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# Food welfare for low-income women and children in the UK: a policy analysis of the Healthy Start scheme

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For Robin Patrick Machell and Victor Henry Streit.

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## Declaration

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## Abstract

Food welfare for low-income women and children in the UK is an unexplored area of food policy. The current food welfare scheme for low-income women and children in the UK is called Healthy Start, and this replaced the previous Welfare Food Scheme in 2006. The main changes were that Healthy Start was intended to be more health focussed and aimed to influence behaviour change by providing a voucher that could be spent on fresh (and later frozen) fruits and vegetables, milk or infant formula. The previous scheme only provided milk and infant formula. In addition it was intended that there would be more interaction with health professionals as part of the scheme. Little is known about why the Welfare Food Scheme changed to Healthy Start and what influenced the initiation, formation and implementation of Healthy Start. Nor is there substantial information on how Healthy Start operates in practice. The objectives of this thesis were to consider what influenced the development of Healthy Start and to consider how Healthy Start as a policy relates to Healthy Start in practice.

After mapping how Healthy Start was developed, what is known about the scheme, undertaking a literature review on subject specific literature, research questions were developed to direct the line of inquiry. A theoretical literature review explored methods of policy analysis that could inform the overarching methodology. Models of policy analysis and literature on the policy process were developed to better understand the policy process that informed Healthy Start.

To address the research questions, three phases of research were undertaken. The first was a policy analysis of publically available policy documents using Kingdon's concept of policy streams to make sense of the process; the second was a series of semi-structured interviews with policy participants to add detail to the first phase. A recurring issue was the role of the Health Professional in delivering Healthy Start, and a case study with health professionals who deliver Healthy Start in one Borough of London was developed to further explore this issue.

The findings indicate that the shift from the Welfare Food Scheme to Healthy Start was largely influenced by political factors, with inadequate consideration of public health objectives and practical components of behaviour change. A lack of training and support for health professionals who are gatekeepers of the scheme was apparent at all points of the policy process. By tracking the development of the Healthy Start scheme and its place within food welfare this research highlights the need for more thorough consultation and thoughtful development if complex schemes crossing welfare and food policy are to be successful.



## INTRODUCTION

Since 2006, Healthy Start has been the government food welfare scheme in the UK that provides supplemental nutrition to pregnant teenagers, low-income pregnant and breastfeeding women and their young children. The broad objective of the scheme is to be a 'nutritional safety net'. Beneficiaries of the scheme receive vouchers that can be exchanged for plain, fresh or frozen fruits and vegetables, milk and/or infant formula. Additionally, free maternal and infant vitamins are available through the scheme.

The UK has provided a form of welfare food provision for women and children since 1940, however there has been little research that examines how, or why, government policies aimed at supplementing the nutrition of vulnerable populations actually come into being. Food policy analysis typically focuses on the outputs of policies: what policies achieve or don't achieve. This thesis also considers the inputs involved in the policy process, specifically factors that influenced the initiation, formation and implementation of Healthy Start.

In attempts to clarify the often messy processes that inform new policies, the process of making policy is often broken down into four stages (Heywood 2000): initiation, formation, implementation and evaluation. There is a lack of analysis that explores the four stages in relation to Healthy Start. The only stage, which has been explored through research, is 'evaluation', although there is a lack of critique or review that unpicks the role of evaluation or impact of evaluation on the Healthy Start scheme. The Department of Health commissioned two evaluations of the scheme that were published in 2013 (Lucas, Jessiman, Cameron, Wiggins, Auterberry and Hollingworth 2013; McFadden, Fox-Rushby, Green, Williams, Pokhrel, McLeish, McCormick, Anokye, Dritsaki and McCarthy 2013). The evaluations provide insight into what was considered in the formation of Healthy Start as well as how the scheme operates on the ground.

The evaluations of Healthy Start (Lucas et al. 2013, McFadden et al. 2013) suggest that the programme is a valuable public health initiative that could support the health of generations of babies born into poverty in the UK. A number of issues and uncertainties with the scheme were also highlighted by the evaluation reports.

Lucas et al. (2013) found that although there is need for a nutritional support programme for vulnerable families, and there are examples of good practice in the delivery of the programme, the policy aspirations of Healthy Start are not being fully realised. For example, it was reported that health professionals tasked with being the gatekeepers of the programme are not being sufficiently trained to deliver Healthy Start nor are they suitably informed about the public health objectives of the programme. Few families reported that the scheme had enabled them to significantly change their diet, however some did report it enabled them to purchase a wider variety of fruits and vegetables for their children.

Healthy Start vitamin take-up by both mothers and children is consistently low, less than 10% in many areas across England (Jessiman et al. 2013). Evaluation has found that the distribution mechanisms for Healthy Start vitamins prevent families eligible for Healthy Start from accessing the free vitamins that they are entitled to. Although the redemption rate of Healthy Start food vouchers is reported to be 80% (Department of Health 2013), the infant feeding survey results found that vouchers are mainly spent on infant formula (McAndrew et al. 2012). The emergence of new data between 2012 and 2013, presents a new perspective in which Healthy Start can be considered.

There remains a lack of research however that connects Healthy Start in practice with the original policy context for the scheme and a lack of research on what influenced the development of Healthy Start from the previous welfare food scheme. From a social policy perspective it is pertinent to explore the policy's beginnings and identify areas, moments and tensions in the policy process that can develop context in which the current operation of Healthy Start can be considered.

Healthy Start traverses both health and welfare policy areas. It is unclear how Healthy Start will be affected by changes to the welfare system in the UK in 2013/14. Given that it is likely that Healthy Start will be affected in some capacity, it is timely to reflect on how and why this programme was developed as a key welfare food policy. Doing so may provide lessons to policy makers on how decisions on the future of Healthy Start can best support the schemes suggested public health objective of being a 'nutritional safety net'.

### Personal motivation

I received a bachelor's degree in American Studies from the University of Manchester in 2005. After working in non-profit fundraising and communications with low-income populations in Chicago, I developed an interest in public health, food and social justice. This interest led me to pursue a Masters of Science in Food Policy in 2008. Throughout the Masters programme, I focussed on the relationship between policy and food poverty and food access. Upon completing the programme, I worked as a researcher for two years in the Centre for Food Policy. A key motivating factor for pursuing a PhD focussed on Healthy Start is the potential practical impact of research findings and the excitement of studying a policy area that is important, timely and unexplored.

### Why study Healthy Start?

Within the UK health inequalities exist as indicated by the differing life expectancies in different geographical areas of the country (House of Commons, Committee of Public Accounts 2010). The many and often multifaceted reasons that prevent people from accessing a nutritionally adequate diet are often referred to as 'food poverty' (Dowler 2001). Both food and nutrition poverty are complicated issues which as a result present challenges to policy makers charged with addressing food or nutrition poverty through a policy response (Dowler 2008, Attree 2006).

A key motivation in studying Healthy Start is that as a policy area, it presents itself paradoxically. Despite the fact that Healthy Start is often described as *the* nutritional safety net for vulnerable women and children (Department of Health 2014), there is relatively little known about how or why it is a nutritional safety net, why it exists in the format that it does and whether or not it is effective. The public rhetoric around Healthy Start is vague, yet it is hailed as an important government measure and the only welfare provision that specifically ring-fences money that low-income families can spend on fresh or frozen fruits and vegetables, milk or infant formula. Compared to food welfare programmes that take place in publically funded institutions, for example free school meals in state schools, Healthy Start receives very little attention from academic scholars, media or government.

Healthy Start is the only government welfare scheme that ring-fences money specifically for food and operates within the domestic sphere. Institutional food

welfare has received considerable attention through academic research (Nelson 2000) and the development of third sector organisations and networks to share best practice and advocate for free school meals. The profile of domestic food welfare, such as Healthy Start is less well known, despite the growing evidence that nutrition in pregnancy and the first years of life can have long term impacts on health (British Medical Association Board of Science 2013). It is the low profile of Healthy Start, despite its potential value that makes it an interesting and valuable topic to study.

The objectives of this work are to consider the initiation, formation and implementation of Healthy Start and to consider how Healthy Start as a policy relates to Healthy Start in practice.

### Contribution to Food Policy

As a programme, Healthy Start encompasses a number of concepts that are prevalent in debates around food policy – food access, nutritional intervention, the role of the state, tensions between civil society, industry and government. This research is being undertaken within the field of food policy. As Healthy Start is a central government funded policy, Healthy Start can be broadly situated into social policy. Social policy differs to food policy, as food policies can exist in non-government settings (Lang and Heasman 2004). Healthy Start could therefore, be described as a ‘social food policy’.

Undertaking research that explores the influencing factors on the initiation, formation and implementation of Healthy Start will develop understanding of domestic food welfare and contribute to the field of food policy by generating new knowledge on what influences food policy development for women and children in England.

Food policy is multifaceted (Murcott, Belasco and Jackson 2013). The following quote summarises a core concept that underpins much of the academic discussions of food policy:

‘Food policy is contested terrain: a battle of interests, knowledge and beliefs’  
(Lang and Heasman 2004 p.13).

The concept of ‘contested terrain’ will underpin the research and ensure the implications for food policy theory are considered.

### Epistemological approach

An integral part of the research design in this thesis is policy analysis. There is a strong literature that describes policy analysis as an ‘applied social scientific activity’ (Yanow 2000 p.3). As the objective of this research is to add to the understanding of a multifarious process and its implications, and not to scientifically test a hypothesis, an interpretive stance is taken. Taking an interpretive approach to policy analysis, enables research to go beyond mapping a process and to consider how different policy actors interpret the issues that initiated and drove the formation of Healthy Start. An interpretive approach supposes that there are multiple interpretations for decisions that can be explored through qualitative methods of data collection (Becker, Bryman and Ferguson 2012).

A key feature of the interpretive approach within policy is whether the social reality of those affected by the policy has been considered by those charged with designing policy (Yanow 2000). Evidence of the social reality of Healthy Start beneficiaries is considered in the literature review and has emphasised the need for methodology to address both the influences on policy design and the considerations for policy implementation.

The research in this thesis aims to add to the policy knowledge regarding the initiation, formation and implementation of Healthy Start. Research by John Kingdon (2003) highlights how policy makers are not always aware of how ideas for policy happened. In developing and adding to knowledge and not proving knowledge, the research in this thesis can be defined as constructionist as it is hypothesis generating (Robson 1993 p.19).

The interpretive approach does not seek to discover an answer or solution to a problem as a positivist approach might. The implications of this epistemology on the methodology, is a focus on qualitative research methods to consider how the different actors interpret aspects of the same policy process.

An interpretive approach supports the objectives of this thesis as it enables both what policies ‘say’ and what policies ‘do’ to be considered. Essentially, the overarching research design is concerned with how Healthy Start developed and how it is interpreted both as a policy and in practice.

The thesis is structured in 10 sections. It may be expected that the methodology chapter would come earlier in the thesis, however due to the large amount of background information and contextualisation, the methodology and research design is presented in chapter 5.

### Thesis structure

The objective of the **first chapter** is to contextualise Healthy Start by starting with the big picture and considering why governments provide welfare food, what is meant by a nutritional safety net and what the policy context was when Healthy Start was developed. It concludes by presenting four timelines of events that occurred throughout the initiation, formation, implementation and evaluation of Healthy Start.

The **second chapter** presents an overview of what is currently known about Healthy Start – covering details such as: eligibility, how the scheme is accessed, who key actors are, how different components of the scheme work. This chapter also critiques recent evaluations of the scheme and further justifies why considering the policy beginnings is appropriate.

The **third chapter** presents a literature review covering historical literature on food welfare, literature about Healthy Start and literature on social policy and behaviour change.

The **fourth chapter** presents methodological literature and discusses ways of using theoretical and methodological literature to undertake effective policy analysis.

The **fifth chapter** presents the methodology and details how multi-method primary research addresses the research objectives of this PhD and enabled a detailed policy analysis to be undertaken. The chapter details three phases of research: the first phase is a policy analysis based on document review, the second phase is semi-structured interviews with policy participants and the third phase is a case study with health professionals in one borough of London.

The **sixth chapter** presents findings from the policy analysis of policy documents.

The **seventh chapter** addresses what influenced the initiation, formation and implementation of Healthy Start and presents findings of both primary research – interviews with policy actors and secondary research – thematic analysis of Hansard

transcripts and unpublished policy documents that were acquired throughout the interview process.

The **eighth chapter** is a case study with health professionals in one London borough.

The **ninth chapter** – triangulates the findings into a discussion on influential factors throughout each stage of the policy process.

The **tenth chapter** presents conclusions, implications for food policy, reflections on the PhD process and recommendations for further research.

## Chapter 1: Background and policy context

*There is no answer to justify a reluctance to provide essential nourishment at the most critical stages of a child's growth and development.*

Hewetson 1946

### 1.0 Food Welfare and Policy

The development of government food welfare programmes in the UK began in the 20<sup>th</sup> century. The origins of such policy developments are often attributed to developments in nutrition as a science (Morgan 2012) and the systems of food provision that were enforced in the Second World War to ensure people across the UK had access to an adequate diet (Burnett 1989). To begin the process of thinking about food welfare as a policy area, this section considers– why governments provide food welfare and the different theoretical concepts that underpin food welfare policy. Specifically, four justifications of food welfare are presented: human capital, human rights, preventing public agitation and social ideology.

In 1943, when presenting a four-year plan for Britain, Winston Churchill said:

*There is no finer investment for any community than putting milk into babies. Healthy citizens are the greatest asset any country can have. (Churchill 1943)*

suggesting that the nourishment of a country's people is a sound investment for the future. In the first half of the 20<sup>th</sup> century, the connection between poverty, food and health was being realised in the United Kingdom (Boyd-Orr 1936). The UK had experienced military embarrassment when enlisted men were not fit to send into the Boer Wars due in part to the effects of poor nutrition. This created a clear connection between the strength of an army with population nutritional status (Fitz Roy 1904, Berridge 2013). A 1904 government report entitled *Report on the Interdepartmental Committee on Physical Deterioration*, highlighted how in order to have a strong workforce and military, governments should invest in human capital (Fitz Roy 1904). Human capital is therefore understood to be one reason why governments choose to subsidise the cost of an adequate diet.



This had been a common understanding for much of the 20<sup>th</sup> century - Hewetson (1946) was concerned that food welfare within a capitalist society did not have the interest of the people as its priority, as policy was being based on future productivity as opposed to rights. A tension therefore emerges from this concept of human capital driving food welfare.

Today, welfare in the UK is made-up of an intricate web of state mechanisms that acknowledge the structural components of poverty (Wallis 2009) by offering benefits in varying forms to the most vulnerable populations within society (Cochrane, Clarke and Gewirtz 2001). The role of the state within welfare development and implementation is multifaceted, described by Deakin as:

a highly complex institution, containing within it, like a nest of Chinese boxes, a whole series of subordinate institutions and linked in a wide variety of ways with series of other agencies and sources of power. (1994 p.2)

In the United Kingdom, the challenge which the government faced when becoming a Welfare State was how to combine the ‘economic engine’ of the free market with arrangements for ensuring social peace domestically’ (Cochrane and Clarke p.20).

The human capital conceptualisation of food welfare clashes somewhat with the human rights perspective on welfare. A human rights perspective argues that everyone is ‘entitled’ to sufficient nutrients and that addressing food insecurity is much more than addressing hunger. The following quote illustrates this point:

The right to food cannot be reduced to a right not to starve. It is an inclusive right to an adequate diet providing all the nutritional elements an individual requires to live a healthy and active life, and the means to access them. (DeSchutter 2011, p.3)

The role and responsibility of the state in ensuring everyone can access an adequate diet has been the focus of discussions around food welfare (Dowler 2007). The United Nations special Rapporteur on the Right to Food said in a report to United Nations Human Rights Council:

States have a duty to protect the right to an adequate diet, in particular by regulating the food system, and to fulfil the right to adequate food by proactively strengthening people’s access to resources, allowing them to have adequate diets. (DeSchutter 2011 p.3)

As well as conceptual understandings on why States provide food welfare, there is also a pragmatic social argument. The following quote from the Ministry of Health in 1940 provides a practical justification to why initially subsidising milk as a welfare food was important socially:

to ensure that the rise in the price of milk made necessary by the increased cost of production and distribution does not effect those classes of the community whose need for milk is greatest (Ministry of Health 110/10: 1940)

Essentially, the increased cost of food production due to the increased cost of fuel in war-time Britain, was preventing access to milk. There was a social dimension to maintaining the status quo. Land, Lowe and Whiteside (1992) suggest that a motivating factor in maintaining access to milk during World War Two was to ‘quell public agitation’ – a very practical driver in developing welfare food policy and one which is neither about productivity or human rights.

More recently, Food Welfare has been conceptualised as a way of addressing overarching social and ideological issues such as economic and health inequalities (Department of Health 2002). The New Labour government that implemented Healthy Start framed the scheme as a way of addressing health inequalities by supplementing the diets of the most vulnerable within society (Department of Health 2002).

Welfare is often discussed in terms of ideologies (Boswell and Clarke 1983) – how welfare will contribute to making a better version of society. This is reflected in the proposal for Healthy Start (Department of Health 2002). Policy is often analysed as being routed in both belief and ideology (Heywood 2000). However, government welfare is formed through policy decisions. As concepts welfare and policy have a complex relationship. Parsons (2002) discusses how ideology and policy are not wholly compatible concepts as the former is based on a system of beliefs and the latter on technical and pragmatic exchanges of information, power and agendas (Parsons 2002).

This issue of the role of the state in designing and implementing food welfare as social policy is multifaceted (Dowler and Finer 2003, Riches 1997). Dowler argues that within networks of policy makers, food as a component of social policy is ‘invisible’

and that there is an assumption from the state that responsibility for food belongs in the private and domestic spheres (Dowler and Finer 2003, p.140). This reflects Riches (1997) thesis that food welfare is being depoliticised, suggesting that governments are quick to pass the responsibility of effectively delivering food welfare to Non-Governmental Organisations, local food initiatives and faith based organisations. There is further academic discourse which supports this statement and criticises the often soft approach taken by government when it comes to making informed food welfare policy that will address the social and public health needs of low-income populations (Leat 1998, Attree 2006, Wilson 1989, Dowler 2008).

A key argument suggests that where food is visible to policy makers (Attree 2006), for example in the Healthy Start scheme, the complexity of food choice, culture and reality are not sufficiently considered. Leat (1998) highlights that the intricacy of both 'welfare' and 'food choice' make food welfare doubly complicated and argues that without substantial research on food and welfare it will be challenging to build an effective and efficient food welfare system in the UK. It is striking that this paper predates the development of Healthy Start yet provides relevant questions that if developed could have provided some valuable insight into the relationship between food and welfare before Healthy Start was developed.

Thus the drivers for developing and implementing food welfare schemes throughout the 20<sup>th</sup> and 21<sup>st</sup> century are unclear and somewhat at odds with each other.

Food welfare often gets overlooked in overall population food and health strategies. The 2010 public health strategy *Healthy Lives, Healthy People* (Department of Health 2010a) laid out proposed plans for public health that will address health inequalities and population health at the time. However the report contains no mention of food welfare and the potential benefit of schemes such as Healthy Start. It is therefore paradoxical that within the Department of Health, Healthy Start is *the* nutritional safety net for low-income children (McFadden et al. 2013; Department of Health 2014) yet it was not mentioned in a national public health strategy.

