



CMA Infant formula and follow-on formula market study: Invitation to comment

The CMA described: *“We are seeking input on the issues raised in this invitation to comment and the accompanying Market Study Notice. We welcome views on any of the issues we have raised, from stakeholders of all kinds, especially those which are supported by evidence. These may cover potential problems in how the UK infant formula market is working for consumers, as well as measures to improve how the market functions to deliver better outcomes for consumers. In addition to general submissions, we welcome responses to any of the questions in the box [3: Consultation questions] below.”*

Comments compiled by First Steps Nutrition Trust on behalf of the Baby Feeding Law Group UK 13th March 2024

General questions

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

We welcome the expanded scope to investigate follow-on formula (FoF), infant or follow-on formula for special medical purposes (FSMPs) and growing up and toddler milks (GUM), because all formulas for children up to 36 months may act as breastmilk substitutes (BMS) (WHO, 2018) and cross-promoted with the intention of marketing infant formula (IF). FoF are not subject to the same level of marketing restrictions as IF, and GUMs are not subject to any specific legislation as regards their composition, marketing, or labelling.

Aside from issues of cross-promotion, GUMs are currently not regulated in the UK and are deemed unnecessary by UK and global public health authorities (NHS 2023, SACN 2023, WHO, 2013). These products are ultra-processed and high in sugar. The use of FoF and GUMs is common in the UK, and other high-income countries, like Australia¹. Data collected from the 2011 Diet and Nutrition Survey of Infants and Young Children (DNSIYC) (Lennox, et al., 2013) and rolling data from the National Diet and Nutrition Survey (NDNS) (years 2016-2019) (Bates, et al 2020) indicated that 36% of children aged 12 to 18 months consume formula milks (mainly FoF and GUM), as do 7% of children aged 18 to 47 months. Among the 36% of children aged 12 to 18 months consuming formula milks, approximately 50% of their free sugars' intake comes from these products (SACN 2023).

Paragraph 45 proposes the exclusion of formulas for infants aged birth to 12 months available on prescription only. We are unsure if this exclusion of prescribed formulas is necessary. Although the payer for prescribed formula is different, some of these products (e.g. soya formulas) can also be purchased, and they can all be ordered online. They are not advertised to the public, but they are promoted indirectly e.g. by companies supporting charities that promote milk allergy as a common and devastating health problem. These products are also likely to be very unhealthy (e.g., high in free sugars). We would therefore recommend that the scope is further widened to include formula for infants aged birth to 12 months available on prescription only. It is important to note that about 9% of UK infants are fed on a prescribed

¹ <https://www.abc.net.au/news/2024-03-12/toddler-milk-nutrition-benefits-marketing-parents/103517864>

product, usually for many months, and prescriptions of low-allergy formula have risen 3-4 fold in the past 16 years (unpublished data from Boyle and colleagues).

Q. What, if any, are the key differences in the infant formula market in each of England, Scotland, Wales, and Northern Ireland that should be reflected in our analysis? Please explain any such differences and how each may affect the analysis.

We are not sure that there are any important differences between the infant formula market devolved nations, but this question would probably best be answered individuals in the devolved nations.

In the UK, the 2010 Infant Feeding Survey (IFS) showed that the incidence of breastfeeding decreases as deprivation levels increase – 73% of mothers in the most deprived quintile initiated breastfeeding, compared to 89% among least deprived mothers. This is seen in all four countries, but the difference is smallest (13%) in England and increases to 25-30% in the other countries (McAndrew, et al., 2012). This means the devolved nations could proportionately have more consumers of infant formula.

Consumer behaviour

Q. How do consumers choose which infant formula to use and what factors drive their decisions? What is the relative importance of these different factors?

Marketing

There is a large amount of research globally and from the UK which shows that the marketing of formula milk plays a role in influencing infant feeding decisions, including product choices. E.g. recent research from the WHO multi-country (which included the UK) study suggests that marketing plays an important role in influence infant feeding decisions and this starts from pregnancy (WHO-UNICEF, 2022).

More specific factors, in order of perceived importance, are as follows:

Brand

- Brand loyalty is common. Often parents stick to a chosen family brand, used over generations (Brown, et al., 2020).
- Brand influence is exerted from marketing targeted to women from pregnancy onwards, e.g. through formula company 'baby clubs'.
- Thereafter the provision of branded infant formula in maternity units is a powerful tool used by formula companies who sell their products into the NHS at prices far below recommended retail price (RRP) and at the same low price across all brands. While there may be no price differential for the NHS, parents may be exposed to a premium product and when they leave the hospital will want to keep buying it (APPG-IFI, 2018).
- Brands are used on labelling of ranges of formula milks given different stage numbers (see below) and cross-branded baby foods (see below) and in all forms of advertising to the public and health care professionals; print (ads to public and in medical journals), TV, online, baby fairs etc (see below).
- Cross promotion using brand is a specific effective marketing tool, used in the UK to circumvent legal restrictions on the marketing of IF, FoF, GUMs or baby foods.
- Data collected from 800 parents of children aged 1-4 in December 2015 (Mintel, 2016) revealed that brand was the most commonly mentioned factor (by 34% of respondents) influencing decision-making around which infant formula product to use.

Price

- The second most frequently mentioned influence on infant formula choice in the same Mintel survey (2016) was product price (31%); although it is not clear from this survey whether this implies low price (perceived as good value) or high price (perceived as denoting a superior product, see more below).

Other factors

- Other factors reported in the Mintel 2016 survey were:
 - Age range featured on the pack (29%) [noting that **'stage' numbers** are now also common]
 - **Availability** in local supermarket (25%)
 - Covered baby/toddler's daily needs in vitamins and minerals (24%) [likely linked to on-pack **health and nutrition claims** such as 'nutritionally complete', see Kamata et al, 2023]
 - Provided comprehensive nutrition (17%) [as above, likely linked to on-pack **health and nutrition claims**]
 - Convenient packaging (e.g., easy to scoop powder) (14%)
 - Organic (13%)
 - With specific ingredients (omega 3, probiotics) (13%) [also likely linked to on-pack claims]
 - Offered specific health benefits (e.g., reduced reflux) (9%) [relates to **formula company use of the FSMP regulations**, see BFLG-UK 2022]
 - Designed for babies with special requirements (e.g., premature, very hungry) (7%) ['hungry baby' could be viewed as an unevidenced health/nutrition claim²].
 - Without certain ingredients (e.g. lactose) (7%) [relates to formula company use of the FSMP regulations, see BFLG-UK 2022]

Brown et al, 2020 also reported factors influencing choice to include price (higher prices being perceived as indicating a superior product), availability and 'marketing slogans', confirming the Mintel data. Their research in addition identified the following influencing factors:

- **Advice or recommendations from family members**
- **Previous use**
- **Input from health professionals**
- **Perceptions of the company e.g. as ethical** [relevant to this may be use of green-washing claims, statements on provenance where this is 'local' and of organic certification]
- **Beliefs about the benefits of certain products**; mothers chose milks based on **added ingredients**, perceived impact on sleep, development or behaviour, and perception that certain milks were more scientifically advanced

On **'stage numbers'**: Consumers are led to believe that they must progress through 'stages' – 1 being IF for 0-6 months, 2 being FoF for 6-12 months, 3 and 4 for 12 months + when the only necessary product if IF for use from 0-12 months, A quote from the WHO multi-country study (2022) from a mother in London, UK: *"If you look at ... stage two and stage three ... It's, kind of, 'Let's continue your journey. Let's help you.'... I felt like... the formula milk is a good thing because it will support your child's growth later on as they're growing... So, I feel like I was tricked into follow-on formula, to be honest."* (Pg 15).

