Infant formula and follow-on formula market study: Feed interim report comment

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Feed is a charity dedicated to providing impartial advice on infant feeding, centring women's voices, choices and experiences. We campaign for the services and support women and their families need during their infant feeding journeys, while also conducting research to better understand and address the inequalities in infant feeding many of them face. We have recently established an Advocates Panel comprising women with lived experience of infant feeding and who play a key role in shaping our priorities, activities and outputs. The panel has been engaged in reviewing the recommendations from the CMA's interim report on infant feeding and has contributed to the response below.

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.

We believe that follow-on milk was largely created to circumvent marketing restrictions and if an advertising and promotions ban on milks was extended to follow-ons, they may disappear. We need to better understand the impact on this for parents, and how this may be influenced by the wider recommendations in your report. Just because it may have been developed in response to marketing rules (and for this reason does not exist in the US) does not mean it does not serve a purpose. Members of our advocates panel referred to the usefulness of having a powdered product for later in infancy that was easier to travel with than cow's milk, and also for use in childcare settings outside the home. "It was a comfort to my daughter when my daughter started nursery – i.e. she had the same thing at home as she did at nursery."

The role parents see for follow on milks warrants further investigation, particularly those in food insecure households. There is no research in this area. However, anecdotally we have heard families living in food insecure households have a preference to use formula milks in older children (those over the age of 12 months) as formula milks are fortified with vitamins and minerals. This is a safety net for them, when their diets are otherwise nutrient deficient.

In addition, historically, follow on and growing up milks were cheaper than first infant formulas; whilst in general the RRP for these milks are now more aligned, follow on and growing up milks can still be sold under offers, compared to first infant formula milks which are not allowed to be sold under offer. As a consequence, consumers may move from first infant formula to follow on milks in order to save money, if a product is on an offer. This aspect may be tackled however if your recommendation to enable price reductions and promotions across the board was implemented.

PROVISIONAL ANALYSIS AND FINDINGS

2. Do you agree with our provisional analysis of market outcomes, as set out in section 4 of this interim report? Please explain why you do or do not agree, providing evidence to support your response where possible.

Yes, this seems to be a thorough and careful analysis. As you note, parents can understand and evaluate the importance for them of tangible differences between products, for example being palm-oil free, organic, or its place of origin (eg from the UK versus European/international). We agree that it is much harder for them to evaluate other differences such as the nutritional benefit of a non-mandatory additive, which is what many companies play on with the signalling of non-verifiable benefits – "inspired by research" or "advanced".

We agree with the analysis that there is currently no way for parents to evaluate the benefits of additional ingredients included in mid-range and premium brands.

As you note: *"Overall, we consider that the understandable benefits of a given product are exacerbated by manufacturers' efforts to signal certain products are superior, including through the connotation of intangible and/or non-verifiable benefits rather than specific or verifiable points of difference about particular products."*

We agree with this analysis, but believe, as you go on to develop in your report, that parents are more vulnerable to these claims than they are with other products on the market because they are often not prepared for the use of formula milk as most believe they will breastfeed, and a significant proportion of them feel guilt and shame as a result. This is the most important driver of this market.

3. ***Do you agree with our provisional conclusions on the potential drivers of these market outcomes as set out in sections 5, 6, and 7 of this interim report? Please explain why you do or do not agree with regards to the following in particular: a. consumer behaviour (section 5) b. the regulatory framework (section 6) c. competition in the market (section 7) i. competition between manufacturers/brands ii. competition between retailers iii. barriers to entry and expansion***

a. consumer behaviour (section 5)

Lack of information

Yes, a lack of information about formula feeding leaves parents poorly prepared for reality of infant feeding and this has consequences.

As you highlight, formula use is far less likely to have been planned than exclusive breastfeeding – your cited survey showing 87% said they had fed formula more, longer or earlier than planned is in keeping with wider data and statistics on infant feeding intentions and outcomes. For example, a recent survey conducted by the British Pregnancy Advisory Service (BPAS) found only 10% of women who were using infant formula had planned to do so before birth.[1] This in turn is corroborated by a multi-arm study published in 2021 in Women and Birth, which found 96.6% of UK women planned to breastfeed.[2] Nevertheless, by 6-8 weeks 63.5% of women are using infant formula to some degree.[3] This will be for a variety of reasons, including difficulties breastfeeding, desire to share more care with partner or wider family, and the need to sleep.