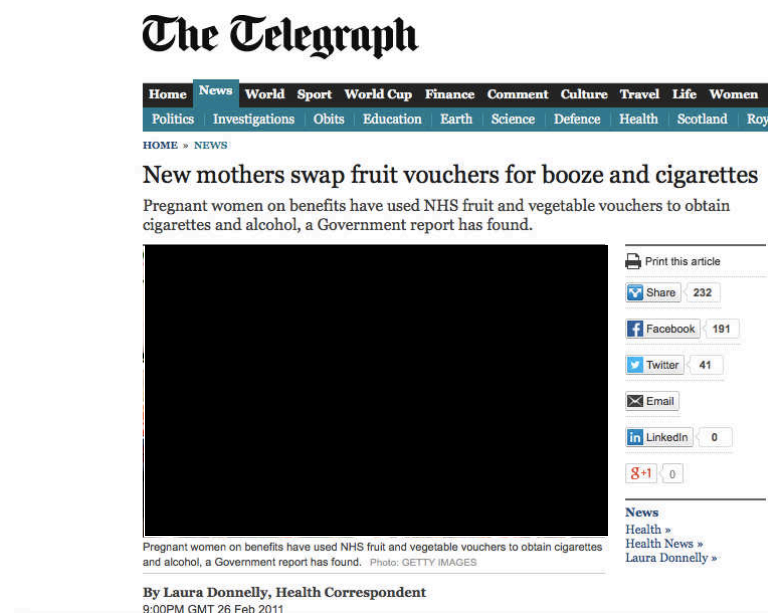
This may indicate how food welfare is viewed by central government and why it is relevant to the study of food policy. The tensions and challenges presented by food policy theorists are present in the discussions of food welfare (Lang, Barling and Caraher 2009). Primarily, these tensions revolve around the relationships between

actors and the complexity of food as an issue area. It has been argued that policymakers have addressed food issues in a somewhat ‘disparate’ manner (Lang, Barling and Caraher 2003) and that it is common for policy makers to neglect the multifaceted nature of food policy issues. Issues associated with food tend to cross-cut a number of policy areas (Murcott, Belasco and Jackson 2013). It had been suggested that policy-makers rarely address how food cross-cuts issues and as a consequence, policy responses fail to be sufficiently integrated (Barling and Lang 2003; Murcott, Belasco and Jackson 2013).

### 1.1 Perceptions of Healthy Start

Before either evaluation (McFadden et al. 2013; Lucas et al. 2013) was published, an initial scoping of grey literature (including a newspaper article, popular online parenting forums and parliamentary debates) gave some indication that perceptions of Healthy Start are wide ranging.

Figure 1 Healthy Start in the news



One headline from The Telegraph in 2011 reads “New mothers swap fruit vouchers for booze and cigarettes” (Donnelly 2011). The article went on to describe how Healthy Start was being taken advantage of by women who would rather buy ‘booze and cigarettes’ for themselves, than food for their children. Although both proponents

and opponents of the scheme provide impassioned quotes in the article, the headline sums-up media reflections of poverty that arguably shape public opinion (McKendrick 2008) and sensationalise an aspect of the scheme without fully considering the positive aspects of Healthy Start. In the article a campaigner from the Tax Payers Alliance is quoted:

*All these endless handouts from the nanny state do nothing but encourage shameless behaviour from those in society who would rather spend money on cigarettes and alcohol than on their own children.*

And:

*It's naive of the Government to give out these vouchers and expect the scheme to have an impact on how much healthy food mums or mums-to-be are buying. This misguided programme is wasting taxpayers' money and should be scrapped. (Tax Payers Alliance in Donnelly 2011).*

On the other side of the debate, a representative from the Department of Health said:

*Voucher misuse is rare and is dwarfed by the benefits. We are working with retailers to drive it down still further. We issue over 2.6 million vouchers a month and get less than 15 reports a month of retailers accepting vouchers for products that are not included in the scheme. We follow all of these up (Department of Health in Donnelly 2011)*

A report from the Rowntree Foundation considered the relationship between perceptions of poverty, the media and public attitudes (McKendrick 2008). Drawing on the work of social theorists (Coughlin 1980, Deakin 1994, Taylor-Gooby 1982, Taylor-Gooby 1985, Norris 1978), McKendrick et al. (2008) outline the features of attitudes toward poverty. The report suggests (p.10) that some key features of attitudes toward poverty are: 'moral distinctions of the relative 'deservingness' of welfare users... belief in individual rather than social-structural explanations of poverty ... and exaggerated concerns about fraud and scrounging.'

Before the McFadden et al. (2013) and Lucas et al. (2013) evaluations of Healthy Start were published, to scope public opinions of the scheme, popular online parenting forums were explored. There are many discussions on MumsNet and NetMums that

describe peoples' experiences of Healthy Start and provide some insight into how beneficiaries view the scheme:

Times are hard and they (Healthy Start vouchers) are there to make life a little bit easier for you financially. (NetMums 2011)

People are standing in line at food banks, times are hard...people are hungry. Don't let your children go without. They (Healthy start vouchers) are just another way of paying. (NetMums 2011)

These forums are generally used for people to raise concerns and ask questions to their online peers, and they therefore do not provide any representative or balanced data, they do however, provide some initial insight into the types of issues people have experienced - from waiting for months to receive their Healthy Start vouchers to being conflicted about what to do about witnessing voucher misuse.

The concerns and confusion that are illustrated in the aforementioned newspaper article and online parenting forums contrast with the political rhetoric around Healthy Start. Throughout the process of conducting research for this thesis, email alerts were set-up for whenever Healthy Start was mentioned in either the House of Lords or the House of Commons. The following quotes contextualise the range of political rhetoric around Healthy Start.

Healthy Start was mentioned in the context of helping out with the cost of living:

We also provide support to low-income families to help with the cost of living, including new born babies. For example, we are investing £105 million per year in Healthy Start Vouchers for low-income families with young children to help with essential foods and vitamins. (House of Commons 2014a)

In a debate on the role of food banks in the House of Lords, Healthy Start came-up as a way the government helps families with food poverty.

We operate a number of government initiatives aimed at helping families with food—Healthy Start, Change4Life, and the School Fruit and Vegetable Scheme—and we are extending free school meals. There are a number of other measures designed to help households in the wider context. These are the ways in which we are tackling poverty. (House of Lords 2014)

In a debate on infant mortality, Healthy Start vitamins were heralded as an important government measure:

If we are really going to tackle infant mortality and reduce our embarrassingly high rates, we need to support, encourage and promote breastfeeding and improve access to “Healthy Start” vitamins. (House of Commons 2014b)

From the above quotes, it is clear that Healthy Start is seen to be a policy response to a range of issues. It is also apparent that there are some uncertainties and gaps in clear understanding of how the scheme works in practice.

## 1.2 A nutritional safety net for women and children

Insufficient nutrient consumption by pregnant and lactating women has been linked to chronic disease experienced by their offspring in later life, and there is also clear evidence that critical periods of human development in gestation impact on health outcomes in later life (Robinson 2001, Dallison and Lobstein 1995, Acheson 1998, Langley-Evans and McMullen 2010, Abu-Saad and Fraser 2010, Godfrey and Barker 2000). Why low-income households are less likely to consume an adequate diet at key stages in the lifecycle is multifaceted (James, Nelson, Ralph and Leather 1997, Nelson, Erens, Bates, Church and Boshier et al. 2007, Scientific Advisory Committee on Nutrition 2011).

In the UK food poverty and food access issues challenge many low-income households to purchase and consume a nutritionally adequate diet (Nelson et al. 2007). In the words of Dowler, Turner and Dobson ‘the reality is there are children and adults who do not have enough to eat or cannot afford to eat healthily’ (2001, p.1). Food poverty and the potential for nutrient inadequacy perpetuates health inequalities among low-income households (Acheson 1998). The nutritional status of women pre-pregnancy, during pregnancy and while breastfeeding can impact on the development and well-being of populations (Scientific Advisory Committee on Nutrition 2011). In the UK, the life expectancy of children living in poverty is estimated to be substantially less than children living in relative wealth (House of Commons, Committee of Public Accounts 2010). Thus, there is a clear problem that demands a policy response.

Experiences of purchasing and consuming food in low-income environments is well documented and the challenges of accessing an adequate diet have been explored by academics during the last few decades (Wilson 1989, Attree 2006, Dowler 2001, Maslan et al. 2013, Dowler, O'Connor 2011). There are studies that explore the barriers that may prevent low-income women from accessing an 'adequate diet' (Anderson et al. 1995, Whelan et al. 2002, Wrigley et al. 2002). The barriers are myriad and include a wide range of social, cultural and economic issues which culminate in the conclusion that there is not one single issue that prevents an adequate diet from being consumed, thus making it challenging to design a policy that will address the range of problems that exist around food.

Within food welfare, much of the academic work has focused on food insecure populations, people who are not getting sufficient calories (energy) (Riches 1997, Poppendieck 1986). Today, there are a growing number of obese people living in poverty who are getting more than enough calories, but insufficient nutrients; this is nutrient insecurity. The problem is therefore complicated and changing.

Food welfare schemes in the UK are often described by policy makers as a 'nutritional safety net' (Department of Health 2002) that will 'catch' the most vulnerable within society and prevent them from developing chronic disease. The objectives of providing a nutritional safety net are undefined. It is unclear whether the safety net is there to catch the most vulnerable and prevent them from falling into nutritional insufficiency, or whether the safety net is there to provide a minimum level of nutritional support to a wider population. Given the intricacy of food and nutrition poverty, building a nutritional safety net would logically require a number of different interventions. Fletcher, Bell and Lambert (2004) suggest three approaches to addressing micronutrient deficiencies: 'dietary diversification; supplementation; food fortification.' (p.606) Healthy Start aims to influence dietary diversification and supplementation.

Within public health, strategies that implement a nutritional safety net have generally been designed to either reduce the average risk for a whole population (Rose 1985) or intervene with a specific group within a population (Lalonde 1974). For example, a whole population approach is taken through the fortification of various foods. Food fortification over the last century has had a significant public health impact (Fletcher,



Bell and Lambert 2004). One study indicated that since folic acid fortification of food in the US, neural tube defects had reduced by 19% (Honein et al. 2001).

Epidemiologist, Geoffrey Rose (1985) compared two types of preventative intervention– the ‘high risk’ strategy where individuals deemed to be at risk of certain diseases and medical conditions receive individualised and appropriate intervention and the ‘population strategy’ where the objective is to lower the average level of disease within a whole population by addressing the root causes (Rose 1985). Both strategies come with pros and cons and Rose (1985) concluded that both interventions are necessary. The high-risk strategy engages high-risk individuals after initial screening but is resource intensive for those providing it and is often challenged by the complexity of individual behaviour change. The population strategy often happens without engaging directly with the public, for example through food fortification.

In considering the nutritional safety net as a concept, the populations for whom the net exists must also be addressed. Within food welfare, the term ‘vulnerable populations’ is used to describe socially defined groups within society that are at particular risk to micronutrient deficiencies. Frohlich and Potvin (2008) define vulnerable populations as ‘populations that share social characteristics that put them at higher risk of risks.’ Additionally, Fohlich and Potvin critique the lack of considering of vulnerable populations in both Rose (1985) and Lalonde’s (1974) approaches to public health intervention. They discuss how population approaches within public health often neglect to do anything to address health inequalities and at times perpetuate them.

Confusion over the concept of a nutritional safety net is demonstrated in recent evaluations of Healthy Start (McFadden et al. 2013; Lucas et al. 2013). One evaluation equates the nutritional safety net to the vitamin component of the scheme, however data from beneficiaries of the scheme indicate that it is the financial component enabling fruits, vegetables, milk and infant formula to be purchased that they believe creates the nutritional safety net they are being offered (McFadden et al. 2013). In addition, as Lucas et al. (2013) state, without being able to measure the impact that Healthy Start has on health outcomes or infant feeding behaviour, it is unclear whether or not the scheme can prevent people from slipping through the nutritional safety net. As the nutritional safety net is undefined, it is possible that it exists as a precaution and not as a measure.

As Healthy Start sits on the intersection of public health and welfare policy, as well as considering the nutritional safety net, it is necessary to consider whether a ‘safety net’ differs in discussions of welfare. The following section provides a brief overview of the origins of welfare safety nets.

The relationship between food, poverty and welfare can be informed by its history. The origins of welfare in the UK link to the study of what people eat. In 1899, concerned that the 1832 Poor Law Act was in fact not solving any of the issues the poor were faced with, Seebohm Rowntree observed the poor in York and used food as a component of the basic measure of poverty. As well as food, Rowntree also used housing cost and sundries (utilities) to assess the determinants of poverty (Rowntree, 1902 p.88). Shocked at what he saw, he began to promote the notion that poverty was not a result of an individuals irresponsible choices, but rather a result of structural factors such as physical environments and the cost of providing adequate food within a family. Thus the foundation for structure and agency debates on poverty developed. Not being able to afford the ‘minimum necessary expenditure for the maintenance of merely physical health’ (Rowntree, 1902 p.87) was classified by Rowntree as a marker of poverty. Concurrently with the development of understanding of poverty as a social problem was the development of nutrition as a science. Food as fuel is a basic concept, however the specific components and the relationship of them to human development at different stages of the lifecycle has been less understood until recent centuries.

Rowntree, primarily looked at energy in, and energy out, and concluded that 15% of households in York were living in poverty, making it difficult to afford an adequate diet in terms of calories and basic nutrition (proteins, fats and carbohydrates). It was clear to Seebohm Rowntree that poor health and a poor diet were prominent among the poor in York. At this time, the system of welfare still stemmed from the Poor Laws and the foci was ensuring the poor could better their character and thus standing in life through working hard. Rowntree’s research on poverty and food challenged this foci and suggested that addressing poverty would address health and that measures to prevent poverty would enable this.

In 1909, Beatrice and Sidney Webb published *The Minority Report of the Royal Commission on the Poor Laws*. The report paved the ground for the welfare state to be considered in the political arena. Although the Poor Laws that had defined poverty in

the UK for centuries were not completely abolished until 1948 through the National Assistance Act, the Webb's report paved the way for liberal thinkers such as Beveridge and Keynes to champion the welfare state a generation later and influence policies such as the National Assistance Act, the foundation of the welfare state and the origins of the 'safety net'.

As Rowntree and the Webbs indicate, historically, food and welfare have an intricate relationship. The very origins of the modern day welfare system in the UK used food as a measure of poverty.

### 1.3 The Welfare Food Scheme

The Welfare Food Scheme was first implemented in 1940 to ensure vulnerable people could access an adequate diet in wartime Britain. Over the 20<sup>th</sup> Century the scheme changed. The government department responsible for the scheme shifted between the Department of Health and the Department of Work and Pensions. How the scheme was accessed, shifted from a system that utilised wartime rationing systems to tokens. Eligibility shifted from being universal – available to all women with young children, to being only available to families with a low socio-economic status. The foods provided shifted from the National Dried Milk to commercial branded infant formulas in 1977 and vitamin tablets replaced cod liver oil in 1975 (COMA 2002). Throughout these changes, which are explored in detail in chapter 3, liquid cows' milk was consistently available.

The final version of the Welfare Food Scheme utilised a token system. Tokens would be collected with other benefits at a local Post Office. When tokens were collected, the beneficiary would be required to choose whether they wanted their tokens validated to exchange for milk or infant formula.

The Welfare Food Scheme was reformed in 2006 and implemented as Healthy Start. The two key sources of information that are consistently referred to as the evidence base for Healthy Start are the *Independent Review into Inequalities in Health* by Donald Acheson (Acheson 1998) and the *Scientific Review of the Welfare Food Scheme* by the Committee on the Medical Aspects of Food Policy (COMA 2002).

Acheson reviewed health inequalities and associated policies, and reinforced the vital link between policy, a child's long-term health and the health of the mother in pregnancy and infant feeding.

Childhood is a critical and vulnerable stage where poor socioeconomic circumstance can have lasting effects...the need for policies to improve the health of (future) mothers and their children is obvious (Acheson 1998 p.9)

Although the connection between maternal health, infant feeding and long term health had been made, Acheson reframed the discussion to consider the relationship between health and economic and social inequalities and the role that policy could play.

Since the 1950s the role of COMA had been to provide independent expert consideration of scientific evidence in relation to food and nutrition policy and provide recommendations to government. In parallel to the Acheson Review, COMA undertook a scientific review of the Welfare Food Scheme. The report of this review was published in 2002. This was one of COMA's final reviews as it was disbanded in 2000 and replaced by the Scientific Advisory Committee on Nutrition (SACN).

The role of COMA was to consider the existing scientific evidence and consider whether the Welfare Food Scheme could respond to the nutritional needs of low-income women and children and whether the scheme could be altered to do this better. The review found that there was indeed a need for a Welfare Food Scheme, however the scheme could be improved by offering additional foods to 'enhance dietary choice,' 'better address the demonstrable inequalities in nutrient intake among women of low socio-economic status' (COMA 2002, p. 110) and disincentivise infant formula feeding.

In addition, COMA also recommended that more information was needed to explore: the reasons why free vitamin uptake was so low; reasons for social inequality links to low breastfeeding rates; the effect of infant formula tokens on infant feeding practices and the effectiveness of interventions aimed at increasing rates of breastfeeding in communities where rates were low (COMA 2002, p.113). The range of information that was lacking at the time of the COMA review indicates an 'information gap' that would need to be addressed in order to successfully reform the Welfare Food Scheme.

The COMA review was undertaken to assess whether or not the Welfare Food Scheme was still the most viable means of creating a ‘nutritional safety net’. The review suggested that current policy incentivised infant formula feeding and did not provide a very wide range of nutrients. Thus there was scope for changing the scheme.

Although the COMA review addressed whether the Welfare Food Scheme responded to the needs of low-income women and children, it also highlighted a political tension – the government had been providing women with the means to purchase more infant formula than cows’ milk, thus going against the recommendation from the government that breastfeeding is always preferable.

The Welfare Food Scheme was solely milk, infant formula and vitamins. The amount of infant formula that could be accessed with a Welfare Food Scheme token was far more than the amount of liquid cows’ milk. Thus, there was concern that the government was endorsing formula feeding over breastfeeding (COMA 2002). The free maternal vitamins did not include folic acid and therefore were not in line with recommendations from an earlier COMA report – *Folic Acid and the prevention of disease* (COMA 2000A).

The COMA review presented a number of options for reforming the Welfare Food Scheme that created a starting point for considering a new scheme. The review presents the United States’ Women, Infants and Children’s Programme (WIC) as an example of a successful scheme that uses a voucher system to enable beneficiaries to access a wider range of foods.

