code Status report 2024'[52], and it is clear that legislation should be strengthened to be in line with the Code and all subsequent World Health Assembly resolutions, including the WHO "*Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes*"[53].

If companies were to end illegal marketing and consequently reduce their marketing spend, they could reduce their product price, as alluded to in the Singapore Market Inquiry into the Supply of Formula Milk[54].

### 5.2 *Clarifying, monitoring and enforcing the existing regulations*

Clarifying the existing legislation is important and feasible (paragraphs 8.50-8.54). The CMA indicates that Regulation 2016/127 does not provide a clear definition of advertising. We would like to highlight that the DHSC Guidance Notes for this Regulation has an Appendix 2[55] containing a list of examples of "*the means by which a 'representation' of information could be considered to be within the context of advertising*". This list is comprehensive, and we question whether the CMA need further clarity in addition to this list. This may indicate the need to ensure the contents of the Guidance Notes become legally binding by enshrining in law and regulation.

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[52] www.who.int/publications/i/item/9789240094482

[53] www.who.int/publications/i/item/9789240084490

[54] Competition Commission of Singapore. Media release: CCS's Findings From the Market Inquiry into the Supply of Formula Milk. www.cccs.gov.sg/media-and-consultation/newsroom/media-releases/formula-milk-market-inquiry-findings *'3. The increase in markup of wholesale prices over manufacturing costs was likely driven by the heavy investment into marketing and research & development activities undertaken by the Formula Milk manufacturers.'*

[55] www.gov.uk/government/publications/infant-and-follow-on-formula-and-food-for-special-medical-purposes/commission-delegated-regulation-eu-2016127-supplementing-regulation-eu-no-6092013-guidance#appendix-2-advertising List of examples of advertising in DHSC Guidance notes Appendix 2: newspapers, magazines, brochures, leaflets, circulars, direct mailings, e-mails, text transmissions, catalogues, follow-up literature and other electronic and printed material (including advertorials); publications for healthcare professionals which are not scientific publications; posters and other promotional media in public places, including moving pictures; cinema and video commercials; non-broadcast electronic media such as YouTube videos, Instagram or other social media, (refer to appendix 3 for further guidance with regard to the internet); television and radio broadcast commercials; correspondence between a trade, business or company and their customers, in writing, orally (including telephone calls and company carelines), electronically or by other means; press releases and other public relations material and activities that can be accessed by consumers; tickets, timetables and price lists; celebrity endorsements in connection with a trade, business, or company product placement in websites. The list is not definitive due to the fact that the nature of advertising is always changing and is intended as guidance only.

The suggestion that *"…governments may wish to clarify what constitutes advertising, particularly online advertising, for the purposes of Regulation 2016/127 and provide detailed guidance on a wide range of examples…"* (paragraph 8.53) can be addressed using the 2023 WHO *Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes*[56]. This existing, comprehensive, and up-to-date guidance should be incorporated when national legislation is strengthened and used to clarify what constitutes online advertising of infant formula. The WHO Guidance could be transposed into UK law. We acknowledge that strengthening legislation would need to be a medium-term strategy.

The CMA suggests "*Clarifying the extent to which advertising is restricted in the existing regulations and subsequently monitoring and enforcing these rules is likely to support the creation of a level playing field for businesses."* (paragraph 8.54). It is important that the requirement of UK legislation for formula advertisements to health care professionals be scientific and factual, be enforced. Preferably, and in line with the Code, these adverts should not be allowed, noting that enforcing them would take considerable time and effort (see First Steps Nutrition Trust's publications[57]). Another supporting measure could be to require hospitals and other healthcare providers (and formula manufacturers) to record their funding and discounts from nutrition companies, analogous to the US scheme for pharmaceutical and device payments to healthcare providers[58].

