

**EXPLANATORY MEMORANDUM TO THE
HEALTHY START SCHEME AND WELFARE FOOD (AMENDMENT)
REGULATIONS 2005**

2005 No.3262

1.

- 1.1 This explanatory memorandum has been prepared by the Department of Health and is laid before Parliament by Command of Her Majesty.
- 1.2 This memorandum contains information for the Joint Committee on Statutory Instruments and the House of Lords Select Committee on the Merits of Statutory Instruments.

2. Description

- 2.1 The draft Healthy Start Scheme and Welfare Food (Amendment) Regulations 2005 (“the Regulations”) are one of a group of three instruments intended to establish the Healthy Start scheme. The scheme is being introduced to reform the current Welfare Food Scheme (“WFS”) set out in the Welfare Food Regulations 1996 (S.I. 1996/1434) (“the 1996 Regulations”). The Health and Social Care (Community Health and Standards) Act 2003 (Commencement) (No. 7) Order 2005, 2005 No. 2278 (C.95), and the Health and Social Care (Community Health and Standards) Act 2003 (Savings) Order 2005, S.I. 2005/2279 are the other two instruments.
- 2.2 The Regulations establish phase 1 of the new Healthy Start scheme in Devon and Cornwall and amend the 1996 Regulations. A previous draft was laid on 19 October 2005 and withdrawn on 1 November 2005 as it did not accurately describe the extent of the phase 1 area in that a wrong post code was used.
- 2.3 The Regulations are subject to an affirmative procedure.

3. Matters of special interest

- 3.1 The Regulations are to be made under section 13 of the Social Security Act 1988 (“the 1988 Act”) both:
 - (i) as saved by the Health and Social Care (Community Health and Standards) Act 2003 (Savings) Order 2005 (S.I. 2005/2279), and
 - (i) as substituted by the commencement of section 185 (replacement of the Welfare Food Schemes: Great Britain) of the Health and Social Care (Community Health and Standards) Act 2003 (“the 2003 Act”) for the purposes set out in article 2 (appointed day) of the Health and Social Care (Community Health and Standards) Act 2003 (Commencement) (No. 7) Order 2005, 2005 No. 2278 (C.95).

4. Legislative Background

- 4.1 The Regulations are to be made under powers introduced by section 185 of the 2003 Act. Section 185 substitutes new provisions to establish one or more schemes for improving nutrition for those in section 13 of the Social Security Act 1988 (schemes for distribution etc. of welfare foods). Section 185 was commenced on 12th August for the purposes of consulting the Scottish Ministers and the National Assembly for Wales. For all other purposes, other than the purposes of the Assembly exercising regulation making powers to prescribe descriptions of food or giving directions, section 185 came into force on 7th October.
- 4.2 The Regulations also rely on the powers in section 13 as saved by the Health and Social Care (Community Health and Standards) Act 2003 (Savings) Order 2005 (S.I. 2005/2279).
- 4.3 This is the first use of the new powers provided by the 2003 Act and accordingly the Regulations are subject to an affirmative procedure. The Regulations implement the specific undertaking given in the course of Parliamentary debate to test the scheme prior to full implementation (Lords debate Hansard 23/10/2003 Column 1744).
- 4.4 The Regulations also amend the 1996 Regulations to remove entitlement to free milk of disabled children aged 5-16 not in relevant education as a direct result of their disability, and entitlement based on entitlement to Pension Credit guarantee credit (guarantee credit). The provision of low cost infant formula to persons currently entitled is also to be removed by these Regulations.

5. Extent

- 5.1 This instrument applies to Great Britain.

6. European Convention on Human Rights

- 6.1 The Parliamentary Under Secretary of State for Public Health (Caroline Flint) has made the following statement regarding Human Rights:

“In my view the provisions of the Healthy Start Scheme and Welfare Food (Amendment) Regulations 2005 are compatible with the Convention rights.”

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 and vitamins to approximately 750,000

claimants (pregnant women and children under 5 years old) in families on qualifying benefits.

