Proposals for reform of the Welfare Food Scheme
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Responses

Responses to this document are invited by Friday 13 December and should be sent to:

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E-mail: healthystart@doh.gsi.gov.uk
Our proposals for Healthy Start will help to lay the foundations for the good health of future generations. They will help to improve nutrition for pregnant women, mothers and young children. There will be a choice of a wider range of ‘healthy’ foods than is available under the present scheme. Advice, support and guidance on nutrition will be available from NHS health professionals for mothers-to-be and new mothers and carers as an integral part of the scheme.

Healthy Start is a new chapter in improving the health of women and children in low income groups. The Welfare Food Scheme was established over 60 years ago and has been of tremendous help to thousands of families, but its approach and its methods are now out of date. Liquid milk and infant formula are the basis of the current scheme. Both are important elements in the diets of mothers and young children but according to the latest scientific evidence they are not sufficient on their own to meet the nutritional needs of these groups. That is why we set out in The NHS Plan – with support from our colleagues in Scotland and Wales – our intention to update the scheme and make the important links with programmes tackling health inequalities and reducing child poverty.
Healthy Start proposes to use fixed face value vouchers, instead of the current milk tokens. The value of the voucher will be broadly equivalent to the value of the same seven pints of liquid milk that are provided by the current scheme. It will give pregnant women, mothers and carers more choice and a more flexible way of providing for their families.

We want to encourage people to share responsibility for improving their family's health. We are proposing that families register for Healthy Start through NHS health professionals – primarily midwives and health visitors. This will open new links between women and children using the scheme and the NHS, from the antenatal period through until the early years of life. The advice and guidance in relevant areas offered by Healthy Start will help mothers make good nutritional choices for their children and contribute to their long term health and development.

We have identified three key changes to the existing scheme in this document:

- to broaden the nutritional basis of the scheme to include fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula;

- to provide greater access to these foods through a fixed face value voucher, roughly equivalent to the value of seven pints of liquid milk, the current allocation; and

- to register scheme members through health professionals and provide advice and guidance on nutrition including breastfeeding.

At the same time, we want to work in partnership with existing providers to build on the contribution of the current scheme in tackling such issues as social exclusion, whether in terms of reaching isolated communities, accessing services or in terms of employment.

Until December, we are inviting views on these proposals, through this document and through a series of meetings with key interest groups, including users of the scheme, health professionals and the food and dairy industry and small firms, to ensure that the new scheme works as effectively as possible. We are also interested in your general views, particularly in terms of how we can make the new scheme contribute to our wider work in tackling health inequalities and improving health.

I want this to be a genuine listening exercise and for ideas and suggestions generated by the consultation to be fully reflected in the new scheme when it comes into operation in 2004.

Hazel Blears MP
1. Introduction: Towards a more effective scheme

1.1 The NHS Plan (2000) set out the aim of ensuring that children have a healthy start in life. It included action on child poverty through a big expansion of the Sure Start, coronary heart disease (CHD) and cancer programmes, and the development of appropriate screening programmes for mothers and children. It also included a reform of the Welfare Food Scheme and the intention to use the resources more effectively to ensure that children in poverty have access to a healthy diet, [with] increased support for breastfeeding and parenting.

Most of The NHS Plan extends to England but the Welfare Food Scheme is a reserved matter and so commitment to reform it covers Scotland and Wales as well. We have discussed reform of the scheme with the devolved administrations and we are working together to develop a common approach to the future of the scheme. The scheme also has many links with devolved matters, such as public health, health services, education and agriculture.

1.2 The proposals in this document are, therefore, part of a wider effort by both Government and the devolved administrations to ensure a healthy start in life for children and reduce health inequalities. This document outlines some of the work taking place across Britain to further these policy aims. They link to a range of developments affecting families and young children, and including changes in nutrition policy such as:

- the National School Fruit Scheme – which will, by 2004, provide all children aged four to six in England with a free piece of fruit every school day
- the Five A Day programme – which is working to increase the consumption of fruit and vegetables in the most disadvantaged areas in England, and
- the promotion of breastfeeding through the infant feeding initiative and related programmes in Scotland and Wales

1.3 Work on National Service Frameworks (NSFs) for children in England and Wales is already under way. As well as the Sure Start programme, other related initiatives that focus on mothers and children in disadvantaged areas include the Neighbourhood Nurseries initiative, the Decent Homes programme that is improving homes in the most deprived areas for families with young children, and family support programmes. In Scotland, there is the Child Care Strategy, the Changing Children’s Services Fund and Sure Start Scotland. While in Wales, the Cymorth initiative brings together Sure Start, Play Grant, the Children and Youth Partnership Fund, and the National Childcare Strategy, with a focus on disadvantaged areas.

1.4 The final shape of the new scheme will reflect the different – and devolved – arrangements for providing public services in England, Scotland and Wales.

1.5 All of these programmes – together with the introduction of the national minimum wage and benefits and tax changes designed to help families, notably the Child Tax Credit from April 2003 – will contribute to the Government’s target on reducing child poverty, namely to make substantial progress towards the eradication of child poverty by reducing the number of children living in child poverty by a quarter in 2004.
1.6 The Welfare Food Scheme was established over 60 years ago. It provides tokens for milk – both in liquid form and as infant formula – and vitamins to expectant and nursing mothers, and to infants and children under 5. It also provides non-means tested milk to those in day care and for a very few disabled children. It covers over 800,000 mothers and children in England, Scotland and Wales.

1.7 The scheme was conceived at a time of wartime shortages and although the coverage of the scheme has been reduced, its working has remained relatively unchanged. These proposals for reform of the scheme will bring it into line with the nutritional needs of mothers and young children in the 21st century.

