**EXPLANATORY MEMORANDUM TO**
**THE HEALTHY START SCHEME AND WELFARE FOOD (AMENDMENT NO. 2) REGULATIONS 2006**

**2006. No.2818**

## 1. Introduction

1.1 This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.

## 2. Description

2.1 The Healthy Start Scheme and Welfare Food (Amendment No.2) Regulations 2006 ("the Regulations") amend the Healthy Start Scheme and Welfare Food Amendment Regulations 2005, S.I. 2005/3262 ("the 2005 Regulations") and the Welfare Food Regulations 1996, S.I. 1996/1434 ("the 1996 Regulations"). They implement the Healthy Start scheme, introduced by the 2005 Regulations, across the rest of Great Britain. The Healthy Start scheme is being introduced to reform the Welfare Food scheme ("WFS") established by the 1996 Regulations".

2.4 The Regulations are subject to a negative procedure.

## 3. Matters of special interest to the Joint Committee on Statutory Instruments

3.1 None.

## 4. Legislative Background

4.1 The Regulations are made under section 13 of the Social Security Act 1988 ("the 1988 Act") as substituted by section 185 of the Health and Social Care (Community Health and Standards) Act 2003 ("the 2003 Act") (benefits under schemes for improving nutrition: pregnant women, mothers and children). They also rely on section 13 as saved by the Health and Social Care (Community Health and Standards) Act 2003 (Savings) Order 2005, S.I. 2005/2279.

4.2 The Regulations amend the 2005 Regulations, amongst other purposes to apply the Healthy Start scheme to Great Britain, and the 1996 Regulations. The provisions of section 185 of the 2003 Act in so far as not in force are to be commenced on 27th October 2006 by the Health and Social Care (Community Health and Standards) Act 2003 (Commencement) (No. 10) Order 2006, S.I. 2006/[ ]. Commencement of those provisions will provide the National Assembly for Wales with powers to prescribe the descriptions of food in relation to the operation of a scheme in Wales and to direct a body

administering a scheme (or part of a scheme) in relation to matters relating to the operation of the scheme (or that part of the scheme) in Wales.

4.3 An order under section 63 of the Scotland Act 1998, the Scotland Act 1998 (Transfer of Functions to the Scottish Ministers etc) (No. 3) Order 2006, is intended to be laid before the Scottish Parliament and Parliament. The Order is intended to provide for the transfer of powers to prescribe the descriptions of food in relation to the operation of a scheme in Scotland and to direct a body administering a scheme (or part of a scheme) in relation to matters relating to the operation of the scheme (or that part of the scheme) in Scotland. The powers are contained in section 13(1) and (7) of the 1988 Act. The Order is also intended to provide for transfer to the Scottish Ministers of payment and reimbursement functions in relation to Healthy Start food vouchers and Healthy Start vitamins provided to beneficiaries in Scotland. The payment and reimbursement functions will be contained in regulations 5(2), 5A(2), 8A(7), 10(4) and 14 (2) of the 2005 Regulations following amendment by the Regulations.

## 5. Extent

5.1 This instrument extends to Great Britain.

## 6. European Convention on Human Rights

6.1 As the instrument is subject to negative resolution procedure and does not amend primary legislation, no statement is required.

## 7. Policy background

7.1 The WFS was established in 1940 as a wartime measure but was subsequently targeted at children in low-income families. It currently provides free milk, infant formula milk and vitamins to approximately 720,000 claimants (pregnant women and children under 5 years old) in families on qualifying benefits.

7.2 New powers were taken in the 2003 Act to reform the WFS. The Healthy Start scheme provides fresh fruit and vegetables as well as liquid milk and infant formula milk to eligible beneficiaries. Phase 1 of Healthy Start was introduced in Devon and Cornwall on 28 November 2005. Phase 2 is intended to be introduced by these Regulations across the rest of Great Britain on 27 November 2006.

7.3 A rapid evaluation of phase 1 of Healthy Start in Devon and Cornwall was undertaken to test the impact and the processes underpinning the scheme. The evaluation results were positive and as a result minimal changes have been made to the 2005 Regulations to implement phase 2.

7.4 The eligibility criteria for Healthy Start vouchers remains largely unchanged. However, the upper age limit for children receiving Healthy Start vouchers will be reduced from the 5th birthday to the 4th birthday with the introduction of phase 2 of the scheme. Those children already aged 4 on 27 November 2006 will not qualify for Healthy Start benefits. Letters have been sent to beneficiaries affected by the impending change.

7.5 The provision in the 2005 Regulations for all pregnant under 18 year olds to receive Healthy Start vouchers, regardless of their income, will apply across Great Britain from 27 November 2006.

7.6 Healthy Start beneficiaries will also be entitled to Healthy Start vitamins from 27 November 2006.

## 8. Impact

8.1 A Regulatory Impact Assessment has been prepared to accompany these Regulations. The impact of these Regulations on the private or voluntary sector is expected to be negligible. However, there may be a small impact on milk roundsmen if customers choose to use their vouchers for fruit and vegetables or with retailers who sell milk more cheaply.

## 9. Contact

9.1 For further information please contact Justine Currell at the Department of Health , Wellington House, 133-155 Waterloo Road, London, SE1 8UG.] Tel: 020 7972 4434 or e -mail: Justine.Currell@dh.gsi.gov.uk.

## FULL FINAL REGULATORY IMPACT ASSESSMENT

*This version of the RIA relating to reform of the Welfare Food Scheme has been updated in June 2006 light of the initial introduction of Healthy Start vouchers in Devon and Cornwall*

### 1. TITLE OF PROPOSED MEASURE

1.1 The Healthy Start Scheme and Welfare Food (Amendment No 2) Regulations 2006

## 2. PURPOSE AND INTENDED EFFECT

### Objective

2.1 These Regulations make further provisions to reform the Welfare Food Scheme (WFS). Specifically, they build on the Healthy Start Scheme and Welfare Food (Amendment) Regulations 2005 by extending Healthy Start vouchers across Great Britain. They also amend the upper age limit for qualifying children to receive vouchers from the 5th birthday to the 4th birthday. This planned change was announced by the Department of Health in 2004 as part of the overall reform package.

2.2 The purpose and intended effect of reform is to:

i) Improve the WFS to better meet the nutritional needs of beneficiaries, within existing budgets.
ii) To use the resources of the WFS more effectively to ensure that children in poverty have access to a ''healthy'' diet and to provide increased support for breastfeeding and parenting (NHS Plan, 2000).
iii) To provide a nutritional safeguard for those pregnant women and children in disadvantaged families.
iv) To increase the flexibility of the WFS to better reflect current dietary requirements;
v) To forge closer links with the NHS to ensure that beneficiaries have access to information and advice about breastfeeding, healthy eating and living.
vi) To improve the health outcomes of disadvantaged families
vii) To contribute to the reduction in childhood obesity by supporting low-income families to make informed choices about eating a varied and healthy diet.

2.3 The 2006 Regulations will apply in England, Scotland and Wales. Northern Ireland is making separate Regulations to introduce equivalent reforms at the same time.

### Background

Legislative

2.4 Prior to autumn 2005, the legislation governing the WFS in England, Scotland and Wales was contained in the Social Security Act 1988 and the Welfare Food Regulations 1996. On 28 November 2005, the Healthy Start Scheme and Welfare Food (Amendment) Regulations 2005, came into force, revising the 1996 Regulations. The key purpose of the 2005 Regulations was to introduce Healthy Start vouchers to Devon and Cornwall for a period of evaluation and testing in advance of their launch nationwide (Phase 1 of Healthy Start implementation).

2.5 This RIA is a revision of the full and final RIA published alongside the 2005 Regulations (which was in itself developed from earlier versions published with the 2002 policy consultation on proposals for WFS reform and the Health and Social Care (Community Health and Standards) Bill 2003 which contained powers to enable reform. It takes into account the early practical impact of the voucher scheme in Devon and Cornwall, which have been independently evaluated.

2.6 The Healthy Start Scheme and Welfare Food (Amendment No 2) Regulations 2006 will not impact upon any other Regulations or policies outside of the current Regulations governing the Welfare Food Scheme and Healthy Start.

Policy

2.7 The first scientific review of the WFS since its inception in 1940 was undertaken in 1999 by the Panel on Maternal and Child Nutrition of the Committee on the Medical Aspects of Food and Nutrition Policy (COMA).

2.8 COMA concluded that whilst the WFS retained great potential for improving the health of nutritionally vulnerable pregnant women, mothers and young children, there were significant flaws within it. The review said that it:

- does not meet the wider nutritional needs of pregnant women and young children, who would benefit from a wider choice of foods to help address health inequalities;
- is a disincentive to breastfeeding;
- provides up to twice as much infant formula as 6-12 month olds need;
- may provide too much milk for 1-5 year olds; and
- does not effectively promote awareness or uptake of free vitamin supplements.

2.9 As a result of the COMA review the Government committed to reforming the WFS within existing budgets to reflect the review's recommendations.

