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Labelling Minimum Age for Infant Foods, submission in response to Consultation paper: Proposal p274 – Minimum Age Labelling of Foods for Infants

I welcome this opportunity to comment on the minimum age labelling of foods.

I note that the proposal dates back to 2003, based on scientific evidence published by WHO in 2001. The delay in changing labelling is deplorable, and has presented measurable and substantial risks to the immediate and future health and development of over 2.5 million infants who were born during this decade.

I strongly support bringing the labelling in line with NHMRC recommendations. The delay in translating these recommendations into a change in labelling requirements is unacceptable. This has been flagged with industry for over a decade. It does not take 3 years to change the labels and remove old stock. At the very most, no longer than 12 months should be necessary. I strongly oppose allowing a further 3 years of transition for this to be put into effect.

I have concerns at the proposal to not require warning labelling other than on first foods.

Especially in light of the Best Start Inquiry recommendations for full implementation of the WHO Code on Marketing of Breastmilk Substitutes, and the recent cessation of Australian Government support for industry self-regulation through the MAIF Agreement, it is crucial for there to be strong regulation of infant and young child food standards and marketing.

It is particular important that there be no impediment to legal action under consumer protection legislation regarding baby food. At present, food regulation may represent a barrier to protecting consumer rights to information that is not false or misleading. Especially given the evidence of long delays in bringing food regulations into line with health recommendations, food regulation should be explicitly prevented from being considered as a defence against actions by consumers under consumer protection legislation.

In the light of evidence on the poor ethical standards of the infant food industry, it is not sufficient to argument that health professionals are the appropriate source of information, nor is it acceptable to allow any health claims on foods for infants and young children.

These points are elaborated in the attached submission.

Dr Julie Smith

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Background

There is increasingly acknowledgement of the role of early life nutrition in population health including later life chronic disease risk as well as health and development through infancy and childhood.

The World Health Organisation is very clear in its evidence based recommendation for exclusive breastfeeding for 6 months, and continued breastfeeding with appropriate complementary foods to 2 years and beyond. [1] However, the Australian National Infant Feeding Survey confirms that exclusive breastfeeding rates in Australia are poor, even though 60% of women breastfeed their child at 6 months. Exclusive breastfeeding rates below levels recommended by health authorities including the NHMRC are therefore substantially affected by, and due to, premature introduction of solids.

This proposal dates back to 2003, and was initiated in regard to scientific evidence on the health gains from exclusive breastfeeding to 6 months that was made available by WHO in 2001. The delay of over a decade in changing labelling of infant foods is deplorable.

While parents make infant feeding decisions based on a range of factors and influences, food labelling influences social norms about the acceptable age for introducing solids and non breastmilk. The FSANZ literature review in the supporting documentation summarises evidence that points clearly to an important role for food labelling in influencing infant feeding decisions; this influence has in my view been understated in the summary documents provided by FZANZ for this consultation. The evidence from FSANZ's 2004 study is inadequate quality to substantiate the argument that labelling does not really matter much for infant feeding decisions, and it is clear that improved labelling is part of a communication strategy affecting health professionals, families and friends, and parents, and broader social norms, that could significantly improve exclusive breastfeeding practices and complementary feeding decisions in Australia.

The more than decade-long delay in amending labelling requirements to align with scientific evidence on overall health gains from exclusive breastfeeding has presented risks to the health of infants for over a decade, and affects the nutrition and health of a population exceeding 2.5 million Australians. The costs of this delay will be reflected in higher acute and current disease burdens and health system costs.[2]

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[1] Divergence from this recommendation creates confusion that needs to be addressed.

[2] Such health system costs and burdens from suboptimal breastfeeding are increasingly being documented in the scientific literature. See Smith JP, Harvey PJ. Chronic disease and infant nutrition: is it significant to public health? Public Health Nutrition 2011;14(02):279-289

Smith JP, Thompson JF, Ellwood DA. Hospital system costs of artificial infant feeding: estimates for the Australian Capital Territory. Australian and New Zealand Journal of Public Health 2002;26(6):543-551.

