

Independent Advice
on the Composition and Modus Operandi
of APMAIF and the Scope of the MAIF Agreement

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In undertaking the following review, I have, as agreed met with and discussed issues of concern with the key stakeholders and a range of individuals involved and concerned with the MAIF Agreement and APMAIF.

As a result of these discussions it is clear to me that despite the significant advances achieved in the promotion of breast-feeding over the last decade or so, there is widespread concern and frustration with the operation of the Agreement. The frustration as conveyed to me is such that I believe the current arrangements for the marketing of infant formula are in very real danger of unraveling.

In my view, there are three broad reasons for the current disillusion:

1. *There is basic disagreement on the purpose of the agreement;*
2. *The expectation of the contribution that the agreement can make to increasing breast feeding rates is beyond the capacity and scope of the agreement; and*
3. *The operation of APMAIF particularly in recent times.*

Purpose of the Marketing in Australia of Infant Formula (MAIF) Agreement

Industry views the agreement as providing a framework for the provision of comprehensive information to all mothers i.e. both mothers who breast feed and those who infant formula feed their infants.

On the other hand, breast-feeding advocates see the agreement solely as a mechanism to curb industry-marketing activity, which may undermine efforts to increase breast-feeding rates. The Agreement clearly reflects a compromise between differing positions and its wording is open to interpretation.

From a public policy perspective, both the need for comprehensive and appropriate information to all mothers, and a practical mechanism for ensuring a consistent implementation of the code, is important for the optimum well being of future generations of Australians.

Given the Government's strong commitment to increasing breast feeding rates in Australia, one of the few areas of consensus was the view that an effective voluntary agreement between government and industry was the more preferred model for ensuring implementation of the code.

Scope of this Agreement

Much of the criticism of the current arrangements relates to activity outside of the scope of the current MAIF Agreement.

Retailing activity and products associated with formula feeding such as teats and bottles have always been outside the scope of the MAIF Agreement. However, changing practices in the retail sector such as the establishment of baby clubs and other promotional activities in pharmacies and supermarkets have heightened concern about the potential to undermine breast-feeding initiatives. The report seeks to provide a mechanism for addressing these issues in a changing environment.



The Operation of Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF)

Criticism and frustration about and within APMAIF is widespread and ranges over almost all aspects of its work.

Some of this criticism is a reflection of the limitation of the current arrangements to which I have already referred. The criticism regarding the slowness and fairness of APMAIF deliberations is valid and in a significant part reflects the panel of three people being responsible for both the investigation and the determination of possible breaches of the Agreement.

There has also been much comment on personality issues that have been perceived to have affected the operation of APMAIF. However, even if there is substance to these claims, it is not in my view the cause of the current difficulties, and at most has only exacerbated these difficulties. I believe the problems being experienced by APMAIF are more structural and the report seeks to provide a more appropriate framework for a comprehensive national policy on infant nutrition.

The Way Forward

I have proposed a public health partnership between the Commonwealth, States and Territories to enable a longer-term comprehensive strategic approach to the promotion of breast-feeding. The aim of such a strategy would be to ensure all parents understand the importance of breast feeding and societal support for their endeavors.

At the same time, it is important to recognise some mothers will for a range of reasons formula feed their infants in part or wholly. They and their babies are entitled to accurate information and advice on how to provide their infants with adequate nutrition.

Such a framework would enable a revamped APMAIF to monitor the infant formula industry and compliance with the WHO Code to ensure its activities do not undermine breast-feeding. At the same time it is important to recognise industry's legitimate desire to develop new products and market share in the infant formula market, albeit a continually shrinking one with Australia's low birth rate.

This balance will require a Panel able to exercise mature judgement, to focus on issues of substance and not get bogged down in minutiae, and in the absence of a clearly written Agreement, to have regard to the spirit of the Agreement in the context of Australia's commitment to the WHO Code.

It is within this framework that I have considered the issue of the provision of free samples of infant formula to health professionals. This issue encapsulates the current dysfunctional nature of APMAIF.

Industry is adamant that consistent with the Agreement it should be able to provide samples to health professionals for evaluation. On the other hand breast-feeding advocates argue these samples would inevitably be given free to mothers and therefore influencing some to cease breast-feeding.