**Rationale for Government Intervention**

2.10 *The Independent Inquiry into Inequalities in Health* (1998), chaired by Sir Donald Acheson, considered evidence relating to health inequalities. It concluded that policies aimed at addressing health inequality issues were particularly important for young women, pregnant women and young children, and recommended "improving the health and nutrition of women of childbearing age and their children, with priority given to the elimination of food poverty and the reduction of obesity". In particular, it found that:

- low birth-weight is closely associated with death in infancy as well as being associated with increased risk of coronary heart disease (CHD), diabetes and hypertension in later life;

- infants whose mothers are obese have a greater risk of developing coronary heart disease in later life; and

- obesity is more prevalent in lower social groups and particularly in women – 28% of women in social class V in England are obese, compared to 14% in social class I (1998).

2.11 Accordingly, the Inquiry emphasised the importance of policies aimed at reducing health inequalities and recommended that "*improving the health and nutrition of women of childbearing age and their children, with priority given to the elimination of food poverty and the reduction of obesity*".

2.12 Further risks were highlighted by an economic review group chaired by Dr Pat Troop, Department of Health's Deputy Chief Medical Officer in 2000, which considered:

> *"options for the future of the Welfare Food Scheme that would provide children, expectant and nursing mothers in low income families with access to a high quality diet, and to reduce health inequalities".*

2.13 The review group estimated that the absence of the WFS would result in a significant reduction in beneficiaries' incomes, which could be assumed to harm health.

2.14 The NHS Plan (2000) also set out the need to ensure that children have a healthy start in life recognising the importance of improving infant and child nutrition to positively impact on health outcomes in later life. To do this it recognised the importance of modernising and reforming current services and delivery to better meet current challenges facing the NHS.

2.15 The COMA review assessed the contribution of the WFS to the prevention of adverse nutritional outcomes for the most vulnerable groups (see above). It concluded that whilst the effectiveness of the Scheme was difficult to assess due to the absence of any comparable baseline cases, it nevertheless:

- meets all of the nutritional requirements of young infants (0-6 months);and
- provides an important safety net for the 0-6 month group who have high growth potential and vulnerability to disease;

2.16 As part of the review of the WFS, COMA concluded that the provision of 1 pint of liquid milk per day together with 1/3 pint of milk for those children in daycare was excessive, and could have a detrimental effect on appetite for other healthy foods. Children receiving WFS tokens and 1/3 pint of milk through daycare would continue to receive excessive amounts of milk if the current scheme were not amended. This could impact upon the recommendations about the importance of a balanced healthy diet for positive long term health outcomes. Introducing an element of flexibility into the scheme would help to remove this concern.

## 3. CONSULTATION

### Within government

3.1 The original review group which undertook a full economic appraisal on options for the future of the WFS comprised officials from the Department of Health, the Department of Social Security, the Department for Education and Employment, HM Treasury and the Devolved Administrations. The Department for the Environment, Food and Rural Affairs, the Small Business Service and the Office of Fair Trading have also been consulted on the proposals.

### Informal consultation

3.2 The views of health professionals and beneficiaries were canvassed during the 1999 review and helped to shape the proposals for the new Scheme.

3.3 The focus groups conducted by the Department of Health following the COMA review reported that parents: A conference convened by the Maternity Alliance:

- were unanimous in their approval of the tokens because they said *"that way you always know that the baby gets the milk";* but
- thought that there were problems in exchanging 7 pints of milk for single token because some milk could become unusable by the end of the week.
- Further focus groups with parents highlighted several key points including:
- the lack of knowledge and information about the WFS – even among health professionals;
- breastfeeding mothers should get the same benefits as other mothers; and
- the need for greater flexibility in delivering the scheme benefits – in particular, there should be more outlets for infant formula.

3.4 A conference convened by the Maternity Alliance:

- endorsed many of the COMA review recommendations, including the proposal to widen the range of foods in the WFS;
- reiterated the WFS's importance for mothers and young children and emphasised the need for greater flexibility in delivery;
- suggested improved support for breastfeeding, the wider availability of infant formula (to ensure that NHS was not giving out mixed messages about the benefits of breastfeeding) and reduced entitlement to infant formula for infants over 6 months, as recommended by COMA;
- highlighted some support for abolishing nursery milk to free up resources in the WFS for better targeting; and
- identified an opportunity to add value to the tokens through better public health and information.

**Public consultation**

3.5 Policy proposals for a replacement scheme, launched for public consultation on 28 October 2002 explored the options for action within the overall framework. As part of the consultation process on these proposals, the Department of Health convened meetings and well attended active listening events to explore ways of making the proposes scheme work effectively. These included the dairy industry, large and small retailers, infant formula manufacturers, doorstep deliverers, health professionals, beneficiaries and voluntary organisations.

3.6 Over 500 written responses were received to the 2002 consultation. A summary of these responses, which indicated overwhelming support for the need for reform, was published in March 2003 (www.dh.gov.uk). We continued to talk to key stakeholders after this summary was published.

3.7 Enabling powers for the introduction of one or more schemes to replace the WFS were included in the Health and Social Care Bill 2003. During the passage of this Bill, the

Government agreed to consult on the draft Regulations for the implementation of Healthy Start.

3.8 The Government's formal response to the policy consultation, published in February 2004, therefore reflected comments made during the Parliamentary debates as well as the responses to the original public consultation exercise, listening events and ongoing dialogue with stakeholders. It set out our policy intentions for a new Scheme, Healthy Start, which would be tested before full introduction throughout Great Britain.

3.9 Draft regulations for Phase 1 (introduction of Healthy Start vouchers in Devon and Cornwall) were published for a further period of consultation ending on 26 April 2005. A total of 80 responses were received from a variety of stakeholders including NHS representatives, health professionals, industry and industry bodies. Many of the responses focused on the overall policy direction with very few responses commenting on the Regulations themselves. No substantial changes were made to the Regulations as a result of the consultation, and they came into force on 28 November 2005.

**Independent Evaluation of Phase 1 of Healthy Start**

3.10 An independent rapid evaluation of the early impact of Healthy Start in Devon and Cornwall was commissioned by the Department of Health in autumn 2005, and carried out by Symbia-Tavistock. An executive summary of the evaluation report, with recommendations, was published on the Department of Health website in July 2006.

3.11 The evaluation used a variety of tools to gather quantitative feedback from health professionals, retailers and beneficiaries. These included postal and telephone surveys, interviews and case studies. Researchers also examined processes employed by contractors involved in issuing vouchers and recruiting and paying retailers.

3.12 Findings of the evaluation were largely positive, and indicated that overall the introduction of Healthy Start in Devon and Cornwall had been successful. Some key points made were that that:

- most health professionals were aware of the scheme and how to apply it, or else knew where to go for information and support
- retailer recruitment, registration and payment processes were effective and well received by retailers themselves
- information provided to potential and actual beneficiaries was clear, straightforward and comprehensive
- over half of beneficiaries surveyed had said they were buying more fruit and vegetables since the scheme was introduced, and that after some initial teething problems, exchange at retailers was generally working well.

3.13 A number of recommendations were made to support national roll-out of Healthy Start, these included that:

- the Department of Health aim to provide information about Healthy Start for NHS staff in a variety of different ways, and pitched at different levels/types of

staff. This information would be improved by including good practice examples that have come to light during Phase 1.

- The Department specifically highlight the links between Healthy Start and specific public health policy objectives (eg obesity, health inequalities) in communications about Healthy Start

- That some form of learning network be established to facilitate delibery of the programme at local and regional levels.

3.14 The findings of the evaluation, continuing discussions with stakeholders, and feedback received via public helplines and the Healthy Start website, have all been taken into account in drafting the Healthy Start Scheme and Welfare Food (Amendment No 2) Regulations 2006, and in planning for their implementation.

## 4. OPTIONS

4.1 Four key options for reform were originally considered in light of the recommendations put forward by COMA:

Option 1 - Implement a scheme such as that set out in the Healthy Start Regulations

Option 2 - Retain the existing Welfare Food Scheme (i.e. do nothing)

Option 3 - End the means tested element of the Welfare Food Scheme, but increase cash benefits to compensate

Option 4 - End the means tested element of the Welfare Food Scheme, with no compensation to beneficiaries.

4.2 All of the above options were considered, however, option 1 was deemed to be the most appropriate as it fully met the objectives set out in part 1 of this Regulatory Impact Assessment.

4.3 The existing WFS could be retained, however the review of the scheme by COMA concluded that the scheme needed to widen its nutritional base to provide effective support to pregnant women and young children. It also concluded that excessive milk is not beneficial to young children as it suppresses their appetite for other healthy foods. The current scheme also requires beneficiaries to exchange their voucher for 7 pints of milk in one transaction. This can sometimes mean that the milk becomes unusable by the end of the week. The proposed option to introduce Healthy Start vouchers would provide greater flexibility as a range of healthy foods can be obtained.