Renfrew MJ, Pokhrel S, Quigley M, McCormick F, Fox-Rushby J, Dodds R, et al. Preventing disease and saving resources; the potential contribution of increasing breastfeeding rates in the UK: UNICEF UK; 2012 18 October. Bartick MC, Stuebe AM, Schwarz EB, Luongo C, Reinhold AG, Foster EM. Cost analysis of maternal disease associated with suboptimal breastfeeding. Obstet Gynecol 2013;122(1):111-9.

Bartick M, Reinhold A. The burden of suboptimal breastfeeding in the United States: a pediatric cost analysis. Pediatrics 2010;125(5):e1048.

The health risks from premature weaning are substantial. These are well established and well documented and will not be rehearsed here. However, it is important note that consumers are not well aware that baby foods including the various kinds of 'formula' as well as solid foods are not sterile products. Nor are they generally aware of the heightened risks of ill health and strong evidence of reduced cognitive development arising from premature weaning from exclusive breastfeeding.[3]

Transitional provisions

Despite evidence that labelling influences mothers ideas about acceptable age for weaning from breastfeeding, the food industry has argued that such labelling is unnecessary and/or costly.

The cost estimates by industry are likely to be highly inflated and cannot be taken as evidence on the true additional costs to industry of complying with the new labelling requirements.

As acknowledged in the supporting documents, industry benefits substantially from food safety and similar government regulation. Such regulation reduces perceptions of risk regarding commercially manufactured food products, enhances consumer confidence, and thereby increases potential sales. It is in the industry's own interest to maintain high standards of labelling and regulation, even if individual companies have a strategic interest and incentive to delay such improvements.

It is appropriate that industry bear the costs of complying with such regulation. The cost estimates by industry should be audited by independent experts, and not accepted as evidence of true costs. The standard of proof should be high in this area, given the costs to public health involved.

Furthermore, as is acknowledged in the supporting documentation, some industry players have already made such changes and there is in any case zero cost. Those players that have not prepared for these changes have had ample notice, and delays in implementing the proposal simply disadvantage those firms who have adapted to changing community expectations and advantages the laggards.

According to market rsearch, the current size of the industry is around $370 million (and less than half of that is milk formula). Hence it is clear that the industry affected by the current proposal is well able to afford to meet the relatively small cost of introducing new labelling, which are only a fraction of turnover, and will have minimal effect on profitability given the likely mark-ups on costs in the industry.

I therefore strongly oppose allowing a further 3 years of transition for this to be put into effect. This has been flagged with industry for over a decade. It does not take 3 years to change the labels and remove old stock. At the very most, no longer than 12 months should be necessary.

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[3] Kramer MS, Aboud F, Mironova E, Vanilovich I, Platt RW, Matush L, et al. Breastfeeding and child cognitive development: new evidence from a large randomized trial. Arch Gen Psychiatry 2008;65(5):578-84;
National Health and Medical Research Council. Dietary Guidelines for Children and Adolescents in Australia incorporating the Infant Feeding Guidelines for Health Workers. Canberra: National Health and Medical Research Council; 2013 February 2013.
Smith JP, Harvey PJ. Chronic disease and infant nutrition: is it significant to public health? Public Health Nutrition 2011;14(02):279-289.

As a former company director, I was involved in a process of changing food labels and removing stock; based on this experience I suggest that it is implausible that industry cannot achieve this at reasonable cost within 12 months if legally required.

Labelling changes proposed

I strongly support bringing the labelling in line with NHMRC recommendations. The delay in translating these recommendations into a change in labelling requirements is unacceptable.

'First foods' vs. non first foods

I have concerns at the proposal to not require warning labelling other than on 'first foods'.

Breastmilk is the first food, and this should be clearly stated in any labelling or marketing of food for infants and young children.

Industry has introduced and promoted such concepts as 'first foods' with little or no evidence to support the developmental or nutritional need. They should be referred to as 'weaning foods', or 'secondary foods' not 'first foods', so as not to mislead consumers. This would reinforce public health messages that breastmilk is the main source of nutrition in the first year of life.