As well as stronger regulations (described above in Section 5.1), there needs to be **independent monitoring and enforcement** for the legislation to achieve its public health intention. We share concerns about limited compliance and enforcement by local authorities (paragraph 8.60), likely due to resource constraints[59] and a lack of clarity in interpreting the regulations. Our experience is attempts to address violations stop at a discussion with the company over an alleged breach, and little change in widespread inappropriate marketing, including practices against the regulations. We suggest the system of improvement notices and legal action needs to be properly implemented, monitored and evaluated. The levying of fines would deter companies from continued violations and the revenue raised could be invested back into enforcement and public health work on infant feeding.

Adequate enforcement of legislation designed to prevent inappropriate marketing of formula milks would protect breastfeeding AND safe and appropriate formula feeding. We acknowledge that this would require investment, resource and capacity, and therefore recommend this as a more medium-term goal. We note that the CMA do not share information on the conflict of interest in primary authorities which we understand exists and needs to be removed.

Recommendations to improve enforcement:

- Clearer Guidance Notes from the DHSC.
- Commission an independent investigation into enforcement.
    - Reassess the current funding mechanism for enforcement, as the current conflict of interest with the formula industry should be removed.
    - Investigate and meet training needs for Trading Standards Officers, on an ongoing basis.
    - Investigate whether the enforcement system is adequately resourced, and address resource constraints to enable enforcement.
- Ensure data is collected to be able to assess effectiveness of the enforcement mechanism, on an ongoing basis.

[56] www.who.int/publications/i/item/9789240084490

[57] static1.squarespace.com/static/59f75004f09ca48694070f3b/t/5d00a07858660d0001500ca0/1560322176680/Scientific%20and%20Factual%20booklet%20June%202019%20for%20web.pdf

[58] openpaymentsdata.cms.gov/

[59] www.tradingstandards.uk/news-policy-campaigns/news-room/2020/ctsi-workforce-survey-report-raises-concerns-over-the-future-of-trading-standards/

## 6. Backstop intervention if the above do not work

### *6.1 Standardised labelling and packaging in all settings*

We note the possible additional measure suggested in paragraphs 8.74-8.75 to require standardised labelling and packaging in all settings, and we agree that this could be a backstop intervention if all of the above suggested possible measure do not work. We imagine this would be a highly effective measure to reduce brand influence and bring prices down, but we are not aware of a precedent and are unsure as to its feasibility.

### *6.2 Public provision of infant formula*

The second "*more significant backstop intervention*" that is "*not actively recommended at this stage*" relates to public provision, (paragraphs 8.101-8.110). We are concerned about the significant logistical and financial implications this may place on the NHS and health care settings and would recommend a thorough impact assessment before such an intervention is recommended. We also recommend that this not be considered until other policy options above have been implemented and their effect evaluated.

We consider that procurement may be feasible but would need to be carefully managed to avoid brand endorsement. The process could be set up in a similar way to the Healthy Start vitamins, which are manufactured by an independent contractor, Brunel Healthcare, but without the NHS branding which would serve as an endorsement. It would be important that consumers still pay for their infant formula, in order to avoid issues with promotion of formula feeding through discounted/free formula.

Relating to the statements about the US approach (paragraph 8.110), it is important that some of the impacts of the WIC programme on infant feeding practices and health are not mentioned and would need to be considered, especially the evidence that WIC beneficiaries may have been more vulnerable during the US formula shortages[60].

We are wary of measures that place additional burden on the already stretched and under resourced healthcare settings, including on health care providers, health professionals and health facilities (including hospitals).