I accept health professionals should have access to comparative information about various products, in order to advise mothers who have decided to cease or reduce breast feeding their infants. However, I think it highly unlikely that the availability of a range of samples, and certainly not from a single supplier, will enable them to better access the suitability of infant formula for individual infants. On the other hand the risk of more wide-spread distribution of samples are real, and samples will inevitably be available to mothers who may well be still trying to breast-feed.

The availability of samples may also lead to health professionals being more likely to advise mothers to cease or reduce breast-feeding, when the alternative may be a time consuming assessment of the mothers

difficulties in breast-feeding. In these circumstances, and given the importance of continuing breast-feeding in order to keep up milk supply, I believe such a practice may well undermine breast-feeding without any advantage to the understanding of a professional's view of a particular product.

In my view the industry's proposal is therefore against the spirit of the Agreement.

The recommendations outlined in the report, if implemented, will enable Australia's commitment to the WHO Code to be honoured through a voluntary agreement. If these changes do not achieve such an outcome, then it will be necessary to consider a legislated statutory framework.

Rob Knowles

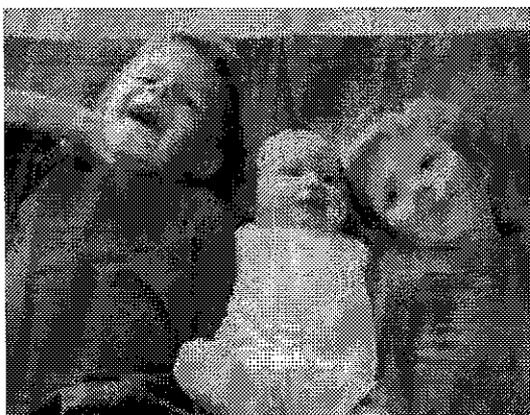


2 INTRODUCTION

Successive Commonwealth Health Departments and agencies have maintained a strong commitment to the promotion and protection of breastfeeding since Australia's endorsement of the World Health Organisation's International Code of Marketing of Breast-milk Substitutes (WHO Code) in 1981.

The areas currently responsible for implementing the WHO Code in Australia within the Health and Aged Care portfolio are the Population Health Division of the Commonwealth Department of Health and Aged Care (DHAC) and the Australia New Zealand Food Authority (ANZFA).

The Minister for Health and Aged Care has requested independent advice on the operation of the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) Panel as a result of discussions held on the 25 October 2000 with the APMAIF Chair, Dr Christine Bennett, Brian Corcoran, First Assistant Secretary, Population Health Division and Ian Lindenmayer, Managing Director, Australia New Zealand Food Authority.



Terms of Reference

The terms of reference for the review is to provide high level independent advice to the Minister for Health and Aged Care and investigate in the following areas:

1. The scope of the current Marketing in Australia of Infant Formula (MAIF) Agreement and its capacity to meet the objectives of the World Health Organisation International Code of Marketing of Breast-milk Substitutes (WHO Code);
2. The current structure and operations of the Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF);
3. Alternative mechanisms and operations of the marketing of infant formula including examination of the links between self and co-regulation approaches;
4. Current international practice concerning the implementation of the WHO Code and specifically the mechanisms for regulation of the marketing of infant formula;
5. Examine whether harmonisation of arrangements with New Zealand should be considered;
6. The regulation of the provision of samples to health professional for professional evaluation; and
7. Following consideration of the above areas, any action which may be required to ensure effective promotion of breastfeeding through the implementation of the WHO Code within Australia.

WHO International Code of Marketing of Breast-milk Substitutes

The World Health Organisation's International Code of Marketing of Breast-milk Substitutes received endorsement from the World Health Assembly in 1981 from all but four member states. Australia was one of the early supporters of the Code at the World Health Assembly.

The WHO Code aims to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding, and by ensuring the proper use of breast-milk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

NHMRC Report of the Working Party on Implementation of the WHO Code

A National Health and Medical Research Council (NHMRC) Working Party was established to consider measures to give effect to the aim and principles of the WHO Code for implementation at Commonwealth, State and Territory levels. The report of the Working Party was released in March 1985.

The recommendations of the report reinforced the importance of support and education for breastfeeding where possible, and included mechanisms for ensuring that the provisions of the WHO Code were adhered to in relation to marketing of breast milk substitutes.