4.4 Ending the current means tested element of the scheme in favour of increasing cash benefits to compensate could result in those most needing nutritional support not getting it. Ring-fencing a particular amount for the exchange of healthy foods is the best way to support and encourage beneficiaries to consume a healthy diet. One particular risk with this option is the concern that additional cash benefits will be

spent on other household bills rather than healthy foods for the pregnant woman or child.

4.5 Again ending the means tested element of the scheme would remove the nutritional safety net currently in place to ensure those in the most disadvantaged circumstances receive vital help and support. Low-income families are more likely to consume a diet that is less healthy. By creating an opportunity to obtain healthy foods as part of a voucher, scheme beneficiaries can be encouraged to eat a more varied and balanced diet. This option would save the Department money, however, there would be no financial assistance available low-income families for healthy foods. This would pose a risk, particularly to children in low-income families who may not otherwise have access to healthy foods as a result of lack of available income.

4.6 Further details about how the scheme would operate are set out below.

**Option 1 – Introduce Healthy Start (already in progress)**

4.7 Healthy Start will maximise opportunities for healthcare professionals to offer good quality information and advice on nutrition, diet and health to beneficiaries, and to focus on promoting breastfeeding as well as offering practical support to mothers who are breastfeeding. This will enhance their public health role, in a way that is consistent with the standards included in the National Service Framework for Children, Young People and Maternity Services, as well as supporting delivery of the White Paper.

4.8 We also wanted to redesign the WFS to be the type of Scheme that pregnant women and families participating in it want it to be. This means it has to offer beneficiaries much greater choice and flexibility and support them to make healthy lifestyle choices whilst respecting their rights to make decisions.

4.9 Key features of the new scheme are:

- A broader range of foods (fresh fruit and fresh vegetables are being added to cow's milk and cow's milk based infant formula at the outset, and this range will be kept under review);
- Fixed value vouchers rather than volume-based tokens that can be exchanged in the widest possible range of participating retail outlets, including food co-operatives and community shops as well as supermarkets, milk roundsmen, greengrocers, farmers markets and others;
- Closer links with the NHS enabling the scheme to become the vehicle for delivering advice and information on diet, exercise, and other health issues to qualifying pregnant women and families; and
- Equal value benefits for breastfeeding and non breastfeeding mothers.

**Phased Introduction of Healthy Start**

4.10 The full programme comprises:

- Introduction of a new application process for pregnant women qualifying for the existing WFS tokens was put in place (achieved 1 October 2004)

- Phase 1: Introduction of Healthy Start vouchers into Devon and Cornwall for a period of evaluation, with simultaneous minor revision of some qualifying criteria for receipt of both WFS tokens and Healthy Start vouchers, and removal of entitlement for certain families to purchase low-cost infant formula (achieved 28 November 2005)
- Phase 2: Roll out of Healthy Start vouchers across Great Britain and simultaneous reduction of upper age limit for children to receive vouchers to 4th birthday (proposed for 27 November 2006)
- Consider revising arrangements for reimbursing daycare providers for milk given to children under 5 in their care (yet to be timetabled)
- Evaluation of the impact and effectiveness of the scheme, with further revisions being made as appropriate (monitoring of Phase 1 completed June 2006, plans for evaluating phase 2 in development)

**Voucher value**

4.11 The weekly voucher value was set for Phase 1 at £2.80, with double vouchers payable to qualifying families with a child aged 0-12 months old. Babies born early receive double vouchers until 12 months after the expected date of delivery. We propose to carry forward these values to Phase 2.

**Healthy Start foods**

4.12 We also propose to carry forward the current range of Healthy Start foods to Phase 2. This means that beneficiaries will be able to use their vouchers to buy fresh fruit and vegetables as well as liquid milk (including semi skimmed and skimmed) and cow's milk based infant formula. It is our intention, over time, to expand the range of foods for which vouchers may be exchanged possibly to include other foods that meet the 5 A DAY composite criteria that are currently being developed. It is anticipated that the composite criteria will have been agreed by late 2006 and then subsequently adopted by manufacturers and retailers.

**Entitlement to vouchers**

4.13 Existing WFS qualifying criteria were in the main carried forward to Healthy Start Phase 1 and we propose to carry them forward again to Phase 2. Differences between WFS and Healthy Start eligibility criteria are set out below.

<u>Pregnant women under 18 years old</u>

4.14 Entitlement to vouchers is given in Healthy Start to all pregnant teenagers under 18 years old, regardless of whether they are receiving any of the qualifying benefits that older pregnant women must receive to qualify for vouchers. Entitlement to vouchers for pregnant under 18 year olds ends at the baby's birth unless a qualifying benefit is claimed by the family. The majority are likely to go on to be awarded Child Tax Credit and to fall within the income threshold set for voucher receipt..

<u>Pension Credit guarantee credit</u>

4.15 In view of the increases in the value of PCgc, receipt of PCgc as a qualifying criterion in its own right was removed for both for Healthy Start and the Welfare Food Scheme from 28 November 2005. However, affected families can still qualify if they are in receipt of Child Tax Credit and not Working Tax Credit with income below the set threshold.

Disabled children aged 5 -16

4.16 Welfare Food Scheme entitlement of children aged 5-16 not registered at a school as a direct result of their disability was also discontinued from 28 November 2005. A one-off goodwill payment has since been made to the very small number of families with disabled school age children who were receiving support from WFS on that date**.**

Provision of low cost infant formula

4.17 Entitlement to low-cost infant formula of those families with children under 1 year old in the past purchased it through the NHS was removed throughout Great Britain from 28 November 2005.

Asylum Seekers

4.18 The Welfare Food Scheme did not provide support to asylum seekers who are pregnant or have young children, and Healthy Start does not do so. Their needs are met by the National Asylum Support Service (NASS) and this principle has been reinforced by the High Court. However, the NASS has said that it will review the benefits it provides to pregnant asylum seekers and those with very young children who are in financial hardship in parallel to the introduction of Healthy Start.

Children aged 4 years

4.19 In the Government response to the Healthy Start consultation published in 2004, we said consideration would be given to reducing the upper age limit for children to receive Healthy Start vouchers from their 5$^{th}$ birthday to their 4$^{th}$ birthday. This was to ensure that we could give greatest support to those in most need by allocating resources to those beneficiaries. There is also a nutritional basis for this reduction in the maximum age, as COMA considered that the current means tested provision of 1 pint of milk a day to these children, combined with the 1/3 pint of milk per day they receive if they are in nursery or day care is excessive. The planned change was later confirmed in the February 2005 consultation paper on draft Healthy Start regulations.

4.20 We propose to make this change across Great Britain at the outset of Phase 2 of Healthy Start, as previously announced. Affected families have already been advised of the change and the reasons for it. The reduction in the maximum age enables the Government to implement the new entitlement for all pregnant teenagers under 18 and to provide double vouchers to each family with a child under aged one up until the first birthday of the child or 12 months from its Estimated Date of Delivery, whether or not the child is breastfed.

**Arrangements for paying daycare providers for supplying milk to children under 5**

4.21 Priority is being given to introducing Healthy Start vouchers across Great Britain as these vouchers are specifically targeted at pregnant women and young children in families on very low incomes, who are the most nutritionally vulnerable. We have therefore decided not to propose changes to the current Welfare Food Scheme arrangements for paying daycare providers for supplying daily milk to children under 5 attending for 2 or more hours at Phase 2.. Instead, we propose that the provisions set out in the Welfare Food Scheme Regulations 1996 which govern these payments will continue to have effect for the time being. Changes to this element of the Welfare Food Scheme will be developed and timetabled at a later date.

**How qualifying women/families will access Healthy Start**

Transfer of Welfare Food Scheme Beneficiaries to Healthy Start

4.22 As a transitional measure for Phase 1. all those in Devon and Cornwall who were receiving WFS tokens when Healthy Start was introduced were automatically moved on to Healthy Start. They were not required to make a specific application for Healthy Start unless or until their qualifying status changed – for example by becoming pregnant, or ceasing to qualify more than 3 months and then re-qualifying. We propose to carry this transitional provision forward to Phase 2 (except in relation to children receiving WFS tokens but who have reached their 4th birthday, as discussed above).

Application procedure

4.23 All newly qualifying women and families will be subject to the new application procedure. They will need to complete a simple application form that includes confirmation from a health care professional that appropriate advice and information on nutrition has been offered. The form will be very similar to that introduced across Great Britain for pregnant women applying for the WFS, and modified for use during Phase 1.

4.24 As we have previously said, their role in the application process will give health professionals an opportunity to identify those in their community who need extra help to establish a healthy diet and to breastfeed. Health professionals will not be required to endorse applicants declarations about which qualifying benefits they receive – this will be verified when application forms are processed.

4.25 The application process will also give health professionals the opportunity to remind pregnant women about the Sure Start Maternity Grant (for which a woman can apply when she has reached the 30th week of pregnancy).