- 7.2 Following the recommendations that came out of a scientific review undertaken in 1999 by COMA (the Committee on Medical Aspects of Food and Nutrition Policy), the Government proposed to reform the WFS. Specific proposals were set out in a consultation paper issued in October 2002. The consultation generated a lot of interest from a range of stakeholders. Consultation responses were largely supportive of the need to reform the WFS and most of the Government's key proposals.
- 7.3 There were differences of opinion on the Government's proposal to require potential beneficiaries to register for the proposed new Healthy Start scheme. Concerns were also raised by the dairy industry about the adverse impact the changes may have on doorstep deliveries of milk and nursery provision of milk. A summary of the responses was published in March 2003 and the Government's formal response was published in February 2004 following further dialogue with stakeholders. Several suggestions were made about the range of healthy foods available under Healthy Start which varied considerably. As a result Ministers decided to restrict the range of foods to make the scheme simpler to administer initially with a view to considering an increase in the range of foods for phase two. Registration plans were also modified to simplify the process in light of stakeholder concerns.
- 7.4 A second consultation on the proposed Regulations was undertaken in February 2005. The changes reflected in the Regulations took into account the views expressed during the initial consultation, subsequent discussions with key stakeholders, and comments made by Parliament during the passage of the bill for the Health and Social Care (Community Health and Standards) Act 2003. In particular, this included providing an additional voucher for mothers with children under 1 year old or within 12 months of their Estimated Date of Delivery, if born prematurely. A response to this consultation has been issued to the respondents.
- 7.4 The Regulations would also provide for the following in respect of phase 1 of Healthy Start:
- A range of foods that includes fresh fruit and fresh vegetables as well as liquid milk and infant formula milk;
 - a fixed value voucher (to the value of £2.80) instead of a volume based token;
 - Giving vouchers to all pregnant teenagers under 18 regardless of whether they are on qualifying benefits
 - An additional voucher per week for mothers of children from birth to age 1 (or 12 months from Estimated Date of Delivery if born prematurely). Whilst our intention is to reduce the upper age limit for children to the 4th birthday it will remain the 5th birthday for phase 1;
 - The requirement for a health professional to sign the Healthy Start application form thus forging closer links with the NHS to provide

opportunities for families to receive advice on diet and nutrition, and other health issues;

- The removal of entitlement to purchase infant formula at a low cost;
- The removal of entitlement to milk tokens for beneficiaries aged 5-16 not registered at a school as a direct result of their disability.
- The removal of entitlement based on guarantee credit.

The Regulations make no change to the existing arrangements for daycare providers to claim for supplying milk daily. Our current intention is to enable nurseries to claim for supplying either milk or fruit at a later date.

- 7.5 The Regulations enable the Healthy Start provisions to be implemented in Devon and Cornwall for phase 1 of Healthy Start. The Government intends to introduce further regulations to extend the provisions to the rest of Great Britain once phase 1 has been evaluated. This is expected to be approximately 6-8 months following the launch of phase 1.
- 7.5 The intention is not to provide asylum seekers with access to the Healthy Start scheme. Their needs are met by the National Asylum Support Service or in some instances local authorities.
- 7.6 As indicated at paragraph 7.4 the Regulations also remove entitlement to milk tokens under the Welfare Food Scheme for children aged 5-16 not registered at a school as a direct result of their disability. This reflects Healthy Start's aim to provide better nutritional support to those most in need. The COMA review concluded that there was no nutritional justification for the continued inclusion of disabled children over 5 years old. A one off good will payment may be made to the small number of families affected (approximately 20).
- 7.7 Entitlement to purchase low cost infant formula through the NHS for certain families in receipt of Working Families Tax Credit with a child under one will also cease. This is to reflect the greater value of current Child Tax Credit payments. It will also support the NHS's role in promoting breastfeeding and reflects the fact that the NHS will not be responsible for distributing infant formula through Healthy Start.
- 7.8 Entitlement to Healthy Start vouchers for those beneficiaries currently in receipt of guarantee credit will also cease. This is because of the increase in the value of guarantee credit. Guarantee credit will therefore no longer be a qualifying criterion for Healthy Start. However, families in receipt of Child Tax Credit with a family income of less than £13,910, will still be eligible for Healthy Start.
- 7.4 During debates on the Bill in the House of Lords Baroness Andrews sympathised with the case put forward by the Noble Lord, Lord Clement-Jones to test the scheme prior to full implementation (Hansard 23/10/2003 Column 1744). As a result Devon and Cornwall was selected as a suitable area to implement phase 1 of Healthy Start. Devon and Cornwall is geographically self-contained with a border that does not

cut across a large urban community. The choice of a geographically distinct area will ensure that there is as clear a demarcation as possible between those beneficiaries continuing to receive WFS tokens and those receiving the new Healthy Start vouchers. It will also reduce any possible confusion between beneficiaries, retailers and health professionals during operation of both schemes.

