HEALTHY START
Proposals for Reform of the Welfare Food Scheme

The Community Practitioners' and Health Visitors' Association is an autonomous section of the amicus-MSF Trade Union with over 18,000 members. It is the third largest professional nursing union and is the only union which has public health at its heart.

The CPHVA welcomes the opportunity to comment on the above proposals as we feel that reform of the Welfare Food Scheme is long overdue. Since its introduction there has been very little revision. It clearly does not meet its purpose in nutritional terms and also creates conflicts for practitioners in service provision in the workplace. Therefore, change that will increase choice and equalise benefits for the identified user groups should be supported. Our comments reflect the views of our membership in England, Scotland, Northern Ireland and Wales.

Our response will firstly comment on the proposals put forward in the Healthy Start document. We will respond to the questions posed and then raise any outstanding concerns or issues.

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

We welcome the proposal to widen the nutritional basis of the scheme to include fruit and vegetables and cereal-based foods.

We recommend that fruit, vegetables and cereal-based foods are made available to women antenatal. However, in terms of cereal-based foods for infants, these need to be obtainable after the age of six months and the term *cereal-based* needs defining because of the range and variation in quality available, as some foods are more nutritionally sound than others.

The expanded choice should be clearly defined with stated purpose. An evidence base should be developed through proper consultation with experts and users to determine food to be included.

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)

We agree that it is a sensible proposal to retain the current age range covered by the scheme presently in place, as it would require a considerable investment to extend the scheme to be

more inclusive and cover a greater age range. We would not support any reduction in the age range.

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

The CPHVA recommends that rather than a fixed face voucher, a fixed food value is determined and produced and implemented as a voucher or in an optional credit card format, which can then be used to subtract designated food items from the food bill in shops/supermarkets that have bar codes or automated systems.

The CPHVA believes that having a fixed food value would ensure equal food amounts irrespective of price. This would counteract price variations between large supermarket chains and local shops. This would ensure equality especially for those living in rural areas or where access to supermarkets is restricted in other ways. Having a food value would also reduce the likelihood of fraud and theft.

We believe this system, while offering beneficial choice, would also recognise the diversity of circumstances and backgrounds of users. Also, it will equalise the benefits to breastfeeding women and those using artificial formula feed.

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)

The CPHVA disagrees with this proposal. If the value of the vouchers is equivalent to seven pints of milk, this is less than the support for formula feeding given previously. This probably will compromise the feeding of artificially fed babies.

Currently, mothers wishing to breastfeed have been disadvantaged. With this proposal giving less to bottle feeding babies, there is no overall demonstrable advantage. There should be maintenance of what is currently available to artificially feeding infants and an increase or equalisation of what is being given to support those who are breastfed.

The CPHVA recommends that the minimum face value vouchers should be the equivalent of a tin of 900 gram artificial formula milk not seven pints of liquid milk. The reason being that we believe that the equivalent value of seven pints of milk is inadequate for the needs of child bearing/breastfeeding women and infants and it will also limit the choice in terms of improving nutritional intake.

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

The CPHVA agrees with this proposal and is willing to support its implementation as and when appropriate.

We would understand that dedicated resources would be identified to support this as no current resources should be diverted from beneficiaries to achieve this.

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

The CPHVA will respond to this proposal by saying that we believe that milk and a piece of fruit should be offered and available to nursery school children. The reason for this is that we believe that implementation of a choice would prove unworkable for nursery schools for example, who chooses – parent or child?, when do they choose?, can they change the choice? This all has implications for ordering. Also, young children do not like to be different and will not be able to understand why they have milk and others have fruit.

The CPHVA would like to also raise the issue of Local Education Authority schools. They do not always take advantage of the milk subsidy schemes. We do not feel that whether a child receives milk or not should be down to the decision of individual head teachers but rather be a national standard (statutory/mandatory).

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)

The CPHVA is in support of having supplementary vitamins in the scheme and inviting the industry to develop a reformulated supplement according to research. We would add that we would wish to see these available to all as part of the scheme or at a subsidised price to those not eligible.

The CPHVA would like to see as part of the educational programme to support Healthy Start evidence around the efficacy of vitamin supplements as there is still widespread controversy in relation to benefits.

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

As above.

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

The CPHVA agrees that vitamins should be delivered separately from the voucher scheme. This will enable promotion to all antenatal and breastfeeding women and infants and children under five years of age.

We would like consideration to be given to the new formulation to be added to the nurse prescribers formulary.

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

The CPHVA agrees with this proposal.

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

The CPHVA has great concerns with regards to a variety of issues such as registration in the antenatal period for Healthy Start – who will determine eligibility?

Linking this with public health activity to improve quality and access to antenatal care for all disadvantaged women in particular is a positive one.

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)

The CPHVA believes that **all** parents would benefit from this kind of intervention as financial status is not necessarily a predeterminant of nutritional status or knowledge. Targeting this intervention could lead to widening inequalities in health. The current proposal is an example of policy change that stigmatises users.

We object strongly that professionals, in particular health visitors, become gatekeepers to benefits in this way. We do not believe

this is an appropriate activity for public health practitioners working in partnership.

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

We are happy with the proposed naming of the scheme as Healthy Start although we do recognise that there are already health schemes in existence with that name.