Beneficiaries who cease to qualify/re-qualify for Healthy Start in a short space of time

4.26 There are some beneficiaries whose circumstances, and therefore their eligibility for Healthy Start benefit, may change on a regular basis - for example as they move in and out of short-term employment. To ensure that they do not repeatedly have to reapply for Healthy Start, the regulations for Phase 1 provided for those who re-

qualify for it within 3 months of ceasing to qualify, to begin receiving vouchers again as soon as they have notified the Department's contractors of their re-entitlement and this has been confirmed by, for example, Her Majesty's Revenue and Customs. We propose to carry this arrangement forward to Phase 2.

**The role of Health Professionals in giving advice on nutrition/breastfeeding**

4.27 Health professionals will give appropriate advice at the time of application, and at other opportunities that may arise later. However, apart from confirming the pregnancy and signing the application form, their precise role is not enshrined in the Regulations. To assist with the introduction of Healthy Start, awareness training was provided to a selected number of health professionals prior to the implementation of Phase 1, and they were asked to cascade this to relevant colleagues. An independent evaluation of the effectiveness of this training, carried out by Symbia-Tavistock as part of its broader project to evaluation the impact of Phase 1, indicated that the training had been - on balance - effective. However, in light of other recommendations made by Symbia-Tavistock on the need to provide information to health professionals and NHS staff in multiple ways, to accommodate the need of a very broad range of staff with different levels of qualification and need, and make more explicit the links between Healthy Start and public health strategic objectives, twe are adopting a different approach for Phase 2.

4.28 We intend to adopt a multi-faceted approach for providing health professionals with the information they need to support Healthy Start at a local level for phase 2. Information packs will contain all the information health professionals need to signpost families to Healthy Start and to provide relevant healthy living advice. Health professionals will be encouraged to link Healthy Start with local initiatives that will support families in eating a healthier diet, and to encourage breastfeeding as the best form of nutrition for infants.

4.29 The core standards of the National Service Framework for Children, Young People and Maternity Services sets out the role that health professionals are expected to play in Healthy Start. It says, "*Healthy Start offers Primary Care Trusts and health professionals a tool for identifying local disadvantaged pregnant women and their families, and for ensuring that local services meet their needs. This will assist effective local delivery of services in a way that reduces inequalities".*

4.30 We anticipate that healthcare professionals will be based in a range of settings in future and it is possible that in disadvantaged areas the midwives/health visitors delivering Healthy Start could be based in Sure Start Schemes or Children's Centres. This could provide opportunities for partnerships between the NHS, Sure Start schemes, voluntary sector and local authority initiatives targeting disadvantaged groups. These might include, for example, community food initiatives in order to provide focused and effective practical support to disadvantaged pregnant women and families with young children.

**Healthy Start Food Outlets**

<u>Registration process</u>

4.31 All Healthy Start foods that vouchers can be exchanged for will be supplied through participating retailers/food outlets. We are aiming to maximise the number and range of food outlets who accept Healthy Start vouchers. All existing WFS suppliers will be contacted and encouraged to register before Healthy Start is introduced in their area. Additional food outlets will be actively recruited through as many routes as possible. Almost 1000 individual retail outlets registered to accept vouchers in Devon and Cornwall during Phase 1, doubling the number of retailers on the Welfare Food Scheme supplier database for those counties. We fully expect this rate of increase to be maintained across Great Britain.

4.32 Retailers complete a simple registration process set out in the regulations that will require each food outlet to agree to supply one or more of the relevant foods, to abide by the rules of Healthy Start, and to provide details of a bank account into which payments can be made using the BACS system. We propose to carry these arrangements forward to Phase 2. Retailers who commented on the arrangements during the rapid evaluation of Phase 1 did not find the registration process difficult and were generally satisfied with the smoothness and speed with which payments were made.

4.33 Food outlets will continue to be registered as long as they continue to meet these simple criteria, and as long as they are actively accepting vouchers (although a food outlet may be barred from the Healthy Start Scheme if they infringe the rules). However, if a given food outlet has not claimed payment for vouchers for a period of 1 year, and has not notified his/her intent to remain on Healthy Start, then registration of that food outlet will cease. This will ensure that the central database is up to date and provides an accurate record of the number, range, and spread of active Healthy Start food outlets.

4.34 Payment will be at the value of the voucher. Food outlets will be encouraged to submit applications for payment on a regular basis to prevent vouchers that have been exchanged but not submitted for payment building up in retail premises. We propose to carry forward the new time limit for claiming payment of 6 months from the expiry date of vouchers that was introduced for Phase 1. We understand that this is consistent with practice in relation to commercial vouchers and retailers did not express any difficulty with it. This shorter time limit will enable voucher usage to be monitored more closely and any problems, including those that could indicate possible fraud, to be picked up and dealt with quickly.

4.35 The reimbursement period for WFS milk tokens will be reduced from 2 years to 6 months to bring the scheme to an effective close. Retailers will be advised of this change prior to the implementation of Healthy Start. This means that all milk tokens accepted by retailers must be submitted for payment by the end of May 2007.

**Risks**

<u>Potential adverse nutritional outcomes</u>

4.36 The COMA review considered those adverse nutritional outcomes that are more frequently associated with the most vulnerable groups such as those in lower social classes and those on low incomes. Failure to meet the wider nutritional needs of

beneficiaries in these groups could potentially increase the risk of these adverse nutritional outcomes:

| Group | Adverse nutritional outcomes |
|---|---|
| Pregnant women and mothers | lower uptake of peri-conceptional folic acid supplements<br>lower dietary intake during pregnancy<br>vitamin D deficiency |
| Infants | lower levels of breastfeeding (see below)<br>earlier introduction of solids (see below)<br>increased risk of failure to thrive. |
| Young children | increased risk of iron deficiency anaemia<br>increased risk of vitamin D deficiency<br>increased risk of dental caries |
| School aged children | poor dietary patterns<br>increased risk of obesity in childhood and in the longer term |

4.37 Options 2, 3 and 4 do not contribute effectively to ensuring that potential adverse nutritional outcomes are minimised. In addition, ending the means tested element of the WFS completely, or increasing cash benefits to compensate, could pose a risk to those most nutritionally vulnerable. This is because we could not ensure that the increase in cash benefits would be used to buy healthy foods thus removing any nutritional safety net for low-income families. Implementing such an option would therefore have a detrimental effect on the diet of pregnant women and young children currently receiving support through the WFS. In addition the dairy industry would object any moves to completely remove access to milk through the WFS.

<u>Breastfeeding and the provision of health advice</u>

4.38 The COMA review also concluded that the current WFS is a disincentive to breastfeeding.

4.39 There is clear evidence that breastfeeding confers both short and long term health benefits for both the mother and the infant/s. Breastfeeding appears to have a protective effect against the most common infectious illnesses that require infants to be admitted to hospital. For example, babies who receive infant formula are five and half times more likely to be admitted with gastro-enteritis when compared with breastfed babies.

4.40 There is also a correlation between social class and breastfeeding: only 67% of babies born to mothers from routine and manual occupations in England were initially

breastfed (Interim IFS results 2005), compared to 89% in managerial and professional occupations.

4.41 The WFS in its current form acts as a disincentive to breastfeeding as the value of the benefit for non-breastfeeding mothers (who are entitled to 900g of infant formula) outweighs the value of the 7 pints of liquid milk provided to breastfeeding mothers.

4.42 Scope for encouraging breastfeeding within the Scheme is also very limited as milk tokens are sent directly to beneficiaries. Contact with the NHS and primary care services is therefore not a core component of the Scheme and valuable opportunities for linking the provision of the benefit to health advice are being missed.

## 5. COSTS AND BENEFITS

### Business Sectors Affected

5.1 The dairy industry as a whole is likely to be affected by the proposed changes as milk supplied under the Welfare Food Scheme accounted for around £70m of milk sales (GB) in 2005-6. The estimated figures for 2002 show that approximately 40% of WFS liquid milk was then supplied to milk token beneficiaries by around 8,400 doorstep deliverers. This figure has since declined steadily to 32% in 2005 and approximately 28% in 2005-6.

5.2 The number of doorstep deliverers who stated that the WFS accounted for more than 7.5% of their sales in 2005-6 was 26. The introduction of Healthy Start may impact the greatest on this very small number of doorstep deliverers should beneficiaries chose to exchange their Healthy Start vouchers elsewhere. For phase 1, we assumed that approximately 1-2 doorstep deliverers at most might become unviable at most in the Devon and Cornwall area as a direct result of Healthy Start but it is not possible to verify if this was the case. 156 doorstep deliverers were registered for WFS in Devon and Cornwall before Healthy Start was introduced. 71 individual doorstep deliverers/milk delivery businesses have chosen to register for Healthy Start, of whom 14 are providing either fruit or vegetables or both in addition to liquid milk.

5.3 For Phase 2 our worst case estimate on numbers of milk rounds becoming unviable as a direct result of the introduction of Healthy Start would be 26 based on the number stating that WFS accounts for more than 7.5% of their sales, and assuming that all of these would experience a complete loss of WFS sales as a result of customers going elsewhere to use their vouchers.