The MAIF Agreement and APMAIF

In response to the NHMRC Report, the Commonwealth government facilitated a self-regulatory model for implementation of the WHO Code in the early 1990s. The resulting voluntary agreement, the 1992 Marketing in Australia of Infant Formulas: Manufacturers and Importers Agreement (MAIF Agreement) covers the marketing of infant formulas by manufacturers.

APMAIF was appointed by the Commonwealth in 1992 to monitor compliance with, and advise the Government on, the MAIF Agreement. As of 1 July 1999 following transfer from Consumer Affairs Division of the Treasury, ANZFA currently holds responsibility for the APMAIF Secretariat services.

APMAIF's roles include investigating alleged breaches of the MAIF Agreement and reporting to the Minister for Health and Aged Care through its annual report, providing advice to the Health Minister on the operation of the voluntary industry code as requested.

The Panel comprises an independent Chairperson (Dr Christine Bennett), a member who represents community and consumer groups (Dr Patricia McVeagh), and a member nominated by the infant formula industry (Mr David Forsythe). The Minister for Health and Aged Care appoints the Chairperson and community representative.

Role of Department of Health and Aged care on MAIF Agreement

DHAC does not have a direct role in the monitoring and regulation of the marketing of breast milk substitutes, but has observer status on APMAIF. This enables the Department to remain informed of current issues relating to the Australian implementation of the WHO Code, and to provide advice to the Panel as required on breastfeeding initiatives funded by the Department.

International Practice in the adoption of the WHO Code

The United Nations International Children Emergency Fund (UNICEF) regularly reviews the progress of countries in adopting the WHO Code (International Code of Marketing of Breast-milk Substitutes) to determine compliance to the minimum standard.

UNICEF has determined that only countries that have adopted legally enforceable measures (enforceable through national legislation and regulations), in implementing the WHO Code are classified as category one. To date just 16 countries fall into this category and it is interesting to note that no major industrialised European nations have category one status.

A further 33 countries have been classified by UNICEF as category two, because they have enacted only some of the model WHO Code provisions. Over half these countries are in the European Union (United Kingdom, Denmark, Finland, France, Germany, Ireland, Norway, Italy, Belgium and Netherlands) and UNICEF comments that most have adopted legislation that is weaker than the WHO Code. In particular the legislation only applies to infant formulas and not to the wider category of breastmilk substitutes, bottles and teats and that advertising is allowed in baby care and scientific publications.

In the United Kingdom, the Baby Feeding Law Group (health professionals and consumer lobby groups), have commented that while the United Kingdom has The Infant formula and Follow-on Regulations 1995, it is weaker than the WHO Code. In particular they believe that the current legislation has a narrow scope, and too many loopholes, which they are actively seeking to change through the parliamentary process.

A total of 49 countries, including Australia and New Zealand have been classified by UNICEF as category three, that are nations which have developed voluntary agreements with infant formula manufactures as the single means of enforcement. UNICEF has noted the Australian approach has proved reasonably successful, with very few violations reported each year. A total of 10 countries have been classified as having taken no steps to implement the Code as determined by UNICEF and interestingly this includes the United States.



In discussions with a number of departmental officers in the Population Health Division a range of activities have been identified, and have been undertaken to support breast feeding in Australia.

The Baby Friendly Hospital Initiative (BFHI)

The BFHI, a joint international initiative between WHO and UNICEF, was announced in 1991. The aim of the initiative was to improve the health of infants through promoting and supporting breastfeeding by eliminating hospital practices which may interfere with successfully initiating and maintaining breastfeeding. The BFHI's "Ten steps to successful breastfeeding" are still being widely used today.

BFHI was funded in Australia by UNICEF until 1995. When this funding ceased, the Australian College of Midwives Incorporated (ACMI) took responsibility for funding and managing BFHI in Australia.

While the Minister for Health and Aged Care, Dr Wooldridge, has publicly supported the BFHI, the Department has not directly funded the initiative. However, the Department has provided indirect support through its funding of the ACMI (representing BFHI) as part of a consortium to develop National Standards for Maternal and Infant Care Services, under the National Breastfeeding Strategy.

Dietary Guidelines for Australians (NHMRC 1991) and Dietary Guidelines for Children and Adolescents (NHMRC, 1995).