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

We refer you to previous noted concerns. In addition, we would then assume there will be resources identified to do this.

Scope and Coverage of Healthy Start (paras 4.5 to 4.14)

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)?

We do not believe currently that there are other food groups that should be included in the remit of the scheme but we would urge the Department to ensure that there was clarity and definition given to ensure that individuals and professionals are clear about what fruit and vegetables and cereal-based foods and foods suitable for weaning specifically means.

We make reference to the definition of cereals previously stated in our response.

We would also recommend that with regards to fruit and vegetables that tinned and frozen foods should be considered.

We would also like consideration to be given for an extension to milk or milk products for example, yoghurt and cheese to be considered after one year of age.

Should the voucher scheme provide extra support for younger infants?

The CPHVA believes, providing the voucher scheme or the proposed scheme is for the food value previously stated ie; a 900 gram tin of milk, equivalent that young infants would be adequately supported and therefore there would be no need for any additional support (other than

good nutritional advice from health professionals). If this is not to be the case then additional support will need to be introduced.

What other options are there for professional support and training and public education? (e.g. to encourage breastfeeding)

We believe that support and training and public education would be enhanced if these were very clearly incorporated into National Service Frameworks or similar policy documents. We support the proposal to improve training and support for health professionals. Current standards of nutritional training and infant feeding are not consistent.

There should be a link between HImPs commissioning services by Local Health Boards, PCTs and LHCCs and National Service Frameworks so that an integrated public health strategy is developed with objectives and outcomes for NHS bodies.

Distribution Issues (paras 4.15 to 4.22)

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

Receiving the vouchers through the post can be unreliable. It is important to provide choice in how this happens.

We would hope that a pilot to determine best practice in terms of distribution is done. We welcome the removal of distribution from clinics but we acknowledge that in rural areas, or areas where access is problematic, this may be difficult.

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

Scope for sustaining contact with the NHS during the early years of life

See also our point made under proposal 12. We would urge the Department of Health to set up initial pilot sites for the scheme as we have grave concerns over a number of issues:

- access to the scheme at other points other than those specified due to financial changes within individual families
- access to the scheme by pregnant girls under sixteen years of age
- access to the scheme by vulnerable groups such as travelling families
- access by ethnic minorities whose first language is not English

We feel 'registration' should occur with the first contact with a health professional.

Potential role of health professionals, lay health workers and Sure Start in the scheme

Health professionals communicating to mothers with information on the availability of the scheme, giving nutritional advice and support are appropriate. However, registration and re-registration is an unnecessary action. It introduces a risk to the establishment of a partnership arrangement between mother and health professional.

Support materials and professional development opportunities for health workers to promote breastfeeding and healthy nutrition among low income groups?

In order to raise the standards of service in this area, there needs to be additional training for health professionals. Locally prepared policy should be developed with information and support that is culturally appropriate to these groups.

We note no reference is made within this consultation for those who have no recourse to public funds, in particular low income group. We would like to see some provision and support available to this group.

Many in the low income group are from ethnic minorities, they are a group discriminated against on many fronts. We would expect the new scheme to address the inequality and discrimination they fact positively.

Also, we note that schemes such as Sure Start and their associated benefits differ in Wales and Scotland.

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

Any suggestions for making the scheme more acceptable to users?

Less stigmatising in order to achieve this remove requirement to register with health professional.

Linking the scheme to Sure Start, HAZ programmes or other community development projects may increase acceptability.

How might we engage professionals more effectively in the promotion of the scheme?

If clearly indicated in the National Service Framework for Children it will be a responsibility to address this. NHS organisations will then need to ensure their professional staff are engaged.

Other Issues the CPHVA Wishes to Raise

- Any reduction in milk carries a risk of overdilution of milk in early introduction of liquid milk.
- Development of food co-ops, mobile shops or other community schemes will be important within certain communities as well as shops and supermarkets, milk rounds. As will be using a variety of venues, parent craft, family centres, healthy living centres to engage with families to give information, teaching and distribute as well as the media.
- It is preferred if organisations supporting the schemes are not for profit.
- As there is the potential for commercial organisations to be affected, we recommend impact assessment to determine the extent of this.
- If health professionals get involved in registration they will be called upon by potential beneficiaries to make some determination regarding their eligibility which they are unable to do – registration or failure to may be veined as an omission by the health professional.
- We are concerned that this document was given only a short consultation period and we also experienced difficulties in accessing copies of the document. We feel an issue such as this affecting such a large number of people should have had a longer and more comprehensive consultation period.
- We would also like to raise concerns regarding children who have food intolerances. How will the new scheme work for them? As many specialist foods are more costly, will they be eligible to receive these foods on prescription? Will nurses be able to prescribe once diagnosis is confirmed? We would like to see these foods added to the Nurses Formulary?
- With regards to breastfeeding equipment, we would like consideration to be given to an expansion of equipment currently available for example, breast pumps.
- We believe that all low income families including families receiving Family Tax Credit, should automatically be in receipt of this benefit.
- We also believe that all families, irrespective of financial status, should be receiving the same nutritional support in line with WHO guidance.

If you have any queries or require further expansion on points raised, please do not hesitate to contact Obi Amadi on 020-7939 7046 or at Obi.Amadi@amicus-m.org