1.8 The new scheme – Healthy Start – will reflect this role and make links with NHS services much clearer.

1.9 A scientific review of the scheme was undertaken in 1999 by the Panel on Child and Maternal Nutrition of the Committee on the Medical Aspects of Food and Nutrition Policy (COMA). This review informed both The NHS Plan and helped shape the proposals in this document.

1.10 These recommendations were discussed with users of the scheme, health professionals and others. While the usefulness of the current scheme was noted, the need for long overdue improvements was emphasised if the scheme is to meet the needs of pregnant women, mothers and young children. These discussions have also contributed to the development of the proposals.

1.11 We are publishing these proposals as part of an active listening exercise among current scheme users as well as engaging industry and health professionals. A programme of meetings with these interested parties is being put in place to expedite this process and to help inform the necessary formal changes to the current scheme. Individual responses to the proposals are also welcome. We will continue to work with interested groups and others after December in developing the administrative arrangements to support the new scheme.

1.12 Responses are invited by
Friday 13 December.

1.13 Please send your views to the Healthy Start team, room 633/4 Wellington House, 133-155 Waterloo Road, London SE1 8UG. Responses can also be submitted by e-mail which, together with any enquiries about the exercise, should be sent to healthystart@doh.gsi.gov.uk

1.14 Further copies of this document are available free from Department of Health, PO Box 777, London SE1 6XH. A version is also available on our website www.doh.gov.uk/healthystart The website will also carry details of the discussions groups and other news about the progress of the proposals. There will be a link to the document from our nutrition website: www.doh.gov/nutritionforum/index.htm

1.15 The scientific review of the scheme undertaken by the COMA panel is being been published simultaneously with this consultation document by The Stationery Office. Copies of the COMA report are available from The Stationery Office, PO Box 29, Norwich NR3 1GN or online from www.tso.co.uk/bookshop
2. Context for change

2.1 The Independent Inquiry into Inequalities in Health (1998), chaired by Sir Donald Acheson, reviewed the evidence on health inequalities and emphasised the importance of policies aimed at improving health and reducing health inequalities of young women, expectant mothers and young children. It showed that a baby’s long-term health is related to the nutrition and physique of its mother. Accordingly, it 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.

2.2 It also recommended increasing benefits in cash or in kind to women of childbearing age, expectant mothers, and young children to help reduce child poverty. Action has included the introduction of Child Tax Credit (due in 2003), the Sure Start Maternity Grant, and the National Minimum Wage. The impact of inequalities on the health of mothers and infants is set out in Figure 1.


2.4 The NHS Plan in England and Improving Health in Wales – A Plan for the NHS with its Partners (2000) are programmes of modernisation and reform to shape the large and sustained programme of government investment in the NHS over the next few years. They herald a new approach to the delivery of services around the needs and preferences of its users.

2.5 The NHS Plan also declared its intention of setting national health inequalities targets on infant mortality and life expectancy. These targets were announced in February 2001. A consultation exercise – Tackling Health Inequalities: Consultation on a plan for delivery (2001) – invited views on the implementation of these targets and received strong support for proposals designed to lay a sure foundation through a healthy pregnancy and early childhood. The results of the consultation were published in June 2002.
2.6 *Improving Health for Wales* built on the success of *Better Health: Better Wales* (1998) which set out the vision of tackling the underlying causes of ill health by assessing the factors that impact on health. In September 2002, the consultation document *Well Being in Wales* was published, which develops further its work to improve health and reduce inequalities through an integrated approach to policies and programmes.

2.7 The report of the Policy Commission on Farming and Food (2002), chaired by Sir Donald Curry, highlighted diet and health as key considerations in the future of the farming and food industries. It noted the prevalence of poor nutrition among children and in poorer families. The proposals for the Healthy Start scheme will help address these concerns, and will form part of the Government’s strategy on Sustainable Farming and Food to be published shortly.

2.8 These changes and developments set the context for the launch of the Healthy Start scheme in 2004. The scheme will focus attention on the diets of pregnant women, nursing mothers and their children as part of a wider effort to reduce child poverty. It will reflect the wider programmes of modernisation and change by laying the foundation for a good start in life that place the users of the new scheme at its heart.

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**Figure 1: Inequalities in Health: Mothers and Children: Some Key Facts**

- The infant mortality rate among children in social class V (1998-2000) was twice that for social class I – from 4 deaths per 1,000 live births (social class I) to 8.1 in social class V. For lone parents the rate was 7.6 per 1,000 live births.

- Infant mortality among babies of mothers born in Pakistan was 12.2 per 1,000 live births, more than double the infant mortality rate for all babies.

- Babies with fathers in social classes IV and V have a birthweight that is on average 130 grams lower than those of babies in social classes I and II. Low birthweight is closely associated with death in infancy, as well as being associated with CHD, diabetes, and hypertension in later life.

- Infants whose mothers are obese have a greater risk of developing coronary heart disease. Obesity is more prevalent in lower social classes – 28 per cent of women in social class V in England are obese, compared to 14 per cent in social class I.

3. The Welfare Food Scheme

**Origins of the scheme**

3.1 A Welfare Food Scheme has been in place since 1940. Originally, benefits were universal, but in more recent years eligibility has been primarily restricted to those on low incomes. This includes families receiving Income-Based JobSeekers’ Allowance, Income Support and Working Families Tax Credit. The nature of the foods provided has been only slightly modified over the last 60 years. Vitamin drops have been substituted for cod liver oil and orange juice, and infant formula has replaced “national dried” milk.

3.2 The current scheme is governed by the 1988 Social Security Act. It costs around £142m each year (GB, 2001-02). Around 55,000 pregnant women and 808,000 mothers and young children – some 23% of the estimated population sector aged 0-4 years – benefit from the scheme.