#### 1.4 Policy Context

*If we are in politics for one thing, it is to make sure that all children are given the best chance in life.* (Tony Blair, Labour Party Conference Speech 1999)

The above quote summarises the central policy issues ‘New Labour’ aimed to address through policy review, institutional reform and development between 1997 and 2010. The number of children living in poverty had doubled since Labour had left office at the end of the 1970s (Hills and Stewart 2005). Reducing income poverty and promoting childhood development were goals that helped pave the way for a Review

of the Welfare Food Scheme in 2002 and the development of Healthy Start between 2002 and 2006.

The emphasis on early years development was clearly demonstrated by New Labour through the development of the SureStart Children's Centre initiatives and other initiatives that aimed to support parents with young children. The Early Years/Sure Start agenda (The Stationery Office 2003) and the Inequality agenda (Acheson 1998; Hills and Stewart 2005; Dowler and Spencer 2007) created a platform for a review of the Welfare Food Scheme. There is an argument, that although New Labour were engaged with the concept of helping children reach their potential, they neglected to fully engage with the welfare of mothers. Lister (2006), in her paper '*Children (but not women) first: New Labour, child welfare and gender*' argued that 'while prioritisation given to children has been welcome, it has been at the expense of their parents' (p.236). Lister (2006) suggests that as more was invested in future generations, more onus was put upon parents to make better choices for their children, however little was invested to support parents, particularly mothers.

The new political sphere focused on reducing the gap between rich and poor and creating long term change for children born into poverty. A number of policy reports were produced during the first seven years of New Labour which outlined priorities for the health and inequality agendas (Acheson 1998; Our Healthier Nation 1999; NHS Plan 2000; Choosing Health 2004). Donald Acheson's report 'Inequalities in Health' highlighted the social value of ensuring health interventions in the early phases of the life cycle, primarily pregnancy, the first year of life and between the ages of 1 and 5, and the first steps towards developing the SureStart programme aimed at providing integrated support for families with children under 5 was taken in 1998 (House of Commons 2010).

During the New Labour administration, new data emerged on the relationship between living on a low-income and diet. The Acheson Report (1998) suggested monitoring the diet and nutrient status of low-income populations in the UK to help inform policy that would respond to health inequalities. In light of this suggestion, the Low-income Diet and Nutrition Survey (LIDNS) was commissioned by the Food Standards Agency and carried out between 2003 and 2005, the final report was published in 2007 (Nelson, Erens, Bates, Church and Boshier 2007). The survey interviewed over 3700 adults

and children across the UK, analysed 24 hour dietary recall, physical measurements and blood samples. The aims of the LIDNS were to collect quantitative data on the nutritional status of low-income populations, consider the relationship between economic, social factors (from cooking skills to education) and nutritional status and the characteristics of populations with dietary intakes above or below the national average. Data on the nutrient status of the general population had been collected annually since 1992 in the National Diet and Nutrition Survey (NDNS) (Scientific Advisory Committee on Nutrition 2008).

Although survey reports acknowledge that there are limitations to using data based on 24 hour recall and food diaries due to inconsistencies in reporting, both the NDNS and LIDNS provide useful data and indications of issues that could be addressed through public health strategies and policies.

Some of the LIDNS findings were similar to the findings from the NDNS which found fruit and vegetable consumption to be below the government recommendation to eat a minimum of five pieces of fruit and vegetables daily. The LIDNS found that low-income populations were more likely to consume soft drinks, processed meat, whole milk and sugar than the general population.

Between 1997 and 2010 the New Labour government increased spending to support six areas of the Early Years Framework (Stewart 2013).

- Parental leave
- SureStart Local Programmes and Children's Centres
- Childcare
- Early Education
- Early Childhood health

Much of the political rhetoric around addressing health inequalities focussed on the concept of 'choice' as the government defined its role as enabling individuals to make healthier choices. This has been criticised as being too soft an approach and one which does not take into account the need for joined-up policy responses to health inequalities (Caraher, Crawley and Lloyd 2009).

In 2007, The Foresight Review reported on a project started in 2005 called ‘*Tackling obesities – Future Choices Project*’ (Butland, Jebb, Kopelman, McPherson, Mardell, Parry 2007). The report outlined the public health and economic impact obesity could have on the UK if not addressed. After highlighting that by 2050, the UK could see 60% of adult men, 50% of adult women and 25% of children under 16 obese, which would cost the NHS £10 billion per year, the report recommended a ‘whole system approach’ to addressing the growing issue of obesity. Thus, growing concerns about obesity and new data on diet and nutrient status influenced the public health policy context of this period.

The broader food policy context of the New Labour government is summarised in the seminal report on integrating issues that involve food – *Food Matters* (The Stationery Office 2008). New Labour’s approach to developing food policies or addressing issue areas that cross-cut food policies has been criticised. Barling and Lang (2003) reviewed the food policy developments throughout the New Labour government and suggest that the decisions made to address aspects of food policy did not take into account the multifaceted nature of food policies.

Barling and Lang (2003) suggest that New Labour somewhat underestimated the complexity of food policy and did not fully grasp the need for integrating food policies that cross-cut government departments as issues that involve food are multifaceted. Exworthy and Hunter (2011), indicate that although ‘Joined-Up Government’ (JUG) was a dominant feature of New Labour rhetoric, the reality is that there are few examples of government successfully ‘joining-up’ or ‘cross-cutting’ to improve health inequalities. The key food policy developments of the New Labour government are presented in the following table.



Table 1 New Labour food policy developments

<b>Initiative/development/report</b>	<b>Date</b>	<b>Government department responsible</b>
<b>Reforming MAFF to DEFRA</b>	1997	DEFRA
<b>Development of Food Standards Agency</b>	1999	Department of Health
<b>5-A-Day</b>	2002	Department of Health
<b>School Fruit and Vegetable Scheme</b>	2004	Department of Health
<b>Healthy Start</b>	2006	Department of Health/Department of Work and Pensions
<b>Health in pregnancy grant</b>	2008	HMRC
<b>Nutrient based standards for school food</b>	2008 – primary schools  2009 – secondary schools	Department of Education
<b>COMA replaced by SACN (Scientific Advisory Committee on Nutrition)</b>	2000	
<b>National Institute of Clinical Excellence in health and Social Care (NICE) formed</b>	1999	

In parallel to agendas concerning inequalities and young children, New Labour were also redefining a modern approach to policy making (Team SPM 1999, Bullock, Mountford and Stanley 2001) driven by a new logic and belief that good policy making and reform could be more efficient in terms of delivery and outcomes (Department of Health 2002; The Cabinet Office 1999).

The policy context outlined above provides a political setting in which Healthy Start is considered throughout this work.

### 1.5 Starting point: initiating, forming and implementing Healthy Start

Policy is made in phases. The ‘stages heuristic’ that are often attributed to the policy process are initiation, formation, implementation and evaluation (Sabatier and Jenkins –Smith 1993). The stages heuristic suggest a linear process to policy making, yet as many have argued, rarely is the process of making policy straightforward. This is a concept that was originally developed to make sense of policy and understand the policy cycle (Sabatier, Jenkins-Smith 1993).

Heywood further suggests that the process of forming policy is often seen as the most crucial stage in the policy process as this is when actions are developed in response to an agenda and it is these actions that will either ‘make things better or make things worse’ (2000, p.32). Lindbolm (1959) suggested that in fact much policy making is a case of ‘muddling through’ as opposed to following a defined process outlined in the ‘stages heuristic’. Although the stages heuristic is not a sufficient model for analysing policy, it presents a framework for organising the narrative of policy development.

The following chapter presents what is known about Healthy Start. There is little information on the initiation, formation and implementation of the scheme. Cairney (2012) suggests when undertaking policy analysis, a two-fold approach is necessary – first mapping what is known – the narrative, and secondly adding to that narrative with qualitative research. This section provides an initial mapping of the events/actions that occurred across the policy process from initiation to evaluation. The narrative information is presented on four timelines below. The timelines are map of events or actions that are considered throughout this work.

Figure 2 Initiation of Healthy Start

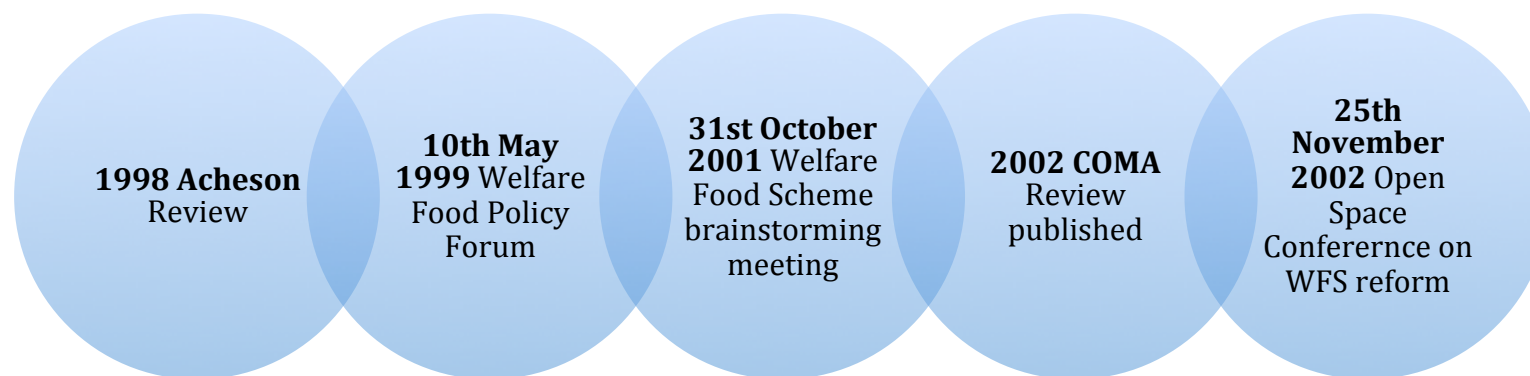


Figure 3 Formation of Healthy Start

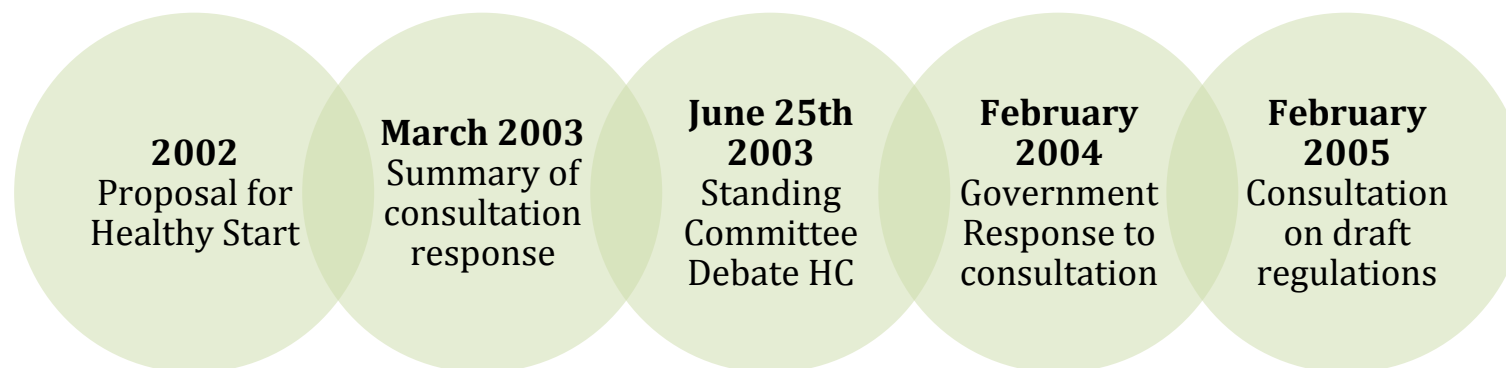


Figure 4 Implementation of Healthy Start

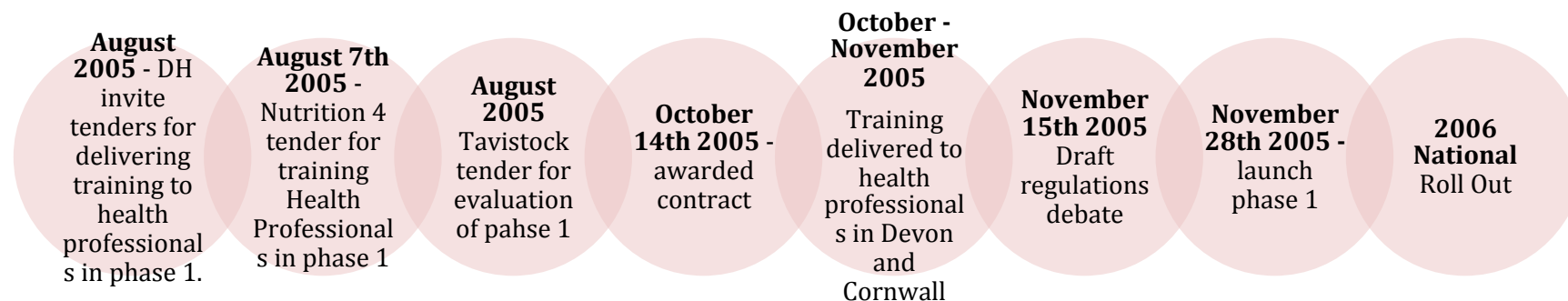
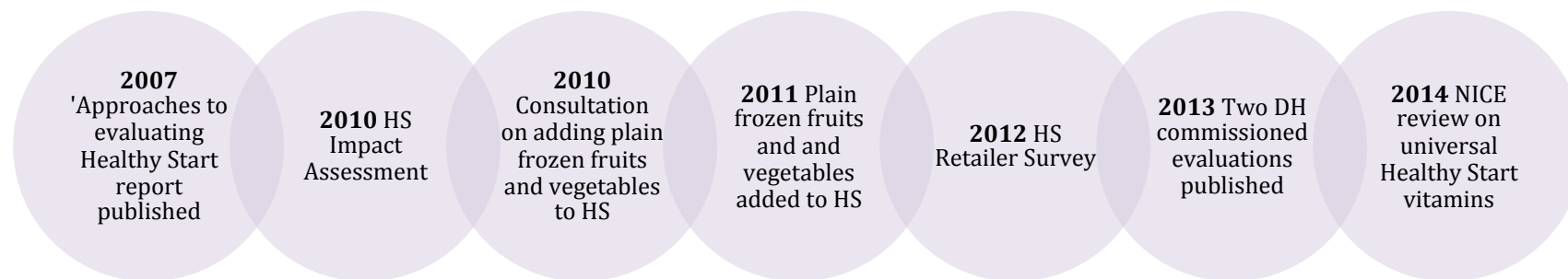


Figure 5 Evaluation and development of Healthy Start since roll out



## 1.6 Summary

This chapter has presented large concepts that relate to Healthy Start and justified the need to research the scheme's policy origins. The next chapter will focus in, and describe in detail what Healthy Start is and what is known about the scheme.

## Chapter 2 : What is known about Healthy Start?

### 2.0 Introduction

To outline what is already known about Healthy Start, this chapter draws on desk research on the scheme – using both published work including the evaluation reports (McFadden et al. 2013; Lucas et al. 2013), the Healthy Start website (Department of Health 2013) and government legislation (Great Britain 1996; Great Britain 2005) and the authors own work, including a Freedom of Information Request (Machell 2011), and email correspondence with the Department of Health. Charts and tables are either referenced to source or marked as ‘authors own’.

The chapter begins by presenting a brief overview of Healthy Start and the legislation that governs the scheme, followed by an overview of Healthy Start actors, management of the scheme, information on eligibility and what beneficiaries receive, and available take-up data. This is followed by a review of Healthy Start evaluations and an overview of what is known about how Healthy Start is used and the financial costs to government.

Healthy Start is described as ‘the UK welfare food scheme for young and low-income pregnant women, young parents and low-income families with children up to the age of four’ and is described as ‘a health policy that offers state funded nutritional welfare to eligible beneficiaries’ (Department of Health 2002).

The scheme began in 2006, replacing the Welfare Food Scheme which gave infant formula or vouchers for milk and free supplements to mothers at baby clinics and which had been operating since 1940 (Department of Health 2002). Whilst it was planned that the total budget for delivering and operating the new scheme would remain the same, Healthy Start differs from the previous welfare food scheme, by offering vouchers which can be exchanged for fruit and vegetables, infant formula and plain milk at any registered retail provider, and coupons to exchange for vitamin supplements for women and children at some community pharmacies and clinics. The weekly voucher for fresh fruit and vegetables, infant formula or plain milk had an original face value of £2.80 which rose to £3.10 in 2009 and has remained at that value to 2014. In 2011

plain frozen fruits and vegetables were included in the items that could be purchased with Healthy Start vouchers.

The Department of Health estimates that in the UK about 550,000 women and children use Healthy Start each month and 80% of eligible families are registered to the scheme (Machell, Department of Health 2013). Take-up is estimated – there is a lack of clear data on how the scheme is used once families’ access it. This issue is further explored later on in this chapter.

## 2.1 Healthy Start Legislation

Legislation for Healthy Start can be found in the 1988 Social Security Act (Great Britain 1998). Healthy Start is governed by Regulations made by the Secretary of State for Health. The Principal Regulations are set out in the 1996 Welfare Foods Regulations (Great Britain 1996). An amendment was made to these regulations in 2005 (Great Britain 2005) after the proposal for Healthy Start (Department of Health 2002) had been consulted and debated in parliament. The amendment enabled regulations for Healthy Start to be enacted and rolled out across the chosen pilot areas before being rolled out nationally in 2006. The explanatory memorandum (Department of Health 2005b) that accompanied the draft regulations state the purpose and intended effect of the regulations were as follows:

- 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.

To establish Healthy Start, the Secretary of State for Health also ordered commencements to the Health and Social Care Act 2003 (Great Britain 2003, Secretary of State for Health 2005b, Secretary of State for Health 2005a) to reflect the changes to welfare food provision through Healthy Start.

Separate regulations were enacted in Northern Ireland. The different national government structure in Northern Ireland meant that Healthy Start is managed by the Department of Health, Social Services and Public Safety.

## 2.2 Healthy Start actors

Healthy Start involves a number of actors with a range of responsibilities and across different levels of government. Table 2 presents an example of Healthy Start actors in England.