You note: "*Our consumer research found that many parents did not feel they had received enough information from the NHS on formula feeding…There were many examples of parents who did not feel they had received enough information particularly ahead of the birth of their baby, as clinical guidelines recommend. Many parents wished they had been better prepared for unexpected feeding situations".*

Clinical guidelines do not recommend the pro-active provision of information about formula feeding so the findings from your consumer research are to be expected. Health care professionals predominantly refer to

[1] Infant Feeding Report, BPAS.
[2] Impact of COVID-19 on breastfeeding intention and behaviour among postpartum women in five countries - ScienceDirect.
[3] Breastfeeding at 6 to 8 weeks: a comparison of methods - GOV.UK.

NICE guidelines which only recommend discussing infant formula feeding with *parents who* say they *are considering formula feeding* their babies, while information about breastfeeding should be provided pro-actively including the nutritional and health benefits for mother and baby.[4] As indicated by the figures above, the majority of women will not express that they are considering formula feeding, even if the majority of them go on to do so. In documents supporting the rationale underpinning the guidelines, the committee involved noted: "*Considering the amount of information that is provided to pregnant women during antenatal care, it would not be feasible or practical to provide information about formula feeding to women who are not considering it and who express they want to exclusively breastfeed."*[5] The committee also recognised that even those women who may be considering formula feeding may be reluctant to ask for support: "*The evidence showed that there are multiple reasons why mothers do not seek information or support with formula feeding. Mothers felt they would be judged for wanting information or support on formula feeding, knowing it would go against the message from healthcare professionals that breastfeeding is best*."[6]

As part of the NHS Long Term Plan published in 2019, all maternity units are expected to "deliver an accredited, evidence-based infant feeding programme, such as the UNICEF Baby Friendly Initiative".[7] There is no other accredited infant feeding programme in the UK. As part of the guidance issued to healthcare professionals by the BFI, they are advised not to "collude" with any women who seeks reassurance that her baby will do "just as well" on formula milk as they would if they were breastfed. *"Sometimes in an effort to be kind, it may be tempting to say things like "it doesn't matter if you breastfeed or not – your baby will do just as well". Kindness is important but as a health professional you have a duty of care to provide evidence-based information. You can talk about the importance of developing a close and nurturing relationship with her baby but don't patronise her with information that she knows is incorrect."*[8]

With regard to the evidence-based information provided in this scenario, the currently available NICE guidance, while recommending that the health benefits of breastfeeding are discussed, does not detail what benefits should be explained, as it was beyond the scope of the review. "*On the basis of their expertise the committee agreed that in practice healthcare professionals would be able to draw on their own knowledge to provide this information to mothers and families."*

In practice, this means that a wide variety of benefits of breastfeeding are communicated to women underpinned by varying standards of evidence, or not conveyed in a way that meets NICE's own standards of communication of benefits and risks, particularly with regard to reduced cancer risk, weight loss for the mother, how breastfeeding improves her mothering instincts, or future infection or obesity risk for the child.

Therefore while the lack of information about formula feeding in the antenatal and perinatal period and its impact on women plays an important role in parents lack of preparedness for formula feeding, the inconsistency of information about the benefits of breastfeeding which will be pro-actively provided to women and their families also contributes to how women feel when breastfeeding has not worked and they need to purchase formula, which surface in your findings on the role of guilt.

<u>Role of guilt</u>

You note: "*Parents us[e] more expensive brands, which our consumer research found can be linked to guilt around formula use…*

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[4] Recommendations | Postnatal care | Guidance | NICE
[5] Formula feeding information and support - NCBI Bookshelf
[6] ibid
[7] NHS Long Term Plan » Maternity and neonatal services
[8] Having meaningful conversations with mothers

"There is also evidence that parents who experience feelings of guilt around formula milk use are particularly vulnerable and therefore at risk of spending more than they need to…. [They] held the view that 'infant formula is second best [to breastfeeding]'." Your research also found that the desire to purchase a premium brand is *"felt particularly strongly amongst mothers who had hoped to exclusively breastfeed. They have heard 'breast is best' and therefore feel even more guilt if they make a rational budgeting decision in their choice of formula brand".*

You found that "*those who wanted and expected to breastfeed and who find out in hospital that they will have to partially or exclusively formula feed are usually extremely vulnerable, particularly if they have thought very little about formula choices. They are often under situational stress and experience feelings of guilt or failure around formula milk use."*

Your findings on the sense of shame and guilt felt by women are widely corroborated: studies have repeatedly found this to be a key theme among women who end up using formula milk when they had planned to breastfeed.