The proposal to require no warning labels other than on 'first foods' and to allow such warnings to be located anyway on the product, is an experiment which could have adverse consequences. These detrimental effects may outweigh the benefits of the changing labels to reflect the NHMRC/WHO 6 months recommendations. This is because parents, health professionals and the community at large gain their impressions on the acceptable age for introducing solids from a wide range of sources including on foods purchased for older infants.

Some will believe that there is no problem with giving foods for older children to infants younger than 6 months if the labelling is not consistent for all foods marketed for infants and young children. Hence to ensure consistent and accurate information, and assist community education and social norms, the warning label 'not for before 4 months' should be required on all food products for infants and young children not just those.

The argument for not having such warnings on the front of packs is weak. Stronger evidence such as from randomised controlled trials should be conducted to justify the change before it is implemented. The methodological quality of studies justifying such arguments must be high; the FZANZ 2004 study does not meet methodological quality standards for health research; as argued earlier, it is the stronger health related evidence standards which should apply in the case of infant and young child feeding because of the important population health implications of early nutrition.

Consumer protection related risks

Food regulations have been used by industry to defend complaints about labelling and marketing under consumer protection and trade practices legislation. The long delays in bringing food regulations into line with health recommendations have exacerbated this.

It is particular important that there be no impediment to legal action under consumer protection legislation regarding baby food. At present, food regulation may represent a barrier to protecting consumer rights to information that is not false or misleading.

Especially in light of the Best Start Inquiry recommendations for full implementation of the WHO Code on Marketing of Breastmilk Substitutes, and the recent cessation of Australian Government support for industry self-regulation through the MAIF Agreement, it is crucial for there to be strong regulation of infant and young child food standards and marketing. It is clear that industry has strong strategies to protect its position against public health regulation of its marketing practices.[4]

It should be specified in relevant legislation that FZANZ regulation is not a relevant consideration for defending against complaints by consumers regarding the marketing of foods for infants and young children.

In recent times there has been an outpouring of evidence regarding lax standards and unethical behaviour by baby food companies, many of which are involved in the baby food industry in Australia. For example in China a number of market leaders have been charged with corruption in marketing to health professionals and the industry has been fined for price fixing and other unethical marketing practices. There is little reason to believe that standards will be higher in Australia, unless Australian regulatory requirements are strict and are strongly enforced.

In the light of such evidence on the poor ethical standards of the infant food industry, it is not sufficient to argument that health professionals are the appropriate source of information, nor is it acceptable to allow any health claims on foods for infants and young children.

Conclusion

It needs to be recognised that 'fair trading' in infant foods needs to be broadly defined. Breastfeeding mothers are major food producers, in Australia and worldwide. However, mothers are not well placed to compete with the strategic messages and social norms influenced by industry marketing, past and present.

Breastfeeding by mothers is a symbolic 'stakeholder' in the infant food market.[5] It is often not well represented in public debates because of lacking of resourcing and profit motives for advocacy on its behalf.

It is more important than ever for there to be strong regulation of infant and young child food standards and marketing. It is clear that industry has strong strategies to protect its position against public health regulation of its marketing practices.[6]

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[4] Smith JP, Blake M. Australian infant food marketing strategies undermine effective regulation of breastmilk substitutes; analysis of trends in print advertising in Australia, 1950-2010. Australian and New Zealand Journal of Public Health 2013;37(4):337-44.

[5] Smith JP. Mothers' milk and markets. Australian Feminist Studies 2004;19(45, November):369-379.

[6] Smith JP, Blake M. Australian infant food marketing strategies undermine effective regulation of breastmilk substitutes; analysis of trends in print advertising in Australia, 1950-2010. Australian and New Zealand Journal of Public Health 2013;37(4):337-44.

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In recent times there has been an outpouring of evidence regarding lax standards and unethical behaviour by baby food companies, many of which are involved in the baby food industry in Australia. In the light of such evidence on the poor ethical standards of the infant food industry, it is not sufficient to argument that health professionals are the appropriate source of information, nor is it acceptable to allow any health claims on foods for infants and young children.