Table 2 Healthy Start Actors in England – Authors own

<b>Actor</b>	<b>Specifically</b>	<b>Role in Healthy Start</b>
<b>Department of Health</b>	Secretary of State for Health, Ministers,	Policy making, evaluation, management on national level, marketing the scheme
<b>Contracted providers</b>	Healthy Start phone line  Healthy Start Reimbursement Unit	Provide information and support to beneficiaries  Process claims from retailers
<b>Department of Work and Pensions</b>		Ensuring applicants to the scheme are eligible based on employment/benefits records.
<b>COMA/SACN/NICE</b>		Provide scientific and public health evidence and recommendations
<b>Local authorities/NHS Clinical Commissioning Groups/ NHS England</b>	Public Health Strategists	Administering the scheme within local communities. Ensuring links are maintained between actors to ensure scheme runs efficiently. Legally obligated to make Healthy Start vitamins available. Making decisions about how to implement vitamins. Commissioning social enterprises, community pharmacies to provide Healthy Start service delivery.
<b>Health professionals</b>	Midwives Nurses Health Visitors GPs	Engaging beneficiaries with the scheme, advising on nutrition for beneficiaries, advising how and where to use vouchers
<b>Retailers and local food projects</b>	Supermarkets and independent retailers and food projects that are registered to the scheme.	Providing fruits, vegetables, milk and formula milk in exchange for Healthy Start vouchers
<b>Healthy Start Issuing Unit</b>	Commissioned by the Department of Health	Issue Healthy Start vouchers to eligible beneficiaries
<b>Healthy Start Phone Line</b>	Commissioned by the Department of Health	Provide advice to beneficiaries
<b>Children’s centres, health centres, GP practices, community pharmacies</b>		Providing Healthy Start vitamins in exchange for HS vitamin coupons and promoting the scheme.
<b>Beneficiaries</b>	Families that meet eligibility criteria	Engaging with the scheme and ultimately benefiting from it

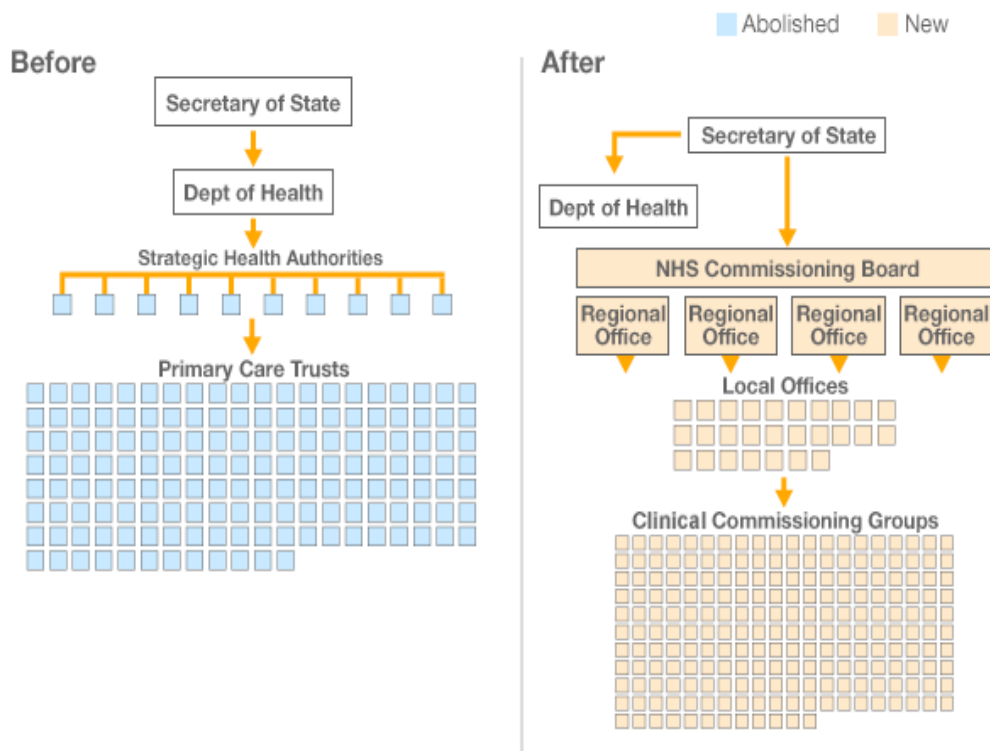
### 2.3 Management of Healthy Start

The management of Healthy Start is divided into local and national responsibilities. Local areas are responsible for ensuring eligible beneficiaries can access Healthy Start maternal and child vitamins. National, central government responsibilities are to promote Healthy Start food vouchers and provide resources to support Healthy Start delivery in local areas.

Between 2006 and 2014 political change has impacted the delivery of Healthy Start on a local level, specifically changes within NHS structures as a result of the Coalition Governments NHS reform, this is described in the White Paper – *Equity and Excellence: Liberating the NHS* (Department of Health 2010b). The Health and Social Care Act (Great Britain 2012) abolished Primary Care Trusts (PCT's). The original legislation that governed Healthy Start vitamin distribution (Welfare Food Scheme (Amendment) 2005) stated that Primary Care Trusts (PCTs) were responsible for making Healthy Start vitamins available to eligible beneficiaries. Since April 1<sup>st</sup>, 2013 Local Authorities, Clinical Commissioning Groups and Public Health England have taken on public health responsibilities that were formerly in the purview of PCTs, including the distribution of vitamins within local areas.

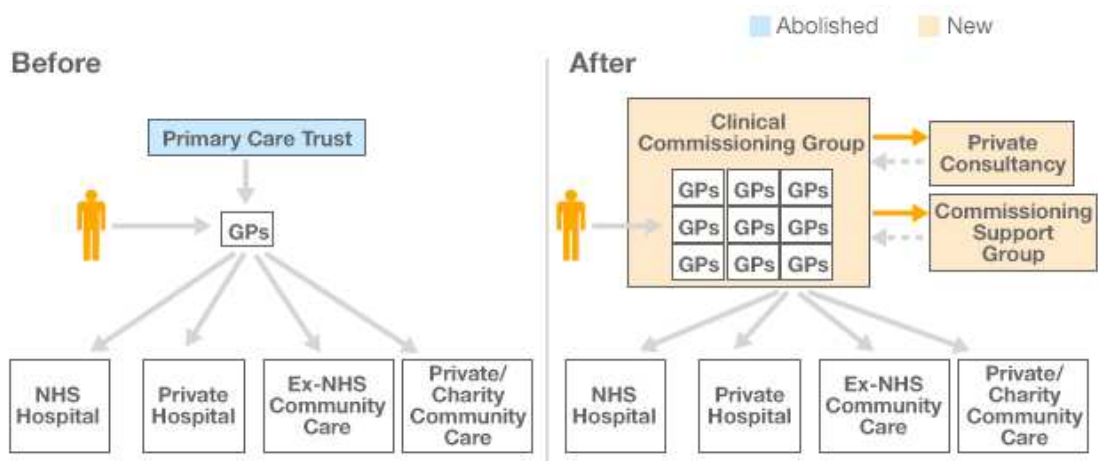
The diagrams (from <http://www.bbc.co.uk/news/health-19674838> accessed 18/06/14) in figures 6 and 7 illustrate how Clinical Commissioning Groups differ to the PCT structure. Notably, the main differences between the two systems are that within Clinical Commissioning Groups, GP's are responsible for directing large amounts of NHS funding. The rationale, is that GPs are more in-tune with the needs of their patients and therefore better understand how the NHS budget can be spent more efficiently.

Figure 6 How the NHS is run



Source: <http://www.bbc.co.uk/news/health-19674838>

Figure 7 Who directs funding?



Source: <http://www.bbc.co.uk/news/health-19674838>

The scheme is led and managed on a national level by the Healthy Start Unit within the Department of Health. Healthy Start is not currently integrated with other welfare benefits, for example, it is not listed on the guide to maternity benefits on the direct.gov website (Department of Work and Pensions 2014). It is unique as it clearly straddles both welfare and public health.

As opposed to other benefits that are the responsibility of Department of Work and Pensions, the NHS and Department of Health are responsible for engaging beneficiaries with the scheme as it is seen as part of public health nutrition policy under the remit of the Minister for Public Health. Applications for Healthy Start from potential beneficiaries must be signed by a health care practitioner to confirm the applicant is at least 10 weeks pregnant, or has a child under the age of four, and individuals are then cross referenced with databases in the Department of Work and Pensions to ensure the financial eligibility criteria. The Department of Health suggest that contact with a health professional is a key distinguishing feature of Healthy Start, as unlike other benefits the contact is viewed as a key time to share information on how to get the most out of the scheme (Department of Health 2002).

#### 2.4 Eligibility and what beneficiaries receive

Table 3 indicates the value of the Healthy Start vouchers. The rationale behind having a value amount in the form of a voucher as opposed to the Food Welfare System's 'token' system was to give beneficiaries more control of their own health and the health of their young children (Department of Health 2002). By enabling expectant mothers and parents with young children to choose to purchase fruits, vegetables, milk or infant formula the scheme aims to reduce nutritional inequalities and empower individuals to make long term behaviour changes (Department of Health, 2002).

Healthy Start is not a universal benefit rather eligibility is subject to the criteria presented in Table 4. The scheme is devised to have an impact on 'vulnerable' women and children by providing a nutritional safety net. There is a push to make Healthy Start vitamins universally available, this issue is discussed in more detail later on in this chapter.

**Table 3 Healthy Start vouchers and vitamin supplements**

Source: <http://www.healthystart.nhs.uk> accessed June 2014.

Beneficiary	Vouchers	Vitamin supplements
Expectant mother	One voucher per week (£3.10)	Free HS women's vitamin tablets
0 – 6 months	Two vouchers per week (£6.20)	Generally, vitamin supplements are not provided for infants between 0 – 6 months however the Healthy Start website says ' <i>in certain circumstances vitamin supplements may be provided to infants under six months old getting Healthy Start vouchers, if healthcare professionals consider that their vitamin stores are likely to be low and that the supplements would benefit them</i> '. <a href="http://www.healthystart.nhs.uk/for-health-professionals/vitamins/">http://www.healthystart.nhs.uk/for-health-professionals/vitamins/</a>
6 months – 1 year	Two vouchers per week (£6.20)	Free HS Children's vitamin drops
Over 1 year but under 4 years old	One voucher per week (£3.10)	Free HS Children's vitamin drops

Due to 2012 Welfare Reforms by the Coalition Government, the eligibility criteria for Healthy Start is currently in a process of being redefined to accommodate the impact of the new system of Universal Credit. Healthy Start is classified as a 'passported' benefit, meaning that as a benefit it remains protected, but eligibility criteria could be changed in response to Universal Credit.

## Figure 8 Eligibility Criteria

You qualify for Healthy Start if you're pregnant or have a child under four years old AND:

- you or your family get Income Support, or
- you or your family get income-based Jobseeker's Allowance, or
- you or your family get Child Tax Credit (but not Working Tax Credit unless your family is receiving Working Tax Credit run-on only\*) and have an annual family income of below £16,190 or less (2014/15)

OR:

- you're pregnant and under 18 years of age

\*Working Tax Credit run-on is the Working Tax Credit you receive in the 4 weeks immediately after you have stopped working for 16 hours or more per week (single adults) or 24 hours per week (couples).

*If you are claiming Universal Credit and are pregnant or have a child under four years old call the Healthy Start helpline on 0845 607 6823 for information about any discretionary support that may be available.*

Source: <http://www.healthystart.nhs.uk/healthy-start-vouchers/do-i-qualify/> Accessed June 2014.

As of April 2014, there is no guidance on exactly how eligibility for Healthy Start may be impacted by the 2012 Welfare Reform Act. There is however information in a report called *Universal Credit: The Impact on Passported benefits* (2012) from the Social Security Advisory Committee (SSCA). The report indicates that the government is considering new approaches to Healthy Start eligibility criteria, the focus is choosing options that 'helps target the most vulnerable, most effectively'. Universal credit is also described as 'an opportunity to make absolutely sure that vouchers are targeted in the fairest and most appropriate way'. No specific details or options for new eligibility criteria are presented.

### 2.5 Healthy Start take-up

Take-up of Healthy Start is based on the number of people registered to the scheme. The response to a parliamentary question in 2014 provides background data on how take-up declined between April 2013 and March 2014.

Figure 9 House of Commons question on Healthy Start take-up: June 25th 2014

### Healthy Start Scheme

**Mrs Hodgson:** To ask The Secretary of State for Health how many parents received Healthy Start vouchers in the latest year for which figures are available; and what the total cost to the Exchequer of such vouchers was. [201421]

**Dr Poulter:** Healthy Start provides a nutritional safety net to pregnant women, new mothers and children under four years old in United Kingdom families claiming income-based benefits, or claiming child tax credit without working tax credit (unless it is working tax credit run-on) with an annual family income of £16,190 or less. Healthy Start vouchers are issued four-weekly by post and the number entitled to receive the vouchers in each complete four week period during 2013-14 is set out in the following table.

<i>Four weeks beginning on:</i>	<i>Total number of households</i>	<i>Total number of women and children</i>
8 April 2013	457,035	557,833
6 May 2013	455,271	555,454
3 June 2013	453,646	553,208
1 July 2013	450,164	548,533
29 July 2013	443,939	540,437
26 August 2013	441,385	537,195
23 September 2013	438,471	533,703
21 October 2013	434,397	528,620
18 November 2013	432,549	526,151
16 December 2013	428,328	520,777
13 January 2014	427,362	519,570
10 February 2014	425,659	517,463
10 March 2014	423,156	514,217

The gradual reduction in the number entitled to support during 2013-14 reflects a decline in the number of households meeting the qualifying criteria.

Approximately £93 million was paid to retailers during 2013-14 for Healthy Start vouchers they had accepted in exchange for milk, formula milk, fresh and frozen fruit and vegetables. Retailers have six months from the use-by date printed on vouchers to claim reimbursement, and typically they claim reimbursement for at least 91% of all Healthy Start vouchers issued.

(House of Commons 2014c)

It is unclear why Healthy Start take-up is in decline. Email communication with the Department of Health inquiring as to why Healthy Start take-up was in decline suggests that a key influencing factor might be the reduced number of children under four who qualified for Child Tax Credit. However, the email correspondence also included the following response: *It (the reduced take-up of Healthy Start) is unlikely to be due to any one key factor and it is too early to tell whether the trend will continue.* Thus, as background data, the take-up data presented in parliament (Figure 9) indicates that there is a lack of clarity over why take-up of Healthy Start is changing.

## 2.6 Review of Healthy Start evaluations

Effective approaches to evaluation design need to be considered before a programme is launched (Rossi, Lipsey and Freeman 2004). The Department of Health commissioned a research team at the Mother and Infant Research Unit at the University of York and University College London to scope different options for evaluating Healthy Start (Dyson, Renfrew, Jenkins, Thomas, McCormick, Pearce and Law 2007). A year after Healthy Start rolled-out, Dyson et al. (2007), reported ‘Policy-related factors and timing limited options for evaluation from the start’ (p.14). In addition, the report describes how a phased roll-out of Healthy Start would have enabled the most robust evaluations to take place and evaluation design was challenging as it was considered after the scheme had rolled-out and not as part of the policy process. The below quote illustrates the extent of these challenges.

Both the most robust approaches to evaluation, a randomised controlled trial or a prospectively planned before-and-after-study, were therefore ruled out from the start. Identifying suitable comparison groups, which we see as fundamental to evaluation, has been a serious challenge as a result. (Dyson et al., 2007 P.14.)

Although challenges to evaluation were predicted, The Department of Health has commissioned three evaluations of Healthy Start since it was piloted in 2005 (Hills 2006, Lucas et al. 2013, McFadden et al. 2013). The first evaluation was part of the policy implementation process and evaluated the original pilot phase of Healthy Start (Hills 2006). The other two evaluations reported in 2013. By



presenting key findings from all three evaluations, this section further contextualises Healthy Start.

The Hills (2006) study evaluated the pilot Healthy Start scheme in Devon and Cornwall then made recommendations to Department of Health as part of the policy formation process of Healthy Start.

This initial evaluation, however, only looked at how Healthy Start was operating in one geographical area, Devon and Cornwall, and interviewed 32 health professionals, 20 retailers and 18 beneficiaries. The significance of this evaluation is theoretically paramount to the policy formation process as it was conducted as part of the pilot, to inform policy makers on any issues with the initial design of Healthy Start. The small number of interviews means that it is not possible to generalise the findings to a national context. The small number of beneficiaries interviewed, also raises questions about what exactly was being evaluated and which group of actors issues were prioritised in the evaluation.

The study recognised that in order for Healthy Start to be successful on a national level, structures need to be in place at a local level to successfully implement the scheme. Other key recommendations were:

- Training for health professionals being fundamental to programme success
- Links with local services necessary for families to get the most out of Healthy Start
- Implement national evaluation tools to aid future evaluation.
- Department of Health make links between Healthy Start and other health initiatives
- Reinforce healthy eating messages by encouraging beneficiaries to go to local practical activities.

Hills's (2006) evaluation evaluated processes on the ground, it did not address how the systems that were implemented in the pilot would be implemented on a larger scale in the national roll-out of Healthy Start. Given that this evaluation was undertaken as part of the development of Healthy Start, questions emerge

regarding the function of research in the development of the scheme. There is a lack of information that explores how this evaluation impacted or influenced decisions about the development or rollout of Healthy Start. Although peer reviewed articles exist on aspects of the evaluation by Lucas et al. (Jessiman et al.), at the time the evaluation reports were being analysed, no peer reviewed articles had been published from McFadden et al.'s 2013 evaluation. To consider the full breadth of data collected, both full evaluation reports are considered in the following section.

Both evaluations published in 2013 broadly address how Healthy Start operates on the ground, however they have slightly different, yet corresponding remits. Specifically, Lucas et al. (2013) undertook a process evaluation of Healthy Start across 13 Primary Care Trusts (PCTs). The objective was to gather experiences of beneficiaries, frontline staff and staff employed at small independent retailers. Methods comprised of qualitative research to glean the views of beneficiaries (n=107), frontline staff (n=65) and staff employed in small independent retailers (n=20). Like Hills (2006), Lucas et al.'s (2013) evaluation does not engage with large numbers of participants, thus findings are not generalizable. Rather findings are considered as indicators of issues emerging in practice.

McFadden et al. (2013) undertook a larger multi-method evaluation to look at voucher and vitamin use in Healthy Start and consider the feasibility of economic impact evaluation. This evaluation includes:

- systematic review of qualitative and economic literature
- qualitative research with Healthy Start participants in London and Yorkshire and the Humber (n=113) and practitioners (n=49)
- Participant demographic questionnaire (n=109)
- national electronic consultation with health professionals (n=620)
- cross-sectoral workshops (n=56)
- consideration of both commercial and public data sets.
- consideration of the first purposeful sample in 2010 Infant Feeding Survey

The methodology draws on range of methods, however the number of beneficiaries interviewed remains relatively low. This reflects a similarity between this evaluation and the former evaluations and studies on Healthy Start.

It is unclear why the Department of Health commissioned two evaluations simultaneously. Neither evaluation makes reference to the other. Despite this, many of the recommendations and implications were similar or the same, thus the benefit of having two evaluations is that they reinforce some of each other's findings. McFadden et al. provide almost 55 recommendations based on their research, whereas Lucas et al. (2013) provide 26 implications of research. Despite the issues that emerged across the evaluations, in both reports there is a general belief that Healthy Start is an important scheme that should remain in place. Key general recommendations that both evaluations make are:

- Universalising vitamins
- Support local areas to make better links with local services such as children's centres
- Raise awareness of Healthy Start in general
- Train any professional who has contact with pregnant women about their role in Healthy Start.

Four striking macro issues emerge from both evaluations as a whole. Firstly, although lots of data is presented from various methods in both evaluations, the data does not fit together to paint a clear picture of whether or not Healthy Start works on a national level. Secondly, methods, findings and recommendations in both evaluations highlight aspects of the policy that were not considered as part of the policy formation process. Thirdly, recommendations from the original evaluation of the Healthy Start pilot programme emerge as issues and recommendations in the most recent evaluations, raising questions regarding how evaluation fed-into the formation of the scheme. Finally the challenge of evaluating Healthy Start, foreseen by Dyson et al. (2007) is to an extent demonstrated in the recent evaluations, as evaluators had to overcome a lack of routine data.