3.3 The nutritional health of pregnant women and children is important because – as the Acheson report emphasised – it is increasingly accepted that early nutrition affects life expectancy. Poor nutrition also helps perpetuate the inter-generational cycle of deprivation and disease.

3.4 The scheme operates across Great Britain with the Department of Work and Pensions acting as agents for the Department of Health until April 2003. In Scotland, reimbursement for the cost of welfare foods, currently around £14m annually, is met by the Scottish Executive Health Department. Similarly, reimbursement for the scheme in Wales – £9 million annually – is met by the Welsh Assembly Government.

**Recent developments**

3.5 The reform of the Welfare Food Scheme is one strand of policy aimed at improving the nutritional health of women and young children, including those in low income groups. The National School Fruit Scheme in England has already been mentioned. Complementary initiatives include Regulations on National Nutritional Standards for School Lunches, breakfast clubs in Sure Start areas and education and health action zones, the Food in Schools programme, the recent infant feeding initiative and other work to encourage breastfeeding. It also complements the undertaking in *The NHS Plan* to improve the overall balance of diet including salt, fat and sugar in food, working with the industry and the Foods Standards Agency, and to promote local action to reduce obesity.

3.6 Scotland’s annual £26m Health Improvement Fund gives priority to children’s diet, and other relevant initiatives in Scotland, such as the National Health Demonstration project Starting Well and the Breakfast Club Challenge Fund, offer similar potential. Proposals for Scottish Nutritional Standards for school meals, *Hungry for Success*, have recently been published for consultation. The award-winning Scottish Community Diet Project has a specific remit to work with low income communities.

3.7 In Wales from April 2003, Cymorth – the Children and Youth Support Fund will provide a network of targeted support for children and young people within a framework of universal provision, in order to improve the life chances of children and young people from disadvantaged areas.
Starting Well

The new £3m Starting Well project shows how child health can be improved by a programme of evidence-based activities that combines intensive home support provided by health visitors and lay health support workers and access to enhanced community-based resources for all families with new babies in target areas. The aim is for 1,800 families to receive intensive home-based support over the next three years. Its objectives are to:

• promote young children’s health (reduce adverse consequences of risk factors, improve opportunities to socialise and learn with other children)
• promote families’ well-being and health (improve parents’ self-esteem; develop parenting knowledge/skills; increase support for parents in addressing adverse life circumstances; increase parental ability to access local services and agencies)
• develop integrated service responses (increase skills of workers in relevant agencies; develop innovative and replicable means of inter-agency co-operation)

Contact with families ideally begins at the antenatal stage with a focus on parenting issues and the provision of practical support. A Family Health Plan is mutually agreed with individual families. Community-based family support services are enhanced through Local Development Funds.

The project has been welcomed by the local community – 98% of eligible families have agreed to take part. By end July 2002, Starting Well’s health visitors are providing intensive home support to almost 800 families.

The project offers support for breastfeeding mothers through the services of a local breastfeeding co-ordinator and peer counsellor. It is hoped that every NHS Board in Scotland will work towards ensuring their breastfeeding strategy will draw on the learning from Starting Well.

Best Fed Babies

In Lanarkshire, extra help is being given to pregnant women and new mothers to reduce the number of low birthweight babies and increase breastfeeding rates in its most needy areas. Working with the ASDA supermarket, the NHS and local authority launched the Best Fed Babies scheme earlier this year. Mothers-to-be are recruited by the community midwife and the scheme provides them with grocery vouchers until three months after the birth of their babies. The aim of scheme is to reduce the incidence of low birthweight babies in the area from 11 per cent to closer to the Scottish average of 2.5 per cent, and increase breastfeeding rates.
Latest Evidence

3.8 The COMA scientific review looked at the evidence to see how far the current scheme met the nutritional needs of mothers and young children in the scheme, and to see how it could improve the health of low income families.

3.9 The review said that

*while the Welfare Food Scheme retains great potential for improving the health of nutritionally vulnerable pregnant women, mothers, and young children, [it] could be improved without additional cost*

3.10 Although the scheme has enabled mothers on income support to obtain guaranteed quantities of milk or infant formula – regardless of the price charged by the retailer – the review found significant flaws. It found that the scheme

- does not meet the wider nutritional needs for 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 actually need
- provides too much milk to 1-5 year olds

Views of Users

3.11 User views on the COMA review recommendations were commissioned by the Department of Health. It was reported that

*parents were unanimous in their approval of tokens because, they said, “that way you always know that the baby gets the milk”*

There were, however, problems in exchanging seven pints of milk for a single token because some milk could become unusable by the end of the week.

3.12 Several points emerged from meetings with mothers using the scheme. These included;

- the lack of knowledge and information about the scheme – even among health professionals
- breastfeeding mothers should get the same benefits as other mothers
- the need for greater flexibility in delivering the scheme benefits – in particular, there should be more outlets for infant formula

3.13 A conference convened by the Maternity Alliance endorsed many of the COMA review recommendations, including the proposal for a wider range of foods in the scheme. It reiterated the scheme’s importance for mothers and young children and emphasised the need for greater flexibility in delivery. It was clear that a new identity would help stress the links with health rather than welfare. Other suggestions included:

- improved support for breastfeeding
- unified tokens or vouchers for all scheme users
- wider availability of infant formula – access problems to NHS clinics as distribution centres were highlighted. There was also concern that the distribution of infant formula from NHS clinics gave mixed messages to mothers against the encouragement to breastfeed
- reduced entitlement to infant formula for infants over six months, as recommended by COMA
3.14 The conference stressed that the universal nursery milk provision in the scheme led some children from relatively well-off families to receive the benefit when children from poorer families – who do not attend day care facilities – do not receive it. There was some support for abolishing nursery milk to free resources in the scheme for better targeting.