- 7.5 Devon and Cornwall also incorporates both urban and rural areas, has small pockets of deprivation as well as larger identifiable disadvantaged populations, currently embodies a range of approaches to the NHS distribution of infant formula through the WFS against which to compare, and is manageable in size. The presence of these factors will aid the evaluation process.
- 7.6 There has been limited media interest in the proposed reforms. However there have been strong concerns expressed by the dairy industry about the possible knock-on effect on viability of doorstep deliveries of milk in areas where milk rounds include a number of WFS beneficiaries.

8. Impact

- 8.1 A Regulatory Impact Assessment has been prepared to accompany the Regulations and is attached as Annex A for reference.

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

1. TITLE OF PROPOSED MEASURE

- 1.1 The Healthy Start Scheme and Welfare Food (Amendment) Regulations 2005

2. PURPOSE AND INTENDED EFFECT

Objective

- 2.1 The purpose and intended effect of the Regulations is to:

- i) Reform the current Welfare Food Scheme (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 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.

- 2.2 The Regulations accompanying this Regulatory Impact Assessment relate only to Phase 1 of Healthy Start which will partially introduce the new Scheme in Devon and Cornwall. Further Regulations will be needed to extend the scheme across the rest of Great Britain in Phase 2. The full reform of the scheme will apply in England, Scotland and Wales. Northern Ireland was included in the review of the WFS and is intending to introduce similar reforms at the same time.

Background

- 2.3 The current legislation for the WFS is contained in the Social Security Act 1988 and the Welfare Food Regulations 1996.
- 2.4 This RIA builds on the partial RIA developed to support the consultation on proposals for WFS reform published in Autumn 2002. It also builds on the RIA published alongside the Health and Social Care (Community Health and Standards) Bill 2003 to support the provisions for new powers to reform the WFS.
- 2.5 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).

- 2.6 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.
- 2.7 As a result of the COMA review the Government committed to reforming the WFS within existing budgets to reflect the review's recommendations. The introduction of the Healthy Start Regulations will not impact upon any other Regulations or policies outside of the current Welfare Food Scheme Regulations.

Rationale for Government Intervention

- 2.8 *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).
- 2.9 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"*.
- 2.10 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”.

- 2.11 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.
- 2.12 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.
- 2.13 The COMA review assessed the contribution of the current 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;
- 2.14 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 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:
- 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 The proposals for the new Scheme, launched for public consultation on 28 October 2002 explored the options for action within the overall framework. As part of the consultation process, the Department of Health convened meetings with the dairy industry, retailers, infant formula manufacturers, health professionals, beneficiaries, doorstep deliverers and small retailers during the consultation period to explore ways of making the proposed Scheme work effectively.
- 3.6 Consultation on the draft Regulations was undertaken in February 2005 but only minor comments were received about the Regulations themselves.

- 3.7 Over 500 written responses were received to the 2002 consultation, which also included a number of well attended active listening events for various groups – industry, health professionals and the voluntary sector for example. 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.
- 3.8 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.
- 3.9 The Government response to the consultation, published in February 2004, reflected the responses to the original public consultation exercise, the listening events and the Parliamentary debates. It set out our policy intentions for a new Scheme, Healthy Start, the detail of which subsequently shaped the drafting of the Regulations.
- 3.10 The draft Regulations were published in a further consultation exercise which ended on 26 April 2005. This consultation contained a Partial Regulatory Impact Assessment for the proposals. 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.

4. OPTIONS

- 4.1 Four key options were 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 to 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 (Proposed option)

- 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 will be:

- 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 To ensure that the new scheme works effectively, we have committed to a phased introduction of Healthy Start. The process has already begun, with the introduction from 1 October 2004 of a new application process for pregnant women qualifying for the existing WFS tokens. This involves the woman filling in a simple form, getting a health professional to confirm the pregnancy and Estimated Date of Delivery, and then sending the form to the token distribution unit for processing and issue of tokens.
- 4.11 Healthy Start will be implemented in a phased approach following Minister's agreement to test the scheme before it is rolled out nationally. Phase 1 is expected to implement Healthy Start in Devon & Cornwall in November 2005, subject to Parliamentary approval. This will allow the operation of the processes underpinning the Scheme - such as supplier registration/reimbursement, voucher exchange at point of sale, and beneficiary application procedures – to be monitored and evaluated before Healthy Start is rolled out nationally.
- 4.12 Monitoring and evaluation of the processes will take place from the beginning of Healthy Start. Once we are satisfied that the processes are working effectively, we would expect to roll the voucher scheme out across the rest of Great Britain, and introduce new arrangements for the provision of milk or fruit in nurseries (Phase 2). Phase 2 is expected to commence mid 2006.