On company **use of the FSMP regulations**: Consumers are led to believe normal baby behaviours are pathological and offered formula solutions, e.g. comfort milk for colic and constipation, lactose free formula, anti-reflux milk (BFLG-UK, 2022). Some of these do have a place in clinical practice but should be used under medical supervision. Some are not evidence based. These formula milks are not innocuous so their marketing to parents for self-medication (by parents of their babies) is unethical.

² https://infantmilkinfo.org/wp-content/uploads/2020/03/Infant-formula-for-hungry-babies_March2020.pdf

Labelling

- A recent UK study by Conway, Ritchie et al (2023) highlights the different ways the labelling of formula milks influenced parent/carer decisions, in line with some of the factors listed above which would be evident from details on the labels, including recommended age of use/stage numbers, product names, health/nutrition claims and marketing slogans.
- The study reported on-pack branding was key to determining decisions made, as mothers were drawn to brands they recognised and brand trust had developed over years of exposure to commercial milk formula (CMF) advertising.
 - *On-pack messaging, including imagery, was understood by mothers as indicating certain products were superior or more similar to breast milk than others.*
 - *CMF products were assumed to vary according to brand and stage, but participants found on-pack information did not explain how. This added to anxiety about choosing 'the best one' and mothers would have liked more support guidance from healthcare professionals (HCPs) when choosing CMF.*
 - *Wide availability of CMF for older infants and children [i.e. variety of stages], and on-pack messaging suggesting progression from one product to the next, led many to believe these products were necessary.*
 - *There was confusion over the appropriate use of specialist products.*
 - *While mothers rarely mentioned on-pack health and nutrition claims, they were attracted to the overall appearance of packs and messaging relating to science, research and nature.*
 - *References to breastmilk and a logo [images] perceived to represent a breastfeeding mother were taken as indicators of closer similarity to breast milk.*

Q. How does price influence which infant formula consumers choose?

Price is one influence of infant formula choice, but probably not as influential brand, as outlined above.

It is likely that the influence of price may vary according to the socio-economic status of the person/family making the choice. However, there is also evidence to show that parents may make sacrifices (i.e. forgo paying other bills or borrow money) to pay for premium formula milk even when they are on a tight budget (APPG-IFI, 2018).

Despite strict regulation of the composition of IF in the UK meaning all IF are nutritionally equivalent, a false assumption exists (fuelled by marketing) that higher prices mean better quality products and parents want to do what is best for their babies. Brown et al., (2020) reported that higher priced formulas were seen by UK mothers as more advanced. Manufacturers of CMF use the strategy of premiumisation to segment brand ranges according to price and imply that premium priced products have more “innovative components/ ingredients” (Hastings, et al., 2020).

Q. Where do consumers get information about infant formula from, and which of these sources are most influential and trusted?

For context, some of the key issues with formula information provision to parents have been documented in an evidence review published by NICE³ (within which Martyn et al 1997 is particularly relevant).

In addition, consumer research from 2019 revealed that “*some parents felt confident using infant milks, around a third wanted further support with choosing milks, preparation and knowing how much milk to give. Almost half of parents did not feel confident combining breast and formula feeding. Younger mothers had lower confidence levels than older mothers.*” (Brown, et al., 2020).

³ <https://www.nice.org.uk/guidance/ng194/evidence/t-formula-feeding-information-and-support-pdf-326764486011>

Sources of information on infant formula include:

- **Product packaging / labelling** plays a role in influencing mothers' selection of infant formula product, as described above (Conway, Ritchie, et al., 2023)
 - Research from Australia and New Zealand (Food Standards Australia / New Zealand, 2022) on the awareness and understanding of stage identification labelling which may be relevant to the UK, confirmed that the stage number is used to inform product choice and sometimes this is done inappropriately: *"Caregivers consider age information on infant formula, follow-on formula and toddler milk labels important. They believe these products are designed for the nutritional needs for specific ages of infant or child; they try to give their infant or toddler a product appropriate for their age. However, the findings suggest a small proportion of Australian caregivers (and potentially New Zealand caregivers) are introducing follow-on formula to infants before six months of age. Further research is needed to determine the prevalence and reasons for this behaviour. The literature review did not find any research in which caregivers' understanding of stage identification label elements was actually tested. The research suggests some caregivers' understanding of terms like 'infant formula', 'follow-on formula' and 'toddler milk' differ from how they are used by government agencies and researchers. The findings support clearly displaying age information to assist caregivers to select appropriate products for their infant."*
 - Research from South Africa also demonstrated the use of product packaging for the purposes of marketing with one participant (a mother of a 12-week old infant) displaying confusion regarding what the number '4' on the tin referred to: *"I think it said four months if I'm not mistaken. I remember seeing a 4 on the actual can but don't really know specifically what age it's for."* – in this case the number 4 referred to a "Stage 4" product, intended for children from aged 36 months and above (Pereira-Kotze, et al., 2022).
- **Information sources beyond 'on tin labelling'**
 - *"Many caregivers seek off-label advice about infant formula. In particular, caregivers report seeking and valuing advice from healthcare professionals. Key pieces of information users of infant formula wish to know that they cannot obtain from on-product labels are: what key nutrients they should look for, knowledge regarding standardisation of all infant formula products, knowledge of nutrients associated with infant reflux and constipation, as well as which products most closely resemble breastmilk. While caregivers who use infant formula seek and value information they receive from healthcare professionals, on occasion they report difficulties obtaining information from these sources. Findings indicate that caregiver decisions to commence using infant formula were informed primarily by informal information sources. Professional advice concerning the use of infant formula was generally provided by healthcare providers after infant formula feeding had begun."* (Food Standards Australia / New Zealand, 2022).
- **Health care professionals**
 - HCP such as midwives, health visitors and GPs who have contact with pregnant women and infants all have a role to play in offering advice and support on infant feeding, including safe and appropriate formula feeding.
 - Unfortunately HCP are subject to marketing which is undertaken in a variety of ways, including adverts in journals (Hickman et al, 2021) and sponsored conferences; e.g. The British Journal of Midwifery conference taking place on March 27th 2024⁴. This means that HCP may provide conflicted company information (marketing) to parents/carers, and promote or recommend or prescribe particular brands and products⁵.