## 7. Response to two specific questions from the CMA in the list of 11 questions (Q1 & Q11):

1. **What is the value derived from follow-on formula for a) parents and babies and b) manufacturers and retailers given that the NHS states that 'research shows that switching to follow-on formula at 6 months has no benefits for your baby. Your baby can continue to have first infant formula as their main drink until they are 1 year old.' CMA analysis has found that follow-on formula is generally priced the same as (or sometimes slightly cheaper than) infant formula.**

#### *a. What is the value derived from follow-on formula for parents and babies?*

We agree with the NHS statement that there are no benefits to using follow-on formula from 6 months and that first formula can be used as the main drink until one year. Further, we would like to highlight that in 1986, the World Health Assembly (WHA) stated "*the practice being introduced in some countries of providing infants with specially formulated milks (so-called 'follow-up milks') is not necessary*"[61]. In 2013, the WHO clarified

[60] www.census.gov/library/stories/2024/04/infant-formula-shortage.html
[61] World Health Assembly, 39. 1986. Infant and Young Child Feeding. WHO. iris.who.int/handle/10665/163189

that it *"…further maintains that as well as being unnecessary, follow-up formula is unsuitable when used as a breast-milk replacement from six months of age onwards"*[62].

In addition to there being no benefit for parents and babies to using follow-on formula, we would like to alert the CMA to possible risks from using follow-on formula, including higher iron content, higher free sugar content and unregulated differences in the whey: casein ratio (see Annex 3).

UK legislation allows promotion of follow-on formula, which is widespread and, as highlighted in the CMA report, is used to cross-promote infant formula, despite this being prohibited by legislation. Prices for follow-on formula are sometimes lower than infant formula, especially when there are price promotions (which are currently legally permissible for follow-on formula) but these are inconsistent and short-term resulting in varied cost savings[63]. As shown by the CMA, this has caused price volatility for follow-on formula. When prices for follow-on formula are lower than infant formula, this can lead to improper use, i.e. giving follow-on formula to infants under 6 months of age[64] especially for families on low incomes. This is dangerous, particularly because of the higher iron content of follow-on formula[65]; hence public health recommendations state that follow-on formula should never be fed to babies under 6 months[66].

***b. What is the value derived from follow-on formula for manufacturers and retailers?***

There are clear benefits of the follow-on formula product category to manufacturers and retailers, as the marketing restrictions are less, allowing companies to promote the product. Together with widespread cross-promotion of follow-on formula with infant formula, this allows companies to indirectly market their infant formula. This was described by companies in the CMA interim report. It is therefore our view that follow-on formula has no benefits and genuine potential harms to parents and babies, only benefitting manufacturers and retailers.

Specific recommendations about follow-on formula, all of which appear in previously mentioned comments:

- Follow-on formula should be price-matched to infant formula.
- Follow-on formula packaging should be distinct from infant formula and the practice of cross-promotion should end.
- There should be pre-authorisation of product packaging of follow-on formula.
- Follow-on formula packaging should include a message that it is unnecessary, to be consistent with NHS wording.
- The Better Health Start for Life and NHS websites need to reconcile the description of follow-on formula as 'unnecessary' but also 'suitable'.
- All prohibitions on the advertising of infant formula should apply to follow-on formula.

In addition, we recommend below that a referral be made to the SACN Subgroup on Maternal and Child Nutrition (SMCN) to review the role of follow-on formula.

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[62] WHO. 2013. Information concerning the use and marketing of follow-up formula. repository.globethics.net/bitstream/handle/20.500.12424/217841/WHO_brief_fufandcode.pdf?sequence=1&isAllowed=y

[63] Our analysis of the cost of FoF to the same brand IF (excluding promotional prices) across a range of retailers showed that there are usually differences in listed prices between IF and FoF. Two exceptions (out of eleven leading brand IF and FoF)are: in November 2024, Cow & Gate's FoF was 85p cheaper per unit than its IF, and SMAs Little Steps IF was £1.80 cheaper than its FoF at certain retailers. Promotions on FoF are generally inconsistent and short-term. Some price reductions and promotions found in an analysis in October were due to end in November. E.g., Hipp's Organic Combiotic Follow On 800g Powder had a reduction of £2 for Black Friday and a Sainsbury's Nectar price saving of £1.35. Tesco Clubcard prices were introduced for SMA Pro Follow-On Milk 800g Powder, saving customers £2.50 per unit. Boots had 15% off when over £40 was spent on selected baby products, incl. many FoF.