Voucher value

- 4.13 The weekly voucher value will be set in Regulations at £2.80, with double vouchers payable to qualifying families with a child aged 0-12 months old. Babies born prematurely will receive double vouchers until 12 months following the expected date of delivery.

Healthy Start foods

- 4.14 Beneficiaries will be able to exchange Healthy Start vouchers for fresh fruit and vegetables as well as liquid milk and infant formula. It is our intention, over time, to expand the range of foods for which vouchers may

be exchanged 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 2005 and then subsequently adopted by manufacturers and retailers.

Entitlement to vouchers

- 4.15 Existing WFS qualifying criteria are in the main carried forward to Healthy Start. Differences between WFS and Healthy Start eligibility criteria are set out below.

Pregnant women under 18 years old

- 4.16 Entitlement to vouchers is also 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. This provision will become effective from the start of Phase 1.

Pension Credit guarantee credit

- 4.17 In the Government's response to the Healthy Start consultation, we agreed to review the continued inclusion of Pension Credit guarantee credit (PCgc) as one of the qualifying benefits. In view of the increases in the value of PCgc, we propose to exclude receipt of PCgc as a qualifying criterion for Healthy Start. However, families in receipt of Child Tax Credit as described in Part II of the draft Regulations will be eligible for Healthy Start.

Asylum Seekers

- 4.18 Healthy Start will not provide vouchers to asylum seekers. Their needs are met by the National Asylum Support Service (NASS) and this principle has been reinforced by the High Court. The regulations therefore make no reference to asylum seekers. 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, we said consideration would be given to reduce the upper age limit for children to receive Healthy Start vouchers from their 5th birthday to their 4th 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 the 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.
- 4.20 Our intention now in order to target resources at the youngest and most vulnerable children is to reduce the upper age limit for Healthy Start to

their 4th birthday. This change is intended to come into effect when Healthy Start is rolled out nationally. It will not apply in the Phase 1 area.

- 4.21 As part of Phase 2 of Healthy Start changes to the daycare element of the current WFS will be considered. The Government proposed, in its response to the consultation, published in February 2004, to include fruit or milk to all under 5 year olds in registered daycare for 2 hours or more per day.
- 4.22 The proposed reduction in the maximum age from Phase 2 will enable the Government to implement the new entitlement for all pregnant teenagers under 18. During Phase 1 all pregnant under 18 year olds will be entitled to Healthy Start. Double vouchers will also be provided for 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.

Provision of low cost infant formula

- 4.23 Entitlement to low-cost infant formula of those families with children under 1 year old who have in the past purchased it through the NHS is to be removed throughout Great Britain at the outset of Phase 1. We have already published our intention to remove this entitlement to reflect the greater value of Child Tax Credit payments.

Disabled children aged 5 -16

- 4.24 Nor will entitlement of children aged 5-16 not registered at a school as a direct result of their disability continue to be provided. In the "Government response to the consultation exercise" (Feb 2004), we set out our intention to remove this entitlement as it has no nutritional basis. Our intention is to remove entitlement for all such children throughout Great Britain from the date on which Phase 1 of Healthy Start begins. A one-off goodwill payment is expected to be made to the very small number of families who are receiving this benefit on that date.

How qualifying women/families will access Healthy Start

Transfer of Welfare Food Scheme Beneficiaries to Healthy Start

- 4.25 As a transitional measure, all those who are entitled to and are receiving WFS tokens when Healthy Start is introduced will be automatically moved onto Healthy Start if they live in the designated area. They will not therefore have to make a specific application for Healthy Start until or unless their qualifying status changes – for example they become pregnant, or a family that has ceased to qualify for a period of time re-qualifies.
- 4.26 During Phase 1, all those entitled to WFS who become resident in the Phase 1 area will be automatically transferred onto Healthy Start. Similarly, Healthy Start recipients who become resident outside the Phase 1 area will be transferred onto the WFS.

Application procedure

- 4.27 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 which has been introduced for pregnant women applying for the WFS.
- 4.28 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.
- 4.29 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

- 4.30 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 provide 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, the Inland Revenue.

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

- 4.31 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 will be provided to a selected number of health professionals prior to the implementation of Phase 1. The training is intended to be independently evaluated before being rolled out across the rest of Great Britain. The training will set Healthy Start in the context of wider public health and nutritional messages.
- 4.32 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”.