⁴ [Midwifery conference is criticised over formula milk sponsors | The BMJ](#)

⁵ <https://www.channel4.com/press/news/channel-4-dispatches-asks-if-ps40billion-infant-formula-industry-putting-profit-babies>

- It is important to note that marketing dwarfs information provision from HCP and the NHS (see below).
- Online information on formula and types of formula milks available from the NHS website⁶ is very sparse and unhelpfully ambiguous, e.g. describing products which lack evidence of effectiveness (like hungry baby formula) as “suitable, but ask your midwife or health visitor”.
- **Infant formula companies**
 - If parents/carers use the internet to search for information on formula, search engine optimisation means that company websites likely come up first, as well as targeted ads and sponsored posts.
 - Company websites are probably used widely but the information is not reliable because of conflict of interest.
 - Digital marketing of infant formula is pervasive, and consumer often obtain information about infant formula from online sources (WHO, 2022). See the table below for a comparison of the social media followings of selected organisations.
 - ‘Baby clubs’ – there are no legal restrictions on these in the UK, and they are used by formula companies to market products to parents/carers from before birth.
- **NHS**
 - Better Health Start for Life⁷ is the parent-facing NHS website. However this government website currently offers no information at all about different types of formula.
- **Non-profit organisations (e.g., charities)**
 - Information on the nutritional composition and costs of all infant formula available in the UK, that is free from commercial influence, is available on the First Steps Nutrition Trust Infant milk info website⁷: The First Steps Nutrition Trust website also has information, such as the “Simple guide to infant formula, follow-on formula and other infant milks”⁸.
 - NCT provides support to parents through their Infant Feeding Line⁹, Parent Content, NCT Baby Cafes, pregnancy and parenting courses and workshops.

⁶ <https://www.nhs.uk/conditions/baby/breastfeeding-and-bottle-feeding/bottle-feeding/types-of-formula/>

⁷ <https://infantmilkinfo.org/>

⁸ <https://static1.squarespace.com/static/59f75004f09ca48694070f3b/t/65ccfd45291a5e1d796b6543/1707932998342/Infant+milks+a+simple+guide+Jan21+SWFeb24.pdf>

⁹ <https://www.nct.org.uk/baby-toddler/feeding/early-days/support-breastfeeding-or-bottle-feeding-our-infant-feeding-line>

Table: Social media following of selected organisations (As of 6 March 2024)

Organisation name	Platform and following	Weblink
Government page (NHS) Better Health Start for Life	84 000 followers on Facebook 51 900 followers on Instagram	https://www.facebook.com/BetterHealthStartForLife https://www.instagram.com/betterhealthstartforlife/
Company groups or pages Kendamums group Kendamil, HiPP & Holle Formulas Parent Support Community group	35 8000 members 42 600 members	https://www.facebook.com/groups/913786519434841 https://www.facebook.com/groups/581570865331337
Kendamil UK	38 000 followers on Facebook 39 000 followers on Instagram 10 400 followers on TikTok 1 600 subscribers on YouTube	https://www.facebook.com/Kendamil https://www.instagram.com/kendamiluk/ https://www.tiktok.com/@kendamil?lang=en https://www.youtube.com/c/Kendamil
Aptaclub UK	215 000 followers on Facebook 30 900 followers on Instagram 3 115 followers on Twitter / X 6 665 followers on TikTok 5 000 subscribers on YouTube	https://www.facebook.com/aptaclubuk/ https://www.instagram.com/aptaamiluk/ https://twitter.com/aptaclubuk https://www.tiktok.com/@aptamiluk https://www.youtube.com/@aptaclubuk
Non-profit organisations First Steps Nutrition Trust	12 000 followers on Facebook 9 889 followers on Twitter/X	https://www.facebook.com/firststepsnutritiontrust https://twitter.com/1stepsnutrition
Early Start Nutrition	1500 followers on Facebook 3051 followers on Twitter/X 7 745 followers on Instagram	https://www.facebook.com/EarlyStartNutrition/ https://twitter.com/EarlyStartRNutr https://www.instagram.com/earlystartnutrition/
UK Formula Feeding & Bottle Feeding Support	2300 members	https://www.facebook.com/groups/156375651677533
Individual health professionals Professor Amy Brown	51 000 followers on Facebook 32 000 followers on Instagram	https://www.facebook.com/breastfeedinguncovered https://www.instagram.com/prof_amybrown/
Emma Picket IBCLC	16 900 followers on Facebook 17 000 followers on Instagram	https://www.instagram.com/emmapickettibclc/ https://www.instagram.com/emmapickettibclc/
Kathryn Stagg IBCLC	15 000 followers on Facebook 1200 followers on Twitter / X 27 000 followers on Instagram 67 900 followers on TikTok	https://www.facebook.com/kathrynstaggibclc/ https://twitter.com/kathstaggibclc https://www.instagram.com/kathrynstaggibclc/ https://www.tiktok.com/@kathrynstaggibclc

Q. How do consumers evaluate the quality of different infant formulas? Are they able to accurately observe their quality and make meaningful comparisons?

Consumers appear to evaluate quality in various ways, including being led by brand name and price. However, because of the poor awareness of the nutritional equivalence of all infant formulas and misleading marketing, including health/nutrition claims, consumers are not able to make meaningful comparisons between products. On the contrary, they are led to believe that there are substantial differences between infant formulas, with implied health and nutrition benefits.

In addition, First Steps Nutrition Trust has observed that the ingredient panel on some infant formula products has been seen to be misleading as regards primary ingredients, but formal complaints made to Trading Standards have not been productive.

More specifically:

Higher price: A marketing strategy/technique used by manufacturers/retailers, referred to as ‘increased value perception’, is where different brands pitch their product at different markets through price variations

and where customers may perceive a product as having better quality if it is more expensive. This is misleading to new parents, particularly those experiencing financial difficulties (Brown, et al., 2020).

Added ingredients / health/nutrition claims: The Channel 4 Dispatches Great Formula Milk Scandal (March 2019)¹⁰ reported that *“what many parents find confusing are the extra ingredients often highlighted on packaging, which makes some products appear better than others.”*

‘Organic’ certification is appealing to some consumers and used in marketing, although there are no health/nutrition benefits of organic infant formula over non-organic infant formula¹¹.

UK provenance is appealing to some consumers. The UK company Kendal Nuticare has been seen to use UK provenance in marketing to NHS because of Government guidance to consider the environment in procurement decisions.

Ingredient and nutrition composition information: We are not aware of any research in to consumer understanding of this labelling information but have observed on social media fora that parents/carers use this information to choose infant formula products. Consumer research from Australia and New Zealand which may be relevant in the UK, found that caregivers use the nutrition information statement and ingredient list for various reasons: *“Caregivers want to identify the differences between infant formula products including which nutrients are present and the levels of these nutrients. However, caregivers struggle to use the current NIS format to make these comparisons.* (Food Standards Australia / New Zealand, 2022). Primary research on the accuracy of ingredient and nutrition composition information on infant formula labels in the UK, and how consumers use this information would be valuable.

Q. To what extent are consumers aware of the different infant formulas? What do consumers perceive to be the differences between them to be?