An overarching issue that emerges from the range of methods used across both McFadden et al.'s (2013) and Lucas et al.'s (2013) evaluations is the lack of a coherent dataset that can provide basic information on how Healthy Start is operating on a national level. The jigsawing together of methods to make sense of how Healthy Start functions in reality reflects in part the challenges of designing evaluation for Healthy Start as stated by Dyson et al. (2007). An implication of both evaluations is the lack of data and data sets that can gauge whether or not HS is fulfilling its policy objectives. McFadden et al. (2013) had drawn on Dyson et al.'s (2007) original scoping report on options for evaluating Healthy Start and concluded that the recommendations made in 2007 remain in 2013. Specifically McFadden et al. (2013) assess whether it is possible to use existing databases to 'assess the impact of Healthy Start vouchers on the demand for fruit, vegetables, vitamins, milk and breastfeeding, and other goods among low-income families' (p.114.) This raises questions regarding how evaluation was considered in the formation of Healthy Start as it is clear that a dataset does not exist that can provide insight into how Healthy Start is used and what the benefits/impact of the scheme might be.

There is a lack of basic and current national level data to contextualise Healthy Start, for example in neither evaluation are there clear statements of overall programme take-up across the UK or indeed the total costs of administering and delivering Healthy Start. Lucas et al refer to the 2010 Equality Impact Assessment (Department of Health 2010b) that outlines the success criteria for Healthy Start, but does not justify what informed these criteria. It is noted that impacts on the beneficiary such as health outcomes and infant feeding practices are outside the scope of the original criteria for success of the scheme, thus justifying why Lucas et al. (2013) evaluated process, not impact.

Without basic data to contextualise Healthy Start, it is difficult to fully understand the implications of findings and recommendations from both evaluations. In addition neither evaluation addresses this data gap. This highlights the intricacy of the structures that govern Healthy Start and reflects the historic lack of data on food welfare programmes in the UK that was posed as an issue in the COMA review of the Welfare Food Scheme in 2002. It further

prompts questions regarding the evidence base that informed the foundation of Healthy Start and signifies an area that requires interrogating through research.

Specific evaluation measures for Healthy Start were not included in the policy design, despite the recommendations made in 2007 by Dyson et al.

Consequently, beyond qualitative accounts that explore different actors' perceptions, there were significant challenges for recent evaluators to gauge the potential effectiveness of the scheme.

Both evaluation teams experienced issues accessing certain datasets (Lucas et al. 2013; McFadden et al.). McFadden et al. (2013) considered the utility of the data collected by the companies commissioned by Department of Health to manage the Healthy Start phone line and the reimbursement unit – Homescan and Kantor. Neither company could provide data in a workable format that could support the evaluation. In addition, the evaluators identify data that exists, but was not accessed. For example, McFadden et al. (2013) tried to access commercially accessible data and found that although commercial information on how Healthy Start is used in Tesco (one of the most used supermarkets by Healthy Start beneficiaries) exists and is held by Dunhumby – a large market research company, it could not be accessed, presumably due to the financial cost. This indicates a tension between government and industry, a familiar issue within the study of food policy (Lang and Heasman 2004) and further suggests research into the intentions behind how Healthy Start was formed and what the considerations were, would be beneficial and contribute toward the research gap.

It was valuable for McFadden et al. (2013) to include data from the first purposeful sample included in the 2010 Infant Feeding Survey. McFadden et al. (2013) state that the 2010 Infant Feeding Survey (McAndrew 2012) is 'the single most promising dataset for analysing the demand of Healthy Start –supported products and for judging the impact of vouchers on this demand' (p.126). For the first time, in 2010 the IFS included a purposive sample of women who would be eligible for Healthy Start and included questions regarding their infant feeding practices. The value of the inclusion is that prior, there had been no data on the infant feeding practices of families in receipt of Healthy Start. Key findings were that the sample population had considerably lower rates of breastfeeding than the

general population and Healthy Start vouchers were primarily spent on infant formula.

In terms of providing information on how the scheme works in general, the IFS data is limited as it only includes women who have an infant under the age of 1 year old – thus excluding Healthy Start eligible pregnant women without children or eligible women with a child/children over the age of 1, but under the age of 4. Additionally, as McFadden et al. (2013) list additional limitations to the IFS data: there is no quantity data other than portions per day; no price or income data meaning that demand analysis is likely to produce biased estimates of demand and impact of Healthy Start and no non-Healthy Start products are reported on. The data on Healthy Start participation and eligibility was also self-reported, which could lead to measurement errors if some participants are unclear on these criteria (p.143). It is interesting, that although there are clear limitations to the data, it is still ‘the most promising dataset for analysing the demand of Healthy Start’ – this raises questions regarding how data collection and monitoring were considered in the design of Healthy Start.

The aforementioned recommendations from Hills (2006) that emerge as issues in Lucas et al. (2013) and McFadden et al. (2013) are:

- Training for health professionals being fundamental to programme success
- Links with local services necessary for families to get the most out of Healthy Start
- Implement national evaluation tools to aid future evaluation.
- DH make links between Healthy Start and other health initiatives
- Reinforce healthy eating messages by encouraging beneficiaries to go to local practical activities.

Although it is a strength that both McFadden et al.’s (2013) and Lucas et al.’s (2013) evaluations are able to provide some data on how Healthy Start operates on the ground, it is striking that there are similarities between both 2013 evaluation findings and 2006 evaluation findings. The parallels indicate that

there is scope for researching how and why the policy has seemingly not taken on board feedback from evaluation. In light of the similarities between issues in 2006 and 2013, the role of research and evaluation in the formation of policy becomes questionable. McFadden et al. (2013) state ‘Evidence from UK studies to inform the design of a national food welfare programme is scarce’ (p.15), further justifying a need to explore how Healthy Start was informed and influenced.

The following section combines evaluation findings with programme literature and policy documents to contextualise Healthy Start further.

## 2.7 Using Healthy Start

This section provides information on how Healthy Start is intended to work and data from recently published evaluations of the scheme. (Lucas et al 2103; McFadden et al 2013). The first area this section considers is how families access Healthy Start.

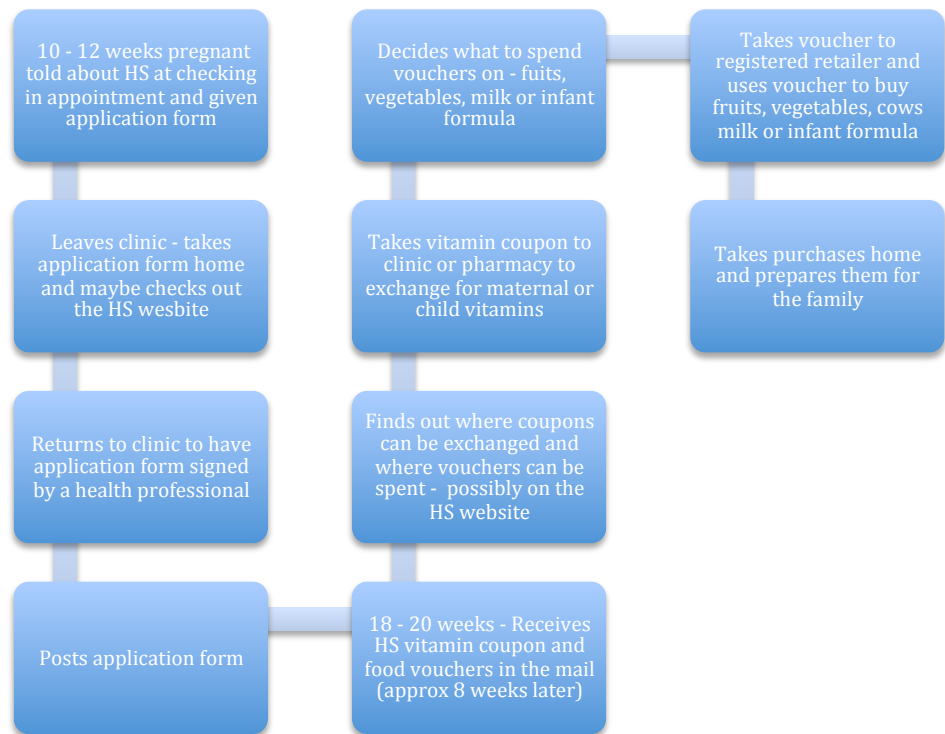
Nutritional interventions for women who are- or who plan to become- pregnant are likely to have the greatest effect if delivered before conception or in the first 12 weeks. (NICE 2008 p.19)

To access Healthy Start there are a number of steps a women goes through. The journey map below (Figure 11) illustrates the theoretical journey a first time mother may go through to access and use Healthy Start during pregnancy. There are a number of different scenarios in which Healthy Start could be accessed depending on the individuals’ circumstance. To use the scheme, the mother needs to be engaged with each step of the process: getting the signature of a health professional, waiting for vouchers, going to different places to use food vouchers and vitamins coupons all takes an investment of time, thus the mother needs to feel she will get a return for this investment.

The onus is all on the beneficiary to make choices about how they will spend Healthy Start vouchers. In addition, there is a practical issue in that women may not receive vouchers until they are 20 weeks pregnant, thus they miss out on supplemental nutrition early on in their pregnancy, the time when it is most

valuable, in particular in terms of the health recommendation that folic acid supplementation is needed in the first 12 weeks of pregnancy (SACN 2011).

**Figure 10** An example of the Process of accessing Healthy Start based on the information presented on [www.healthystart.nhs.uk](http://www.healthystart.nhs.uk)



Application for Healthy Start is, in theory, initiated at the pregnancy checking in visit by the midwife, nurse or doctor. This is the most likely scenario for first time mothers, however families receiving other family based health services may access Healthy Start through health visitors or Children’s Centres or be referred by the Job Centre or Citizens Advice Bureau. Recent evaluation data raised concern that there are people who were eligible for Healthy Start that were not aware of the scheme and the scheme was particularly hard to access for people who did not speak English as their primary language (Lucas et al. 2013). This indicates, that Healthy Start is not always part of the routine discussions at checking-in appointments. Lucas et al. (2013) indicated that sometimes a health visitor introduces Healthy Start after a child has been born. Thus, although there is the theoretical way in which women access Healthy Start, we know that in reality this varies.



The application form for the scheme must be signed by a registered health professional to vouch for the applicants' eligibility in being pregnant or with a child under four, for example a midwife, nurse, health visitor or GP. This information is then sent back to the Department of Health who send the information to the Department of Work and Pensions to check financial eligibility data. Little is known about this process and how the Department of Health and the Department of Work and Pensions communicate regarding Healthy Start.

Healthy Start food vouchers can be redeemed at any participating retailer. All the large supermarkets accept them and many small independent retailers accept them as well. There is no evidence of enforcement to ensure retailers are only accepting Healthy Start vouchers in exchange for fresh or frozen fruits, liquid cows' milk or infant formula. It is estimated that 70% of Healthy Start vouchers are spent at supermarkets (Department of Health 2012). The remaining 30% are spent at 'pharmacies, market stalls, independent shops and milk roundsmen' (Department of Health 2012 p.2).

Until 2011, vouchers could only be used to purchase fresh fruits and vegetables, milk and infant formula. In 2011 after a consultation, the scheme was amended to include frozen fruits and vegetables (Department of Health 2011b). There is no evidence to explain why frozen fruits and vegetables were initially excluded from the scheme.

In 2009, the Secretary of State for the Environment, Food and Rural Affairs launched the Fruit and Vegetable Task Force. The objective of the Task Force was to 'address low fruit and vegetable consumption in the UK by considering: availability and convenience, value for money and quality and taste'. The Task Force recommended that frozen and canned fruits and vegetables were included in Healthy Start (Fruit and Vegetable Task Force 2010). The Department of Health ran a consultation to gather opinions of Healthy Start stakeholders (Department of Health 2011b). The consultation concluded that adding plain frozen fruits and vegetables to Healthy Start could help increase the amounts of fruits and vegetables consumed by beneficiaries and legislation was amended to include plain frozen fruits and vegetables.

Canned fruit and vegetables were excluded as these can have added salt or sugar and fruit and vegetables with added sugar or salt were not considered eligible for 5-a-day logos by The Department of Health.

Low fruit and vegetable consumption is associated with low-income environments across Britain (White et al. 2004, McEntee 2008, Wrigley 2002, Nelson 2000, Nelson et al. 2007). It is seldom a single issue such as 'cost' that prevents many low-income individuals from consuming the recommended amount of fruits and vegetables. Recent evaluation data (McFadden et al. 2013) indicates that mothers have chosen to use Healthy Start vouchers to purchase items that would normally not be within their budget, for example fresh strawberries or grapes. Mothers reported that a benefit of Healthy Start was that it enabled them to provide a wider range of fruits in particular to their young families (McFadden et al. 2013; McFadden et al. 2014). However, the 2010 Infant Feeding Survey (McAndrew et al. 2012) indicates that 68% of mothers using the voucher aspect of Healthy Start in the first year of life, reported spending them on infant formula.

The most recent *Diet and Nutrition Survey for Infants and Young Children* (DNSIYC) also included a sample of Healthy Start beneficiaries (Sommerville, Henderson and Lennox 2013). The original sample alone was too small for analysis so a 'boost' sample of Healthy Start beneficiaries was included. In total 580 beneficiaries were sampled and four day food diaries were used to estimate food and nutrient intakes. The participants were grouped into families with an infant between 4-11 months or toddlers between 12-18 months. Thus, an initial limitation to this data reflecting Healthy Start impact is that there is no account for infants 0-4 months, or those aged 18 months – 4 years. The survey results indicated that none of the beneficiaries exclusively breastfed their infants/toddlers. Bearing in mind that the survey sample was beneficiaries with an infant or toddler between 4 and 18 months old, it is plausible that participants may have breast-fed in the first four months, however this information is not reported. Overall 47% of beneficiaries spent their Healthy Start food vouchers solely on infant formula and 25% spent their vouchers solely on fruits and vegetables. The report states:

For much smaller proportions of households, vouchers were spent only or mainly on cows' milk (9% overall), or on mixtures of fruit and vegetables and infant formula or cows' milk, or on supplements. (2013 p. 4).

The above statement indicates some confusion in the survey as Healthy Start vouchers cannot be spent on supplements, there is a separate token that can be exchanged for these. The report indicated that 3% of the eligible sample households received Healthy Start vouchers, but did not spend them.

Beyond the focus group information from the evaluations (McFadden et al. 2013; Lucas et al. 2013) and the limited IFS and DNSIYC survey data, it is not clear how Healthy Start vouchers are spent. The Department of Health does not appear to monitor what Healthy Start vouchers are redeemed for

### **2.7.1 Support for using Healthy Start food vouchers**

Theoretically as part of the scheme, beneficiaries also receive advice from health professionals to help them get the most out of the food voucher aspect of the scheme. As well as one-on-one advice from a health professional on a local level, there is a range of pamphlets from the Department of Health that offer advice on using the vouchers (See Appendix 1). They contain recipes and example shopping lists. These pamphlets indicate one aspect of support that beneficiaries receive in terms of making healthier choices with the vouchers. Recent evaluation data suggests health professionals are not accessing the resources that are available to them (McFadden et al 2013).

There is also a Healthy Start website that offers advice about how to access the scheme, where vouchers can be spent and a small selection of recipes that include ingredients that can be purchased with Healthy Start vouchers ([www.healthystart.nhs.co.uk/](http://www.healthystart.nhs.co.uk/)). A review of the recipes provided on the Healthy Start website details how many of the recipes appear incomplete and untested (Machell and Donovan 2013).

The nutritional advice available on the Healthy Start website is general advice that focuses around the Eatwell Plate. The Eatwell plate is the Government dietary guidance for the whole population, thus not specified to the needs of individual groups within the population. This advice is aligned with the general

advice from the NHS choices website that again focuses on the Eatwell Plate and 5-A-Day.

To address the lack of specific dietary advice for Healthy Start beneficiaries, an independent charity developed a Healthy Start recipe resource aimed to support people delivering Healthy Start and families in receipt of Healthy Start to make the most out of the Healthy Start food vouchers (Machell and Crawley 2014).

Despite the general advice on websites and in pamphlets (Appendix 1 provides an overview of informational resources produced by the Department of Health), a distinguishing feature between Healthy Start and the Welfare Food Scheme is the role of the Health Professional in delivering the scheme. NICE guidance (2008) suggests health professionals play a key role in supporting Healthy Start beneficiaries to use the scheme to improve diet and promote behaviour change.

An important innovation was its emphasis on the need for health professionals to give participating mothers health and lifestyle advice. This advice has to cover diet during pregnancy, breastfeeding and the importance of fresh fruit, vegetables and vitamins. (NICE, 2008 p.17)

There are studies that indicate that even brief behavioural counselling from a nurse in primary care can increase the consumption of fruits and vegetables by low-income populations (Steptoe et al. 2003). In addition, the NICE report on *Maternal and Infant nutrition for low-income families* provides five key areas that health professionals delivering Healthy Start should have proficient knowledge in. The five points are detailed in the figure below:

Figure 11 NICE expectations of health professionals' knowledge

Professional bodies should ensure health professionals have appropriate knowledge and skills to give advice on the following:

- The nutritional needs of women and the importance of a balanced diet before, during and after pregnancy (including the need for suitable folic acid supplements)
- The rationale for recommending certain dietary supplements (for example vitamin D) to pregnant and breastfeeding women
- The nutritional needs of infants and young children
- Breastfeeding management using the Baby Friendly Initiative (BFI) training as a minimum standard
- Strategies for helping to change their eating behaviour, particularly by offering practical food based advice.

Hills (2006) suggested that training for health professionals and nutrition advice and support for Healthy Start beneficiaries is paramount to the success of the scheme. Lucas et al. (2013) highlighted that although health professionals are being successfully signed-up to Healthy Start, there are issues with aspects of the delivery. The most recent evaluations indicate that health professionals rarely received training about the mechanics of Healthy Start or how to support Healthy Start families to get the most out of the Healthy Start scheme. Information about Healthy Start tended to be learned on the job but rarely through formal training (Lucas et al 2013). Lucas et al.'s evaluation emphasises that although the Department of Health produce pamphlets and guides to support Health Professionals deliver Healthy Start, 'very few' health professionals were aware of the materials. This raises questions regarding how the Department of Health envisioned the role of health professionals delivering Healthy Start to be realised.

An important aspect of Healthy Start to ensure Health Professionals are prepared to deliver the programme is developing and implementing sufficient training (Hills 2006). The original proposal for Healthy Start indicated that training and support would be available for health professionals (Department of Health 2002). The need for training and support was welcomed by health professionals that participated in the Healthy Start consultation exercise (Department of Health

2003). McFadden et al. (2013) provide some examples of best practice with regard to training:

We have a short training package that is easily delivered in team meetings and to new staff. This training is being cascaded throughout the children's centres and delivered in health visiting teams across the county. (McFadden et al. 2013 p.95)

There are both examples of flaws in the delivery process of Healthy Start as well as examples where local areas do create opportunities for Healthy Start families to make the most of local services. Lucas et al. (2013) gave the example of a local area that worked closely with a Children's Centre to provide access to free cooking classes and breastfeeding support groups, thus providing an example of how local area services can enhance support for Healthy Start. The range of practices in delivering the scheme across different local areas is highlighted in both evaluations. A prominent theme of both evaluations is the lack of platforms for sharing best practice. For example both evaluations recognise variations between local arrangements for supporting Healthy Start, yet as McFadden et al. (2013) indicate there has been no systematic mapping of the different models for delivering Healthy Start and assessment of which models are particularly successful. The barriers and enablers for local areas to deliver Healthy Start, a national scheme, have not been explicitly considered.