- 4.33 In autumn 2004, we distributed an Infant Feeding Resource Pack to all midwives and health visitors. The pack was specifically designed so that additional inserts can be provided over time, for example to support delivery of advice on nutrition and health to Healthy Start beneficiaries and other pregnant women and families. It will be the key tool for health professionals to use to promote Healthy Start among their client base. The Department of Health will also be discussing with health professional bodies what more needs to be done to ensure that health professionals are equipped to deliver their broader public health role in the context of the proposals contained in the *Department’s Choosing Health – Making Healthier Choices Easier* November 2004 on improving people’s health.
- 4.34 We anticipate that healthcare professionals will be based in a range of settings 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

Registration process

- 4.35 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. There will be 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.
- 4.36 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.
- 4.37 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.

4.38 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. A time limit of 6 months from the expiry date of vouchers is set in the Regulations for claiming payment. We understand that this is consistent with practice in relation to commercial vouchers.

Risks

Potential adverse nutritional outcomes

4.39 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-conceptual folic acid supplements lower dietary intake during pregnancy vitamin D deficiency
Infants	lower levels of breastfeeding (see below) earlier introduction of solids (see below) increased risk of failure to thrive.
Young children	increased risk of iron deficiency anaemia increased risk of vitamin D deficiency increased risk of dental caries
School aged children	poor dietary patterns increased risk of obesity in childhood and in the longer term

4.40 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.

Breastfeeding and the provision of health advice

- 4.41 The COMA review also concluded that the current Scheme is a disincentive to breastfeeding.
- 4.42 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.
- 4.43 There is also a correlation between social class and breastfeeding: only 57% of babies born to mothers in social class V % in England were initially breastfed (2000), compared to 91% in social class 1.
- 4.44 The Scheme 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.
- 4.45 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 Scheme accounts for around £90m of milk sales (GB). The estimated figures for 2002 show that approximately 40% of WFS liquid milk was supplied to milk token beneficiaries by around 8,400 doorstep deliverers. This figure has since declined to around 35%, in 2004, and most recently 30% in 2005. The approximate number of doorstep deliverers registered with the WFS as at 31 March 2005 is 6000. This is in the region of 3%-5% of all doorstep sales for the dairy industry, which equates to approximately 500 milk rounds.
- 5.2 The number of doorstep deliverers who have stated that the WFS accounts for more than 7.5% of their sales is less than 100. The introduction of Healthy Start may impact the greatest on these 100 doorstep deliverers should beneficiaries chose to exchange their Healthy Start vouchers elsewhere. For phase 1 we have assumed that approximately 1-2 doorstep deliverers may become unviable in the Devon and Cornwall area.
- 5.3 However, the dairy industry estimate that up to 1,500 milk rounds across Great Britain may become non-viable following full implementation of

Healthy Start. This 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.

- 5.4 In total, around 12,000 other retailers across GB could also be affected by the introduction of Healthy Start. This includes small stores and conveniences (which supply approximately 32% of liquid milk to beneficiaries under the Scheme), large multiple grocers (23% of sales) and small multiple grocers and other outlets (10% of sales). In Devon and Cornwall there are approximately 500 retailers currently participating in the WFS. We expect that this figure will rise to over 1000 participating retailers with the introduction of Healthy Start, as a result of the expansion in the range of foods available under the scheme. Small businesses may also benefit from the scheme as they may take the opportunity to diversify the range of products they sell.
- 5.5 Infant formula manufacturers who currently gain over £32m of sales through the WFS may also be affected. This is because all sales of infant formula will be undertaken through retail outlets rather than NHS clinics.
- 5.6 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. However, any changes to the provision of milk through registered daycarers will be implemented as part of Phase 2.
- 5.7 This section has been informed by the views of key stakeholders, including the dairy industry, doorstep deliverers and other retailers and small businesses, a summary of which can be found in *Healthy Start: The results of the consultation exercise*, published in March 2003. *The Government response to the consultation exercise*, that took account of the responses to the consultation and other views that emerged through parliamentary debate, was published in February 2004.

Analysis of Costs

Option 1 – implement Healthy Start Regulations

Economic costs

- 5.8 If the voucher results in a substantial shift in buying patterns, this may adversely affect doorstep deliverers¹ (who currently receive 35% of milk tokens). We estimate this could mainly affect 1-2 doorstep deliverers, with WFS sales over 7.5%, in the Devon and Cornwall area. Those retailers not able to offer the full range of permissible 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

¹ It is likely that urban areas will be more affected than rural as the majority of doorstep deliveries take place in urban areas.

have hitherto not been able to participate in the WFS. This could include, for example, greengrocers, farmer's markets and local community food initiatives.

- 5.9 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. 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 will also lead to increased sales in retail at full retail price.
- 5.10 We estimate that the total spending within the food and retail industry as a whole would be maintained at over £125m per year.