There appears to be very low understanding that all infant formula are nutritionally equivalent. Feedback from one NCT practitioner relevant to this point: *“it is striking how few parents in antenatal classes realise that there is no real difference between cheap and expensive [infant] formula...”*. Research by Brown et al (2020) also reported: *“Most parents perceived that all formula milks had similar ingredients but around a third also believed specific milks to have better ingredients, or ones that would affect sleep or development. Younger mothers were more likely to believe this.*

As regards different formula milk types, results from the WHO Multi-country study report (2022) showed that in the UK, there has been some success in countering the marketing message regarding the public health message that FoF and GUM are not needed: *“Health professionals can be powerful channels of counter-marketing. In the United Kingdom, national guidance states that stages 2–4 formula products are not required and that if feeding with formula, stage 1 should be used for the first 12 months before moving on to cow’s milk. Interviews with health professionals in the United Kingdom revealed that this guidance was usually provided by health professionals and health visitors visiting women in the first days after birth. Interviews revealed that this guidance was effective, and that many were cynical about the marketing of formula milks for older infants, and instead followed the advice of health professionals.”* (Pg 16 - <https://www.who.int/publications/i/item/9789240044609>)

¹⁰ <https://www.channel4.com/press/news/channel-4-dispatches-asks-if-ps40billion-infant-formula-industry-putting-profit-babies>

¹¹ See FAQ “Are there any benefits of organic over non organic infant formula” here: <https://infantmilkinfo.org/faq/faq-types-of-infant-milk-and-ingredients/>

Q. Are consumers aware that all infant formulas provide all of the nutrients a healthy baby needs?

No. It seems that when parents/carers use infant formula to feed their babies, they are aware that it contains the nutrients that a baby needs for the first weeks and months of life, as the introduction of other foods does not commonly occur until 4/5 months of age (although that is earlier than the 6 months that WHO, SACN and NHS advise) (McAndrew, et al., 2012). However, there appears to be low awareness of the nutritional equivalence of all infant formula and that all infant formulas are nutritionally adequate. This is illustrated by many consumers spending more to buy more expensive infant formulas that they perceive to be better than lower cost alternatives, as well as health care professionals recommending certain brands over others. Marketing of formula milk products using health and nutrition claims based on the inclusion of non-mandatory ingredients is likely to be one key driver, noting that non-mandatory ingredients are those deemed safe but lacking evidence for any health or nutrition benefit. An example of such marketing is this recent advert for follow-on formula seen in a supermarket magazine, and in a reel on social media (bearing in mind that parents/carers often perceive advertisements for follow-on formula to be adverts for infant formula, Brown et al 2020).



<https://www.facebook.com/reel/393709163380220>

Primary data collection may be useful to better understand wider public, parent/carer and health care professional awareness of the nutritional equivalence of all infant formulas and reasons for perceived differences.

**Q. Do consumers try more than one infant formula at the outset or consider switching later on?
What factors drive their decisions and influence their choices?**

Brand loyalty is common and strong, where parents stick to one brand, often the chosen family brand used over generations (Brown, et al., 2020).

An example of loyalty to a specific branded product is as follows. In March 2016, Nestle's SMA First Infant Milk had a change in branding (to SMA Pro First Infant Milk) and added certain ingredients¹². One mother felt this negatively affected her child and launched a campaign calling for the product to be banned. The petition received over 13 000 signatures¹³.

Whilst brand loyalty is high, parents/carers do sometimes switch brands or types of formula milk in response to perceived problems that may simply be normal baby behaviours (for example, crying, possetting or spitting up, etc.). This is driven by misuse of infant behaviour and development in commercial milk formula marketing, which has been documented in the UK and globally (BFLG-UK, 2022; Rollins et al., 2023). *"The combination of sophisticated industry marketing practices and weak enforcement of regulations have created a market environment where parents are encouraged to self-diagnose a perceived feeding problem, and then find an infant milk 'solution', without advice from a healthcare professional. Commercial milk formula companies initially use sophisticated marketing techniques to exploit parents' anxieties around common baby feeding behaviours such as constipation, reflux and colic. They may then subtly raise awareness of these behaviours, framing them as problems that can be solved by purchasing a product (Shewan, 2021). The 'baby clubs' operated by most commercial milk formula companies are a convenient vehicle for this type of marketing, and most include advice on managing common feeding-related issues. These are often framed as problems or symptoms (with images of distressed, crying babies), making both an emotional appeal to parents and medicalising normal baby behaviours. Some websites include a symptom checker¹⁴ for parents to record their baby's feeding behaviour (see images). The parent is then encouraged to take this to their pharmacist or GP. Baby clubs do not explicitly recommend their iFSMP products in these symptom checkers, but may disingenuously suggest symptom management techniques, or even refer to the NHS website (which does not recommend any change of formula, except occasionally for reflux), whilst at the same time marketing iFSMP named as 'anti-colic', 'anti-reflux', 'comfort' along with a legally required statement of use, such as 'for the dietary management of reflux and regurgitation'. In short, the ready availability of these products (which are also routinely more expensive than the same brand infant formula, see Appendix 1) steers parents toward self-diagnosing 'problems' and then purchasing the formula solution presented by the manufacturer."* (BFLG-UK, 2022).

Relevant research from Australia and New Zealand found: *"It does appear common for Australian caregivers to believe problems experienced by their infant are due to the formula they are feeding. This aligns with the findings from the international research that suggests caregivers are motivated to use formulas designed for special dietary purposes when they believe their infant is experiencing problems. The marketing of formulas for problems such as colic and reflux suggests to some caregivers that what the infant is eating must be causing the problems and can imply that changing (either from another formula or from breastfeeding) to a specialised formula for the condition will solve the problem. It is unclear what proportion of caregivers would do this without first seeking advice from a health professional. Evidence from the United States suggests that around half of mothers discuss their choice of formula with a doctor. However, this rate is not specific to caregivers considering a special formula (who may be more likely to consult a doctor). Evidence from Australia suggests it is common for caregivers to discuss formula feeding with a health care practitioner, but it is not clear how often they would discuss their choice of formula."* (Food Standards Australia / New Zealand, 2022).

Q. To what extent is it possible to influence consumer decision-making either when the initial decision about which infant formula to use is made or later on? Does this vary for different consumers?

The various approaches to infant formula provision in Unicef Baby Friendly Initiative accredited maternity services seek to influence consumer decision-making, by trying to exemplify that all infant formula brands

¹² <https://www.herfamily.ie/news/nestle-defend-sma-recipe-change-240497>

¹³ <https://www.change.org/p/nestle-ban-sma-pro-formula-milk>

¹⁴ <https://www.cgbabyclub.co.uk/baby/health/baby-symptom-checker.html> and <https://www.aptaclub.co.uk/baby/baby-tools/baby-symptom-checker.html>

are nutritionally equivalent. These approaches include offering a selection of branded infant formulas, rotating the branded infant formulas being offered, and plain labelling branded infant formulas prior to provision; i.e. seeking to remove the powerful brand influence. We are not aware of any research which has assessed the impact of these approaches on later infant formula choices, and such research would be insightful.

We believe that generic, plain labelling of infant formula is a promising approach to tackle inappropriate marketing and misplaced brand loyalty that could be tested (and First Steps Nutrition Trust has developed a plain label that is compliant with UK law and the Code).

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

Yes. Compared to ubiquitous formula marketing, there is a dearth of independent, evidence-based information on formula and formula feeding to support safe and appropriate formula feeding practices by parents/carers. It should be noted that this information is needed by parents/carers using formula and all those that influence and support them, including grandparents and health workers. And also, that information needs to be provided in the context of adequate support for parents/carers. The provision of such information and support requires adequate and sustainable funding.