[64] CMA Interim Report. Appendix B: The consumer journey. Chart: Type of Formula Fed by Age of Baby (pg 6). assets.publishing.service.gov.uk/media/672cce8ccfb0b183cd67cb2c/_Appendix_B_the_consumer_journey_.pdf

[65] 7 of the 11 FoF products we analysed would exceed the recommended amount of 0.86 mg iron/100ml for IF.

[66] www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/bottle-feeding/types-of-formula/

**11. Are there any other possible remedy options which are not outlined in section 8 which we should consider? If so, please outline how the option would work and its likely impact on market outcomes (such as price, product differentiation and/or choice).**

We suggest that the CMA should:

- Bear in mind public perception and possible misinterpretation[67] of recommendations and take steps to address these.
- Consider the potential need to ensure independent infant formula product testing to assess compliance with composition and safety standards.
- Assess the price of ready to feed starter packs of infant formula, because of their high and fluctuating prices[68], when they are bought (the first days, when parents are most anxious) and because this is the format sold in to the NHS.

We provide the following recommendations to Government to complement the final policy recommendations to address high infant formula prices. These need to be implemented concurrently with other measures intended to reduce infant formula prices, while protecting breastfeeding and safe and appropriate formula feeding where needed:

- Improve accessibility, value, and the eligibility criteria of the **Healthy Start** scheme[69], 1. So that women who are breastfeeding can be supported to access a nutritious diet to continue doing so and to mitigate the risk that they stop and then struggle to afford infant formula, and 2. To support parents who have chosen to formula feed to access infant formula.
- Support local authority / health board implementation of Code-compliant emergency pathways for families with infants experiencing food insecurity[70].
- Given the recent WHO recommendation that cows' milk or another animal milk can be given as a main drink after 6 months, we suggest the SACN SMCN urgently review the necessity for infant or follow on formula between 6 and 11 months. If cows' milk was judged to be appropriate for use from 6 months of age for non- breastfed / partially breastfed babies, this would reduce the issues of pricing and marketing of follow-on formula and growing-up milks. Even the term 'follow-on' can imply for families that breastfeeding stops at this stage and now follow-on formula is the right choice.

## 8. Next steps

We hope that this response provides helpful context to the CMA's market study on infant and follow-on formula in the UK, together with BFLG member's expert insights regarding the most effective, proportionate and feasible possible measures to address high prices and other market concerns. We look forward to the final report in February 2025 and remain available to engage with the CMA between now and February, as needed.

[67] www.bbc.co.uk/news/articles/c1lgqpv577mo
[68] See graph 3: https://infantmilkinfo.org/wp-content/uploads/2024/11/Summary_of_trends_November-2024.pdf
[69] https://foodfoundation.org.uk/publication/healthy-start-working-group-policy-positions
[70] https://www.unicef.org.uk/babyfriendly/local-authorities-guide/

## Annex 1: Product differentiation

The features on which infant formula products can be differentiated can be grouped according to those that are verifiable and potentially valid, compared to others that are neither verifiable nor valid:

- ***Verifiable features used to appeal to environmentally conscious parents - invalid***

Claims such as 'organic', 'UK made' and 'palm oil free', even if verifiable, are being misused for marketing purposes (e.g., greenwashing). This misleads parents and should not be allowed unless the benefits of such features can be clearly demonstrated. Recent research from the British Retail Consortium[71] found that 74% (of 132, 000 products evaluated across 7 online retailers) contained some type of "green claim", with 1 in 7 of these claims having a high risk of misleading consumers. Strict regulations ensure there are no significant nutritional differences or health benefits between 'organic' and non-organic infant formulas, and pesticide residues are strictly limited in both. While organic milk production is generally more sustainable, the environmental benefits of organic formulas must be weighed against the broader environmental impact of the infant formula industry[72]. 'UK made' and 'palm oil free' are claims/features which seek to appeal to environmentally conscious parents. However, these obscure the fact that the manufacture, packaging and distribution of commercial milk formula which is made of hundreds of constituent ingredients from a global supply chain[73] has large negative environmental impacts[74]. The CMA is currently investigating misleading environmental claims, including whether a lack of information on products' environmental impact misleads consumers[75].