5.4 However, the dairy industry estimated in 2002 that up to 1,500 milk rounds across Great Britain may become non-viable following full implementation of Healthy Start. On the basis of these figures, it could affect 630,000 doorstep customers and reduce industry revenue by £135 million per annum. Closed milk rounds are most likely to be predominantly in the more disadvantaged areas of the country.

5.5 In total, around 14,000 other existing WFS retailers across GB could also be affected by the introduction of Healthy Start. This includes small stores and conveniences (which supplied approximately 33% of liquid milk to beneficiaries under the Scheme

in 2005-6[1]), large multiple grocers (28% of sales) and small multiple grocers and other outlets (10% of sales). In Devon and Cornwall there were approximately 500 retailers participating in the WFS before Healthy Start was introduced, but nearly 1000 individual Healthy Start retail outlets by June 2006. This includes 6 food co-operatives and box schemes.

5.6 Infant formula manufacturers who gained approximately £25m of sales through the WFS in 2005-6 may also be affected. This is because all sales of infant formula will be undertaken through retail outlets rather than NHS clinics. During Phase 1, some retailers reported that cheaper brands gained retail sales over those that could not be purchased for the value of 2 Healthy Start vouchers and this is expected to be repeated across Great Britain when Healthy Start is rolled out. During Phase 1 there were no significant reductions in the amount of powdered infant formula purchased by the NHS in England as a whole but this is expected to change following introduction of Healthy Start.

5.7 Voluntary organisations and charities are not normally involved in the scheme at present, although some independent and grant maintained nurseries may operate or be on a charitable or voluntary basis. Because no changes are being made as yet to arrangements for paying daycare providers for milk provided their situation remains unchanged at the moment.

5.8 This section has been informed by the views of key stakeholders, including the dairy industry, doorstep deliverers and other retailers and small businesses, expressed in public consultation (a summary of which can be found in *Healthy Start: The results of the consultation exercise*, published in March 2003, and in ongoing discussions. It is also informed by the findings of the independent rapid evaluation of Phase 1 – the executive summary and recommendations of which were published on the Department of Health website in July 2006.

## Analysis of Costs

### Option 1 – implement Healthy Start Regulations

Economic costs

5.9 If the voucher results in a substantial shift in buying patterns, this may adversely affect doorstep deliverers[2] (who currently receive 35% of milk tokens). Milk roundsmen involved in Phase 1 appear to have accepted 16% less vouchers per week in the first few full months of Healthy Start than the number of tokens they accepted between December 2004 and March 2005, with an average weekly reduction in

[1] 2005-6 figures have been used, even though Healthy Start came into effect in the middle of this financial year, because they are likely to more accurately represent shares of different retail sectors at the point that it was introduced than figures for 2004-5. Retailers registering for Healthy Start have remained on the Welfare Food Scheme database and many will still have been seeking payment for milk tokens accepted for some time after the launch of Healthy Start in Devon and Cornwall..

[2] It is likely that urban areas will be more affected than rural as the majority of doorstep deliveries take place in urban areas.

income from the scheme of 20%. Dairy Crest has estimated that the impact on sales nationwide at roll-out of Healthy Start could be up to £0.5m a year if this is replicated.

5.10 Those retailers not able to offer the full range of Healthy Start foods products or smaller businesses who may find difficulty in competing with larger retailers and supermarkets may also be affected. However, this must be balanced against the new opportunities that will be created for businesses that have hitherto not been able to participate in the WFS. This could include, for example, greengrocers, farmer's markets and local community food initiatives. As of June 2006, [6] box schemes or co-operatives had registered for Phase 1, and of the retailers who commented on this for the evaluation, 60% felt that Healthy Start had had a positive impact on their business either because it had led to new customers or because customers using vouchers had spent more in the shop.

5.11 Infant formula manufacturers could be adversely affected if breastfeeding rates increase, but they also stand to benefit as infant formula is to be made more widely available in retail outlets and pharmacies, with those offering lower priced brands gaining the most. They will also benefit from the removal of restrictions on the specific brands and pack sizes of infant formula which may be supplied, as well as the inclusion of ready to feed versions. The discontinuation of supply of reduced price infant formula through the NHS has also no doubt already led to sales through retail across Great Britain.

5.12 We estimate that the total spending within the food and retail industry as a whole would be maintained at almost £100m per year.

Social costs

5.13 Option 1 should not create extra work for healthcare professionals' staff although there will be a cost in terms of educating health professionals about Healthy Start, and time will need to be made by healthcare professionals to participate in this. However, because for Phase 2 we are developing a range of information materials, many of which can be used or accessed in the workplace, health professionals will have flexibility about how they learn. There are existing standards for the provision of advice on diet and nutrition to pregnant women and families. This option aims to encourage Healthy Start beneficiaries to understand their entitlement to advice and support and to take advantage of their rights to time with health service staff.

5.14 Option 1 assumes that the provision of nutritional advice, leading to increased uptake of breastfeeding and vitamins, could be accomplished within routine contacts at clinics, in the community, or in homes, with a midwife or health visitor. This could also be achieved through parenting classes, group sessions, or peer support. It is not envisaged that any more time would be required, but that the quality of existing contacts is improved. Findings of the rapid evaluation of Phase 1 in this respect were that information about benefits was already being provided in antenatal clinics and that Healthy Start information was beginning to be incorporated into antenatal booking appointments. Healthy eating advice was already being provided by both midwives and health visitors though more concrete information to reinforce the Healthy Start messages (for example through making links with locally available

classes or courses on healthy eating) was not being given. This needs to be encouraged for Phase 2.

5.15 We expect that time would be freed up as NHS staff would no longer have to distribute infant formula to WFS/Healthy Start beneficiaries. In addition they are already no longer required to sell it at reduced price to certain families on certain benefits, on production of evidence of entitlement. There may be a small additional time burden due to increased take up of vitamin entitlement when these are promoted but we do not think that this will be significant as vitamins are distributed only periodically and not to all beneficiaries. Vitamins will continue to be distributed to beneficiaries by NHS staff in the shorter term, but a range of distribution options is being considered for the longer term.

5.16 Option 1 may create inequality in terms of pricing policies by retailers in certain areas. This may be to the detriment of those families in areas where access to retailers is more difficult.

5.17 We do not think that there would be any significant environmental costs or any impact on the promotion of race equality, although we would welcome comments on these issues. No comments were made on either point in the rapid evaluation of Phase 1.

**Option 2 - retain the current token based Welfare Food Scheme;**

Economic costs

5.18 Exclusively maintaining milk, infant formula and vitamins within the Scheme would disadvantage other areas of the food industry which would not be able to access the market, worth almost £100m per year in 2005-6, if the Scheme did not extend to a wider range of ‘‘healthy’’ foods.

**Social costs**

5.19 The Scheme’s recipients would however bear the costs of the status quo being maintained, as they would be denied access to a choice of ‘‘healthy’’ foods and could not meet their wider nutritional needs via the Scheme. Scope for encouraging breastfeeding and healthier eating within the existing WFS is limited as milk tokens are either sent directly to beneficiaries or, though this practice is being phased out, collected from a Post Office. Contact with the NHS and primary care services is therefore not a core component of the WFS and valuable opportunities for linking the provision of the benefit to health advice are being missed.

5.20 We do not consider that there would be any significant environmental costs or any impact on the promotion of race equality, although we would welcome comments on these issues.

**Option 3 - end the means tested element of the Scheme but increase cash benefits to compensate;**

Economic costs

5.21 The impact on industry could potentially be severe, although the £17m Government spending on nursery milk would be retained as this is a universal benefit. Some existing spending on milk could be maintained if beneficiaries were compensated through increased cash benefits, but as the funds would not be ring-fenced, there is no guarantee that that the benefits would be spent on foods. The absence of ring-fenced funds for "healthy" foods could also result in a widening of health inequalities. Although there would be minimal ongoing costs for the Department of Work and Pensions, start up costs would be in the region of around £1m.

5.22 In addition, there would be costs to government of educating WFS beneficiaries about healthy diets for themselves and their families.

5.23 We do not think that there would be any significant environmental costs or any impact on the promotion of race equality, although we would welcome comments on these issues.

**Option 4 - end the Scheme, with no compensation to beneficiaries;**

Economic costs

5.24 Ending the WFS would have a disproportionate effect on existing suppliers, particularly doorstep deliverers, the dairy industry and rural economies as almost £100m of government spending would be taken out of the market altogether. Although not the key factor in decline of doorstep sales of milk, it could hasten the existing 8-9% p.a. decline in such sales as welfare milk accounts for 5% of all doorstep sales in the UK. According to the industry, this would be equivalent to the loss of between 500-1500 milk rounds and would affect a total of 630,000 customers. The industry estimates that only 75% of these sales would transfer to larger shops and supermarkets, resulting in a permanent and immediate loss of sales to the industry of approximately £35m per annum.