The evaluations (Lucas et al. 2013; McFadden et al. 2013) highlight a lack of clarity on the role of the health professional in delivering Healthy Start. Both evaluations indicate a lack of engagement with the importance of nutrition advice and support from health professionals. Lack of awareness of the objectives of Healthy Start and how the scheme was intended to function, was identified in recent evaluations (McFadden et al. 2013; Lucas et al. 2013). Lucas et al. (2013) note that many of the health professionals that participated in the evaluation workshops did so to find out more about Healthy Start, indicating that there had been few opportunities to find out about information prior to this, and that general knowledge about the scheme was low.

Lucas et al (2013) found that there was little evidence of parents who are registered to the Healthy Start scheme, receiving advice on diet or nutrition from a health professional.

We can find no examples of parents who recall information about the food vouchers provided by health professionals explicitly linked to health and nutrition advice. (Lucas et al. p.62)

A sizable portion of parents in our sample did not recall receiving any advice about diet and nutrition (Lucas et al. p.63)

As well as one-to-one advice there are resources for pregnant women in the UK that can provide advice on diet. There are a number of national level initiatives aimed to support the health and wellbeing of women throughout pregnancy and while breastfeeding.

Initiatives vary across the UK. Although there are initiatives that cross-cut all four regions (see table 4), there are also variations in each region. For example, in England the Change4Life Campaign and subset, the Start4Life campaign are key sources of information on promoting healthy lifestyles to the general public. In Northern Ireland, the primary healthy lifestyle campaign is ‘Get A Life, Get Active’. In Scotland it is ‘Take life on, one step at a time’ and in Wales it is Change4Life Wales. The main public health strategies are not managed centrally in the UK.

Another example of a national resource that has been implemented or managed differently across the regions is the ‘*Birth to Five*’ book – a free resource that from its first publication by The Health Education Council in the 1980’s until the coalition Government in 2010 was given as a hard copy to all new parents. The resource provided guidance and advice on becoming a parent, looking after yourself and your child and how to find more resources with useful information. Since 2010 the resource has been available via a weblink in England, while Northern Ireland continued to make the resource available as a hard copy, Wales produced their own version and Scotland refers parents to resources on the NHS website.

When the *Birth to Five* book ceased to be available in hard copy to every Mother, there was serious concern from health professionals, as a policy briefing from Unite, the Union (Professional Officer Team 2011), illustrates, one member of the Community Practitioners and Health Visitors Association said:

...we are here to reduce health inequalities, lets not disadvantage those most in need by withdrawing this excellent resource... (2011 p.285)

The relevance of these differences in the broader public health context, is that the resources and agendas that Healthy Start delivery can draw on, differs across regions.

A strong theme for the practitioners who participated in this study was that strengthening the interrelationships between Healthy Start and other public health policies and practices such as Start4Life, Change4Life and the obesity agenda would raise its profile as a scheme that offers tangible benefits for those in need. (McFadden et al. 2013, P.154)

There is an emphasis on Healthy Start linking to other agendas (Department of Health 2002), however, there appear to be few mechanisms in place to ensure this happens. Hills's (2006) evaluation findings suggest that it will be the responsibility of individual health professionals to link to other agendas as there are no inherent mechanisms within the scheme that ensure this will happen. In addition, the authors recognise that the delivery of Healthy Start will be affected by wider policy changes that occur alongside the scheme, for example changes in NHS structure or changes in dietary guidance (Hills 2006).



**Table 4 Agendas and initiatives for pregnant women, breastfeeding women, families with infants or young children (Authors own)**

	Type of resource	Description	Who for	Managed by
<b>Healthy Child Programme</b>	Information and support	Referred to as The Red Book, log-book for parents, health visitors/midwives record baby's development after routine checks.	All parents	NHS
<b>Family Nurse Partnership</b>	Information and support	Bespoke Health Visiting for eligible pregnant teenagers and their partners. The program is offered in 90 areas of England and there are 11,000 places at one time. This is proposed to increase to 16,000 by 2015.	Pregnant teenagers or teenagers with a child under the age of two.	NHS
<b>Children's Centres</b>	Information and support	Community centres focussed on providing maternity services, resources, social services and often childcare to families with children from birth to five.	All families with young children.	
<b>Baby Friendly Initiative</b>	Training/information	UNICEF Framework to promote, support and protect breastfeeding.	All pregnant women	UNICEF -UK

There are also a number of government initiatives that aim to support the nutrition of infants and young children specifically. The following table summarises these.

**Table 5 Government initiatives for infants and young children**

Scheme	Beneficiaries	Free
<b>Nursery Milk Scheme</b>	Children under 5	189 ml (1/3 pint) of milk for each day they attend approved day care facilities for 2 hours or more.
	Babies aged under 12 months	dried baby milk made up to 189ml (1/3 pint)
<b>National School Fruit and Vegetable Scheme</b>	Child aged between 4 and 6.	piece of fruit or vegetable each day at school.
<b>Universal Free School Meals (as of September 2014)</b>	All 4-6 year olds	School meals

### 2.7.2 Breastfeeding and Healthy Start

Exclusive breastfeeding for the first 6 months of life is the recommended best practice for infant feeding (Department of Health 2003a). The National Institute for Health and Care Excellence (NICE) were tasked with developing guidance on improving the nutrition of low-income pregnant and breastfeeding women and their young children (2008). The role of NICE is to provide guidance for best practice in health and social care (National Institute for Health and Clinical Excellence 2014). A key recommendation was to ensure Healthy Start was promoted and delivered effectively. Additionally, another key area was to support women who are less likely to start and maintain breastfeeding to breastfeed.

The IFS survey (McAndrew et al. 2012) found that Healthy Start vouchers were primarily being used to purchase infant formula. Although this finding is not representative of all Healthy Start families for the reasons previously mentioned, it does give some indication as to whether or not Healthy Start affects infant

feeding practices. Notably, it suggests that Healthy Start beneficiaries are not using the scheme very differently to how the Welfare Food Scheme was used (COMA 2002). Lucas et al. (2013), support this finding with qualitative data:

Many frontline health professionals reported that the scheme was still referred to by mothers as 'milk tokens' and in fact that was what the majority would be spending the vouchers on, not fruit and vegetables. (p.36)

Some thought you could only use the vouchers for milk and many referred to the vouchers as milk tokens (p.79)

Lucas et al. (2013) further highlighted how people were still thinking in terms of the Welfare Food Scheme, despite the fact that Healthy Start replaced it in 2006. The following quote is from a beneficiary in Leeds:

*I only knew about the milk not the other things because they are milk token vouchers. (p.80)*

This supports the findings from the 2012 IFS and DNSIYC. In addition, the IFS also found that breastfeeding rates among the Healthy Start representative sample were significantly lower than the general population.

Specific breastfeeding education is not part of the Healthy Start scheme. However, all pregnant women in the UK can receive advice on breastfeeding if they attend free ante-natal classes provided by the NHS in their area. It has been reported that about 75% of low-income women do not attend ante-natal classes (Redshaw and Heikkila 2010). There are examples of local areas that have successfully integrated nutritional services into the Healthy Start by referring beneficiaries to services at government funded community centres for families with young children. Activities and services that some Children's Centres provide include: breastfeeding support groups, healthy eating sessions and cooking classes.

Promoting breastfeeding was considered a key component of Healthy Start (Department of Health 2002). In theory this is supported by enabling mothers to buy fruits and vegetables and milk for themselves to consume while

breastfeeding and by ensuring contact time with a health professional when the application form is signed, therefore presenting an opportunity for the health professional to talk to the mother about the benefits of breastfeeding. This is different to the Welfare Food Scheme, which essentially promoted bottle feeding by offering free infant formula in return for milk tokens at baby clinics (COMA 2002).

The 2010 Infant Feeding Survey (McAndrew et al. 2012) indicates that the initiation of breast feeding (defined as a baby ever having been put to the breast or given any expressed milk in the first 24 hours of life) has been increasing since the 1990's. However, exclusive breastfeeding rates remain low and mothers with managerial and professional backgrounds are more likely to breastfeed than mothers without a managerial or professional background. The survey also reported that initial breastfeeding rates were considerably lower among Healthy Start beneficiaries (56%) compared to the average (81%). It is internationally established that breastfeeding is beneficial for all mothers and infants, and should therefore be promoted by the state and health professionals. The tension between making infant formula available to low-income households and the promotion of breast feeding has been a feature of discussions on food welfare (House of Commons, Hansard (Debate) 2005). In the proposal for Healthy Start a key proposed feature was supporting and incentivising breastfeeding (Department of Health, 2002). However, the scheme wholly relies on a mother choosing between spending the voucher on milk and fruit and vegetables for herself to consume while breastfeeding or infant formula. There are no mechanisms in place to address the factors that have been recognised as influential on infant feeding practices among low-income populations. For example NICE (2008) recognised social and cultural factors as highly influential on infant feeding practices, there is little evidence that Healthy Start is designed to address these underlying issues that may be central to changing behaviour.

### **2.7.3 Healthy Start Vitamins**

Free vitamins for women and children were part of the Welfare Food Scheme and continue to be part of Healthy Start (Leaf, RCPCH Standing Committee on Nutrition 2007). Folic acid was added, and vitamin A was removed, from the

formulation of free vitamins previously provided through the Welfare Food Scheme. Pregnant women are advised to avoid any supplement containing vitamin A. Healthy Start maternal vitamins comprise of vitamin C, vitamin D and folic acid. Healthy Start children's vitamin drops comprise of vitamin A, vitamin C and vitamin D. The Healthy Start website recommends children take Healthy Start vitamins until they are five. However, to receive Healthy Start children must be under four.

Within pregnancy, SACN reports indicate that women living on low-incomes are less likely to reach the recommended daily amount of folate and iron (SACN 2011). Both of which are essential to foetal development (SACN 2011). Pregnant and breastfeeding women are also likely to be more at risk of vitamin D insufficiency.

Figure 12 Healthy Start vitamin coupons and vitamins from [www.nhs.healthystart.uk](http://www.nhs.healthystart.uk)



Once successfully signed-up to the scheme, beneficiaries receive Healthy Start coupons in the post every 8 weeks (Department of Health 2014). Reported vitamin take-up for the scheme by both pregnant and breastfeeding women and children has been low. Jessiman et al. (2013) reported take-up as less than 10%. Figure 12 illustrates the Healthy Start vitamin coupons and Healthy Start vitamins.

Vitamins are available in exchange for Healthy Start vitamin coupons at vitamin distribution points which in England include children's centres, health centres and clinics and some community pharmacies. The Healthy Start regulations state

that the vitamin component of Healthy Start is the responsibility of local areas. Local areas can therefore decide how Healthy Start vitamins will be made available and promoted.

It is the responsibility of NHS England, Clinical Commissioning Groups and Local Authorities in England, trusts and health boards in Scotland and Wales, and the Business Services Organisation in Northern Ireland to make the vitamins available. (Department of Health 2014)

The Healthy Start website provides 11 case studies to illustrate the different ways local areas have chosen to distribute Healthy Start vitamins for women and children (Department of Health 2014). Examples range from providing maternal vitamins at checking-in appointments, making Healthy Start vitamins universal, i.e. available to all pregnant women regardless of income and vitamins are managed and administered by local NHS bodies.

Lucas et al.'s 2013 evaluation of Healthy Start suggests that vitamin take-up within the Healthy Start scheme is low for a number of reasons, one is low promotion of the scheme by health professionals (Lucas et al. 2013). An article based on the findings of the Lucas et al. evaluation links low awareness of the scheme in general with the reported low take-up rate for Healthy Start vitamins (Jessiman et al. 2013). It is striking that although vitamin take-up is generally low, the focus of Health Professionals is found to be primarily on the vitamin component of Healthy Start as opposed to other aspect of the scheme.

An interesting feature of the programme at all sites was the attention paid to vitamins, almost to the exclusion of the wider aims of the Healthy Start programme. (Lucas et al. 2013 P.21)

Other issues seen as causing low vitamin take-up are unreliable local supply and distribution systems, confusion over the need for vitamins among beneficiaries and a lack of clarity around the actual coupon that is sent to beneficiaries with Healthy Start vouchers. Health professionals describe the frustration of not being able to provide vitamins that women are entitled to (McFadden et al. 2013 p.82).

*Women ask and you feel terrible not being able to give vitamins to women who request them. (Health Professional, Tower Hamlets in McFadden 2013 p.82.)*

A recurring suggestion from health professionals across both evaluations is to mandate that Healthy Start vitamins become universally available to all pregnant women and children under the age of four, regardless of income, as has happened in some areas of England already such as Birmingham and the boroughs of Hackney and Tower Hamlets in London. Findings from a national electronic survey of health professionals found that 69.8% agree that all pregnant women should receive free Healthy Start vitamins regardless of whether they are eligible for Healthy Start (McFadden et al. 2013 p.85).

As local areas are legally responsible for the distribution of Healthy Start vitamins, some areas have chosen to universalise vitamins. This has enabled lower administration costs and wider distribution of vitamins. It is of value to note that although distribution of vitamins is reported on, there is no data on whether or not women and children are taking the vitamins. In the national electronic survey with health professionals, 29.3% of participants strongly agreed with the statement 'local women understand the importance of vitamins for their children' and 18.9% strongly agreed that 'local women understand the importance of vitamins for themselves' (McFadden et al. 2013 p.83). This could indicate a challenge to the vitamin component of Healthy Start.

In October 2013 there was a call from the Chief Medical Officer of the United Kingdom to make Healthy Start vitamins universal to all children under the age of five (Davis 2013). The basis of this call is founded in concern that among British children, cases of nutritional rickets may be on the rise (Allgrove 2004). In response to the recommendation from the Chief Medical Officer in 2014 NICE are conducting an economic analysis examining the cost effectiveness of moving the Healthy Start Vitamin programme from a targeted to a universal offering. Although growing numbers of local areas are choosing to make Healthy Start vitamins universal, this analysis will assess whether there is an economic case to change the policy centrally, making it mandatory that all women and young children receive Healthy Start vitamins.

A consultation document provides information on the issues that are being considered by NICE (National Institute for Health and Clinical Excellence (Great Britain) 2014c). Healthy Start specific recommendations that are being consulted on, are presented below:

The Department of Health should amend existing legislation to allow Healthy Start vitamins to be more widely distributed and sold. It should also renegotiate existing arrangements with the manufacturers to encourage them to provide the supplements direct to pharmacies. (NICE 2014a P.4)

- **Recommendation 6:** Improve access to Healthy Start supplements

Local authorities should:

- Review current accessibility, availability and uptake of Healthy Start supplements.
- Consider how accessibility, availability and uptake could be improved. For example:
  - Consider offering free Healthy Start supplements to all pregnant and breastfeeding women and children aged under 4 years.
  - Use a range of outlets, in particular, high street or supermarket pharmacies, children's centres and clinics.
  - Use outlets with different opening times that are accessible by public transport and are frequently visited by pregnant and breastfeeding women, and families and carers of children aged under 4 years.
  - Setup a central hub for ordering, storing and distributing Healthy Start supplements across the local authority area. Individual distribution sites should be encouraged to order supplements from the central hub, rather than holding their own licence and managing their own stock. (NICE 2014a p.6).

NICE had made similar recommendations in 2008 (p.107). Specifically, in 2008 NICE recommended that Healthy Start vitamins be made available to women who are eligible for Healthy Start and might become pregnant – to ensure maximum nutritional benefit. In addition, NICE (2008 p.107) recommended that



Healthy Start vitamins be made available to non-eligible pregnant women, universalising the vitamin component of the scheme. There has been considerable movement to make Healthy Start vitamins universal, the CMO used Birmingham as an example of a City that had successfully universalised Healthy Start vitamins. The city of Birmingham has piloted universal Healthy Start vitamins. Results indicate a 59% reduction in incidents of vitamin D deficiency (Moy et al. 2012).

Although Healthy Start vitamins are formulated to supplement a range of nutritional requirements for pregnant women and young children, vitamin D has been central to many discussions of Healthy Start vitamins, specifically discussions around universalisation of vitamins. The call from the CMO to make Healthy Start vitamins universal has enabled media to somewhat reframe Healthy Start as a vitamin D intervention. An article in The Guardian states:

It is disgrace is that we already have a political response to the vitamin D problem. It was launched in 2006 and is called Healthy Start. This directed that mothers with the lowest incomes receive vouchers for fruit and vegetables as well as free vitamins – including vitamin D – for themselves and their infants. (Michie 2013)

The guidance around vitamin D in pregnancy is ambiguous. The World Health Organisation says: ‘There is limited evidence on the safety of vitamin D supplementation during pregnancy’ (World Health Organisation 2012 p.5). A 2007 NICE report that considered the effectiveness and cost effectiveness of interventions to promote an optimal intake of vitamin D to improve the nutrition of pre-conceptual, pregnant and post-partum women and children in low-income households also suggests that more research in this area is necessary.

The evaluation from McFadden et al. (2013) draws on a small scale study in their literature review (Garton 2008). Although the study was small scale and there is some detail missing to contextualise it, it reflects the evaluation findings that Healthy Start vitamins are often hard to access due to confusion over delivery pathways.

It is also unclear how free prescriptions work within the Healthy Start scheme – all pregnant women, and children are entitled to free prescriptions from a GP. Therefore, free vitamins could be accessed through that route. There is no evidence that this has been considered in any of the regions.

#### **2.7.4 Healthy Start in Northern Ireland, Wales and Scotland**

Healthy Start is unique in the way it is managed across borders in the UK. In Scotland, Northern Ireland and Wales, health and social services are ‘devolved issues’, meaning the regional governments make decisions pertaining to policy for these areas. However, benefits and social security are ‘reserved issues’ meaning UK parliament can make laws that govern these issues. Healthy Start presents a unique scenario as it straddles both public health, which is a devolved issue, and benefits, which is a reserved issue. The UK government governs Healthy Start and the devolved administrations are responsible for vitamin distribution (see table 6). Thus it is unique as the only health policy which operates in all four regions of the UK and is funded by the UK government, not the devolved administrations. Questions emerge regarding the implication of this set-up and how the devolved administrations view Healthy Start.