- ***Other verifiable features related to ingredients – potentially valid***

There are other features of infant formula which can be verified, and which yield no nutrition or health benefits, but are rather for religious, ethical or other reasons. These include halal status and the use of algal oil instead of fish oil for vegetarian products. On the latter, it should be noted that there is no vegan infant formula on the UK market that can be used without medical supervision, illustrating that differentiating features related to dietary preferences may not be necessary.

- ***Differentiation features that are neither verifiable nor valid***

There are some claims used by formula manufacturers for marketing purposes that are neither verifiable nor valid. These include the benefits of using whole cows' milk / milk fats (see interim report para 7.23) or A2 cows' milk in their formulas[76].

- ***Addition of non-mandatory ingredients***

Marketing based on differentiation due to the added non-mandatory ingredients also misleads parents; see our March 2024 submission to the CMA invitation to comment[77]. Disallowing the addition of such ingredients for which there is no evidence of health or nutrition benefit would allow for entry and expansion into the market by own-label products (since inappropriate marketing would be restricted) and ensure that infant health is better protected. The European Food Safety Authority (EFSA) has stated that some of these non-mandatory ingredients may place a burden on infant metabolism and the CMA presents evidence that they increase the price of the products. This is an unacceptable outcome, as all possible measures need to be

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[71] brc.org.uk/news/corporate-affairs/analysis-shows-average-of-three-green-claims-on-every-product/

[72] First Steps Nutrition Trust (FSNT). 2024. Frequently Asked Question (FAQ): Are there any benefits of organic infant formula compared to non-organic infant formula? Infant milk info website. infantmilkinfo.org/wp-content/uploads/2024/01/Organic-formula_milk_FAQ31012024.pdf

[73] Childs R & Sibson V. 2023. Ultra-processed foods (UPF) in the diets of infants and young children in the UK: What they are, how they harm health, and what needs to be done to reduce intakes. FSNT. www.firststepsnutrition.org/upfs-marketed-for-infants-and-young-children

[74] Andresen EC, Hjelkrem AR, Bakken AK, Andersen LF. 2022. Environmental Impact of Feeding with Infant Formula in Comparison with Breastfeeding. *Int J Environ Res Public Health*. 24;19(11):6397. doi.org/10.3390%2Fijerph19116397

[75] www.gov.uk/government/collections/misleading-environmental-claims

[76] See FAQs: 'are infant formula that contain whole cows' milk different to other infant formula?' and 'are infant formula that contain A2 cows' milk different to other infant formula?' at https://infantmilkinfo.org/faq/faq-types-of-infant-milk-and-ingredients/

[77] www.bflg-uk.org/s/CMA_IF-and-FoF-Market-Study-Invitation-to-comment_FINALFSNTBFLGresponse_13Mar2024.pdf

contributing to reduced price. The addition of non-mandatory ingredients is used for marketing purposes. There is much evidence to demonstrate that the results of industry funded research are biased towards the company funding the research and therefore any claims about "innovative" ingredients made by manufacturers require evidence that is independently verified.

- ***Mis-categorised infant milks regulated as foods for special medical purposes (FSMPs)***

For some non-breastfed babies, a standard first infant formula may not meet their nutritional needs, because of conditions like cows' milk allergy, inherited metabolic conditions, illness or prematurity. These infants may need 'specialised' infant formulas, classified by the World Health Organization and Food and Agriculture Organization's Codex Alimentarius as FSMP. This product category includes soya formula, extensively hydrolysed formula and amino-acid formula, used for formula-fed infants with cows' milk allergy.