Breastfeeding is a key guideline in both of these publications, which are widely used by nutrition and other health professionals. Breastfeeding is the guideline of highest priority in the Dietary Guidelines for Children and Adolescents.

Infant Feeding Guidelines for Health Workers (NHMRC, 1996)

These guidelines were developed to assist health workers to promote breastfeeding and to provide information on the appropriate use of infant formula. The guidelines aim to help all health workers understand how the WHO Code and the MAIF Agreement affect their work in both advising on breastfeeding and on using infant formula.

The National Breastfeeding Strategy (1996-2000)

In the 1996 Budget, the Commonwealth allocated \$2 million over four years to the National Breastfeeding Strategy. The objective of the Strategy is to increase the national incidence and duration of breastfeeding, with a target of 80% of babies being at least partially breastfed at age 6 months by the year 2000. Projects funded under the strategy have focussed on:

- Family education, including fathers
- National accreditation standards for maternal and infant care services
- Employer and workplace support
- Health professional education
- Aboriginal and Torres Strait Islander populations
- Antenatal education
- National breastfeeding monitoring (through the National Nutrition Monitoring and Surveillance Project).

In addition, a grant of \$50,000 per annum for three years from 1998-99 was allocated to the Nursing Mothers Association of Australia to provide infrastructure support for its work in promoting and supporting breastfeeding in Australia.

National Public Health Nutrition Strategy (2000–2010)

Maternal and child nutrition are key focus areas of Stage Two of the National Public Health Nutrition Strategy (NPHNS) currently being developed. The NPHNS will include a number of strategies to promote the benefits of optimal nutrition during pregnancy and lactation, and to increase the initiation and duration of breastfeeding, as articulated in the National Breastfeeding Strategy. The National Aboriginal and Torres Strait Islander Strategy and Action Plan (NATSISAP), a key component of the NPHNS, will also include strategies to improve nutrition for Aboriginal and Torres Strait Islander mothers and to promote breastfeeding.

The NPHNS and NATSISAP are being developed under the auspices of the Strategic Inter-Governmental Nutrition Alliance (SIGNAL), the nutrition arm of the National Public Health Partnership. SIGNAL comprises the Commonwealth and all State Governments key government health research and data agencies and experts in public health nutrition.

This ensures that a national strategic approach is taken in the development of maternal and child nutrition initiatives in the context of general public health.

National Child Nutrition Initiative (2000–2002)

The National Child Nutrition Initiative (NCNI) aims to improve the diet of children from the antenatal stage through the school years, by working with parents and/or carers within community settings. Factors related to nutrition knowledge and skills and access to nutritious foods will be addressed within the Initiative, which will particularly target families from disadvantaged areas, including Aboriginal and Torres Strait Islander families. The Initiative will focus on building community capacity to implement and sustain local-level projects. Support for and promotion of

breastfeeding as optimal nutrition for infants will be an integral part of the National Child Nutrition Project (NCNP), and \$15 million has been allocated to the NCNP over three years.

In holding discussions with Departmental and ANZFA officers, the consultant can advise the current the roles and responsibilities for Childhood /Breast Feeding Policy and the APMAIF Panel is allocated in the following manner across Government.

Role of Department of Health and Aged Care

As indicated above, the primary role of the Department of Health and Aged Care in relation to breastfeeding, is to develop and implement national strategies to support and promote the breastfeeding of infants until at least the age of six months and to promote optimal nutrition for women during pregnancy. DHAC also represents the Australian position on these issues in international forums.

Key roles include:

- ensuring that a focus on breastfeeding is included in all national strategies and policies involving child and maternal nutrition;
- funding projects to support and promote breast feeding, as in the National Breastfeeding Strategy and the National Child Nutrition Initiative;
- maintaining a dialogue with key organisations such as the Nursing Mothers Association of Australia, on issues relating to breast feeding and infant nutrition;
- representing Australia on infant feeding issues in the international arena, including participating in WHO and UNICEF forums; and
- responding to correspondence from Members of Parliament, community groups and individuals where breastfeeding is the primary subject matter of the correspondence;
- In addition the Department has a role to coordinate Commonwealth policy development on public health and safety and consumer protection in relation to food. As part of this role, the Food Policy Section attends APMAIF meetings as an observer and coordinates departmental responses to APMAIF agenda items.