Social costs

- 5.11 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. 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.
- 5.12 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 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.
- 5.13 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 would no longer be 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 but we do not think that this will be significant as vitamins are distributed only every 13 weeks and not to all beneficiaries.
- 5.14 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.
- 5.15 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 2 - retain the current token based Welfare Food Scheme;

Economic costs

5.16 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 over £100m per year, if the Scheme did not extend to a wider range of “healthy” foods.

Social costs

5.17 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.

5.18 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

5.19 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 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 £1 million.

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

5.21 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

- 5.22 Ending the WFS would have a disproportionate effect on existing suppliers, particularly doorstep deliverers, the dairy industry and rural economies as over £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.
- 5.23 The Scheme also accounts for over £32m of infant formula and around £28,000 of vitamin sales, which could be adversely affected if the Scheme were not in existence.

Social costs

- 5.24 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.
- 5.25 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 the Healthy Start regulations

Social benefits

- 5.26 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).
- 5.27 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.

5.28 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.

5.29 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;

Economic benefits

5.30 The existing 18,000 suppliers would continue to benefit if the Scheme was unchanged and the dairy industry would maintain a guaranteed market of around £72 million worth of milk sales in GB.

Social benefits

5.31 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.

5.32 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

5.33 Nursery milk, 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 the Inland Revenue.

- 5.34 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

- 5.35 This option could result in the release of up to around £140m (per year) 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.
- 5.36 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.

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. The Phase 1 Rapid evaluation will look at the impact of introducing the Healthy Start vouchers on retailers and doorstep deliverers, in particular the percentage of vouchers exchanged through different retail outlets. This will help to identify any potential impact across the rest of Great Britain once Phase 2 of Healthy Start is implemented.
- 6.2 Welfare milk sales currently account for around 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, around 95 of the current 6,000 doorstep deliverers (less than 1%) involved in the Scheme 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 very small number of individual suppliers.
- 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.

- 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”.

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 95 doorstep deliverers who have stated in their applications that Welfare Milk accounts for more than 7.5% of their total sales.
- 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.
- 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, in rural areas like those in Devon and Cornwall will be encouraged to join the scheme. 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 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 there 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, 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.

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. Targeting of local retailers and producers will be undertaken to ensure that all beneficiaries have access to Healthy Start outlets. This will be monitored throughout Phase 1 in Devon and Cornwall.
- 7.11 All retailers, including small businesses, would 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 over £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 £92m 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 95 doorstep deliverers who have stated in their applications that Welfare milk accounts for over 7.5% of their sales.
- 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.
- 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 scheme, 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 current scheme, 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 intends to consult and 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), and its counterparts, and Healthy Start contractors to develop operational procedures to discourage and prevent fraud. To assist with this we have proposed new measures, as well as continuing with existing fraud measures, to minimise any possible fraudulent activity. For example, for the first time, retailers participating in the Healthy Start scheme will sign a declaration as part of the registration process agreeing to abide by the rules of the scheme. Additionally, all new beneficiaries wishing to participate in the scheme will need to complete and sign a declaration at the bottom of the application form.
- 8.5 As a result of the Arms Length Body Review, the NHS CFSMS will, in the future, become part of the NHS Business Services Authority. Allegations of fraud within Healthy Start will be referred for investigation as appropriate. As the Agency's own remit is restricted to England and Wales. Special arrangements will be made to encompass this role in Scotland. In the meantime, the NHS CFSMS is advising us on how Healthy Start processes should be fraud-proofed.
- 8.6 As now, a range of enforcement sanctions would be available and used as appropriate to deal with identified fraud. In addition, the Regulations provide for barring suppliers from participation in the Scheme if they infringe its rules, and legal action against those who deliberately defraud the scheme whether as suppliers or by claiming vouchers to which they are not entitled.
- 8.7 We are currently developing, with our contractors, a fraud reporting database to ensure that any claim anomalies are identified and where appropriate referred for further action to NHS CFSMS. The initial set-up and administrative costs relating to the new database is £5,000. On-going costs are expected to be in the region of £2-3k per annum. No additional costs are expected in relation to the management of fraud as part of Healthy Start.