5.25 The Scheme also accounts for approximately £25m of infant formula and around £21,000 of vitamin sales, which could be adversely affected if the Scheme were not in existence.

Social costs

5.26 Ending the Scheme with no compensation would have a disproportionate impact upon low income families and could widen health inequalities. Opportunities for linking to health advice and breastfeeding support would be lost.

5.27 We do not consider that there would be any significant environmental costs or any impact on the promotion of race equality, although we would welcome comments on these issues.

**Analysis of Benefits**

**Option 1 – implement Healthy Start**

Social benefits

5.28 The fixed face value voucher will equalise the benefits for breastfeeding mothers and will give beneficiaries greater choice about how they meet their families' nutritional needs. The voucher will potentially enable them to shop around for best value and purchase a more varied basket of "healthy" goods (although this may in practice be dependent upon the range and accessibility of retail outlets in their locality). The rapid evaluation of Phase 1 indicated that there was evidence to suggest that the change from milk tokens to Healthy Start vouchers had begun to change what beneficiaries were buying, in particular for those with children over 1 year old. Many were buying more fruit and vegetables than they were previously, using their vouchers for this as well as milk. The majority of those surveyed, however, were using vouchers with the same retailers they had used previously – which were multiple retailers or supermarkets. They were almost uniformly positive about being able to buy a broader range of products with the vouchers.

5.29 The "healthy" food voucher, the widening of the nutritional basis of the Scheme, and incentivisation of contact with health professionals will provide greater opportunities for the NHS to provide active support for pregnant and nursing mothers and young children through the provision of timely and relevant nutritional and health advice. This in turn could improve rates of breastfeeding amongst low income groups, especially as NHS clinics will no longer be giving a mixed message by supplying infant formula at the same time as promoting breastfeeding. It should, over time, also increase take-up of vitamins.

5.30 The implications of these changes for NHS staff are therefore that:

- NHS staff would spend more time providing health education and nutritional advice and less on supplying or selling infant formula, together with associated administration;
- This advice would be targeted at low income and other vulnerable groups in line with existing NHS priorities;
- This would be a call on the time various staff, that could include nurses and midwives, staff in ante-natal and post-natal/infant clinics, Health Visitors, GPs and practice nurses and nutritionists and health educators;
- Staff in NHS clinics would no longer have to spend any time distributing, or selling infant formula or carrying out related administration;
- Staff in NHS clinics over time distribute vitamins, but would do so in the context of existing contacts and so the increase in workload would be minimal.

5.31 We do not consider that there would be any significant environmental, economic benefits or any significant impact on the promotion of race equality, although we would welcome comments on this.

**Option 2 - retain the current token based Welfare Food Scheme;**

<u>Economic benefits</u>

5.32 The existing 21,000 WFS suppliers would continue to benefit if the Scheme was unchanged and the dairy industry would maintain a guaranteed market of around £70m worth of milk sales in GB.

Social benefits

5.33 A nutritional 'safety net' for young infants would be maintained and some of the nutritional needs of older infants and mothers would be met by the Scheme's contribution to their overall diet.

5.34 We do not consider that there would be any significant environmental benefits or any significant impact on the promotion of race equality, although we would welcome comments on this

**Option 3 - end the means tested element of the Scheme, but increase cash benefits to compensate;**

Social benefits

5.35 Daycare milk for the under 5s, which is a universal benefit, could be maintained. This option would be much simpler to administer than the current Scheme, but would incur start up costs for the Department of Work and Pensions and Her Majesty's Revenue and Customs.

5.36 We do not consider that there would be any significant environmental or economic benefits or any significant impact on the promotion of race equality although we would welcome comments on this.

**Option 4 - end the Scheme, with no compensation to beneficiaries;**

Social benefits

**5.37** This option could result in the release of around £126m per year[3] for other public health initiatives. However, there is no guarantee that those initiatives would reach the current target group of the Scheme's beneficiaries and therefore contribute to reducing health inequalities.

**5.38** We do not consider that there would be any significant environmental or economic benefits, or any significant impact on the promotion of race equality although we would welcome comments on this.

## 6. THE SMALL FIRMS' IMPACT TEST - CONSULTATION WITH SMALL BUSINESS

6.1 As previously stated, the proposed Scheme could have a disproportionate effect on a small number of doorstep deliverers if the introduction of the fixed face value voucher resulted in a major shift of buying patterns away from milk and away from doorstep deliverers who are currently involved in the Scheme. Doorstep deliverers continuing

[3] 2005-6 figures. A figure for 2005-6 has been used as, though Healthy Start was introduced midway through the financial year, it better reflects current beneficiary numbers which have been steadily declining. Cost for Healthy Start in Devon and Cornwall are included in this figure. When proposals for Healthy Start were first consulted on in autumn 2002, WFS expenditure was approx £142m per annum.

to be involved could also face a 16% drop in vouchers taken (compared with milk tokens previously taken) if the experience of Phase 1 is replicated nationwide.

6.2 Welfare milk sales currently account for around 3-5% of all doorstep milk sales in the UK. The dairy industry estimates that this is broadly equivalent to around 500-1500 milk rounds, based on an assumption that all beneficiaries would no longer purchase milk from these suppliers and that each individual round would lose a third of sales.

6.3 In practice however, the proportion of deliverers who may be dependent on Welfare Milk sales to remain viable is likely to be much lower. According to the information provided by those suppliers which submit applications for the Scheme, 26 of the 6,500 doorstep deliverers (less than 0.5%) involved in the Scheme in 2005-6 rely on Welfare milk to provide over 7.5% of their total sales. Welfare milk may account for up to 40% of total sales for a proportion of this 0.4%.

6.4 In view of the existing 8-9% per annum decline in doorstep milk sales the introduction of the fixed face value voucher could bring new opportunities for doorstep delivery businesses if they were able to diversify and deliver a wider range of products. Of the 71 milk roundsman who registered to take part in Healthy Start up to June 2006, 14 offer fresh fruit and or vegetables alongside milk to their Healthy Start customers.

6.5 Some small retail businesses could be adversely affected by the proposed reform if beneficiaries chose to shop around to obtain best value. However, small retail businesses could benefit if they could provide a wider range of goods. There would also be new opportunities for suppliers providing even only one of the range of permissible foods, and this would benefit a variety of small business and community food access initiatives, particularly in rural areas.

6.6 Registration arrangements for those wishing to participate in the scheme are intended to remain simple. Mechanisms for paying suppliers for vouchers redeemed will be more straightforward than under the existing WFS, and no discount will be deducted from the voucher value (as is currently the case with milk tokens), This will help small businesses as the full value of each voucher will be reimbursed, which is an incentive to participate in the scheme as it is “money in the till”. The rapid evaluation of Phase 1 indicated that retailers involved in Healthy Start in Devon and Cornwall were generally content with the mechanisms and timescale for claiming payment. Several commented that dealing with a fixed value voucher made the scheme much simpler for them to participate in.

## 7. COMPETITION ASSESSMENT

7.1 It is likely that the proposals for a fixed face value voucher would increase price sensitivity amongst beneficiaries and lead to greater competition between food suppliers.

7.2 The introduction of the fixed face value voucher could alter existing buying patterns as beneficiaries would be able to purchase a more varied basket of ‘‘healthy’’ goods and also shop around for best value. This could have an impact on small businesses,

and doorstep deliverers in particular, who could lose out to larger retailers if the shift in buying patterns was significant.

7.3 A high proportion – around three quarters – of the foods likely to be available under the new Scheme is currently bought from supermarkets. This would have the greatest impact on the 26 doorstep deliverers who stated in their applications that Welfare Milk accounted for more than 7.5% of their total sales in 2005-6.

7.4 There would be nothing in principle to stop doorstep deliverers or smaller retailers broadening the range of goods they offer, but in practice it may be unlikely that doorstep deliverers would be able to compete with the buying power of major supermarkets or have access to the necessary supply chains. The costs and practicalities of adapting to offer a wider range of foods may also impinge upon doorstep deliverers' ability to benefit from the new Scheme, although this may be less of an issue for other small retail outlets. Evaluation of Phase 1 suggested that Healthy Start vouchers were affecting buying patterns, in particular increasing the amount of fruit and vegetables purchased by beneficiaries. Three out 20 retailers surveyed stated that as a result of Healthy Start they now stocked goods that they did not sell before. 10% felt that Healthy Start had had a negative impact – these were doorstep deliverers reporting loss of sales.

7.5 Widening the range of foods will however bring new opportunities to other sectors of the food industry such as producers and suppliers of fresh fruit and vegetables. In particular, alternative retailers, such as farmer's markets and box schemes and other small businesses in rural areas will be encouraged to join the scheme, 6 did so in Devon and Cornwall up t June 2006. This again will provide new opportunities for local producers and will help beneficiaries to exchange their vouchers more locally, should they choose. Infant formula manufacturers could benefit if the formula was made more widely available than at present, but could also lose out if breastfeeding rates increase. The pharmaceutical industry would benefit in the longer term from the plans to reformulate vitamin supplements and improve rates of take-up within the Scheme.