Role of Australian New Zealand Food Authority

In line with its role of establishing the regulatory framework area, ANZFA provides all administrative processes relating to the establishment and functions of the APMAIF. The operation of APMAIF includes, but is not necessarily limited to;

- Providing secretariat services
- Administering funds and industry contributions
- Managing Government appropriations
- Publishing the APMAIF Annual Reports
- Support of an ANZFA Observer at APMAIF Meetings



THE WAY FORWARD AND RECOMMENDATION ON APMAIF OPERATIONS

Overview of the Issues

As a result of listening to the issues and frustrations raised in the first instance, it must be said many issues that have been raised are outside the scope of the current MAIF agreement. Currently there is not a comprehensive long-term strategy to address the 'whole of government' approach to the promotion of breast-feeding across Australia.

It needs to be recognised that the MAIF Agreement and APMAIF are always going to experience difficulties unless the broader issues are addressed over the short to medium term. I would recommend 'a way forward' for the Commonwealth is to establish a Public Health Partnership with State and Territory Governments, managed through the Population Health Division.

Given the importance of infant nutrition for long-term health outcomes, it is an issue of such significance for both the Commonwealth and State/Territory Governments, that all parties might be interested in getting a clear, comprehensive, strategic approach to the promotion of good infant nutrition.

The Public Health Partnership would be a strategy built around the promotion of breast feeding for optimum health outcomes, but would include strategies aimed at mothers that choose not to breast-feed. In particular, once these mothers have made this choice then they and their infants are entitled to informed and accurate information about how best to provide adequate nutrition to assist that child's development.

To give substance to the strategy, I would recommend the establishment of the position of Infant Nutrition Co-ordinator at a National level. This would be a position held by an Australian/International expert in infant nutrition who is highly regarded within the community and has a recognised standing in infant nutrition. The Government needs to give consideration as to whether they would prefer the expert to be working on either a full-time or part-time basis.

The Infant Nutrition Co-ordinator would be supported by a broad-based Advisory Council to advise the Commonwealth State/Territory Governments on the various components of a comprehensive strategy under the Public Health Partnership. In addition, a panel of appointed scientific experts in infant nutrition would be established, who would provide advice as required on an ad hoc basis, to the Infant Nutrition Coordinator on technical issues.

It is recommended that Population Health Division officers would be responsible for providing administrative support to the Public Health Partnership and Commonwealth policy advice on infant nutrition issues to support the work of the Infant Nutrition Coordinator.

A partnership would also provide a frame work for initiatives that State and Territory Governments might take to promote good practices with the Health Services that they fund and operate. Such an approach would allow for initiatives within public and private maternal services to be encouraged that promote breast-feeding. A good example was the UNICEF former role in funding Baby Friendly Hospital Initiative (BFHI) from 1991 to 1995.

The partnership approach will be able to build on the existing BFHI initiatives and provide a framework for seeking to encourage Australian media, and in particular television production of programs that openly encourage a positive role model for breast-feeding in society. It is anticipated that this would be undertaken through popular media personalities and creating role models in the development of Australian TV drama shows.

Secondly the targeting of particular groups to promote breast-feeding initiatives, which are under represented, or who do not have high retention rates of breast-feeding is recommended under the partnership approach. In particular two groups that stand out are women in the workforce and those that come from low socio-economic backgrounds, where breast-feeding is not regarded as the norm, by the women and their partners.

The need for specific initiatives that target groups was identified during the community consultation phase of this report with many good suggestions being provided. Such a strategy would see a sustained effort to lift and further improve breast-feeding rates, and to promote good nutritional practices for mothers who do not or only partly breast-feed, for less than the recommended duration.

In 1995 the National Health Survey (NHS) was undertaken and in particular collected national data on breastfeeding in Australia. Recently this NHS data was reviewed by Dennis Trewin, the Acting Australian Statistician who in 1999 wrote a paper titled "Children, Australian: Social Report 1999". The report determined that although 87% of mothers initially breastfed their child, only 69% continued to do so for 8 weeks or more. By 26 weeks, only 47% of mothers were still breastfeeding. It was found that mothers discontinued breastfeeding for a variety of reasons, most commonly because they were not producing enough milk (32%), or they felt it was time to give up (22%)¹. It is expected that by targeting these two reasons given would lead to a significant improvement in health outcomes and would also provide a better context for the operation of the voluntary agreement with infant formula companies.