However, there are some product categories (e.g., comfort milks and hungry baby formulas) currently mis-categorised by manufacturers as foods for special medical purposes (FSMPs), that lack evidence[78]. The misleading marketing of these products should not be allowed, especially when they are more expensive than infant formula.

Infant milks regulated as FSMPs have valid differentiating features but, where categorised appropriately, these relate to clinical purpose and should not be used for marketing[79]. These products, intended for use with medical supervision, often lack regulatory oversight, leading to unsupervised overuse and higher costs compared to equivalent first infant formulas[80].

[78] This is not acknowledged in the interim report, e.g. paragraph 4.12 where is it suggested, inappropriately, that the absence of own brand comfort and hungry baby milks is problematic.
[79] Baby Feeding Law Group (BFLG-) UK. 2022. Infant milks marketed as foods for special medical purposes (FSMP): The case for regulatory reform to protect infant health. www.bflg-uk.org/our-work#reports
[80] Sibson VL & Westland S. 2024. Specialised Infant Formulas: Overused, Overpriced and Obesogenic. Clinical and Experimental Allergy. 54:452–454 doi.org/10.1111/cea.14532

## Annex 2: Evidence on impact of price reductions

There is very little literature that shows a direct correlation between price discounts on formula milk and its impact on purchases and/ or breastfeeding rates. Part of the reason for limited evidence on price reductions on infant formula and inducement of purchasing, is that it is such a basic principle of the Code that it is prohibited by law in most countries. However, in efforts to identify any tangential evidence on the topic of price discounts and formula milk:

There are qualitative studies which have shown that price can highly impact consumer's purchasing decisions[81]. Some studies have found that with price increase of a certain formula brand, consumers will change to a less expensive brand or prematurely move over to follow-on formula because it is typically less expensive compared to infant formula[82]. A 2022 study found that free coupons (although violation of the country Code law) relating to baby food products or companies (including formula) were viewed favourably by women and impacted their opinions about formula milk and complementary foods[83].

From reports published by the World Health Organization, UNICEF and IBFAN we know Code violations including article 5.3 are still rampant in countries where breastfeeding rates are below optimal[84].

In some cases, consumer purchasing intentions are shaped by perceived quality of the product, not as much the price. This comes more after cases where safety of formula products has been questioned (melamine, low iron content etc.)[85,86].

In the face of limited evidence of price reductions and inducement of infant formula purchasing, it might make sense to look at regulation of other markets:

- The example of recent introduction of Minimum Unit Pricing in Scotland for alcohol has been shown to reduce overall drinking and excessive drinking[87]; arguably policies that use low, promotional prices will have the reverse effect.
- There are studies showing price reductions/ discounts can significantly influence the purchase of the discounted product, although not formula specifically[88,89].
    - A study in the UK calculated the effects of price promotions on 10 foods including 7 HFSS (children's cereal, flavoured yoghurt, crisps sold in multipacks for home consumption, peanut butter, biscuits, cola flavoured beverages and lemonade) and 3 non-HFSS (baked beans, ketchup and unflavoured (natural) yoghurt)[90]. This study found that among high-purchase

[81] Fekadu M. 2018. Factors influencing consumer infant formula purchasing decision. A thesis submitted to St. Mary's University School of Graduate Study in partial fulfilment of the requirement for the degree of Master of Business Administration (GMBA). www.repository.smuc.edu.et/bitstream/123456789/4333/1/mahlet%20fekadu.pdf

[82] Rothstein JD, Winch PJ, Pachas J. et al. 2021. Vulnerable families and costly formula: a qualitative exploration of infant formula purchasing among peri-urban Peruvian households. *Int Breastfeed J.* 16, 11. doi.org/10.1186/s13006-021-00356-6