There is a wealth of evidence showing the large flow of marketing information/misinformation to consumers (WHO-UNICEF, 2022, Rollins et al., 2023, Baker et al, 2023; Perez-Escamilla, et al., 2023). The direct competition for consumer attention from formula companies makes communicating balanced, independent health and product information difficult. Therefore, the first step would be to stem the flow of misinformation by **regulating breastmilk substitute marketing to the public and health workers in line with guidance from the WHO** (the International Code of the Marketing of Breastmilk Substitutes, and all subsequent WHA resolutions). It should be noted that breastmilk substitutes include all formula milks marketed for use to 3 years of age, and bottles and teats, and that marketing includes digital marketing, influencers and social media; the recent “Guidance on regulatory measures aimed at restricting digital marketing of breast-milk substitutes” from the WHO (WHO, 2023) should be incorporated when national legislation is strengthened. As well as stronger regulations, there needs to be independent monitoring and enforcement for the legislation to achieve its public health intention.

Secondly, there is a need to **provide sufficient, independent, evidence-based, practical information on formula and formula feeding** as an alternative to the marketing provided by formula companies. As described above the current information offer from the NHS is ambiguous and incomplete. There are many ways in which this information could be provided, but the provision needs always to be independent and free from commercial influence; e.g.

- Improve public health messaging and information provision on formula and formula feeding for families who need it, whilst adhering to Unicef Baby Friendly Initiative principles, which align with the Code and are intended to protect breastfeeding. More specifically,:
 - There should be more and clearer information on the Better Health Start for Life website (the NHS public-facing content).
 - There should be improved coverage of Unicef Baby Friendly Initiative (BFI) accreditation across different settings, beyond maternity units, for example to neonatal units, health visiting services, workplaces, communities, child centres and beyond.
- The NHS websites should provide clearer information, through their contacts and website, for example that all formulas meet the same nutritional standards. This message should also be displayed on product packaging.
- Coordinated public health messaging campaigns, led by government and supported by non-industry partner organisations.

- Ensure relevant health professionals (including midwives, health visitors, GPs, and dietitians) receive adequate training on formula and formula feeding based on independent, evidenced based information.

Q. What other changes, if any, could help consumers to make more effective choices in respect of infant formula and follow-on formula?

In addition to suggestions made above, investigate the feasibility and benefits of providing free infant formula to beneficiaries eligible for the Healthy Start scheme.

The role of the regulatory framework

Q. Are the regulations around labelling and marketing of infant formula enforced effectively? If not, how could enforcement be improved?

No. Enforcement of the provisions on marketing in the current legislation is not systematic (there is no monitoring) and while it is possible to raise a complaint via formal channels (albeit complicated to navigate) it rarely leads to rectification of the problem. First Steps Nutrition Trusts' experience is that the enforcement mechanism does not work and there are widespread breeches of the law, e.g. non-compliance with formula labelling requirements (Conway, Esser, et al., 2023; Kamata et al, 2023), non-compliance with the requirement of ads to health professionals to be 'scientific and factual' (Hickman et al, 2021), illegal use of health and nutrition claims (Cheung et al, 2021); and widespread but illegal cross promotion (Conway, Esser, et al., 2023; Kamata et al, 2023).

Currently, Trading Standards Officers are responsible for enforcement of the infant formula legislation and they are under serious capacity constraints (CTSI, 2020; JTS, 2023). In the absence of routine monitoring, compliance is only assessed when potential violations are reported. However, because of capacity issues it can take months to years for any response or action to be taken. Another challenge is the conflict of interest that exists in the current enforcement mechanism system. It is our understanding that Trading Standards Officer (TSO) posts with primary authority for formula companies are part funded by the formula company – another conflict of interest which would stand in the way of effective enforcement. This is done through the Primary Authority Partnership¹⁵.

As well as poor enforcement of the marketing restrictions which do exist, the shortcomings of the UK law in relation to the Code means the regulatory framework is not able to meet its public health objectives (to promote and protect breastfeeding, and enable safe and appropriate formula feeding where necessary). The most obvious example is that by allowing promotion of FoF, and not enforcing provisions designed to limit cross promotion, IF is being effectively marketed (Brown, et al., 2020).

Recommendations for how enforcement could be improved

- Clearer Guidance Notes from the DHSC (even though they would still be non-mandatory).
- Revisit who is doing the enforcement, and their funding source (need to end the current conflict of interest with the formula industry).
- Investigate and meet training needs for Trading Standards Officers, on an ongoing basis.
- Commission an independent investigation into enforcement.
- 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 or otherwise of the enforcement mechanism, on an ongoing basis.

¹⁵ <https://www.gov.uk/guidance/local-regulation-primary-authority>
<https://primary-authority.beis.gov.uk/about>

**Q. Do manufacturers indirectly promote infant formula, and/or cross-market it via other products?
If yes, how do they achieve this and what is the impact on consumers?**

Yes, cross promotion is widespread, characterised by marketing which makes the formula brand and/or other products (FoF/GUMs) the focus. Cross-promotion has been documented as a common practice to circumvent national legislation limiting marketing of infant formula. The WHO has stated that mothers and carers are confused by this strategy, and its practice needs to be stopped (WHO, 2019). See references above and more below.

Data collected from 1307 mothers in the UK in 2019 (Brown, et al., 2020) showed that:

- Almost all participants reported seeing a wide range of adverts for infant milks across different formats and locations (i.e., media – TV, billboards, magazines, social media, cinema; in health care settings and by HCPs).
- Two-thirds believed they had seen an advert for infant formula, suggesting significant cross promotion through marketing of follow on and toddler milk products (since advertising for IF is illegal). This finding has been reported previously from qualitative interviews and quantitative surveys conducted with Australian women in 2007 and 2008 (Berry, et al., 2010; 2012).
- Three-quarters of participants found adverts emotive, with those who used infant milks and younger mothers perceiving adverts more positively.
- Some found adverts confusing or concerning if they promoted products that they could not afford.

As shown above in the social media reel produced by Aptamil to promote a 'baby fair' where they will be exhibiting, FoF advertising and advertising based on the brand is directed at the public, including pregnant women, their partners and families.

As well as cross promotion between different 'stages' of infant milks, formula companies also use common branding on baby foods such as cereals; e.g. [Cow & Gate Creamy Porridge Baby Cereal 125g - Boots](https://www.boots.com/cow-gate-creamy-porridge-baby-cereal-125g)¹⁶. It should be noted that WHO Europe recommends that such cross promotion should not be allowed (WHO-Europe, 2022).

Through cross promotion, marketing tactics such as price discounts are used legally on FoFs, GUMs, and baby cereals which use the same branding as infant formula which is subject to stricter marketing rules.

Relevant evidence from Australia found: *"The studies by Berry and colleagues suggest that some caregivers who see advertisements for toddler milks believe they are seeing or have seen advertisements for infant formula. This is more likely to occur where they glance at an advertisement and do not read it carefully. The third Berry et al. (2012) study also suggests that caregivers may remember the brands and claims featured in toddler milk advertisements and attribute them to infant formula products."* *"Further research is needed to determine whether claims about toddler milk products on infant formula or follow-on formula packaging influence perceptions of or purchase intentions towards infant formula products."* (Food Standards Australia / New Zealand, 2022).

Another strategy for indirect promotion of infant formula is by manufacturers sponsoring international activities and organisations which identify specific nutrients, rather than overall dietary patterns, as important for health. This supports the perceived value of optional ingredients they add to their products.