There is a need for the Australian retail sector to reach a formal or informal agreement on a code of practice. In particular there is a need for pharmacies and supermarket chains to be included as part of the public health strategy, as there is no doubt that some practices used in the retail sector can undermine promotion of breast-feeding.

The consultant is of the view that there is little chance of the existing MAIF agreement being simplified due to the divergent views held by the industry and consumer organisations.

The problems around the Panel and the MAIF Agreement are more a structural matter rather than

personality driven. The MAIF Agreement is a compromise, and clearly its wording is open to interpretation and the only way forward is for the agreement to be seen in the context of Australia's commitment to the WHO Code. The Panel ought to focus on issues of significance and not get bogged down on minor detail.

Fourthly there is a need for a clear separation of investigation and deliberation responsibilities, and the APMAIF secretariat; wherever it is located ought to have responsibility for receipt and investigation of complaints or breaches under the MAIF Agreement. The Panel will then be able to focus its energy on whether a breach has occurred or not. An appeal process about a Panel decision should be introduced for issues of a technical nature. It is recommended that the appeal be referred to the expert panel set up under the Infant Nutrition Co-ordinator.

The role of this panel will be to provide advice which is expert in nature and to ensure that an element of natural justice comes into play for the infant formula companies that does not currently exist. It is anticipated that this appeal process will take place in the shortest timeframe and the decision will be final, with no other right of appeal. In addition the APMAIF Annual Report should be made available on the Website, after it has been tabled in Federal Parliament by the Minister for Health and Aged Care.

Current Regulatory Framework – MAIF Agreement

The existing MAIF Agreement should remain the basis for the co-regulatory agreement on Infant Formula with no change to the actual agreement. In addition, the Government should consider legislation to create a framework for implementing the WHO code, if Infant Formula Manufacturers withdraw from the existing MAIF agreement.

¹ Children, Australian: A Social Report 1999 by Dennis Trewin, Acting Australian Statistician, ABN Cat No. 4119.0

Harmonisation with New Zealand

The consultant has held discussions with New Zealand Ministry of Health senior staff and reviewed the New Zealand Code of Practice for the Marketing of Infant Formula, which has moved to a self-regulatory Industry Code of Practice in 1996. All manufacturers, marketers and distributors of infant formula operating in New Zealand have agreed to abide by the self-regulatory code, including the appeal process mechanism in which an adjudicator makes the final decision.

Recommendation:

It is clear from discussions with New Zealand officials that there is no interest in New Zealand at this time for harmonisation with Australia.

The existing co-regulation framework as set in the MAIF Agreement should remain in place until 2005 when the matter of harmonisation between Australia and New Zealand could again be reviewed by Senior departmental officers.

In order to promote harmonisation, it is recommended that the MAIF Panel develop closer ties with its New Zealand counterpart. It is recommended that the Panel members and Departmental and ANZFA observers could visit New Zealand in 2001 to strengthen professional links.

In undertaking this review the consultant has discovered a number of criticisms of the administrative arrangements of the APMAIF Panel which has resulted in long lead times investigating breaches under the MAIF Agreement.

The chief area of concern has been the time in which it takes the APMAIF Panel to investigate an official complaint, make a determination on the breach and then notify affected parties. In discussions with community and industry leaders, a high degree of frustration was expressed at the delays in resolving complaints. The industry peak body Infant Formula Manufacturers Association of Australia (IFMAA) advised that it was not uncommon to have to wait between six to nine months before a determination was made, which would mean an infant formula company may have gained an unfair competitive advantage over commercial rivals.

The community representatives also expressed concern at the time it took to investigate a complaint and the Panel's apparent unwillingness also to notify key organisations of decisions over breaches. They also expressed disappointment that the current APMAIF secretariat was unwilling to provide verbal advice on whether possible breaches should be investigated or not. This has resulted in a loss of confidence by key people in the Nursing Mothers Association, the Australian Midwives and the Lactation Consultants Association in notifying the APMAIF Panel of breaches.

The consultant is of the opinion that these delays are further impacting on the considerable friction that exists between the community and industry Panel members.

Investigations undertaken by the consultant have determined that Panel members are involved partially in the investigative process when a complaint is made to APMAIF and that this process adds to considerable delays in the investigation of complaints.