[83] Cetthakrikul N, Kelly M, Baker P. et al. 2022. Effect of baby food marketing exposure on infant and young child feeding regimes in Bangkok, Thailand. *Int Breastfeed J* 17, 64. doi.org/10.1186/s13006-022-00503-7

[84] AIMI (Asosiasi Ibu Menyusui) Indonesia & IBFAN (International Baby Food Action Network). 2021. Breaking The Code – International Code Violations on Digital Platforms and Social Media in Indonesia During the COVID 10 Pandemic. www.babymilkaction.org/wp-content/uploads/2021/06/Breaking-the-Code-AIMI-Final.pdf

[85] Goldberg I, Roosen J, Nayga RM Jr. 2009. Parental response to health risk information: experimental results on willingness-to-pay for safer infant milk formula. *Health Econ.* 18(5): 503-18. doi.org/10.1002/hec.1381

[86] Zhang J, Waldron S, Dong X, & Dai X. 2024. Mediating Roles of Perceived Quality and Perceived Behaviour Control in Shaping Chinese Consumer's Purchase Intention for Domestic Infant Milk Formula (IMF). *Foods,* 13(19), 3099. doi.org/10.3390/foods13193099

[87] www.alcohol-focus-scotland.org.uk/resources/afs-shaap-mup-briefing-april-2023.pdf

[88] Familmaleki M, Aghighi A, Hamidi K. 2015. Analyzing the Influence of Sales Promotion on Customer Purchasing Behavior. *Int J Econ Manag Sci.* 4: 243. www.hilarispublisher.com/open-access/analyzing-the-influence-of-sales-promotion-on-customer-purchasing-behavior-2162-6359-1000243.pdf

[89] Ni Mhurchu C, Blakely T, Jiang Y, Eyles HC, Rodgers A. 2010. Effects of price discounts and tailored nutrition education on supermarket purchases: a randomized controlled trial. *Am J Clin Nutr.* 91(3):736-47. doi.org/10.3945/ajcn.2009.28742

[90] Watt T, Beckert W, Smith R, & Cornelsen L. 2023. The impact of price promotions on sales of unhealthy food and drink products in British retail stores. *Health Economics,* 32(1), 25–46. doi.org/10.1002/hec.4607

consumers "*price promotions induce consumption—and waste –through behavioural effects, associated with increased household inventory (stockpiling)".* When consumers encounter a promotion, they may expect it to be temporary, prompting them to stockpile. Frequent price changes complicate food choices, making it harder for shoppers to make informed decisions. Removing price promotions could improve clarity.

There is evidence from England that relatively small financial incentives may prolong breastfeeding in areas with low baseline prevalence[91]. This emphasises the importance of family economic decisions in this space. If money incentivises longer breastfeeding, it may do the reverse.

In summary, we feel that it can be confidently deduced that price has a significant impact on purchasing decisions and likewise infant formula, and it seems counterintuitive to require evidence that "money off" entices purchase.

The argument that "a ban on promotion restricts access to and affordability of products" is recognised as a common industry tactic for pushing back on Code-aligned legislation and has been refuted by global public health and legal experts. Reduced pricing may entice parents to buy products, but once sales end, some may struggle to afford them at regular prices. If breastfeeding has been compromised or stopped, families might resort to unsuitable, cheaper alternatives for infant feeding. We encourage the CMA to fully engage with the UNICEF August 2024 briefing: "Countering Industry Arguments Against Code Implementation: Evidence and Rights-Based Responses"[92] which recommends that *"To address issues of affordability for caregivers who cannot afford formula, governments should implement long-term, sustainable price controls or social protection measures."*

[91] Relton C, Strong M, Thomas KJ, et al. 2018. Effect of Financial Incentives on Breastfeeding: A Cluster Randomized Clinical Trial. *JAMA Pediatr.* 5;172(2): e174523. jamanetwork.com/journals/jamapediatrics/fullarticle/2665743