Formula manufacturers also promote specific scientific concepts which will support sales of specific product categories. For example, they support research and educational initiatives which focus on early rapid growth in babies born small or early. Their formula products lead to more rapid short-term growth compared with breastmilk, but carry other serious health risks. This shaping of scientific agendas is seen also in the area of allergy, where formula companies promote false concepts that normal baby symptoms

¹⁶ <https://www.boots.com/cow-gate-creamy-porridge-10272090>

are caused by allergy, that allergy affects up to 40% of babies and that allergy in babies is very dangerous. They do this by sponsoring charities, health professional organisations and educational activities and by partnering with policy-makers and regulators and their membership to subtly influence the framing of issues. These influence both health practitioner, media and consumer decision-making by driving increased use of low-allergy formula products.

Q. Does manufacturer engagement with the healthcare sector affect consumer outcomes? If yes, how does this occur and what is the impact on consumers?

Yes, this is a major source of concern (Cattaneo, et al., 2023; FSNT, 2018).

CMF industry sponsorship of HCP and events

Manufacturers sponsor healthcare professional organisations, academic journals, key opinion leaders in medicine and dietetics. CMF manufacturers sponsor most conferences, study days and educational activities which relate to infant and young child nutrition in the UK and internationally. A current example of sponsorship is the British Midwifery Journal conference in March 2024: <https://www.bjmconference.co.uk/> <https://www.bmj.com/content/384/bmj.q345>

There is also previous evidence of HCPs gifts or sponsorships from commercial milk formula companies. The Channel 4 Dispatches Great Formula Milk Scandal (March 2019)¹⁷ stated: *“We contacted all 195 clinical commissioning groups in England – the bodies responsible for spending your local NHS money. We found that since 2014 almost a third had recorded a breach of the World Health Organization guidance – such as a gift or sponsorship from a formula company. Five out of the seven local health boards in Wales had also recorded such breaches.”*

CMF industry use of HCP as “category entry points” for marketing

The 2023 Lancet Breastfeeding Series documented the practice whereby HCPs are valued by the CMF industry for the influence they have regarding health-related decisions like infant feeding and using a CMF, and are used by the industry as conduits to promote CMF use. In marketing terms, category entry points are “the mental cue that customers use to access thoughts and memories when in a buying situation” (Rollins, et al., 2023). Research from the WHO Multi-country study (2022) reported that in the UK, 30% of women had received recommendations from health professionals to use a formula product.

Research from South Africa revealed that HCPs in the private sector reported frequent contact with industry representatives (over two-thirds reported exposure to industry representatives to present products, provide training or sponsor educational activities). HCPs held strong opinions regarding the equivalency of breastfeeding to CMF, citing information from industry representatives and product packaging. HCPs were very knowledgeable on FSMPs and these were valued as solutions to infant feeding challenges. Less than half of the HCPs interviewed had heard of the national regulation related to marketing of BMS (Doherty, et al., 2022). One HCP reported feeling that “they [CMF manufacturers / representatives] push their products through me”.

CMF industry advertising to HCP

Manufacturers are allowed to share scientific and factual information with HCPs but it has been well-documented that they are also sharing promotional information and not sticking to information that is scientific and factual (as outlined above). Therefore, marketing to HCP is poorly limited under current legislation and the relevant legal restrictions are not enforced.

CMF industry influence on research and clinical guidelines

e.g. Industry-driven overdiagnosis of cows’ milk allergy

¹⁷ <https://www.channel4.com/press/news/channel-4-dispatches-asks-if-ps40billion-infant-formula-industry-putting-profit-babies>

In many areas, for example the area of cows' milk allergy, there really is no information available in the public domain which does not contain recommendations that serve a marketing purpose but are inappropriate and carry health risks. Even randomised controlled trials conducted by formula companies, which often involve UK health professionals and scientists, are often marketing vehicles which serve to misinform the scientific community and health professionals (Helfer, et al., 2021).

There have been concerns raised around the influence of the commercial milk formula industry in the development of allergy guidelines, since many of the health care professionals involved in this work and their committees have received funding / sponsorship from the industry or manufacturers of CMF (including specialised allergy products (van Tulleken, 2018). There is overdiagnosis of milk allergy in young children in some countries, leading to unnecessary use of specialized formula which can potentially harm mothers and infants (Allen, et al., 2022). From 2006 to 2016, prescriptions of specialist formula milks for infants with cow's milk allergy (CMA) increasing by nearly 500% while NHS spending on these products increased by nearly 700% from £8.1m to over £60m annually. Epidemiological data give no indication of such a large increase in true prevalence. Rather, the extensive links between the formula industry and the research, guidelines, medical education, and public awareness efforts around CMA have raised the question of industry driven overdiagnosis (van Tulleken, 2018). As a result of this, there has been an example of an alternative approach to developing milk allergy guidelines, using a Delphi consensus study to form recommendations from non-conflicted, multidisciplinary experts and these advise narrower criteria, more prominent support for breastfeeding and less use of specialized formula, compared with current guidelines (Allen, et al., 2022).

Industry influence of academics, who train future HCP

This engagement has a potential strong impact in the content of some of the training for example of dietitians - a very influential group.

Conflicts of interest on national government advisory committees

The level of relevant conflicts of interest on UK government advisory committees related to nutrition – including formula manufacturers - has been noted by independent observers on multiple occasions, and is a cause for concern (Gornall, 2015).

Q. Could the regulatory framework be improved to deliver better outcomes for consumers? If so, what do you consider should be changed and why?

Yes. Two core actions are needed:

1. Strengthened regulations governing the marketing of formula milks and other breastmilk substitutes in line with the Code and all subsequent resolutions (with adequate monitoring and enforcement).
2. Regulatory intervention on price of infant formula, to bring prices down across the board and in the long term

Additional regulatory changes should address non-mandatory ingredients (as outlined above), and consider the introduction of plain labelled infant formula, at least in maternity settings.

Strengthening UK law in line with the Code

In order to meet the public health intentions of the law (i.e. to encourage and protect breastfeeding, and enable safe and appropriate formula feeding where necessary) there should be full implementation of the Code in the UK (WHO, 1981; UNICEF, 2023). **This should not be compromised by any regulatory reform intending to improve market outcomes.** This is explained more on the first page of the BFLG-UK briefing note to clarify misconceptions about the UK law on marketing infant formula (BFLG-UK, 2024). The UK currently scores 40/100 on the Global Code Status Report (which is updated every 2 years), indicating that it contains only 'some' provisions of the Code (WHO, UNICEF and IBFAN, 2022).

During 2022, the BFLG-UK conducted comprehensive mapping and assessment of the current UK laws governing the marketing, labelling and safety of breastmilk substitutes, bottles, teats and foods for infants and young children. The following documents have been shared:

- Pereira-Kotze C, Clark D & Sibson V. 2022. Mapping of current UK laws governing the marketing, labelling and safety of breast-milk substitutes, feeding bottles, teats and foods for infants and young children. BFLG-UK.
- Clark D, Pereira-Kotze C & Sibson V. 2022. Assessment of current UK laws specifying weaknesses and where they fall short of the minimum standard of the International Code of Marketing of Breastmilk Substitutes, subsequent relevant World Health Assembly Resolutions and the WHO Guidance on ending inappropriate promotion of foods for infants and young children. BFLG-UK.