Although Healthy Start is a national scheme managed by the Department of Health, the devolved administrations have powers to manage Healthy Start vitamin distribution and promotion in different ways. This varies between the devolved administrations. The table below (Table 6) indicates how England, Scotland, Wales and Northern Ireland make Healthy Start vitamins available:

Table 6 Healthy Start in England, Northern Ireland, Scotland and Wales

Region	Protocol for distributing vitamins	Body responsible
<b>England</b>	<p>NHS England will be responsible for commissioning Children's Public Health services (0-5 years) until 2015, after which the responsibility moves to Local Authorities (LAs).</p> <p>NHS England and Clinical Commissioning Groups (CCGs) do not distribute vitamins themselves. But they are responsible for commissioning organisations which provide child health clinics and maternity services to distribute vitamins locally, for example, Foundation Trusts, social enterprises, community pharmacies etc.</p> <p>LAs commissioning or providing child health clinics are responsible for distributing vitamins to beneficiaries. They may choose locations such as Children's Centres and community pharmacies as distribution points where beneficiaries can access Healthy Start vitamins by exchanging the vitamin coupon that arrives in the post to the beneficiaries home with the Healthy Start vouchers.</p>	NHS England; Clinical Commissioning Groups and Local Authorities
<b>Northern Ireland</b>	Beneficiaries post vitamin coupon to distributors. Distributors post vitamins directly to beneficiaries home.	Business Services Organization
<b>Scotland</b>	<p>As in England, Children's drops and women's tablets distributed to beneficiaries via community pharmacies, practices, and some midwives/health visitors. Health boards can sell to non-beneficiaries.</p> <p>Children's vitamin drops can be sold for £2.38 Women's vitamin tablets can be sold for £1.14 Community Pharmacies may also sell Healthy Start vitamins to non beneficiaries. However this is not covered by regulation and therefore Community Pharmacies can determine the selling price. In addition Scotland has free prescriptions.</p>	Trusts and health boards
<b>Wales</b>	<p>Beneficiaries can exchange Healthy Start vitamin coupons at participating community pharmacies. Health boards can sell them to non-beneficiaries for the following prices (which are inclusive of VAT): Children drops: £1.64 per bottle Women's tablets: £0.83 per bottle</p>	Trusts and health boards

## 2.8 Cost of Healthy Start to the government

The cost of Healthy Start to the government was originally estimated to be between £142 and £143 million per annum (Department of Health 2002). There are no publicly accessible records stating how much the scheme has cost the government since it began in 2006.

Healthy Start was originally charged with being a more efficient scheme (Department of Health 2002). The budget was going to stay the same but nutritional intervention was predicted to increase (Department of Health 2002). A curious feature of the scheme is the eligibility criteria. The requirements for eligibility are based purely on category i.e. pregnant, with a child under the age of four and income i.e. on income support, job seekers allowance, income-related employment and support allowance, or Child Tax Credit (but not Working Tax Credit unless your family is receiving Working Tax Credit run-on only) and has an annual family income of £16,190 or less (2011/12). This raises questions regarding the efficiency of the scheme as nowhere is there a nutritional status requirement, thus the government has cast a very large welfare net to cover all low-income pregnant women instead of those most at risk of nutritional deficiencies.

The Welfare Food Scheme provided milk tokens to 750,000 claimants (pregnant women and children under the age of 5). If these claimants claimed 1 Healthy Start voucher per week for 1 year, the cost of the voucher alone would cost the government approximately £121 million. Thus from these numbers, it would appear that not all eligible beneficiaries are accessing the scheme or redeeming their vouchers. Below is a breakdown of the spending per year between 2006 and 2012.

A Freedom of Information Request to the Department of Health resulted in the following information (Department of Health 2011a):

**Table 7 Government spending on Healthy Start**

	<b>2007/2008</b>	<b>2008/2009</b>	<b>2009/2010</b>	<b>2010/2011</b>
<b>Vouchers UK</b>	£88.5 million	£88 million	£101 million	£99.5 million
<b>Vitamins</b>	£26K	£36K	£42K	£115K
<b>Administration</b>	£4.5 million	£4 million	£5 million	£5 million
<b>Total</b>	93 million	£92million	£106 million	£104.5 million

These costs are to the nearest £0.5million

The ‘vouchers’ total for each year includes backdated voucher payments which make up on average around 1.3% of the voucher total.

Table 8, presents data provided in a written answer to question asked in parliament in 2014 regarding the costs of three different food focussed health initiatives.

**Table 8 Comparative Costs of Healthy Start**

	2010-11	2011-12	2012-13
Healthy Start (United Kingdom)	105.3	105.2	104.9
Change4Life (England) – part-funded by commercial partners	10	10.3	14
School Fruit and Vegetable Scheme (England)	40.5	41.3	38.3

From: <http://www.theyworkforyou.com/wrans/?id=2014-03-31a.193496.hands=%22healthy+start%22#g193496.r0>

## 2.8 Summary

Although the evaluations provide insight into operational issues with Healthy Start, they do not address the impact of policy design on operational issues. The evaluations specifically, contextualise a potential tension between central government – those making policy and local areas – those implementing policy. The relationship between both policy, makers and policy implementers has not been explored within the context of Healthy Start. This presents an opportunity to develop new knowledge on Healthy Start within the context of food policy. In addition the evaluations indicate that there are issues and uncertainties within Healthy Start that have been consistent since its formation in 2006.

## Chapter 3: Literature review

### 3.0 Introduction

Hart (2001) recommends that all research projects need to review both topic literature pertaining to the subject of study and methodological literature pertaining to *how* the subject will be studied. This chapter presents topic literature and the following chapter, theoretical literature. The objective of this chapter is to hone the research questions.

Dunleavy (2003) offers the perspective that ‘any new work rests on the accumulations of previous and current literature’ (p.28). Literature will be used to direct the lines of inquiry taken in addressing the research problem outlined in chapter 1. The following section provides details of the methods used to undertake two types of literature review.

### 3.1 Methods

The literature review was undertaken in three distinct phases. The background to Healthy Start indicated that there is considerable lack of context on the history of the Welfare Food Scheme, despite being heralded as important and in place since 1940. The first phase of the literature review explores the origins of the Welfare Food Scheme and how it changed over the 20<sup>th</sup> and 21<sup>st</sup> centuries. The second phase of literature review considers literature that specifically focuses on Healthy Start or literature that explores the ideas and concepts presented in the background to Healthy Start. Research questions are presented at the end of this chapter.

#### 3.1.2 Historical Literature Review

There is a limited literature and discussion on the development of the welfare food scheme and the changes to it over the second half of the 20<sup>th</sup> century. Murcott provides an overview of some of the post-war changes to food culture (1994) and Land et al (1992), draw on public records to present detail on how the welfare state developed between 1939 and 1971. However there is not sufficient literature to draw from, thus primary research was necessary to develop an historical background to welfare food in the UK.

### *3.1.2.1 Data collection*

To develop contextual knowledge on Welfare Foods in the UK, it was necessary to undertake historical research. Data was collected in the National Archives in Kew. The National Archive database was searched using the terms: ‘Welfare Food Scheme’ and ‘National dried milk.’ These terms were chosen to search the National Archives as the ‘Welfare Food Scheme’ was the key policy for delivering welfare foods in the 20<sup>th</sup> century and ‘National dried milk’ was a key feature of the scheme. There is a dearth of published literature on either topic. By casting a broad net and searching for documents that contained information on either the ‘Welfare Food Scheme’ or ‘National dried milk’ a policy context for welfare foods could begin to be developed.

The search returned a number of files that were requested and collected upon arrival at the National Archives. These included Public Record files from the Ministry of Health, the Ministry of Agriculture, Food and Farming and the National Assistance Board, covering the period of 1940 – 1971. In total five files were reviewed. Documents from these files are referenced in the literature review as follows:

(National Assistance Board, AST 7/500 )

(National Assistance Board 36/228)

(National Assistance Board, AST 7/896)

(Ministry of Health MH 110/10)

(Ministry of Health MH 110/5)

The files included a range of document types comprising government memos, Hansard transcripts, press releases from government departments, promotional flyers and correspondence between government ministers and local area practitioners. Description of the type of document will accompany each reference, where possible Hansard references are provided.

Information on the Welfare Food Scheme after 1971 was accessed through the COMA review (2002), material from the Maternity Alliance (Dallison and

Lobstein 1995) and the Department of Health (2002, 2003 and 2004). These documents were not accessed through the National Archive.

As files cannot be removed from the National Archive, key documents were photographed and notes were written while in the National Archives. Photographs of the documents were then analysed (See Figure 13).

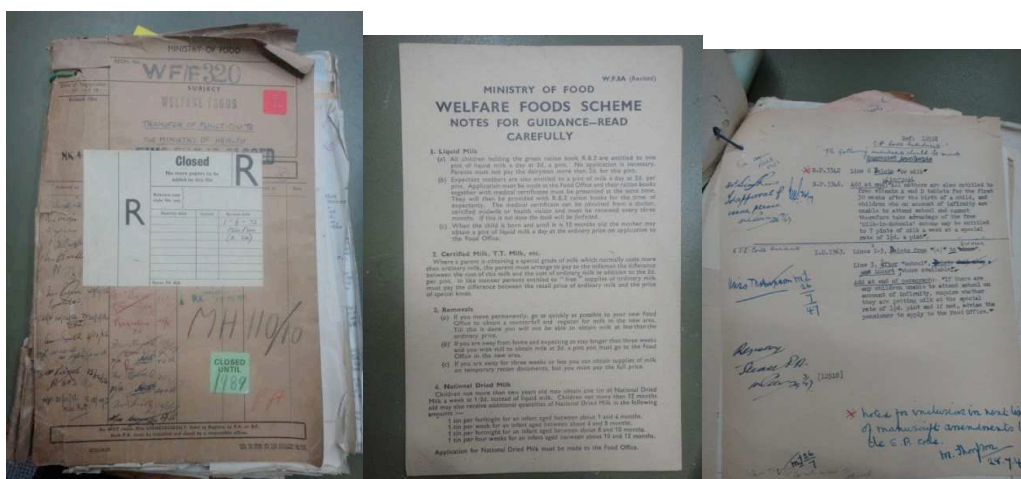
The files of data obtained at the National Archive were not organised in a systematic manner, other than all containing qualitative data that pertained to the Welfare Food Scheme in a specific time period. Thus, there was a sense that the materials were put together in an ad-hoc manner, indicating that there could be other sources of data in other files that would not be found through systematic searches. Thus, a hands-on approach to sifting through the data proved the most effective method for piecing together a narrative of the Welfare Food Scheme's history. It is however acknowledged that there is likely to be additional data that could add another layer of detail to the narrative which was not found in the files consulted.

#### *3.1.2.2 Analysis*

Narrative analysis was undertaken to develop the narrative around the origins of the Welfare Food Scheme and its development across the 20<sup>th</sup> century. This was done by noting down significant findings and ordering them in a timeline (see figure 14). Findings were significant when they demonstrated a change in the scheme or provided information on events, people or actions that influenced changes to the Welfare Food Scheme. Thematic findings were derived from the narrative findings by considering what is the same, and what is different, to what is known about Healthy Start?



Figure 13 Welfare Food files at the National Archives



### 3.1.3 Method: Literature review of Healthy Start specific literature

Literature for this section was accessed and located by searching online databases (British Library, Ebscohost, Ovid Online). The following broad and different search terms were used and limited to the UK:

- Healthy Start
- Welfare Food Scheme
- Food welfare
- Nutrition intervention
- Low-income women nutrition intervention
- Pregnancy nutrition intervention

Broad terms were used, again to cast a wide net in order to try and build a literature that was relevant to the study of Healthy Start. In addition to literature searches, which did not return much literature, bibliographic leads and articles referred by colleagues were also reviewed.

Initial topical literature searches of Healthy Start found a lack of a substantial (academic or grey) literature pertaining to Healthy Start specifically, or indeed food welfare for low-income women and children in the UK. The implications of this initial finding is that a systematic literature review in the classical sense, would not capture the range of literature necessary to develop a body of literature that would inform the direction of research.

As there was very little literature that specifically pertains to Healthy Start, the literature that does exist is wide ranging in purpose and quality. It is however reviewed in this chapter, as it helps define issues both with the scheme and the research area. Consideration was given to the context of literature reviewed, i.e. who the intended audience was, the role of the author in relation to Healthy Start etc. (See Table 9 p.100). Much of the literature is essentially commentary on the proposal for Healthy Start or the initial rolling out of the scheme, not academic research. The value in including all literature, is that it provides insight into who was engaged with the process of forming and developing Healthy Start.

There has been very little academic research undertaken to explore aspects of Healthy Start. One research project of note took place in Sheffield in 2006. A number of articles have been published to disseminate findings from this research. The articles returned in literature searches looking for research on Healthy Start therefore returned multiple articles that all stem from the same research project (See Table 10 p.106).

### **3.1.3 Broader topical literature**

Due to the lack of research that has been undertaken and published on Healthy Start, the literature search was broadened to consider literature that looks at food welfare for women and children and literature that considers the relationship between social policy and behaviour change. This literature was collected through searching online databases. Bearing in mind the purpose of a literature review defined by Hart (2001), each section of the topical literature review will critically examine literature, consider the implications for developing research questions and identify the research gaps.

## **3.2 Historical background of the Food Welfare Scheme**

The objective of reviewing the historical documents was to develop a contextual narrative that could help further understanding of the policy context for Healthy Start. Thus, the data was analysed for both narrative evidence and themes. It is acknowledged that developing an absolute history is a near impossible task (Carr 1961). The point of this analysis is to develop the historical knowledge on the formulation and evolution of the Welfare Food Scheme, to provide a deeper

context that will inform aspects of the policy analysis on the formation and implementation of Healthy Start.

The historian E.H. Carr (1961) discusses how the narrative of history is influenced by the facts historians have chosen or been able to examine. There is a dearth of literature on the history of the Welfare Food Scheme from its inception in 1940, to its reform into Healthy Start in 2006. There is, however, historical data that can be drawn upon to develop a history of the scheme and create context that can help frame analysis of the formation and implementation of Healthy Start. Policy documents pertaining to the development of Healthy Start, consistently make reference to the history of the Welfare Food Scheme being routed in wartime nutrition for women and children.

The Welfare Food Scheme was introduced in 1940 as a wartime measure to help ensure the provision of an adequate diet under rationing conditions (COMA, 2002 p.iii)

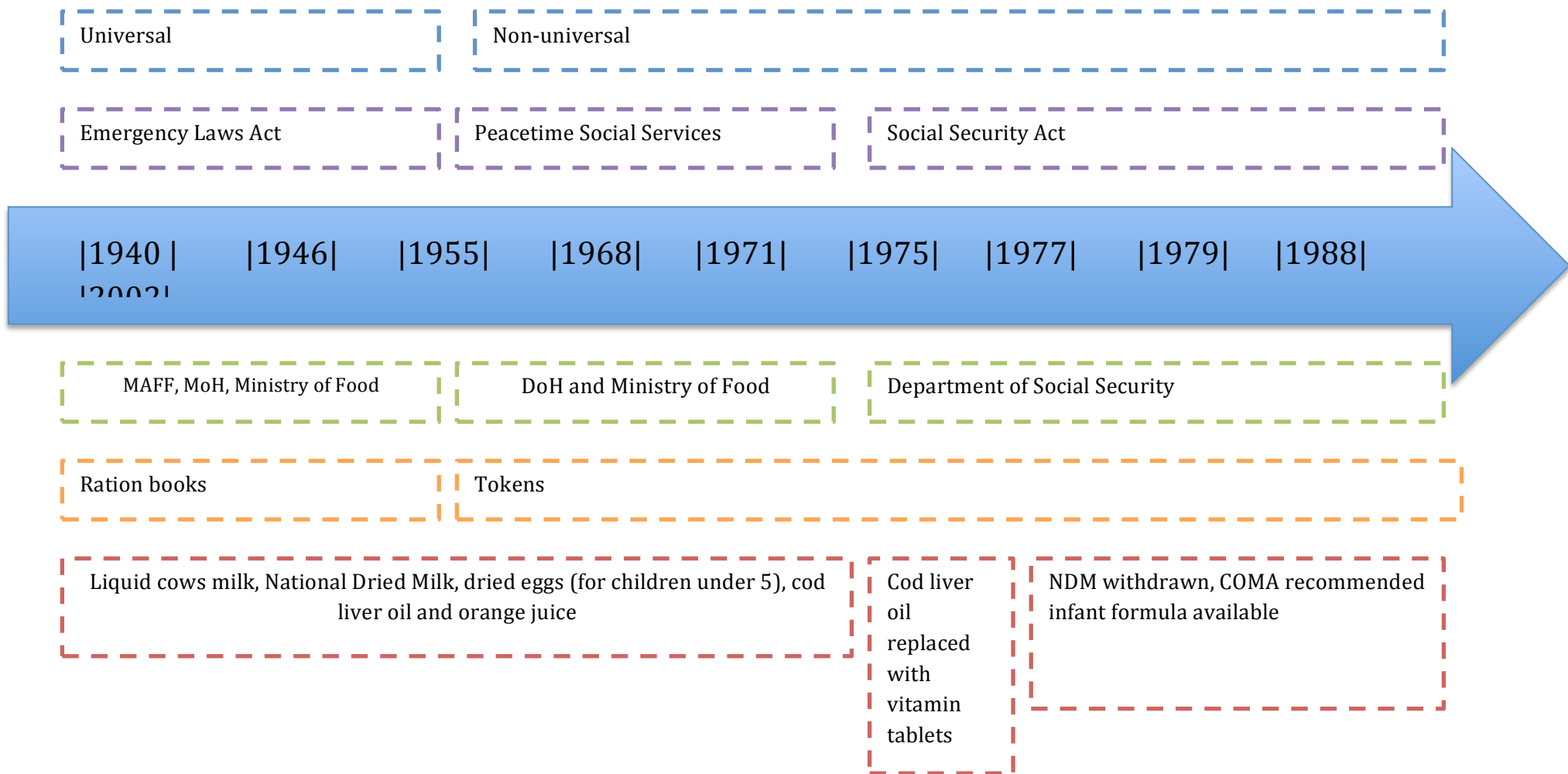
The Welfare Food Scheme was established over 60 years ago... The scheme was conceived at a time of wartime shortages and although the coverage of the scheme has been reduced, its working has remained relatively unchanged. (Department of Health 2002)

The above quotes illustrate one version of the policy history of the Welfare Food Scheme, however, it is unclear what has informed this historical narrative. In order to fully engage with the policy context of Healthy Start, it is crucial to develop a broader understanding of the Welfare Food Scheme's history.

This chapter is structured in two sections. The first section presents the available evidence on the origins of the Welfare Food Scheme and the second section outlines the changes to the Welfare Food Scheme between 1940 and 2006, specifically changes to eligibility, delivery mechanisms and the foods provided.

The following diagram provides an overview of changes to the Welfare Food Scheme between 1940 and 2002 (when Healthy Start was proposed).

Figure 14 Overview of changes to the Welfare Food Scheme 1940 - 2002



### 3.2.1 Origins of the Welfare Food Scheme: Focusing event

*What no one foresaw in 1939 was that unique opportunity for the improvement of national diet was to be afforded, not by a continuance of peace, but by the outbreak of war.*

(Burnett, 2005 p.285)

The quotes by the Department of Health (2002) and COMA (2002) used in the introduction to this chapter indicates the simplification of what is a more multifaceted story regarding the origins of the Welfare Food Scheme. The simple version of history does not provide insight into the food policy tensions that were present in the development of the Welfare Food Scheme. A combination of factors initiated the formation of the Welfare Food Scheme. Factors that are explored include: the existence of a National Milk Scheme, war, budget restrictions, advances in nutrition science and public agitation.