3.15 The conference also identified an opportunity to add value to vouchers through better public health and information supported by:

- providing practical health education with the vouchers, such as nutrition, recipe ideas, cooking tips
- publicising opportunities to improve cooking skills, possibly in association with Sure Start, and
- improving awareness of the scheme among health professionals and other health workers

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**North Hull**
A health visitor in an area of high deprivation initiated an intervention that included one antenatal visit that focused on the benefits of breastfeeding. A breastfeeding support group was also set up. Breastfeeding initiation rates more than doubled from 14% to 34%. The breastfeeding rates for women in areas with standard health visiting contact remained unchanged.

**Taunton and Somerset**
Midwives working in conjunction with health visitors on a large council estate with high deprivation and unemployment established a breastfeeding support group. Sixty-five percent of the mothers who attended the group were under 25 years of age. Ten local women trained as peer supporters, and midwives and health visitors received training on supporting breastfeeding mothers. The breastfeeding initiation rate increased from 55% to 74%.

**Doncaster**
Midwives set up a peer training programme to enable local young mothers who had breastfed to support other mothers in hospital and in the community. Ten volunteers were recruited and trained. Mothers viewed volunteers as strong and effective role models, a source of practical advice and someone approachable who had sufficient time to talk. Their knowledge and experience meant they could support women in integrating breastfeeding into everyday life. Breastfeeding rates increased from 51% to 60% during the project. Peer supporters are now going into schools to talk to teenagers about the benefits of breastfeeding.

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**Figure 3: Encouraging Breastfeeding**
The Infant Feeding Initiative in England funded 79 breastfeeding practice projects over three years. The projects show how changing practices to meet the individual needs of disadvantaged groups can increase breastfeeding rates.
4. Healthy Start

4.1 These proposals for Healthy Start are designed to make the most effective use of the resources available under the current scheme – around £142m a year – and to bring the scheme up to date. These options take account of the evidence from the COMA review (see annex 3) and user views from the conferences and discussion groups held after its publication. The results of this exercise will also help shape the working of the new scheme.

4.2 The new scheme is being built on the central recommendation of the COMA review to broaden the range of foods in the scheme to meet the current nutritional needs of pregnant women, nursing mothers and young children.

While the Welfare Food Scheme offers chiefly milk and infant formula, Healthy Start will offer a choice of ‘healthy’ foods to pregnant women, nursing mothers and their children.

4.3 This document outlines how Healthy Start will work and it covers the following issues:

- scope and coverage
- issues of distribution, and
- the inclusion of health advice

4.4 It also underlines the opportunities in Healthy Start to link to other relevant public health programmes – breastfeeding, smoking in pregnancy – as well as with the Sure Start programmes in England, Wales and Scotland.

4.5 **We propose** to widen the nutritional basis of the scheme. The COMA review recommended broadening the range of foods on offer in the scheme to more closely meet current nutritional needs, and to help address health inequalities. The range of foods available under Healthy Start is likely to include fruit and vegetables, cereal-based foods, other foods suitable for weaning, and in addition to milk and infant formula. The detail of how the Healthy Start proposals compare to the current scheme is set out in Figure 4.

4.6 **We propose** to retain the current age range so that children will be eligible for the scheme up to their fifth birthday as at present.

4.7 **We propose** to introduce a fixed face voucher instead of the present token. This voucher – together with the wider range of foods – will equalise the benefits for breastfeeding and non-breastfeeding mothers, and address the perverse incentives that discourage breastfeeding. Building on recent initiatives, we are also looking to identify other ways of encouraging breastfeeding – and improving the overall value of nutritional benefits available to mothers and their babies.

4.8 We have not fixed the value of the voucher. The face value will be influenced by the results of this consultation exercise. **We propose**, however, that the voucher will enable pregnant women and mothers to buy a wider range of foods broadly equivalent to the value of seven pints of liquid milk a week – the allowance provided under the current scheme. While a flat rate value scheme has administrative advantages, current arrangements provide infant formula for bottle-fed infants aged 0-6 months in order to meet their specific nutritional needs. We are considering how give extra support to this group within the new scheme and would welcome views. The current scheme also provides infant formula for infants aged 6-12 months.
4.9 **We propose** to launch a programme of public education and information. This will provide support for pregnant women, mothers-to-be and carers to help them make the best use of their vouchers in obtaining a more balanced diet for themselves and their children. It will also help link with other public health and nutrition policies, such as breastfeeding and smoking in pregnancy. This programme will be underpinned by training and support for health professionals.

### Nursery Milk

4.10 Milk for children at nursery and in child care to their fifth birthday is an important, non-means-tested, part of the scheme. It has valuable health aspects, including the prevention of dental caries but, as with younger age groups, the COMA review noted the risk that some children might be receiving excessive amounts of milk – in this case, through double provision at home and at nursery.

4.11 **We propose** to offer a choice of milk or a piece of fruit to these children. This takes account of the comments in the COMA review and is in line with our commitment to widen nutritional choice under the scheme.

4.12 The arrangements for Healthy Start will need to take account of the changes in educational arrangements where children over the age of three will have the right to a nursery school place from 2004.