7.6 The UK infant formula market is relatively concentrated with the top three firms possessing more than 50% of the market share (Mintel, 2002). Existing WFS arrangements limit the infant formula brands that beneficiaries may obtain in exchange for their token and require WFS beneficiaries to obtain the infant formula from NHS clinics. The new scheme will enable beneficiaries to exchange their token for infant formula at any retailer and their will be no limitations on which brand they must use.

7.7 Whilst this may have an impact on the sales of brands that are currently recognised for the purposes of the WFS (and early indications are that cheaper brands are gaining in retail share), the new arrangements will give more choice to consumers and enable vouchers to be exchanged for brands that are currently unavailable to WFS beneficiaries. Although expanding the number of infant formula providers might increase concentration and have a slight distortion effect on competition within the wider market for infant formula, it is not clear that this would have a significant impact on competition within this market in itself. Any significant impact that is seen in the future is likely to be due to individual manufacturers of infant formula products choosing to revise their prices to gain custom from Healthy Start beneficiaries. Such

revision of prices by one manufacturer has been evident in Devon and Cornwall during Phase 1.

**Rural Proofing**

Beneficiaries' access to retail outlets

7.8 The introduction of the fixed face value voucher is intended to provide greater choice and flexibility for beneficiaries in terms of which "healthy" foods they purchase and from where. In practice, however, choice and spending power may be dependent upon local factors, such as the accessibility and range of retail outlets which are available and the quality and extent of transport links.

7.9 Although these issues are not restricted to rural areas ("food deserts" are also a feature of peripheral urban areas), we recognise that rural areas may be disproportionately affected by the absence of local food outlets. According to the Department for Environment, Food and Rural Affairs, 78% of rural settlements do not have a general store and this figure rises to 91% in settlements with fewer than 100 people.

7.10 Whilst the overall strategy for improving access to services in rural areas falls within the remit of the Department for Environment, Food and Rural Affairs, we intend to work to ensure that beneficiaries in rural areas are not disadvantaged by the reformed Scheme. Recruitment of retailers in for Phase 1 aimed to target small, local businesses as well as larger ones to ensure that all beneficiaries had access to Healthy Start. Although densely populated areas in Devon and Cornwall achieved more local outlets, mapping techniques combined with targeted recruitment were used to ensure that there was the best access possible to Healthy Start retailers (within the limitations of the numbers of eligible businesses in each area) for beneficiaries in all the different postcode sectors. We propose a similar mapping approach for Phase 2, and will also work with retailer representative bodies to maximise the number of outlets that participate.

7.11 All retailers, including small businesses, could be eligible to participate in the Scheme. We do not propose to restrict participation to those who can supply the full range of foods, but would also accept those who can supply one of the range, including milk roundsmen, greengrocers, farmers' markets, retail pharmacies, and community food access initiatives. We would particularly encourage food access initiatives who could work with small businesses to provide to provide innovative services to beneficiaries, which could in turn help to support the economic viability of small businesses.

Impact on land based industries and the rural economy

7.12 Total spending on the Scheme is expected to be maintained at its current level, enabling the food industry as a whole to benefit from a guaranteed market of almost £100m per year. Sectors of the food industry which are not currently involved in the Scheme therefore could benefit from the proposal to widen the range of foods which can be purchased.

7.13 The proposals will also help to address the concerns contained in the report of the Policy Commission on Farming and Food (2002) chaired by Sir Donald Curry, which highlighted diet and health as key considerations in the future of the farming and food industries and noted the prevalence of poor nutrition amongst children and in poorer families.

7.14 However, the proposed reforms will bring about a shift in buying patterns and as a consequence the milk sales worth around £70m a year which are generated by the existing Scheme for the dairy industry could no longer be guaranteed. Although UK milk consumption as a whole is not dependent upon the WFS, the changes could exacerbate the 8-9% per annum decline in doorstep sales. The changes could particularly affect the 26 doorstep deliverers who stated in their applications that Welfare milk accounts for over 7.5% of their sales in 2005-6.

7.15 The reforms could also have knock-on effects for dairy farmers, depot managers, relief roundsmen, drivers, clerical and support staff if the shift in buying patterns and decline in sales was significant. The dairy industry estimates that the extent of job losses in these sectors would be approximately 20% of the number of self-employed franchisees, bottled milk buyers and roundsmen. These estimates are, however, based upon the assumption that all doorstep Welfare milk sales (5% of the GB total) would be lost, which experience during Phase 1 has shown is unlikely to be the case. Indeed, 20% of the milk roundsmen registered during Phase 1 are offering fresh fruit and/or vegetables in addition to milk.

7.16 The overall impact on the dairy industry would be dependent upon the industry's ability to adapt to changing market conditions, and potentially to diversify, in order to arrest the decline. Some sectors of the industry have already adapted their business model and have successfully diversified to offer a range of other food products and also mail delivery. Where diversification is impractical, participation would still be possible, and this will cushion the impact of reform on those businesses affected.

## 8. ENFORCEMENT, SANCTIONS AND MONITORING

8.1 As with any cash or in kind benefit, there is a risk of fraud with all four options. For example, a cash only benefit could lead to generic benefit fraud, or the use of the postal service could lead to vouchers being stolen or mis-delivered, or beneficiaries could sell their vouchers.

8.2 The proposed scheme would reduce opportunities for certain types of fraud by introducing the fixed face value voucher. Under the current WFS, which provides 7 pints of milk whatever their overall cost, suppliers can inflate the prices they charge for reimbursement or give the customer less than the full 7 pints which they are entitled to. As suppliers would be reimbursed for a fixed amount, fraud based upon the overstatement of milk prices would be eliminated.

8.3 As with the WFS, it would be an offence to trade for other than the goods specified and standard counter-fraud procedures would be used to investigate any claims of malpractice. The Department of Health has consulted and will continue to work with suppliers on the practicalities of introducing the fixed face value voucher to ensure that the Scheme is as efficient and easy to administer as possible.

8.4 We are working with the NHS Counter Fraud and Security Management Service (NHS CFSMS), its counterparts in Scotland and Northern Ireland, and Healthy Start contractors to develop operational procedures to discourage and prevent fraud. We have already introduced new measures, as well as continuing with existing measures employed in the Welfare Food Scheme, to minimise the opportunities for fraud and to facilitate enforcement action should it occur. For example, for the first time, retailers participating in the Healthy Start scheme during Phase 1 haved been given a carefully worded list of terms and conditions and have signed a declaration as part of the registration process agreeing to abide by these. Additionally, all new beneficiaries wishing to participate in the scheme have completed and signed a declaration confirmation that they have provided true information and will follow the rules of the scheme. We propose to carry these measures forward to Phase 2.

8.5 We have also developed a fraud management database to ensure that any anomalies relating to voucher use are identified and, where appropriate, referred for further action to NHS CFSMS or its counterparts. The initial set-up and administrative costs relating to the new database were £5,000. On-going costs are expected to be in the region of £2-3k per annum. Each contractor has also developed and agreed with the Department of Health and NHS CFSMS an internal protocol for identifying and acting on suspicions of fraud and misconduct arising from their day to day management of the scheme.

8.6 Allegations of fraud within Healthy Start arising from monitoring through the fraud management database, application of contractor protocols, or reported directly by beneficiaries, retailers, health professionals or the public, will be referred to the appropriate fraud enforcement agency for investigation. Cases of relatively minor misconduct will be managed by the contractors themselves, who will report to the Departments of Health on action taken.

8.7 A range of legal sanctions is already available to deal with identified fraud in Healthy Start. In addition, retailers may be barred from participation in Healthy Start for misconduct. We propose to carry these forward to Phase 2.

8.8 During Phase 1 no cases of suspected fraud or deliberate misconduct were reported to contractors or NHS CFSMS. The independent evaluation indicated that there were some accidental breaches of the rules by staff of retail outlets, particularly in the early days. A few such issues also were reported via beneficiary helplines. Contractors acted swiftly to address these with the retailers concerned.

**MONITORING AND REVIEW**

8.9 The independent rapid evaluation of Phase 1 of Healthy start provided valuable information about the impact in Devon and Cornwall on beneficiaries, retailers and health professionals. As part of its report on this evaluation, Symbia-Tavistock considered what type of evaluation might be helpful over time. It recommended that any further evaluation project should be on a national basis with support for local evaluations and should:

- assess the effectiveness of the training strategy in different areas and address any gaps

- assess the communication strategies and address gaps similary

- gather more systematic information about the impact in areas with large ethnic minority communities

- gather examples of good local practice that can be fed back to encourage local innovation and commitment .

8.10 The impact and effectiveness of Healthy Start on long term health outcomes will be monitored and evaluated over time.