Research by Professor Ellie Lee at the Centre for Parenting Culture Studies into British mothers' experience of formula milk use in 2007 found one third felt feelings of guilt or shame when they first fed their babies formula milk and nearly half were "uncertain they were doing the right thing".

"I felt absolutely awful. You can't explain it. I just felt really guilty. I felt as if I'd failed as a mum. . . . It felt like I was going to harm him or something by giving it to him. [The feelings lasted] for a good four or five months definitely." [9]

Low-income

Inability to afford formula can lead to unsafe practices, and our research at Feed highlights this. Food insecure families are still often buying the most expensive products, and sometimes forgoing food themselves to afford this. The reasons for this are complex, but lower income families may feel increased stigma and judgment about their parenting which may drive some of these choices towards brands deemed "higher quality".[10]

"Don't know what I would have done if I didn't have enough for Kendamil (as I believe it's the most nutritional formula milk) but even then it's been an added £100 on the food shop that we can't really afford on maternity leave" Anna, Food insecure mother

"I have found that the families I support who use formula will use the more expensive milks (that they can't afford) as they feel they are getting the best for their babies. It can be challenging to help them to understand that the cheaper formula brands are just as good." Jo, Outreach worker

Provisional conclusions on consumer behaviour

We largely agree with your evaluation and conclusions, and think throughout you have well evidenced that parents often use price as a proxy for quality, and that you have demonstrated the desire to buy the premium brands is more acutely felt among those who had hoped to breastfeed, who are strongly subscribed to breast is best messaging, and feel they are failing their baby. This speaks to a wider problem of addressing the guilt around infant feeding clearly felt by many parents. This is a wider cultural issue, but your recommendation that parents need access to timely, clear, accurate and impartial information on formula feeding from a balanced, trusted source is critical, and needs to be seen as the "golden thread" of all your

[9] Health, morality, and infant feeding: British mothers' experiences of formula milk use in the early weeks - Lee - 2007 - Sociology of Health & Illness - Wiley Online Library
[10] Out of Milk: Inquiry into the impact of food insecurity on infant feeding in the UK — feed

recommendations, none of which will work unless this aspect is addressed. Given the nature of the information required and how it can be accessed, it is worth considering what the best source of this would be and we will go on to discuss this further in our response.

We also agree with the concern that in this market, parents may place disproportionate weight on signals of difference between product that may in fact be non-tangible – price becomes a proxy for quality, and signals like "inspired by science" implying product superiority can be hard to evaluate.

We consider that while advertising and marketing of parenting clubs organised by formula companies is problematic, their influence increases because of the lack of other sources of information and discussion in the antenatal period.

b. the regulatory framework (section 6)

Regulatory framework and regime

We agree that there is a case for revising the restrictions on price promotion and with your analysis here. We think this would benefit consumers in their ability to find the lowest price option of their preferred product at retail outlets. However, we note that unless the context in which women and families are making their decisions changes (guilt and limited information which leads to the positioning of price as a proxy for quality) price reductions alone are unlikely to bring around significant changes.

There is however also a role for price reduction in combatting stigma, as it enables products to be more normalised in so far as they are treated in a similar way to other general grocery products. We feel this stigma is particularly prominent in relation to the use of loyalty cards and vouchers, as an area also covered by the notion of "price reduction". We believe enabling families to earn loyalty points on formula purchases, and to spend cash equivalents on purchasing formula would have a positive impact on both family finances, as this is often the singularly most expensive item in the weekly shop, and also impacts how parents feel about their purchase, as the inability to use points or collect them on infant formula puts the purchase in the same category as tobacco and lottery tickets.

We agree that follow-on milk is largely a promotional vehicle for the brand which objectively confers no benefit to the infant above first infant formula, although we do think this warrants further research into parents perspectives. As discussed, the same marketing and price reduction regulations do not apply to follow-on formula milks, which means that these products can sometimes offer families a more cost effective and less stigmatised solution to first infant formula.