Expert Opinion

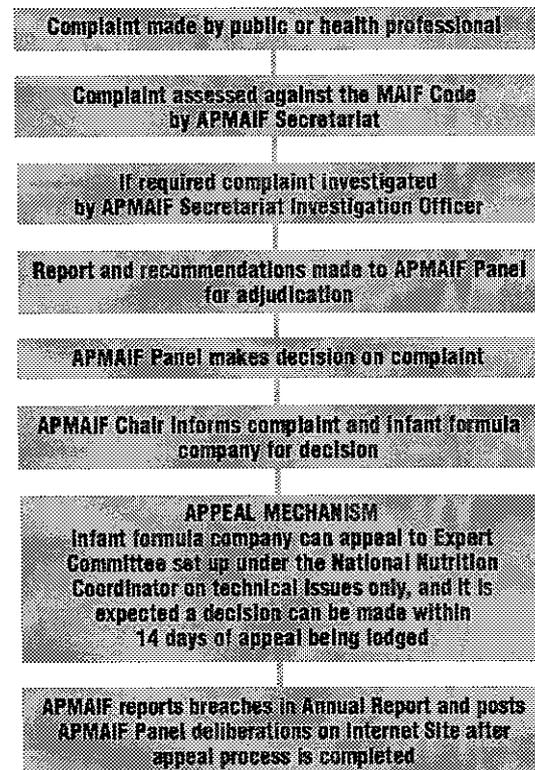
The consultant noted that there was a high degree of concern expressed by the Infant Formula Manufacturers Association of Australia at the "secretive" use of expert opinion when investigating a breach of the MAIF Agreement and the lack of transparency in this process. Industry is particularly concerned that it cannot obtain documentation from APMAIF which sets out why the Panel made a ruling based on the expert opinion.

Recommendation:

A departmental officer is required to be appointed and undertake all aspects of investigation of complaints on the MAIF Agreement, write a report and forward a recommendation to the APMAIF Panel for deliberation at its regular three monthly meetings.

I recommend that APMAIF implements an appeals process to ensure that a natural justice process takes place in relation to investigation of breaches under the MAIF Agreement.

APMAIF Natural Justice Flow Chart for Complaint Investigation



Review of MAIF Agreement

APMAIF has been reviewing the existing MAIF Agreement with a view to making it clearer and more user friendly and to clarify its interpretation. The Panel has preferred to refer to a 'code of conduct' for the revision, in preference to an 'agreement' (the current terminology). There has been widespread consultation by the Panel on the draft industry agreement and all public submissions have been carefully considered.

The Industry Representative on the Panel, Mr David Forsythe has notified the Panel (10 January 1999) that at an Infant Formula Manufacturers Association of Australia (IFMAA) meeting held on 17 December 1999, it was agreed that industry should not proceed any further with the revised Draft Code of Conduct and continue with the existing MAIF Agreement.

IFMAA companies have major reservations about the contents of the draft document, especially in regard to a number of legal issues, which have already been conveyed to APMAIF. At the same time, the Industry is aware of some health sector concerns about the Draft Code of Conduct and believes it would be almost impossible for industry and the health sector to agree on a final Code of Conduct, which is satisfactory to all parties.

Funding of APMAIF

In 1997, industry signatories to the MAIF Agreement agreed on a funding arrangement whereby they would contribute towards the costs associated with the secretariat services, which were then provided by the Consumer Affairs Division of the Treasury.

ANZFA has negotiated with signatories to the MAIF Agreement to continue to fund 70% of the secretariat services (\$70,000 for 2000-2001). These negotiations have been formalised with the IFMAA and invoices have been sent to signatories. The

remaining expenses incurred by APMAIF are funded by a Government appropriation of \$33,500, or approximately 30% of the APMAIF budget.

Recommendation:

That a range of transparent measures should be brought in to address industry concerns about being adequately consulted over budget issues. It is recommended that a Memorandum of Understanding on the agreed budget and secretariat services to be provided, be signed off each year between the IFMAA chairman, the chair of APMAIF and the Secretariat.