In 2022 WHO Europe proposed a “Model Law” for controlling the marketing of breastmilk substitutes. Our view is that it would be extremely helpful if all regulation relating to infant formula, follow-on formula, FSMP, growing-up milks, bottles and teats were all regulated under one piece of legislation, as has been developed in this model law and it is fit for purpose, with necessary adaptations (WHO-Europe, 2022).

Nb. on the communication of information on formula prices: We are concerned with paragraph 52 in the Invitation to comment on the infant and follow-on formula market study document by the CMA, which states: “Although brands may engage in ‘indirect’ marketing and cross promotion to influence consumer choice of infant formula, the strict regulatory prohibitions on ‘direct’ marketing may have a restrictive effect on the ability of both retailers and suppliers to communicate their prices to consumers. This may be acting to limit competition on the price of infant formula.” We feel that the current 'strict' regulatory prohibitions on direct marketing do not prohibit retailers/suppliers from communicating their prices to consumers appropriately. However, this communication could be improved by requiring prices to be shown in the unit of consumption; so per ml of made up formula rather than per g of dry powder.

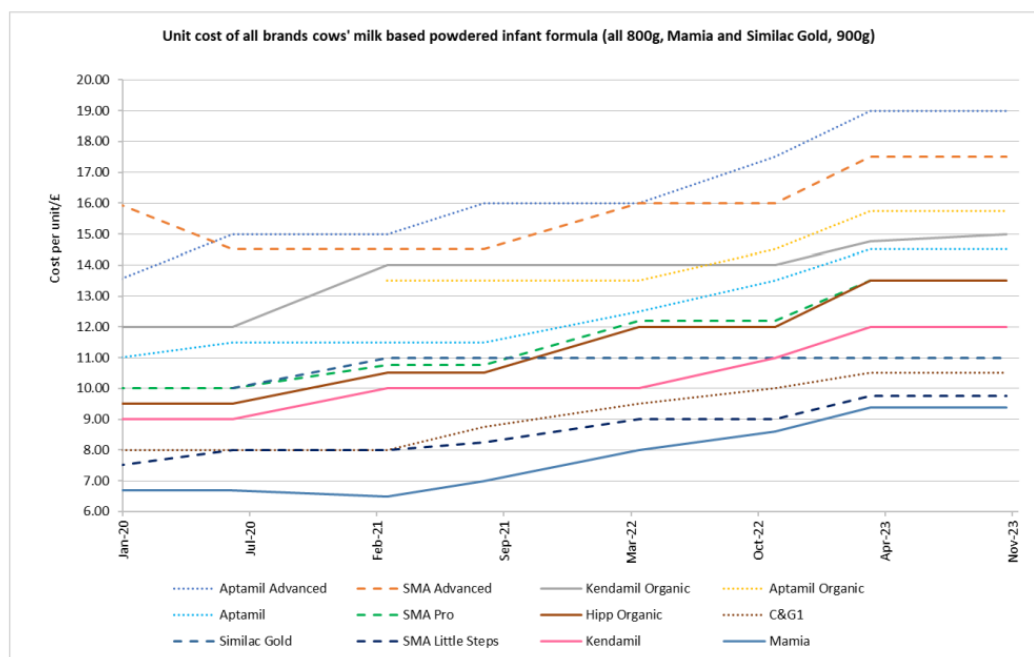
See more on recommended price controls below.

Supply-side features of the market

Q. How strongly do infant formula manufacturers compete on price, and what could be done to strengthen price competition?

There have long been big variations in the cost of different commercial milk formulas available in the UK (even within different brands from the same manufacturer) and prices have risen steeply in the past few years from a high base (FSNT, 2023). In November 2023, the range in price of the seven leading brands of infant formula was £9.75 for the cheapest to £19.00 for the most expensive per 800g tin.

Graph 1. Unit cost of all brands cows' milk based powdered infant formula



This data show that formula companies offer different brands of nutritionally equivalent infant formula to appeal to different consumers, at different price points i.e. “entry-level” vs. “premium”; a practice known as market segmentation. For example, Danone sells Cow & Gate, Aptamil and Aptamil Advanced. Bearing in mind that prices have reduced since November 2023, as of March 2024, Aptamil Advanced 1 sells for £18 per unit, Aptamil 1 for £13.50 per unit and Cow & Gate for £10.50 per unit (see attached Excel spreadsheet – FSNT, March 2024). We question why one retailer has 3 different brands with differing prices points, for an essential product that has a comparable nutrient content.

Another example, SMA Advanced¹⁸ is one of the most expensive products, mainly due to the use of partially hydrolysed whey protein as an ingredient. A Food Standards Agency (FSA) / Committee on Toxicity of Chemicals in Food, Consumer Products and the Environment (COT) report shows there is no evidence for partially hydrolysed formulas (pHF) preventing allergies (COT, 2016). For many years, SMA Nutrition (a brand of Nestle) claimed that partially hydrolysed formula prevented allergies and sold the product as a FSMP. After complaints about their inappropriate marketing, the product is sold at a higher price (i.e., premium product) without the health claim that it prevents allergies.

Likely due to significant recent media coverage on infant formula prices, from the November 2023 CMA report and other reporting, some manufacturers and retailers have voluntarily begun reducing their formula prices:

- Around November 2023, Danone (the manufacturer accounting for the majority of the infant formula market in the UK) reduced the price of their infant formula starter packs by 17% but did not bring down the price of the brand equivalent powdered infant formula: see the First Steps Nutrition Trust November infant milks cost report¹⁹ and a narrative on this in the First Steps Nutrition Trust December 2023 newsletter²⁰.

¹⁸ <https://www.smababy.co.uk/formula-milk/sma-advanced-first-infant-milk-powder>

¹⁹ https://infantmilkinfo.org/wp-content/uploads/2023/12/Costs-of-IF-FOF-and-milks-marketed-as-FSMP-available-over-the-counter-in-the-UK_November_06122023_Final.pdf

²⁰ <https://www.firststepsnutrition.org/december-2023#9>

- In January 2024, Danone cut 7% off the wholesale price of powdered Aptamil baby formula, with major UK retailers passing the saving onto consumers²¹ – e.g. Iceland reduced the price of three 800 g Aptamil powders from £12 to £11.20²².
- In February 2024, retailer Iceland reduced the cost of Nestle’s SMA Little Steps Infant Formula by £2 to £7.95, making it “the cheapest infant formula on the market”²³.
- In response to this, on 28 February 2024, Aldi reduced the price of its own-brand Mamia (from £8.99 to £8.89 per 900g – i.e., equivalent to £7.90 per 800g) to ensure that they were still the cheapest formula on the market²⁴. This seems like a nominal / insignificant change to Aldi, just so that they can still be known as “the cheapest formula” on the market.

Historically in the UK, there has not been this competition on price, and this is illustrated by the variations in prices between similar brands. Companies rely on marketing to sell more expensive products, with the reassurance that a product is “closest to breastmilk” and brand loyalty. Since the manufacturers are sure of their market, they don’t need to compete on price. It seems that the threat of price caps has forced the recent competition on price and changes seen above, where retailers are getting involved.