We agree that non-verifiable claims such as "inspired by research", "advanced" are influential for purchasers but they have no way of evaluating them. While you may have found broad compliance with health and nutrition claims, most packs carry information like "contains DHA" prominently, when this is a mandatory ingredient in all products, but which labelled thus works to imply superiority. In this sense, all products are "inspired by research". It is meaningless.

As has been highlighted well, most companies now have a brand family to imply superiority of the most expensive products – currently it is almost impossible to understand the differences between these.

c. competition in the market (section 7) i. competition between manufacturers/brands ii. competition between retailers iii. barriers to entry and expansion

We agree with the conclusion that prospects for future entry are limited and unlikely to have a material impact on price competition in the immediate term, however we consider that this is partly to do with the regulatory framework as it stands and the broader context in which formula feeding is not pro-actively discussed; women feel guilt about their decisions, and in this environment heritage brands thrive making

entry very challenging. We consider that if the broader climate changed, there may be more possibilities for entrance to the market, however we accept that this is a long-term aspiration. Broadly, we encourage the CMA to consider this as a process which is unlikely to be fixed by one intervention. We agree that some of the recommendations could result in levelling the playing field.

We find the analysis of the degree to which more expensive products generally reflect an increase in the costs of the underlying ingredients extremely helpful and the low uptake on the premium brands in the context of their broader sales (0-5% for both Aptamil Advanced and SMA Advanced). As you note: *"In other words, part of manufacturers' rationale for maintaining the premium ranges – despite relatively low sales and [%] than on standard ranges – is likely to be indirectly supporting sales and pricing of the standard ranges*."

We consider important the findings that while the premium brands do contain more expensive ingredients (but only occupy a small section of the market) the cost of the difference in ingredients between mid range and basic products is much less significant. We consider this would be important information to convey to consumers given the role the mid range brands play in the market.

We also acknowledge the CMA's own recognition that price scrutiny of this areas has been intense and it is unlikely to be maintained. However, we think ongoing monitoring of the relationship between cost of ingredient as supplied by the manufacturer and proportionate cost of product is important information for the consumer to have in order to drive decisions, alongside information that there is no nutritional difference between products. Further in our response we put forward a proposal to increase price transparency in the sector.

4. Are there any other factors which we have not addressed in the report which you consider could be contributing to the outcomes we observe?

Any additional factors are referenced in our responses so far.

PROVISIONAL VIEWS ON POSSIBLE REMEDIES

6. Please provide your views on whether the possible remedies we have set out in section 8 would be effective and proportionate in addressing the issues we have identified (on their own or in combination). We also invite views on the specific questions below, noting that stakeholders can refer to the same remedy in response to Question 7 and 8 if they consider the remedy could have both positive and negative impacts.

<u>Information in healthcare settings</u>

We agree on the proposals put forward to improve access to information on nutritional equivalence, real time retail costs, and scientific claims.

We agree on the role healthcare professionals play in this, including on conveying that follow-on milk is optional and largely a marketing vehicle. Our position is that information about formula feeding needs to be pro-actively provided, not merely in response to questions about infant formula, given that the majority of families will go on to use it despite plans to exclusively breastfeed.

We agree that there is an important role for an impartial source to provide information on the above, including providing real-time data on prices, composition and scientific claims. However, we also consider it to be important that this is done in the context of unbiased, non-judgmental support for the decision a woman and her family are taking with regard to how they are feeding their baby. The CMA qualitative survey

highlights beyond doubt the role that guilt plays in this market and unless this is addressed alongside information on cost, equivalence and scientific claims, the much needed shift is unlikely to happen. It is imperative therefore that any information is hosted by organisations who support families' decisions and recognise the role that the healthcare message of "breast is best" has played in the outcome we see. This does not mean denigrating messages about the nutritional value of breastfeeding, but recognising that there are many factors which may mean it is not the optimal or practical choice for that woman and her family at that time.

We agree on the issues of supply of infant formula in healthcare settings, and that this is a key point of brand influence. For our advocates who received infant formula in hospital this influenced their choice. "My personal experience was that I stuck to the same brand my daughter was given in hospital". We consider however the proposals to address this to be unlikely to influence the change needed and likely to create bureaucratic obstacles in terms of increased inventories and pressure on staff to offer a range of options or regularly rotate brands. White label packaging of ready to feed units would still need to carry the name of the manufacturer by law and for safety reasons. Therefore, we think this would not remove the commercial influence if that is the intention. Even if a product is decanted, parents will likely ask which formula they are giving their infant. There are ethical and duty of care considerations about withholding information. It is likely this information will be shared with families and therefore removes the benefit of decanting or relabelling.