Reluctance of Industry members to sign the MAIF Agreement

APMAIF is responsible for the monitoring of compliance with the MAIF Agreement and continues to write to Manufacturers inviting them to become signatories to the MAIF Agreement. Unfortunately a loophole has occurred where Amcal and Guardian have declined to become a signatory to the Agreement, on the basis that the Agreement does not cover retail activities.

Amcal and Guardian have argued to APMAIF that they only retail infant formulas and that their "home brand infant formula product" is manufactured by a third party, (Snow Brand Pty Ltd). This Australian firm is currently a signatory to the MAIF Agreement, and therefore these companies continue to argue to APMAIF that they are not required to sign the Agreement. Nevertheless it remains an issue with many community groups and the APMAIF Panel, that Amcal and Guardian remain outside of the MAIF agreement.

Recommendation:

It is recommended that the Parliamentary Secretary for Health and Aged Care and departmental officers meet with these companies and requested that they sign up to the current MAIF Agreement and this should be undertaken as a priority in 2001.

Bottles and Teats

APMAIF and DHAC continue to receive complaints in relation to the marketing of infant bottles and teats. The WHO Code applies as much to infant bottles and teats as it does to infant formulas, however the MAIF Agreement does not include bottles and teats. This was raised as an area for concern by some Panel members who have expressed a degree of frustration over this situation.

The Federal Bureau of Consumer Affairs (FBCA) began in 1992 to negotiate the introduction of a code of practice for marketing activities with the Baby Products Association (BPA), which represents the manufacturers, and importers of infant bottles and teats. This has not been progressed since 1996 when it was concluded that implementing the code would not be feasible. The Panel prepared a submission commenting on the draft BPA code.

The Panel has acknowledged the complexity of the task but urged the Government to continue efforts to develop an appropriate agreement on marketing of bottles and teats, to reflect the International Code as closely as possible.

It is the consultants understanding that there were significant obstacles to the implementation and changes of the BPA code in that industry would not agree to any changes in the code.

Retailer activity

In its latest Annual Report, APMAIF raised concerns with the marketing practices of retailers and pharmacies. Many of these activities would have constituted breaches of the MAIF Agreement had retailer activity been covered in the Agreement. The Panel considers that this type of activity undermines the work it does with manufacturers and continues to write to manufacturers asking them to notify retailers of the provisions of the MAIF Agreement and requesting them not to promote infant formula products to the public.

The MAIF Agreement has been authorised under the Trade Practices Act 1973, because it contains marketing restrictions. Authorisation is only granted where the public benefit is shown to outweigh any anti-competitive effect. Signatories can legally follow the provision of the authorised Agreement, but could be in breach of the Trade Practices Act 1973 if they agree to further market restriction, which is not covered in the Agreement.

Recommendation:

Priority should be given to the development of a voluntary code of practice for the Retail Industry with particular reference to Pharmacies and Supermarkets across Australia. As a first step, a representative from the retail sector should be appointed to APMAIF.

Panel Membership

The size and composition of the current APMAIF panel have contributed to its present difficulties. With only three people on the panel, stalemates have become common. Personality issues have also had more impact than would be the case with a larger group.

Recommendation:

It is recommended that the Panel membership be expanded to five (5) to ensure that it functions more effectively and creates a more collegiate mentality on the Panel.

In considering an expanded Panel Membership for the APMAIF Panel, the Government should seek people with expertise and experience in:

- Public Health with infant nutrition expertise
- Retailer Pharmacy

At the time of appointing the next Chair, consideration should be given to the selection of a person with legal experience, preferably in the health sector. In addition the community seeks to have a member of the panel who is clearly identified as a consumer.

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CONCLUSION

A Way Forward for Government, Industry and Consumers

The key focal point for the MAIF Agreement and the APMAIF Panel, both now and in the future should be the ability of Government and Industry to co-operate in an open manner in such a way that results in the ongoing successful operation of the voluntary MAIF Agreement.

To ensure that this commitment remains focused for both parties, it is recommended that Government adopt the Public Health Partnership Framework Arrangement. It is felt that this approach will provide the best opportunity for Governments and Industry to resolve issues that remain outside of the current Agreement.

If there is not a commitment by Industry to co-operatively work with Government on issues that are outside the current MAIF Agreement, then it is recommended that serious consideration be given to legislative reform to achieve the required public health outcomes, and ensure Australia's commitment and integrity to the WHO Code remains strong.