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**Figure 4: Current Scheme and Healthy Start Compared**

<table>
<thead>
<tr>
<th>Who gets what</th>
<th>Current scheme</th>
<th>Healthy Start proposals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women</td>
<td>7 pints milk each week, paid by token</td>
<td>Fixed face value weekly voucher for ‘healthy’ foods (covering fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula)</td>
</tr>
<tr>
<td>Age 0-6 months</td>
<td>Either 900g infant formula, or mother gets 7 pints milk each week if breastfeeding</td>
<td>Fixed face value weekly voucher for ‘healthy’ foods (covering fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula), possibly at a higher rate Breastfeeding and non-breastfeeding mothers will get the same benefit</td>
</tr>
<tr>
<td>6-12 months</td>
<td>Either 900g infant formula, or mother gets 7 pints milk each week if breastfeeding</td>
<td>Fixed face value weekly voucher for ‘healthy’ foods (covering fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula) Breastfeeding and non-breastfeeding mothers will get the same benefit</td>
</tr>
<tr>
<td>12 months to 5th birthday</td>
<td>7 pints milk each week paid by token</td>
<td>Fixed face value weekly voucher for ‘healthy’ foods (covering fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula) Breastfeeding and non-breastfeeding mothers will get the same benefit</td>
</tr>
<tr>
<td>Non-means tested: children in nursery or day care</td>
<td>1/3 pint of milk a day</td>
<td>1/3 pint of milk or piece of fruit each day</td>
</tr>
</tbody>
</table>
Vitamins

4.13 We propose to retain vitamins in the new scheme and promote their uptake among mothers and young children covered by the scheme. Vitamin supplements are an essential part of the scheme according to the COMA review but the current level of uptake and the awareness of the supplements is extremely low.

4.14 We acknowledge that further work will be needed on this part of the scheme to bring it up to date. In particular, a reformulated version of supplement for mothers and children will be needed to match the COMA review recommendations. We propose to invite expressions of interest from industry in developing reformulated vitamin supplements for the scheme.

We would be interested to hear your views on the proposed nutritional scope of the scheme, including:

- are there any other foods that should be included in the remit of the scheme (beyond fruit and vegetables, cereal-based foods, other foods suitable for weaning, as well as milk and infant formula)?
- should the voucher scheme provide extra support for younger infants?
- what other options are there for professional support and training and public education? (e.g. to encourage breastfeeding)

Figure 5: The Work of Sure Start

**West Cumbria**
Sure Start Copeland is funding a food co-op to improve access to well-priced, healthy food. Local producers deliver produce to the group and volunteers put it into bags. Buyers usually have to collect, but special deliveries can be arranged. For a couple of pounds a week people get seasonal produce that hasn’t travelled far, so it’s still fresh. Another project is called Big Beautiful Babies, where mothers come for exercise and healthy eating advice. If parents are eating healthily they are more likely to feed their kids healthy food.

**Bridgwater, Somerset**
At Bridgwater’s Growing Project, parents and children are learning how to grow fruit and vegetables with support from a community horticultural worker and tutor. Following on from this, a basic food hygiene course and cooking sessions take place so that the fruits of their labours can be appreciated to the full. A local parent involved in the project said; “The Growing Project gets you back in to having a social life, it’s good fun for all of us, and gives us the chance to grow our own food, and cook and try new foods.”

**Mansfield, Nottinghamshire**
Sure Start Ravensdale has very popular cook and eat sessions where 20 parents and children enjoy making simple, nutritious meals. These sessions are helping local families to improve their diets, realise that children have small appetites, and if they are constantly provided with sweets between meals, they are unlikely to have space for meals, and also to eat together as a family. It is also helping families to realise that it is often cheaper to prepare home cooked food rather than to buy ready made.
Distribution issues

4.15 Healthy Start will be run by the Department of Health throughout Great Britain. It will link with devolved policies on public health, health inequalities and nutrition.

4.16 We have already proposed to distribute benefits by a fixed face voucher that will give access to the range of foods outlined above. This voucher will cover fruit and vegetables, cereal-based foods, other foods suitable for weaning, liquid milk and infant formula. Initially, it will be issued through a central contractor to provide greater flexibility and to reduce the administrative burdens of the scheme. In the longer term, we may consider options for linking the scheme more closely to the NHS.

4.17 Indications from industry suggest that the distribution of the wider range of foods to be covered by the voucher is likely to be feasible using the same outlets as at present, including doorstep delivery, local retailers (including post offices), supermarkets, local co-ops and community businesses. We are interested in exploring possible links with food co-ops and similar local initiatives under the new scheme to link with other work on improving food access.

4.18 A fixed face voucher could also improve access to healthy foods in deprived communities by acting as an incentive to shopkeepers to stock a wider range of ‘healthy’ foods than at present and help increase the use of the local shops.

4.19 We propose to deliver the vitamins separately from the fixed face voucher scheme.

4.20 Under the Welfare Food Scheme, vitamins and infant formula are distributed at NHS clinics in person to scheme users. Infant formula will no longer be distributed in person through NHS clinics but rather distributed through retail outlets, including pharmacies and linked to the voucher. Making infant formula more widely available will help meet concerns about access of both the COMA review and users of the scheme. It will also overcome concern about mixed messages on breastfeeding from the NHS, and significantly reduce the administrative pressures on these clinics.

4.21 We are exploring options for the supply of vitamin supplements. These options include continuing to provide vitamins through NHS clinics or through prescribing vitamins to mothers and children covered by the scheme.

4.22 Clinics will have an opportunity to refocus their efforts on advice and guidance on the health and nutritional needs of mothers, babies and young children. The lack of a clear link between mothers and children covered by the scheme and the NHS and health advice has been a longstanding weakness of the current scheme. The absence of such a link was highlighted by the COMA review and developing such links is dealt with in the next section.

We would be interested to receive views on issues related to the distribution and administration of the scheme, for example:

- how could the scheme be extended to link with and support other initiatives aimed at improving food access, such as food co-ops, community businesses and home delivery?
4.23 We propose to build better links between the NHS and the mothers and children who will be covered by Healthy Start, using the scheme to help secure access to health advice and support in the period before birth and the early years of life.