We consider one option that has not been proposed is the commissioning of an alternative supplier of non-specialist infant milk products to the NHS which has no wider commercial interest in the sale of formula in the UK market, and that this is achievable. This product could also be open about costs to supply in order to be able to supply the NHS.

Information in retail settings

We consider that clear and accurate information in retail settings is important on nutritional equivalence and a clear and factual assessment on some of the health and nutrition claims via QR code is critical. We are about to pilot such a proposal with a leading supermarket. We consider information could also be included regarding the relation between cost of ingredient and cost of product to highlight that increased cost does not necessarily proportionately reflect increased cost of ingredient.

We agree with separating first infant formulas from follow on milks within the shelf layout.

We support the advertising of price reductions and would also like to see the CMA be more specific on recommending the ability of consumers to collect and spend loyalty points as they can with any other product barring tobacco and lottery tickets, as this is not an inducement to sale. Other countries following the same marketing restrictions on infant formula have not interpreted the rules in the same way to prohibit this and have higher breastfeeding rates than the UK. This could be achieved by clarifying the existing regulation as it is currently the cautious over-interpretation of this as an inducement to sale which has prevented retailers from implementing it.

Clarifying the existing regulations

Baby milk clubs

Baby milk clubs are the product of a healthcare system that does not support formula feeding parents. Companies with commercial interests have stepped in to fill the gap. Currently the NHS recommends and signposts to third sector organisation who support breastfeeding families, where families feel excluded from these groups, as they are not exclusively breastfeeding, they turn to alternatives, not recommended by healthcare professionals as they do not align with the breast is best message.

Labelling rules

We support proposals to ensure that follow on formula has entirely different branding from first formulas. We suspect this may result in a reduction in the follow-on formula market, and may make it easier for new entrants if there is no expectation of having to produce a follow-on as well.

We believe the proposal for standardised labelling with similar colour schemes has risks and benefits and our advocates are divided on this issue, with some feeling it could destigmatise the purchase of more affordable products and change the wider unregulated landscape in which products are promoted. As one of our advocates noted, "I see mum influencers on social media swear by this or that formula. Would their posts look so pretty if the boxes all looked the same…would there be fewer sponsored posts and would more mums recommend based on their own experience rather than wanting to look like the "best" mum for recommending the most advanced/aesthetic formula?" while others felt it could increase the already significant stigma among parents making this purchase, as recognised by the CMA, by clearly differentiating it from other grocery items and making it comparable with cigarettes. We think this would only be acceptable if accompanied by new standardised messaging which moderates the language currently required by the infant feeding regulations, supporting the health benefits of breastfeeding while also noting the varied reasons why formula or combined feeding is adopted by many families and is a safe alternative or addition to breastfeeding.

We agree with restrictions on non-verifiable or ambiguous claims such as "advanced", "pro" or claims which apply by law to all infant feeding products with regard to composition, such as inclusion of DHA or "inspired by research".

In essence we are supportive of proposals which reduce the ability of brands to compete against each other on claims of superiority which cannot be evaluated by parents, but we also believe it is essential to change the context in which parents are making their choices to ensure guilt is not a driving factor in unnecessary premium purchases in the first place.

We believe the above proposals create both risks and benefits for new entrants.

Advertising

As one of our advocates noted, currently "follow-on milk marketing is one of the only places whereby parents can see their own feeding experiences reflected and normalised. By removing the promotion of follow-on milk, formula feeding will become even more stigmatised". Whether formula advertising plays a role in the decision to formula feed in the first place, or supports brand selection once a decision has been made is in any event contested: the US which has no such restrictions (and therefore no follow-on milk) has far higher reported rates of exclusive breastfeeding at six months than the UK.[11]

If the decision is taken to extend the prohibition of advertising follow on formula, it would have to be accompanied by broader changes to the regulation to enable more balanced, evidence-based information about formula feeding to be imparted (current rules for example compel anyone offering information to emphasise the superiority of breastfeeding and the social consequences of formula feeding) and b) to enable manufacturers and retailers to communicate information about their products and price changes in line with the framework we have set out above i.e. with clear restrictions on claims around product superiority. Otherwise, further restriction on advertising follow-on formula simply adds to the stigma around infant formula and formula feeding, given that follow-on formula is currently the only vehicle for advertising and promotion of infant milks.