MONITORING AND REVIEW

- 8.8 As anticipated in the Government's response to the Healthy Start consultation, the Regulations would introduce the Healthy Start voucher scheme into a defined geographical area. This would allow the operation of the processes underpinning the Scheme - such as supplier registration/reimbursement, voucher exchange at point of sale, and beneficiary application procedures – to be monitored and evaluated. We are not setting an absolute time limit on this introductory phase as it must be sufficiently flexible to respond to experience. However, we anticipate that it would last around 6 months and then, subject to satisfactory results, we would expect to roll the voucher Scheme out across the rest of Great Britain, and introduce new arrangements for the provision of milk or fruit in nurseries, in one go. Northern Ireland has its own scheme, and is reforming it in parallel.
- 8.9 During the introductory phase, the existing WFS would continue outside the Healthy Start area. The current WFS arrangements for reimbursing nursery and day care providers for providing milk would also be unchanged throughout Great Britain. Women and families moving into or out of the Healthy Start area would be able to swap their Healthy Start vouchers for milk tokens and vice versa, or may be offered payment in lieu if they cannot use the vouchers/tokens they have been issued with.
- 8.10 We have committed to specifically evaluating the operation of the voucher scheme in Phase 1, subject to Parliamentary approval of the Regulations. We have also committed to monitoring and evaluating Healthy Start over time, and to setting up an expert reference group to oversee this.
- 8.11 We expect that the rapid evaluation for the purposes of assessing whether the voucher scheme is working well in Phase 1 will largely measure processes. For example, it would need to consider whether our communications routes are effective in reaching potential beneficiaries, and whether contracts for issuing Healthy Start vouchers to beneficiaries, and for reimbursing retailers who accept them are operating efficiently. Some qualitative evaluation with beneficiaries, health professionals, and retailers to assess the Scheme's acceptability would also be helpful.
- 8.12 This project would link in with the local Phase 1 manager, drawing on their practical experience with Phase 1 as well as carrying out evaluation of its own, including sample surveys of beneficiaries, health professionals and retailers.
- 8.13 For the longer term, monitoring and evaluation would have to consider not just processes and acceptability, but the impact of Healthy Start on health and on behaviour, and the extent to which the Scheme should be modified in response to emerging information about dietary needs.
- 8.14 This longer term monitoring and evaluation would require the establishment of baseline data against which to measure change over

time. It is this longer term evaluation that will also require the expert steering group that we have promised Parliament that we will establish.

- 8.15 We propose that the project we commission to evaluate Phase 1 should lay the ground for longer term monitoring and evaluation of the Scheme. Phase 1 rapid evaluation would establish some baseline data, identify further baseline requirements, and develop an overall monitoring and evaluation strategy incorporating recommendations for a reference group. We also propose to consider over coming months whether there are existing tools that we could use to establish baselines and monitor change against them – for example the National Infant Feeding Survey and the dietary assessment tool being developed for the School Fruit and Vegetable Scheme.

9. IMPLEMENTATION PLAN

9.1 Indicative Timetable

Action	Timing
Development of Communications to support Healthy Start	April – November 2005
Laying of Healthy Start Regulations for Phase 1	October 2005
Development and delivery of training for Health Professionals in Devon and Cornwall	October – November 2005
Phase 1 implementation in Devon and Cornwall	28 November 2005
Commence Phase 1 Rapid Evaluation	December 2005
Evaluation of health professionals training	December – January 2005
Establish expert scoping review	January 2006
Evaluation of supporting communications	January – April 2006
Review and revise training materials and awareness sessions	February – April 2006
Review and revise supporting communications	April – June 2006
Delivery of Phase 2 training to health professionals	April – August 2006
Findings and recommendations from Phase 1 rapid evaluation	May 2006
Development of Phase 2 Regulations	May – June 2006
Lay Healthy Start Phase 2 Regulations	July 2006
Implement phase 2 of Healthy Start	September 2006
Commencement of longer term evaluation	September 2006 onwards

- 9.2 Delivery of the implementation plan will be supported, in phase 1, by a local Healthy Start Co-ordinator who will be based in Devon and Cornwall. The role of the Healthy Start Co-ordinator will be to manage the implementation of phase 1 and be the local contact for, in particular, health professionals but also retailers and beneficiaries.
- 9.3 The Co-ordinator will be responsible for dealing with any local issues that arise and will report any observations about the scheme to the Healthy Start policy team. The Co-ordinator will have a large part to play in ensuring stakeholders work collaboratively and will liaise regularly with the Healthy Start policy team, Healthy Start contractors, local health professionals, beneficiaries and retailers to ensure smooth implementation and operation of the scheme.
- 9.4 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 the training and awareness materials being developed.
 - Effective promotion and uptake of the scheme, particularly among pregnant women.
 - Recommendations and findings are taken into account when developing Regulations for Phase 2 of Healthy Start.