4.24 The scheme will work on the same principle as the Sure Start Maternity Grant. This has already demonstrated how benefits and health advice can be linked, with award of the grant dependant on a health professional certifying that the applicant has received advice on maternal and child health. We are interested in aligning more closely the arrangements for pregnant women between Healthy Start and the Sure Start Maternity Grant, not least to make the best use of primary care resources.

4.25 There are considerable potential gains in an approach that brings the poorest mothers into closer touch with the NHS at an early stage in their pregnancy. The evidence suggests that low-income families tend to have poorer access to preventive health care and poorer health outcomes. Acheson and others have shown that targeted intervention at this stage may help to reduce the risk factors for these children. Establishing a firm link between Healthy Start and preventive health provision could provide a lever to help ensure improved services that are accessible to low income groups as well as offering an incentive for service uptake.

4.26 There is clear evidence that breastfeeding confers both short and long term health benefits for both the mother and infant and that these benefits extend beyond the periods of breastfeeding. Women from disadvantaged areas, whose children are generally most at risk from ill health, are the least likely to breastfeed. For example, in England, only 57 per cent of babies born to mothers in social class V were initially breastfed (2000), compared to 91 per cent in social class I. This gap widens to 26 per cent of mothers who have never worked breastfeeding after six weeks, compared to 60 per cent among mothers in higher occupations.

4.27 The evidence indicates that one of the health benefits of breastfeeding appears to be the protective effect against the most common infectious illnesses that require infants being admitted to hospital. For example, compared to babies who are breastfed, babies who receive infant formula are five-and-a-half times more likely to be admitted with gastroenteritis. There is a clear need for increased support for breastfeeding mothers, particularly those from disadvantaged areas.

4.28 High quality antenatal and parenting support depends on a flexible approach, with services tailored to individual needs and preferences and based on the best available evidence. Additional support needs to be targeted towards disadvantaged families and communities. The link between Healthy Start and preventive services should support this approach. Figure 6 shows how we propose to make it work:
Before the birth of the child

4.29 We propose that mothers-to-be should register for Healthy Start through an early antenatal booking visit, preferably before 14 weeks, following confirmation of pregnancy. Relevant advice and guidance in areas such as nutrition in pregnancy and smoking cessation will be given as part of the booking visit. The midwife will register the mother-to-be in the Healthy Start scheme, on a similar basis to the Sure Start Maternity Grant.

4.30 There is good evidence of improved outcomes when mothers receive comprehensive antenatal care with regular reviews. There is also evidence that disadvantaged groups currently have fewer antenatal contacts. The Healthy Start link is designed to encourage uptake of antenatal care among low-income groups and help reduce health inequalities.

After the birth of the child

4.31 There is an opportunity to build on the new birth visit at home to promote additional contacts between the new mother and baby and the NHS, including the provision of advice and support on breastfeeding and nutrition.

4.32 We propose to carry forward benefits until a review at a child health clinic within the first three months of life. The mother would use this clinic visit to re-register for the scheme.

4.33 This visit will provide an opportunity to encourage continued breastfeeding and healthy weaning, promote the uptake of immunisation, and offer physical examination – in accordance with the best available evidence.
4.34 Healthy Start is designed to build on the primary care contacts already established with pregnant women and mothers and children, and encourage wider use of the available services, including community health visitors and community services. We are exploring further opportunities for re-registering at a clinic attendance when the child is between 12 and 14 months.

4.35 The contacts between the NHS and children from 0-5 years are linked to the timing of formal programmes, such as immunisation and child health promotion programmes. After age 1, these NHS contacts are less frequent and determined by need. There are links between this older age group and other services, such as nurseries and Sure Start.

4.36 In the longer term, we are interested in ways of developing incentives for the new scheme that will encourage the pursuit of healthy choices and engagement with NHS services on a continuing basis.

4.37 The introduction of Healthy Start will be accompanied by a programme of public education and professional training. This will help get the best out of the contacts between NHS primary care services and the users of the scheme.

We would welcome any further views on the

- scope for sustaining contact with the NHS during the early years of life
- potential role of health professionals, lay health workers and Sure Start in the scheme
- support materials and professional development opportunities for health workers to promote breastfeeding and healthy nutrition among low income groups?
- enhancing regional and primary care service links with food and nutrition policies?
5. Establishing Healthy Start

5.1 The NHS Plan envisaged that a new scheme would be in place by 2004. The steps needed to move from the proposals set out in this document to making it happen on the ground are summarised in Figure 7.

5.2 The main elements of Healthy Start have been shaped by the COMA scientific review and the subsequent conference and discussion groups set up to consider the review's recommendations. This document also invites views and suggestions on the proposals and about how to make the new scheme work effectively. The change of the name and the principles on which it operates will require formal amendment.

5.3 The administrative arrangements of the current scheme will need to be revised before the introduction of Healthy Start as the Department of Health takes over responsibility for issuing scheme tokens across Great Britain from April 2003 through a central contractor. Transitional arrangements for 2003-04 have been agreed.

5.4 Beneficiaries paid by automated credit transfer and qualifying new Child Tax Credit beneficiaries will have tokens issued by post by the new contractor from April 2003. Existing beneficiaries paid by order book will continue to obtain their tokens from the Post Office until October 2003. From October, the contractor will issue all tokens.

5.5 We will be seeking to learn from good practice elsewhere in establishing the new scheme. Evaluation will be built in as the scheme develops.
A New Identity for the Scheme

5.6 We propose to call the new scheme Healthy Start. This change of name is an important chance to signal a shift of emphasis in the new scheme to health rather than welfare and dependency. Scheme users and health professionals observed that the scheme had lost the public affection it had enjoyed when provision was universal. The challenge for Healthy Start is to restore this affection and esteem.