Regulatory intervention on price of infant formula, to bring prices down across the board and in the long term

While this recent competition and fall in prices is promising for consumers, it is our opinion that mandatory limits on profits for an essential product (i.e., in the form of government-mandated price caps) would be a more equitable solution that would bring the cost of infant formula down further. As a precedent, Greece implemented a 7% profit cap on infant formula from March 2024²⁵ and has already fined a company for profiteering²⁶. Price caps would also prevent manufacturers and retailers are using the infant formula price increase and cost-of-living crisis to their advantage, (i.e., exploiting the situation) to use established marketing strategies such as “the loss leader strategy”²⁷ to attract customers, and as well as reducing and advertising the reduction in prices of unnecessary formula products; i.e. FoF and GUMs.

Q. Are there any ways in which the entry and expansion of brands or own-label products could be encouraged and supported? If so, what do you consider could be done and why?

Yes. The competitive advantage of brands could be reduced by disallowing the addition of non-mandatory ingredients that have no health benefits and may actually place a burden on infant metabolism (as per the opinion of EFSA), but add to the price and are used by manufacturers for marketing, as outlined above.

In the short term, we would advise investigating 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.

²¹ <https://www.theguardian.com/business/2024/jan/10/danone-to-cut-7-off-wholesale-price-of-powdered-aptamil-baby-formula> and <https://www.nutraingredients.com/Article/2024/01/19/UK-supermarkets-match-Danone-s-Aptamil-baby-formula-price-cuts>

²² <https://metro.co.uk/2024/01/10/this-popular-baby-formula-will-cheaper-next-week-20091042/>

²³ <https://metro.co.uk/2024/02/26/iceland-supermarket-launches-baby-formula-cut-price-cost-7-95-20351428/>

²⁴ <https://www.thegrocer.co.uk/aldi/baby-formula-price-war-looms-as-aldi-undercuts-icelands-cheapest-claim/688819.article>

²⁵ <https://apnews.com/article/greece-inflation-prices-controls-baby-formula-2502e32d352b401cf03477c4205ecc1e>

²⁶ <https://www.ot.gr/2024/01/23/english-edition/greek-authorities-slap-baby-formula-company-with-e561000-fine-for-profiteering/>

²⁷ <https://www.investopedia.com/terms/l/lossleader.asp>

Q. Why is there a lack of price differentiation for infant formula at a retail level?

We believe that there is price differentiation for infant formula at retail level, and that this actually presents a challenge given that all infant formula products are nutritionally comparable. There is a range in prices of comparable products, between the same product sold by different retailers (Food Foundation, 2024; FSNT 2024) and between different brands sold by the same retailers as outline above (FSNT, 2023). In addition, formula manufacturers' ability to choose which infant formulas to market under FSMP regulations and which under IF and FoF regulations allows them to add a price premium. These high prices are unjustifiable and exploitative, especially when products lack evidence of effectiveness (BFLG, 2022).

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

There might be some examples where innovation has led to a change in the mandatory ingredients; for example DHA. However, much of the innovation by the industry does not translate into robust evidence for health benefits, but is being used to drive addition of non-mandatory (optional) ingredients, which increases the input (and therefore retail) cost of the product and to underpin inappropriate health/nutrition claims. Health and nutrition claims for infant formula are poorly substantiated and potentially harmful (Munblit, et al., 2020).

While there is lots of innovation in terms of packaging and adding ingredients, these do not benefit babies or their families. Our view is that there is too much opportunity for innovation around the addition of novel ingredients (e.g. synthetic analogues of certain Human Milk Oligosaccharide (HMOs) and Milk Fat Globule Membrane ('MFGM'), the current situation permits the addition of novel ingredients based on data from clinical trials conducted by the manufacturer, with obvious conflict of interest. Most of the research conducted on optional ingredients is funded by the manufacturers themselves and not of good quality (Helfer et al., 2021). More specifically, the randomised controlled trials that form the bedrock of product development for formula are biased by selective reporting – with the majority of trials never being published, and those that are published only reporting specific datapoints. Over 90% claim a favourable finding, and it was estimated that just 2% of formula trials report reliable findings (Helfer, et al., 2021). For DHA and other ingredients which are supposed to help with development, the situation is the same. Datapoints are selectively reported and when independent investigators do manage to access the full study dataset, there is no benefit seen (Verfürden, et al., 2021). One study that looked specifically at DHA using original trial datasets found no evidence for a benefit on cognitive outcomes (Verfürden, et al., 2020).

Q. Is there scope for further innovation in this market? If yes, where are the opportunities; what are there barriers to achieving this; and how might these be overcome?

As companies do already “innovate” (e.g., the addition of non-mandatory ingredients) we would question how much more innovation is needed in this industry.

Rather than encouraging further similar innovation we recommend a revisiting legal permissible non mandatory ingredients in infant formula: they do not confer health/nutrition benefit, the European Food Safety Authority (EFSA) acknowledges they place a burden on infant metabolism, and their addition only adds to the price of the product and gives an opportunity for companies to differentiate their products including by increasing their price.

Any future innovation should be better controlled, particularly with respect to managing conflict of interest. In particular, infant milks which are foods for special medical purposes may require continuous development and to keep updated with latest technologies. Munblit et al (2020) makes recommendations which provide scope for innovation without new developments being used as claims, driving inappropriate price inflation and undermining public health efforts to promote and support breastfeeding. Innovation is

welcome where science is able to provide better evidence for optimal levels of essential nutrients and this should inform an update in the mandated nutrition composition for all infant formula, not just for 'improving' premium products.

In addition, we suggest a review of the standard, type and strength of evidence required to permit the addition of novel ingredients to infant formula, to reduce the number of ingredients added that are not supported by a robust evidence base for efficacy. Currently this is done internationally through Codex, but a more efficient process could be formation of a national committee to assess the validity of innovations with a view to mandating them (or more likely, rejecting them) as part of the compositional standards for infant formula.

In addition to the recommendations made in our answers above, we would like to reiterate four core actions we recommend the UK Government implement to address high infant formula prices, as follows:

- 1. Improvement of the Healthy Start** scheme for pregnant teenagers and teenage mums, and families with children under 4 on very low incomes in England, Wales and Northern Ireland. Improvements needed include increasing the cash allowance in line with food inflation and increasing coverage by switching to autoenrollment and extending the scheme to families with no recourse to public funds²⁸.
- 2. A public health messaging campaign around the nutritional equivalence of all first infant formula**, the logic being if parents better understood this they would 'trade down' to cheaper products where available. However, and aside from there being only one own brand product at present, a root problem here is inappropriate marketing, which requires:
- 3. Enforcement of existing legislation designed to prevent inappropriate marketing of formula milks and to protect breastfeeding AND safe and appropriate formula feeding, and strengthening of this legislation in line with the International Code of Marketing of Breastmilk Substitutes and subsequent World Health Assembly Resolutionsiv.**
- 4. Government establishment of pricing policies and practices to ensure infant formula is provided at lower prices on a long term basis; e.g. through a price cap**

²⁸ [Healthy Start Working Group Policy Positions 2023.pdf \(foodfoundation.org.uk\)](https://www.foodfoundation.org.uk/wp-content/uploads/2023/04/Healthy-Start-Working-Group-Policy-Positions-2023.pdf)

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