10. POST IMPLEMENTATION AND REVIEW

- 10.1 As part of the phased approach for introducing reforms to the WFS, a rapid evaluation of Phase 1 is intended to be undertaken. The purpose of the evaluation would be to consider the impact of the changes on the three key stakeholders, beneficiaries, retailers, and health professionals. It would also consider the effectiveness of the processes put in place to operate Healthy Start. Specifically, this will include:
- The application process
 - Take up rates of Healthy Start
 - Use of Healthy Start vouchers
 - Range and location of retailers
 - Impact on health professionals
 - Flexibility of the scheme and its processes
 - Practical implementation Retailer
 - Acceptability of Scheme for all key stakeholders
 - Analysis of fraud notifications and associated action.
- 10.2 The evaluation would be undertaken by an independent company and, subject to approval and implementation timetables, we would expect an evaluation report including findings and recommendations to be produced by May 2006.

- 10.3 The findings and recommendations from the rapid evaluation of Phase 1 will be taken into account when developing Regulations for Phase 2 of Healthy Start. This would ensure that the impact on key stakeholders is minimised and the processes supporting Healthy Start were effective and workable.
- 10.4 In addition, training provided to health professionals would also be evaluated to ensure that the training meets the required objectives, and could be easily cascaded to other health professionals in the field.
- 10.5 The communications developed to support Healthy Start would also be evaluated. Any findings and recommendations would be taken into account when developing communications for Phase 2. Consideration would also be given to the requirements for Wales and Scotland. The aims of the Healthy Start communications would be tested through the evaluation. They are:
- To communicate with existing and potential beneficiaries so that they are aware of the changes to the scheme, the greater choice they offer, and the opportunities for more effective local NHS support for improving family diet
 - To encourage and help beneficiaries to use the choice available to them to improve their diet through healthy eating.
 - To link in with the 5 A DAY programme by drawing on 5 A DAY work to give families ideas and information about using fruit and vegetables, as well as broader encouragement to eat healthily beyond Healthy Start
 - To deliver effective communications with all the Phase 1 PCTs and health professionals in them to ensure colleagues understand the changes within Healthy Start and also to encourage a sense of enthusiasm, and progress.
 - To encourage Phase 1 PCTs to think innovatively about potential partnerships with local voluntary groups and producers to maximise the effectiveness of Healthy Start
 - To create effective feedback channels between the project team and Phase 1 PCTs to ensure a steady, two-way stream of information concerning progress and achievements, and encourage a sense of ownership.
 - To communicate the Phase 1 implementation experience more generally within the NHS to prepare the ground for the wider rollout.

- To work with Healthy Start contractors to communicate with retailers so that they understand, and are ready for, the changes, and to pave the way for communications with retailers nationally.
 - To ensure that other government departments are offering good advice to recipients about accessing Healthy Start and pursuing problems
 - To win the support of our third party advocates, providing regular updates and encourage their enthusiastic support and public endorsement.
 - To make good use of internal communication channels within HIP and DH so that staff understand the importance and value of Healthy Start and are aware of progress.
- 10.6 To undertake evaluation of Healthy Start in the longer term an expert scoping review would need to be carried out. The purpose of the expert scoping review would be to establish the principles and objectives for longer term evaluation, specifically identifying and analysing health outcomes relating to Healthy Start.

11. SUMMARY AND RECOMMENDATION

Summary

- 11.1 The attached table 1 sets out the estimated economic costs and benefits to the Government of the four options identified.
- 11.2 Table 2 also sets out the estimated costs to business of each option.

Recommendation

- 11.3 The introduction of the fixed face value voucher, Option 1, is the preferred route.
- 11.4 In addition to having a net economic benefit of over £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” foods 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).

11.5 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

Weighting factor:
2

OPTION	Costs to government £M	Monetary value to beneficiaries £M	Weighted monetary value to beneficiaries £M	Net economic benefit £M	Life-years gained
<u>1. Healthy Start food voucher</u>					
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/fruit	£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
<u>2. Maintain WFS</u>					
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 ²	£0.3			-£0.3	
Total				£110.6	-64
<u>3. Cash Benefits</u>					
Benefits paid	£113.7	£113.7	£227.3	£113.7	
Vitamins	£0.7	£0.7	£1.4	£0.7	
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
<u>4. No Scheme</u>					
-	£0	£0	£0	£0	0

² 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.

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 groups³. 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 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.

³ "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.)

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: 2nd November 2005

Caroline Flint MP, Parliamentary Under Secretary of State, Department of Health

Policy Contact:

Justine Currell

Level 7, Wellington House
133-155 Waterloo Road
London
SE1 8UG

Tel : 020 7972 4434
e-mail: justine.currell@dh.gsi.gov.uk