5.7 We propose that this change in identity should be accompanied by more effective promotion of the scheme. As a first step this will include making

- health professionals and health care workers more aware about the scheme as a useful public health intervention
- users more knowledgeable about the choices under the new scheme, through well designed information and health education materials
- potential users more aware of the existence and benefit of the scheme

5.8 The Maternity Alliance conference emphasised the importance of engaging health professionals in the work of the scheme. This will be vital, given their role in registering applicants for the new scheme. The conference suggested that the role of health professionals will be helped by the ready availability of clear evidence-based information to assist promoting scheme benefits. Leaflets and other materials will also need to take account of different language needs. Information about the role of the scheme will also need to be included in basic professional education and continuing professional development.

We would welcome further views and suggestions including

- any suggestions for making the scheme more acceptable to users?
- how might we engage professionals more effectively in the promotion of the scheme?
ANNEX 1: Summary of proposals and questions

Healthy Start is designed to meet the nutritional needs of pregnant women, mothers and young children in a scheme that is modern and flexible to users and makes links to the NHS primary care and other relevant services. This annex lists the proposals and questions in the document.

**Proposals**

1. **We propose** to widen the nutritional basis of the scheme (para. 4.5)

2. **We propose** to retain the current age range covered by the scheme so that children will be eligible for the scheme up to their fifth birthday as at present (para. 4.6)

3. **We propose** to introduce a fixed face voucher instead of the present token (para. 4.7)

4. **We propose** that the voucher will enable pregnant women and mothers to buy a wider range of foods broadly equivalent to the value of seven pints of liquid milk (para. 4.8)

5. **We propose** to launch a Healthy Start public education and information campaign (para. 4.9)

6. **We propose** to offer a choice of milk or a piece of fruit to these (nursery school) children (para. 4.11)

7. **We propose** to retain vitamins in the new scheme and promote their uptake among mothers and young children covered by the scheme (para. 4.13)

8. **We propose** to invite expressions of interest from industry in developing reformulated vitamin supplements for the scheme (para. 4.14)

9. **We propose** to deliver the vitamins separately from the fixed face voucher scheme (para. 4.19)

10. **We propose** to build better links between the NHS and the mothers and children covered by Healthy Start (para. 4.23)

11. **We propose** that mothers-to-be should register for Healthy Start through an early antenatal booking visit (para. 4.29)

12. **We propose** to carry forward benefits until a review at an early child health clinic within the first three months of the birth of the child (para. 4.32)

13. **We propose** to call the new scheme Healthy Start (para. 5.6)

14. **We propose** that this change in identity should be accompanied by more effective promotion of the scheme (para. 5.7)

**Questions**

**Scope and Coverage of Healthy Start**

( paras 4.5 to 4.14)

*We would be interested to hear your views on the proposed nutritional scope of the scheme, including*

- are there any other foods that should be included in the remit of the scheme (beyond fruit and vegetables, cereal-based foods, other foods suitable for weaning, as well as milk and infant formula)?
- should the voucher scheme provide extra support for younger infants?
- what other options are there for professional support and training and public education? (e.g. to encourage breastfeeding)
Distribution Issues (paras 4.15 to 4.22)

*We would be interested to receive views on issues related to the distribution and administration of the scheme, for example;*

- how could the scheme be extended to link with and support other initiatives aimed at improving food access, such as food co-ops, community businesses and home delivery

Making Better Links with the NHS and Primary Care (paras 4.23 to 4.37)

*We would welcome any further views on the*

- scope for sustaining contact with the NHS during the early years of life
- potential role of health professionals, lay health workers and Sure Start in the scheme
- support materials and professional development opportunities for health workers to promote breastfeeding and healthy nutrition among low income groups?
- enhancing regional and primary care links with food and nutrition policies?

A New Identity for the Scheme (paras 5.6 to 5.8)

*We would welcome further views and suggestions including;*

- any suggestions for making the scheme more acceptable to users?
- how might we engage professionals more effectively in the promotion of the scheme?

The closing date for responses is **Friday 13 December.** Please send your views to the Healthy Start team, room 633/4 Wellington House, 133-155 Waterloo Road, London SE1 8UG. Responses can also be submitted by e-mail which, together with any enquiries about the exercise, should be sent to healthystart@doh.gsi.gov.uk
The Welfare Food Scheme was introduced as a war-time measure to improve the nutritional status of children. It was originally a universal benefit, but since the 1950s most of the scheme has been linked to receipt of Income Support benefits. It is provided under the 1988 Social Security Act.

Currently, the scheme provides milk and vitamins in kind, primarily to expectant and nursing mothers, babies and children aged under 5 in low income families (i.e. those in receipt of Income Support or Income Based Job Seekers Allowance).

### ANNEX 2: The current scheme

<table>
<thead>
<tr>
<th>For those in receipt of Income Support (IS) or Income-based Job Seekers Allowance (IBJSA)</th>
<th>Milk token issued without application, with benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>• a token for 1 pint of milk each day for pregnant and nursing mothers, and for children under 5 years of age in families. (Breastfeeding mothers are expected to drink the milk.)</td>
<td>Exchange at registered retailers, or milkmen</td>
</tr>
<tr>
<td>• or, for babies under 1 who are not breastfed, a token for one 900g tin of infant formula each week instead of liquid milk</td>
<td>Exchange at NHS clinics or outlet appointed by NHS</td>
</tr>
<tr>
<td>• vitamins are also available free of charge for pregnant women and children</td>
<td>Issued on application at NHS clinic</td>
</tr>
</tbody>
</table>

**Non-means-tested elements, for all families:**

- one-third of a pint of milk each day for children under 5 attending nursery or day care

**Other beneficiaries:**

- a pint of milk a day for children aged 5 to 16 who are not registered pupils at a school because of disability (very few children qualify for this latter benefit).