8.11 Voucher value and the range of Healthy Start foods will also be kept under specific review and revised as and when appropriate in light of developing scientific knowledge about nutritional needs, and rises in relevant retail prices.

## 9. IMPLEMENTATION PLAN FOR PHASE 2 OF HEALTHY START

### 9.1 Indicative Timetable

| Action | Timing |
|---|---|
| Development of Communications to support Healthy Start Phase 2 | January - November 2006 |
| Report and recommendations on evaluation of Phase 1 finalised | June 2006 |
| Laying of Healthy Start Regulations for Phase 2 | October 2006 |
| Recruitment of retailers begins | October 2006 |
| Development and delivery of information for Health Professionals | October 2006 |
| Phase 2 implementation (vouchers introduced nationwide) | 27 November 2006 |
| Scoping study on longer term evaluation finalised | 2007 |
| Longer term evaluation project begins | Late 2007 |
| Changes to nursery milk element of WFS/any revised arrangements for the supply of vitamin supplements | TBA |

9.2 The key objectives identified for the delivery of Healthy Start are:

- To ensure that beneficiaries, retailers and health professionals understand the Healthy Start scheme.

- Health Professionals are supported through training and awareness materials .

- Effective promotion and uptake of the scheme, particularly among pregnant women.

## 10. POST IMPLEMENTATION AND REVIEW

10.1 The findings and recommendations from the rapid evaluation of Phase 1 have been taken into account when developing Regulations for Phase 2 of Healthy Start. As already mentioned, plans are underway to implement a longer-term evaluation project which will aim to look more specifically at the health impact of the scheme over time. Voucher value and the range of foods allowed will also be specifically monitored.

## 11. SUMMARY AND RECOMMENDATION

### Summary

11.1 The attached table 1 sets out the economic costs and benefits to the Government of the four options identified, as estimated prior to the introduction of Healthy Start in Devon and Cornwall.

### Recommendation

11.2 The introduction of the fixed face value voucher, continuing to proceed with Option 1, is the preferred route.

11.3 In addition to having a net economic benefit of almost £100 million per year Option 1 would allow a range of valuable non-monetary benefits to be passed on to beneficiaries. It would:

- ensure that funds were ring-fenced specifically for "healthy foods" (unlike Option 3);
- provide opportunities for meeting the wider nutritional needs of beneficiaries and would give them greater choice about the range of "healthy" foodbs which they could purchase (unlike Option 2);
- equalise the benefits for breastfeeding mothers and remove the disincentive to breastfeed which is inherent in the existing Scheme (Option 2);
- enable closer links to be established between beneficiaries and the NHS, which in turn could improve the take-up of breastfeeding amongst low income groups and also overcome the adverse nutritional outcomes which are frequently associated with the most vulnerable groups; and
- support efforts to reduce health inequalities (unlike options 2,3 or 4).

11.4 We recognise that Option 1 would do little to reverse the long-term decline in doorstep milk sales, but on balance believe that the basis of the Scheme does need to be changed in order ensure that the wider nutritional needs of beneficiaries are met. Option 2 would retain milk as an integral part of the Scheme (unlike Options 3 and 4, which would have worse implications for the dairy industry). We intend to work with industry to look at ways of enabling all existing suppliers to play a full role in the revised Scheme.

**Table 1 – Overall Costs and Benefits**

| OPTION | Costs to government £M | Monetary value to beneficiaries £M | Weighting factor: 2<br>Weighted monetary value to beneficiaries £M | Net economic benefit £M | Life-years gained |
|---|---|---|---|---|---|
| **1. Healthy Start food voucher** | | | | | |
| Vouchers paid | £110.8 | £110.8 | £221.5 | £110.8 | |
| Vitamins | £1.6 | £1.6 | £3.3 | £1.6 | |
| Education | £1.4 | | | -£1.4 | |
| Nursery milk | £19.6 | £19.6 | £19.6 | £0.0 | |
| Administration | £9.6 | | | -£9.6 | |
| ***Sub-total*** | ***£143.0*** | ***£132.0*** | ***£244.4*** | ***£101.4*** | |
| NHS administration | £0.3 | | | -£0.3 | |
| NHS: infant gastroenteritis | -£0.3 | | | £0.3 | |
| **Total** | | | | **£101.4** | 64 |
| **2. Maintain WFS** | | | | | |
| Liquid milk | £80.7 | £80.8 | £161.5 | £80.9 | |
| Formula | £33.5 | £38.9 | £77.7 | £44.3 | |
| Vitamins | £0.03 | £0.03 | £0.06 | £0.03 | |
| Nursery milk | £19.6 | £19.6 | £19.6 | £0.0 | |
| Central admin. | £8.9 | | | -£8.9 | |
| ***Sub-total*** | ***£142.6*** | ***£139.3*** | ***£258.9*** | ***£116.3*** | |
| NHS administration | £5.4 | | | -£5.4 | |
| NHS: infant gastroenteritis[4] | £0.3 | | | -£0.3 | |
| **Total** | | | | **£110.6** | -64 |
| **3. Cash Benefits** | | | | | |
| Benefits paid | £113.7 | £113.7 | £227.3 | £113.7 | |
| Vitamins | £0.7 | £0.7 | £1.4 | £0.7 | |

[4] These figures were taken from *Breastfeeding: Good Practice Guidance to the NHS*, Annex G (May 1995, Department of Health). The costings were updated using Hospital and Community Health Services Pay and Prices Index, and factored to take account of the likely increase in breastfeeding as a result of the switch to Healthy Start.

| | | | | | |
|---|---|---|---|---|---|
| Education | £4.1 | | | -£4.1 | |
| Nursery milk | £19.6 | £19.6 | £19.6 | £0.0 | |
| Administration | £4.8 | | | -£4.8 | |
| ***Sub-total*** | ***£142.8*** | ***£134.0*** | ***£248.3*** | ***£105.6*** | |
| NHS administration | £0.1 | | | -£0.1 | |
| NHS: infant gastroenteritis | £0.0 | | | £0.0 | |
| **Total** | | | | **£105.4** | 0 |
| **4. No Scheme** - | £0 | £0 | £0 | **£0** | 0 |

NB: FIGURES TO BE ROUNDED (EG TO NEAREST MILLION)

**Notes:**
Most of the benefits of the WFS, and of Options 3 and 4, are targeted at the poorest 20% of children. HM Treasury's Green Book gives advice on weighting benefits by income groups[5]. It suggests a weight of around 2 for the poorest quintile of the population. This is why the 3rd column of the Table doubles the benefit values for those benefits that are targeted (but not for nursery milk which is not targeted).

Option 1: Assumes that the take-up of vitamins would increase in line with an educational programme linked to health advice. Administration would reduce due to NHS clinics no longer having to distribute infant formula and the expected decrease in supplier fraud. Assumes that the total value to beneficiaries will remain approximately the same as the present Scheme. The profile over time would change as we are proposing to give more support to younger infants. There may be some change in milk buying from doorstep delivery to other retailers. The worst case scenario for doorstep retailers could be that all WFS doorstep delivery sales (5% of GB total) could be lost – but the scenario that no beneficiaries at all spend their food vouchers on doorstep milk seems highly unlikely. Continued sales of milk bought with the vouchers would mean that other parts of the dairy industry would continue to benefit.

The final column of the Table subtracts the costs of provision from the (weighted) value of the benefits, to give a net economic value. The 'No Scheme' option has zero net value. But the other three Options all have a net value of over £100 million per year. In addition there are further unquantified benefits to health and equality – for these see descriptions of options in sections 2, 4, 8 and below.

Option 2: Under Option 1, the beneficiaries receive liquid and formula milk worth, to them, about £119m. (The monetary value of the formula milk to the beneficiaries is based on its retail price – this is greater than the price at which the WFS is currently able to purchase

[5] "Broadly, the empirical evidence suggests that as income is doubled, the marginal value of consumption to individuals is halved: the utility of a marginal pound is inversely proportional to the income of the recipient. In other words, an extra £1 of consumption received by someone earning £10,000 a year will be worth twice as much as when it is paid to a person earning £20,000 per annum." A5.12, *Green Book*, HM Treasury, TSO, 2003. (Weighting is strongly encouraged: "Where appraisers decide not to adjust explicitly for distributional impacts, they must provide a justification for this decision." 5.41.)

formula milk, but then the WFS and NHS incur other administrative costs distributing the formula milk.)

Option 3: This option keeps government expenditure roughly the same. It is assumed that nursery milk would be retained as this is not a means-tested benefit. Administration costs would reduce if the current Scheme were effectively wound-up. This option would encourage people to use the opportunity to talk to a health care professional and obtain good quality nutritional advice.

Option 4: This is the baseline "do nothing" option, which has no costs and no benefits.

## 12. DECLARATION AND PUBLICATION

'I have read the Regulatory Impact Assessment and I am satisfied that the benefits justify the costs'.

**Signed: Caroline Flint…….**

**Date: 23rd October 2006 ……**

**Caroline Flint MP, Department of Health**

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