[92] www.globalbreastfeedingcollective.org/reports/countering-industry-arguments-against-code-implementation-evidence-and-rights-based

## Annex 3: Follow-on formula

In response to the CMA's question on the value derived from follow-on formula to parents and babies, we have done some preliminary investigations into the **nutrition composition** of follow-on formulas available on the UK market. The recommended nutritional composition of infant formula (IF) and follow on formula (FoF) are defined by regulations in the UK. The range of values overlap for all nutrients so in theory it would be possible to produce an IF and FoF with the same composition, just marketed differently. Despite this, compositional differences regarding iron and carbohydrate sources are of public health significance and potentially concerning:

- The higher **iron** content of FoF is extensively used by manufacturers in claims, serving as marketing and promotion, despite being in conflict with public health guidance that after six months of age additional iron requirements should be met by including iron rich complementary foods in the diet. Obtaining iron from foods is more efficient as the iron is more bioavailable than in fortified products. FoF may contain more iron than is needed for infants 6-12 months of age to meet their recommended nutrient intakes, particularly if parents or carers are following public health guidance to include iron rich complementary foods in the diet[93].
    - Regulations state that IF must contain between 0.2-0.86mg of iron per 100ml and FoF should contain 0.41–1.47mg of iron per 100ml.
    - For the 11 leading brand products we analysed, the average iron content was 0.38mg higher on average for FoF when compared to IF, which is significant as the iron content of FoF is nearly double that of equivalent IF. For example, Aptamil's First Infant Milk Powder has 0.53 mg iron/100ml, and the follow-on equivalent has 1.0mg iron/100ml.
    - The recommended nutrient intake for iron at age 7-12 months, when FoF is often introduced, is 7.8mg/day. If an infant of this age drinks 920ml of commercial milk formula per day, the average iron intakes from FoF would be 8.5mg of iron per day, which is 0.7mg more than recommended intakes at 7 months.
    - Although not of toxicological concern, adverse outcomes are associated with long-term excess iron intakes, which may result in a reduced uptake of other trace metals and the oxidation of lipids[94]. Studies among iron replete toddlers have shown adverse effects on cognitive outcomes and growth for infants with high iron intakes[95].
- Due to the permissibility of a wider range of **carbohydrate** sources for FoF compared to IF, FoF can contain free sugars, sucrose, fructose and honey. Excess free sugar intake is associated with overweight and obesity and dental caries. Therefore, public health advice states that babies under one year do not need sugar, and that honey should be avoided for toxicological reasons. In our opinion, it is illogical that a product designed for children under 1 year of age should be permitted to contain ingredients that contradict public health advice for this age.
- Most FoF contain less **whey** and more **casein**; e.g. SMA Little Steps First IF has a 70:30 Whey:Casein ratio, and their follow-on equivalent has a 23:77 ratio. NHS guidance states that first infant formula based on whey protein is thought to be easier to digest than other types of formula, advising that first infant formula is the only formula a baby needs unless a healthcare professional has suggested otherwise[96]. The whey-to-casein ratio in IF and FoF is not regulated, and the rationale for manufacturers adjusting this ratio between the two products remains unclear. Further research is needed to understand the reasons for these changes and their possible health implications.

[93] www.nhs.uk/conditions/baby/weaning-and-feeding/what-to-feed-young-children/

[94] Aggett P, Agostoni C, Axelsson I, et al. 2002. Iron metabolism and requirements in early childhood: do we know enough? A commentary by the ESPGHAN Committee on Nutrition. *Journal of Pediatric Gastroenterology and Nutrition*, 34, 337-345.

[95] Idjradinata P, Watkins WE & Pollitt E. 1994. Adverse effect of iron supplementation on weight gain of iron-replete young children. *The Lancet*, 343, 1252-1254. doi.org/10.1016/s0140-6736(94)92151-2

[96] www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/bottle-feeding/types-of-formula/