- 1 tin of infant formula each week at a fixed reduced price for families with a child under 1, for families whose Working Families Tax Credit is reduced by £71 or less.

**Costs:** The scheme covers England, Scotland and Wales and costs £142m a year.
ANNEX 3: Summary of scientific review of the Welfare Food Scheme

Report of the Panel on Child and Maternal Nutrition of the Committee of the Medical Aspects of Food and Nutrition Policy

Introduction

The COMA Panel on Maternal and Child Nutrition has undertaken the first scientific review of the Welfare Food Scheme since its inception in 1940. It has

• reviewed current dietary recommendations
• identified from national data, population groups vulnerable to adverse nutritional outcomes
• evaluated the contribution of the current scheme to prevention of these vulnerabilities, and
• identified further information needs and highlighted improvements likely to be cost neutral

History and Entitlement

Originally the scheme incorporated universal provision. Subsequently it was targeted at the most socio-economically vulnerable. Today, a quarter of children under five are beneficiaries by virtue of their family’s income. The scheme has two principal beneficiary groups:

• pregnant women, mothers and young children in families eligible for certain social security benefits. With the exception of children under one year of age, all are entitled to a pint of milk a day (using redeemable milk tokens) and free vitamin supplements (available from designated clinics). Infant formula instead of milk is available for infants who are not breastfed
• children under five years attending scheme-registered day care facilities can receive one-third of a pint of milk a day. Children aged 5-16 not registered at school by virtue of mental or physical disability are entitled to a pint of milk a day.

Current diet and vulnerable groups

The following adverse nutritional outcomes were considered

Pregnant women and mothers
• low uptake of periconceptional folic acid supplements
• low dietary intake during pregnancy
• vitamin D deficiency

Infants
• low levels of breastfeeding
• early introduction of solids
• failure to thrive

Young children
• iron deficiency anaemia
• vitamin D deficiency
• dental caries

School aged children
• poor dietary patterns
• fatness

These outcomes were frequently associated with lower social class, low income, low maternal age, low educational attainment or ethnic minority origins.
**Effects of the scheme**

In addition to the nutritional contribution of welfare foods, the scheme offers significant economic benefit to low income households. It also has potential to meet a significant proportion of nutrient intakes of all beneficiaries. The entire nutrient requirements of young infants are met by the provision of infant formula.

Uptake of vitamin supplements, potentially the most valuable scheme product, is very low among all beneficiary groups, in contrast to milk uptake which is very high. The majority of mothers prefer to use their tokens for infant formula reflecting the low prevalence of breastfeeding. Approximately 50 percent of children in day care attend facilities registered with the scheme. Children already receiving milk by virtue of their families’ income may consequently receive excessive amounts of milk.

There is a need to consider the scheme’s place in the context of other public health programmes directed towards prevention of nutritional vulnerability. These include health education programmes, professional and peer support initiatives, secondary prevention (notably screening programmes), fortification of food and fluoridation of water.

**Conclusions**

- the Welfare Food Scheme retains great potential for improving the health of nutritionally vulnerable pregnant women, mothers and young children
- the current provisions meet entire nutrient requirements during the first half of infancy. They therefore provide an important safety net for this group who have high growth potential and vulnerability to disease
- currently there is no incentive for mothers to breastfeed as the retail value of the formula allocation exceeds that of liquid milk they receive
- vitamin supplements are a simple, cost effective intervention not merely for those who are current beneficiaries of the scheme. Currently uptake is very low and improved systems of provision are needed
- the volume of formula provided for children over six months exceeds requirements and could be reduced in favour of provisions which would encourage timely complementary feeding. Extension of formula provision into the second year of life would probably reduce the prevalence of iron deficiency
- consideration should be given to changing the formulation of vitamin preparations provided to pregnant women, breastfeeding mothers and young children
- provision of milk for children attending day care facilities should take account of milk entitlement at home in order to reduce the risk of excessive intake at the expense of a more varied diet
- the individual nutritional requirements of children with special needs should be met by a means more flexible than the Welfare Food Scheme
ANNEX 4: The US Food Programme for Women, Infants and Children – The WICs Programme

Established in 1972, the Special Supplemental Food Programme for Women, Infants and Children, the WICs programme, aims to ‘improve the nutrition and health status of low income, nutritionally at risk pregnant, breastfeeding and postpartum women, and pre-school children by providing vouchers for a range of nutritious foods, nutrition education and some health care’.

The Federal Government manages the scheme and State health departments (and local health service providers) are funded to implement it. Most participants receive food vouchers from the State. The vouchers can only be used in authorised shops, list the foods that can be bought and are issued on a regular basis. Some agencies also distribute foods through warehouses or deliver them to participants’ homes.

The core list of foods included in the scheme are high in nutrients frequently found to be lacking among the target groups. Providers can make some decision as to the foods they include in the scheme, and participants can choose, to some extent, how they use their vouchers. Core foods currently included are:

- Fortified milk formula for artificially-fed infants
- Fortified cereal and juice (or fruit juice)
- Milk, cheese, eggs, dried beans and peas, carrots, peanut butter and canned tuna

A Farmers’ Market Nutrition Programme has been introduced to increase consumption of fruit and vegetables.

Breastfeeding education and peer-counsellors became part of the programme in 1991. Mothers are strongly encouraged to breastfeed but infant formula is provided.

In 2000, over seven million women, infants and children participated in the scheme with a cost of around $4 billion dollars (£2.7 billion pounds). 75% of funds are for foods and around 15% is spent on nutrition education.