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[11] Breastfeeding Report Card | Breastfeeding Data | CDC

Price controls

We need to understand more about the implications of this. Currently there are more affordable products on the market which may not be as widely used as they could be. Our provisional position is that changing the context in which women and their families make their choices (pro-active information, destigmatisation of their decisions) is likely to lead to longer lasting change than an intervention which may ultimately reduce choice and not be effective. As has happened with university fees, when price caps are introduced there is a gravitation towards the same place, rather than a variation in prices.

Public provision

We agree with the CMA that for this measure to be effective "a precondition is likely to be the successful implementation of the information remedies designed to change the behaviour of parents in this market". We believe that introducing public formula provision now for all the reasons stated in the report is unlikely to be received favourably by consumers.

That said, we do believe there is significant potential for a milk without wider commercial interests to be supplied under contract to the NHS as previously highlighted, and that this could have a range of wider benefits for improving the market as whole through price transparency.

7. Which of the possible remedies (on their own or in combination) set out in section 8 are likely to have the biggest impact on improving outcomes for parents who need or choose to use infant formula?

We believe the biggest impact is through the pro-active supply of information delivered in a fair and balanced way, in a timely manner and measures to reduce the shame and stigma associated with formula feeding for some individuals. This was a critical finding from the qualitative work you have done and is endorsed by other studies, over a long period of time. For this reason we suggest the CMA takes 'fair and impartial information' as being the "golden thread" that runs throughout all its recommendations. If there are to be new recommendations on packaging formats and branding of first and follow-on formulas, this also needs to be accompanied by new uniform messaging which makes clear that infant formula is a safe alternative to breastfeeding, used by parents for a wide variety of reasons, and that all options provide complete nutrition for their infants.

A useful example is messaging around termination of pregnancy by charities providing abortion, who are contracted by the NHS to provide information and clinical services to women facing an unwanted pregnancy. Providing advice and information in a non-judgmental way, including for example information about the numbers of women who have the procedure each year and the wide variety of reasons for doing so, does not increase the number of women deciding to end a pregnancy, but it does reduce the associated stigma around doing so. This is why it is so important that this information comes from trusted and impartial sources, who are not perceived to have an interest – either in the promotion of the "breast is best" message or in the commercial sale of infant formula, but in supporting the choices of families.

Please explain why, including which of the following outcomes you think would be affected:

a. price

There are affordable products available. Reducing guilt driven purchases by pro-active, non-judgmental advice and information provided in a timely manner should make the purchase of these products more accessible.

b. product differentiation and/or

This could be helpful but only if accompanied by non-partial information and advice otherwise it is likely that existing heritage brands who are able to charge the price premium because of name recognition will continue to prevail.

b. choice

Impartial advice and information including on scientific claims around composition should make it easier for parents to exercise genuine choice.

8. Are any of the possible remedies set out in section 8 likely to have an adverse effect on the following outcomes for parents in this market?

There is a risk that in the absence of pro-active provision of impartial information and advice changes to packaging, particularly uniformity of design and colour, will further increase stigma and enable companies to continue to infer superiority through price.

Any action taken by the CMA if part of a package needs to ensure the full remit of measures are implemented in a timely manner for this reason.

9. Do you consider that revising the regulations to ensure that manufacturers and retailers are permitted to publicise (i) prices and (ii) price reductions (section 8) is likely to induce the use of infant formula? If yes, please explain to what extent you consider this is likely to occur and any possible mitigations.

This does not induce the use of infant formula because by the time the decision to purchase a brand has been made, the decision to formula feed has been made. The CMA has itself acknowledged that there is no evidence lower cost is a factor in the decision to formula feed.

We support this proposal, and would like this to include enabling the collection and use of loyalty points and vouchers in a purchase.

10. Are any of the possible remedies set out in section 8, likely to have an adverse effect on outcomes or unintended consequences for businesses or any other stakeholders in this market? If so, please explain what these outcomes are and why they may arise.

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 would like to see a centrally commissioned infant milk available in the NHS that is not available commercially, accompanied by pro-active information about safe make up and storage of feeds, baby's feeding needs and how those change over time, differences in milks available, costs, and retail locations offering price promotions or permanent reductions.