Drawing on public records Land et al, indicate that the original proposal for a National Milk Scheme was rejected by the Treasury in 1939 as they considered it 'financially impractical' (Land et al. 1992 p.104) however the government change in 1940 and the effects of war created a new context in which the Minister of Food, introduced the National Milk Scheme in 1940. The cost of producing and distributing food in war time Britain increased significantly due to increased costs of fuel, as a result the cost of milk went up, causing public agitation (Land et al. 1992 p.104). The government expanded and adapted the National Milk Scheme to become the Welfare Food Scheme, which rolled out in 1940 by the Ministry of Food (p.104). It was therefore the combination of food rationing and the National Milk Scheme that formed the original Welfare Food Scheme for expectant mothers and young children. Land et al (1992), provide evidence that the National Milk Scheme was used in part to alleviate the public agitation of the price increase of milk, thus indicating the origins of the scheme were not wholly grounded in welfare or public health.

As COMA (2002) highlight, rationing was introduced to ensure fair distribution of food to the British people, however there was concern from the Ministry of Food that the rations may not provide the necessary nutrients to vulnerable people, thus the new

Welfare Food Scheme for pregnant women and young children was introduced with the following objective:

to ensure that the rise in the price of milk made necessary by the increased cost of production and distribution does not effect those classes of the community whose need for milk is greatest (Ministry of Health MH 110/10 )

Documents indicate that the policy was originally proposed by the Ministry of Health to the Unemployment Assistance Board (Ministry of Health MH 110/10).

Correspondence between the two government bodies imply concerns regarding the initial proposal for the scheme which acknowledged the potential scale and financial challenges of a welfare food scheme.

we have under consideration a rather ambitious scheme for providing milk either free or at reduced prices for the classes to whom the consumption of milk is physiologically important...The whole conception is at the moment in a rather embryotic stage and it may well be that he scheme is too ambitious financially (Ministry of Health, January 1<sup>st</sup>, 1940 in Ministry of Health MH 110/10)

The period between the correspondence proposing a Welfare Food Scheme and the rolling out of the scheme in 1940, saw an Interdepartmental Conference on Milk occur, at which the pros and cons of a free or cheap milk scheme were discussed (National Assistance Board 36/228 ). The Treasury, the Ministry of Food, the Unemployment Assistance Board, the Ministry of Agriculture and the Ministry of Health, were all represented at the conference, illustrating the original multi-agency approach taken in setting-up the Welfare Food Scheme. On July 1<sup>st</sup> 1940, the scheme was rolled out nationally. As part of the Emergency Laws Act of 1940, the first and foremost concern was the war effort and the urgency of responding to the challenges presented by war. As Murcott (1994) suggests the urgency of war time meant that food was not regulated by trade interests, but by the needs of the people (p.156). Thus the Welfare Food Scheme began as a focussed and integrated policy, addressing a specific issue presented by war – emphasising the need for vulnerable people to have access to adequate nutrition through subsidised food in the form of milk.

In addition, Land et al. (1992), provide evidence that suggests that the Ministry of Health had originally intended the scheme to be integrated into post war arrangements, however the Treasury fought against the intention, the reason being: ‘the provision of subsidised milk to homes, in times of increased supplies, would only reduce domestic bills and not increase consumption.’ (1992 p.122).

It is unclear where the evidence for the above quote comes from. The origins of the Welfare Food Scheme indicate a tension between the Treasury and the Ministry of Food and provide an illustration of the fluidity of influencers on the scheme, for example the National Milk Scheme, which was essentially the cornerstone of the Welfare Food Scheme, seemingly came into being as the result of a government change, not because there was unified agreement within central government that providing free or discounted milk to expectant women and young children was important.

Cochrane and Clarke (2001) emphasise the role that World War II had on defining and shaping the British Welfare State. However in post-war Britain, the challenges of providing food for health in the welfare state were complex and are expressed by John Hewetson in a short pamphlet published in 1946 called *‘Ill-health, Poverty and the State’*. Hewetson argues that within a capitalist society poverty and ill health will never be a priority to the state ‘with its rigid division of men into few rich and many poor’ p.6. The discussion in the pamphlet brings-up issues that those studying food policy today continue to address:

The intimate connection between ill health and poverty can no longer be disregarded. (1946, p.6)

Hewetson’s pamphlet indicates a historic disregard for the relationship between ill-health and poverty, an issue that the topical literature review in chapter 2 indicates is an issue still being addressed today in the works of Dowler (2008), Caraher and Dowler (2007) and Lovelace and Rabiee-Khan (2013).

From reviewing public records it is clear that the origins of the Welfare Food Scheme are more complicated than the brief comments made in Healthy Start policy documents suggest (Department of Health 2002, COMA 2002).

### 3.2.2 Changes to the Welfare Food Scheme 1940 - 2006

There is an understanding that the Welfare Food Scheme changed between 1940 and 2006, however there is little analysis of exactly how, or what changed and why these changes occurred. This section presents a historical scoping of the changes to the Welfare Food Scheme between 1940 and 2006.

#### *Eligibility*

Murcott (1994) argues that the universal eligibility of the Welfare Food Scheme has been ‘whittled down’ since the 1940s. The original intent was for the scheme to provide milk for all pregnant women and young children. Milk was considered “physiologically important” for pregnant and nursing women and their young children (Maude, 1940). However correspondence between the Ministry of Health and the Unemployment Assistance Board indicate that the original intention of the scheme was to serve poorer households, however contention over the calculation of eligibility is apparent in the policy documentation– the Ministry of Health proposed a ‘rough and ready test of family income, less rent’ (Maude 1940). This was however, not a satisfactory measure in the eyes of the Unemployment Assistance Board. Thus, a tension from the start of the scheme appears to be identifying those who are most nutritionally vulnerable. A memo from the Cabinet Office entitled ‘Benefits in kind to young children and expectant mothers’ in 1946 indicates that the scheme was universal however, milk was free to those holding an RB2 ration book, indicating that they had young children. The complexity of defining and administering a means test apparently influenced the Ministry of Agriculture Food and Farming (MAFF) to maintain the universal aspect as it was simpler to administer (AST 7/896). The issue of eligibility was brought up in parliamentary debate, as Hansard transcripts in figure 15 indicate:



*HC Deb 07 August 1940 vol 364 cc228-9W [228W](#)*

*Miss Ward* asked the Parliamentary Secretary to the Ministry of Food whether, as adequate nutrition is of paramount importance in the treatment of tuberculosis, and, owing to the rationing of meat, butter, and margarine, and the shortage of eggs, tuberculous persons find difficulty in obtaining a diet suitable to enable them to resist the disease, he will arrange to extend the scheme for the purchase of cheap milk to tuberculous patients receiving domiciliary treatment?

*§ Mr. Boothby*

I would refer my hon. Friend to the answer which I gave to my hon. Friend the Member for Romford (Mr. Parker) on 25th July to the effect that for the present it is not possible to consider the extension of the National Milk Scheme to categories of the population other than those for whom it has been devised—expectant and nursing mothers and children under five years of age.

**Figure 15 Changes to the National Milk Scheme**

It was not until the 1968 Welfare Foods Order that the scheme was no longer universal and was only available to ‘Family’s with special circumstances’. This evolved into free milk being available for all mothers with two or more children under the age of five in 1971. With this change the focus of the scheme shifted as this quote from a debate in the House of Commons indicates:

The aim of this scheme is to enable those in need to buy food and other necessities on equal terms with the rest of the community. (Hansard 1971)

By 1979, the scheme was available only to mothers with a low-income and by 1988, the Social Security Act was passed and the eligibility for free milk was restricted to mothers in receipt of income support (Dallison, Lobstein 1995).

Thus a shift from focussing on war-time necessity to the broader topic of peace time inequality, occurred within the scheme. The changing and narrowing of eligibility for the scheme, could reflect some of the early tensions with the Treasury, which emphasised the cost of administering a Welfare Food Scheme in relation to its potential take-up (Land et al. 1992).

### *Management*

Compared to other welfare benefits the management of the Welfare Food Scheme has always been unique as a result of the constant but changing role of the Ministry/Department of Health. The participation of the varying government departments and indeed governments has been fluid over the decades in which the

Welfare Food Scheme existed, in that those participating in the management of the scheme changed frequently.

The scheme was originally managed by the Ministry of Food and the Ministry of Agriculture, Fisheries and Farming (MAFF) under an Emergency laws Act. In 1946 the scheme became part of peace time social services and continued to be managed by MAFF (COMA 2002). By 1955, MAFF were transferring responsibility for much of the scheme to the Ministry of Health. However MAFF still maintained responsibility for liaising with the Milk Marketing Boards, procurement and delivery of welfare foods to local areas (Meeting with MAFF and MoH to discuss responsibilities, June 6<sup>th</sup> 1955 in Ministry of Health M110/10). This enabled MAFF to maintain a close relationship with the dairy industry, as historically, they were the government body responsible for processing reimbursements for milk servicemen and dairy producers.

As the Welfare Food Scheme, was the only benefit supporting nutrition in pregnancy, it had an important role which some argued was not realised by government (Dallison and Lobstein, 1995). Thus in the early 1990s, it was of growing concern to organisations such as the campaigning group, the Maternity Alliance, to highlight the challenges of consuming an adequate diet on a low-income (Dallison and Lobstein 1995). This was an issue that was being addressed in theory, however the multifaceted reality of the issue had been seemingly overlooked by government and the inadequacies of the Welfare Food Scheme were not being recognised (Dallison and Lobstein 1995). This reflects a number of issues presented in the topical literature review in Chapter 3.

A 1995 report from the Maternity Alliance outlines the apparent disconnect between the Department of Social Security and the Department of Health from the reality of what the Welfare Food Scheme provided and what the objectives of the scheme were (Dallison and Lobstein, 1995 p.13). They recount, a 1992 House of Commons Health Committee hearing in which the Department of Social Security were questioned about their knowledge on the amount of money spent on food by pregnant women on income support. The committee concluded:

...the Department of Social Security cannot comment with authority on the adequacy of income support rates for providing a balanced diet for pregnant women in the absence of research to support its view. (Dallison and Lobstein, 1995 p.13)

The Maternity Alliance called for research by the Department of Health and the Department of Social Security to explore ways in which pregnant women and young children could be better supported by the Welfare Food Scheme. To date, there is no evidence to suggest this research was undertaken or commissioned.

#### *Operation and delivery of welfare foods*

The main changes to the operation of the Welfare Food Scheme revolve around the systems and professionals charged with delivering the scheme. The scheme shifted from a ration book based scheme, to a scheme based on tokens that could be exchanged for a specified amount of milk or infant formula and eventually was replaced by voucher based scheme in Healthy Start.

The operation and delivery has changed significantly. The structure of rationing during the war made it possible to promote the Welfare Food Scheme through the same mechanism that enabled rations to be delivered: the ration book. Thus the original operation for delivering the Welfare Food scheme was relatively straightforward as coupons for free or discounted milk were available through ration books specifically for families with young children. As the whole population was engaged with rationing, the likelihood of mothers learning about the scheme may have been high, making it more straightforward to promote the scheme. The role of the 'milk officer' comes-up in various documents available through Hansard, thus a specific person employed by the Welfare Office/Ministry of Food to promote and explain the National Milk Scheme or the Welfare Food Scheme existed. Figure 16, illustrates the role of 'milk officer' in coordinating a national food policy on a local level.

**Figure 16 The role of the Milk Officer**

*HC Deb 07 August 1940 vol 364 cc228-9W [228W](#)*

“Milk officers operating the National Milk Scheme have interviewed medical officers of health or officers in charge of welfare centres in their areas and are arranging for the welfare centres, so far as possible, to hold stocks of national dried milk and to issue these to holders of Ministry of Food permits who desire to collect the milk at these centres. In many cases welfare centres are also actively helping in distributing application forms to those who appear to be eligible for the benefits of the scheme, and are giving these applicants advice. Milk officers are also co-operating by exhibiting notices regarding welfare centres, when requested to do so, at milk offices, and by distributing appropriate literature concerning welfare centres with permits or other matter sent to applicants or permit holders under the National Milk Scheme.”

This specifically contrasts with the accounts of how the Welfare Food Scheme operated in its last decade, or indeed how Healthy Start operates today. Until it was replaced in 2006, the Welfare Food Scheme was still tied into the benefit system and tokens for milk or infant formula were collected from benefit centres along with other benefits and then taken to an NHS clinic to be exchanged for infant formula or with the local milk serviceman or in retail shops for liquid cows' milk.

A clear constant throughout the history of welfare foods has been the delivery of a national scheme by local area services. It is also clear that the way local areas deliver food welfare has significantly changed. Thus the scheme has shifted from an emergency law, to social welfare and currently aligns more with health promotion or nutritional intervention, reflecting the shifts between different government departments managing the scheme between 1940 and 2006.

#### *Changes to welfare food provision*

The shifting components of the Welfare Food Scheme illustrate both evolving knowledge of nutrition and the relationship between government and industry. When relations with industry became too explicit, the policy venue occupied by the Welfare Food Scheme became a mechanism to shift focus to health promotion. Thus the clarity of focus, which was apparent when the scheme began was blurred and the purpose of the scheme became unclear and less focussed.

The original scheme comprised of liquid cows' milk, National Dried Milk (NDM), orange juice and cod liver oil (COMA 2002). The orange juice and cod liver oil were eventually replaced by vitamin tablets containing vitamins A, D and C (Great Britain 1975). A significant change to the Welfare Food Scheme, and one, which many may argue (Dallison and Lobstein 1995), indicated a compromise of government values was the replacement of the National Dried Milk with a list of industry brand infant formulas recommended by COMA (COMA 2002). The reason why this move is controversial, is that as analysis of food policy indicates, the role of the food industry in public health initiatives weakens the credibility of government and a tension between government, civil society and industry can prevent the desired public health outcomes (Lang, Barling and Caraher 2009, Lang and Heasman 2004). It is suggested that the role of the dairy industry in the Welfare Food Scheme presents a conflict of interest for the government, as industry often operate within a productionist paradigm which can compromise a public health intervention (Rayner and Lang 2012).

The 2002 COMA review highlights how the 'National Dried Milk (NDM) was manufactured under licence from the government' (COMA 2002 p.5). However a 'Welfare Foods Circular' from 1946 indicates that the National Dried Milk in one division was in fact manufactured by Nestle Ltd. The information about Nestle in 1946, came with a note stating that 'this information is confidential and must not be divulged to the public' (Welfare Food Service Circular/RNF/FEO 586, 1946 in MH110/5).

The role of industry in the history of the Welfare Food Scheme presents evidence of shifting participants/actors in the scheme which as Kingdon (2003) articulates, presents new challenges without necessarily providing a solution to the original problem. Thus the decision to engage industry in providing a social service, became a problem in itself and detracted from the original objectives of a welfare food scheme for women and children.

Although it is clear that the scheme has changed significantly since its inception in 1940, there are a number of elements that have remained related to the challenges of operating and monitoring the scheme. There appears to be a historical lack of data collection and monitoring which as a result meant, that the last review of the Welfare Food Scheme was heavily based on proxies (COMA 2002). A memo between a local

area and central government from 1947 indicates that statistical returns from local areas were ceased due to ‘insufficient manpower’ (Memo, 1947 in National Assistance Board Ast.7/896). Although this decision may have had short term savings in the long run decisions such as this may have perpetuated the historical lack of data that remains today, as numbers for welfare food take-up are still estimated. This was not addressed in the reform of the Welfare Food Scheme and again indicates the financial constraints of the Welfare Food Scheme and its perceived social value by the Treasury.

Take-up of the scheme and promotion of the scheme are also issues which have remained relatively consistent throughout the policy life of the Welfare Food Scheme. Land et al.’s guidance indicates that vitamin take-up of the scheme was historically low (Land et al. 1992) (See Figure 17).

The take-up rate was disappointing, especially in relation to vitamin supplements (McNalty 1953)

Distribution centres were often inconvenient and the health value of the various products was not always appreciated (R/G 23/59).

**Figure 17 Encouraging take-up of welfare foods**

HC Deb 07 December 1953 vol 521 c1606

26. **Mr. Willey** asked the Minister of Food what steps he is taking to encourage the consumption of welfare foods.

**Major Lloyd George** I welcome the opportunity of assuring the hon. Member that by all means at my disposal my Department continues to stress the importance of welfare foods.

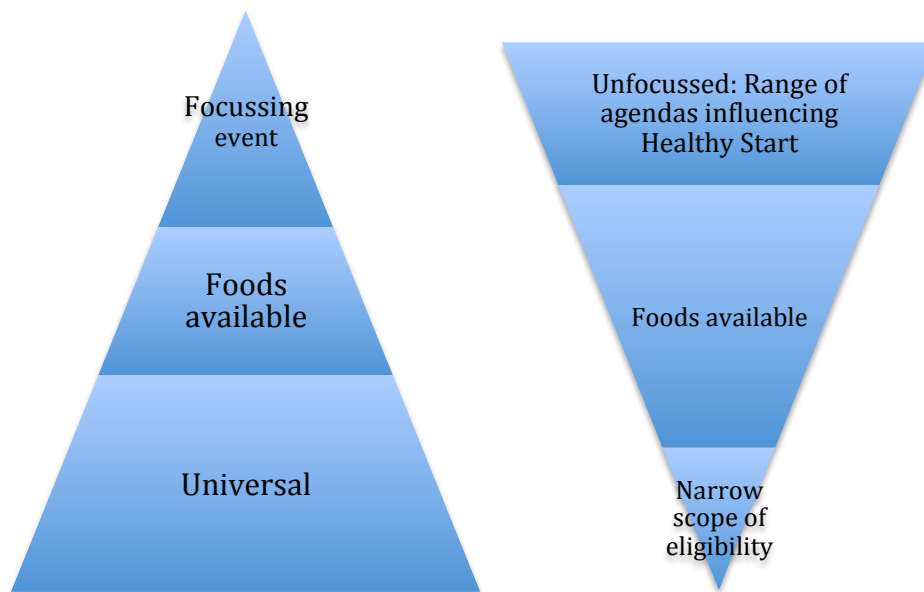
Thus, there appears to be a number of historical issues within the scheme that have not been addressed, but have however influenced the schemes development, specifically the focus on financial efficiency and the lack of a clear picture as to whether or not the scheme was indeed successful. Rather the historical data drawn

upon in the chapter paints a broad brushstroke picture of the issues that faced the Welfare Food Scheme, but provides no clear record of the impact it had.

From reflecting on the changing terrain of food welfare over the last century, it appears there are some areas that remain unclear, specifically: the tensions between food welfare being a human right and a component of the capitalist model; the shifts between food welfare policy as a universal benefit to a means tested benefit; the visibility of food/depoliticisation of food welfare and the historical separation of food welfare in theory and practice.

It is clear that changes have taken place. The first triangle in Figure 18 illustrates how the Welfare Food Scheme began with a focussing event, had few foods available and was universal. The second triangle illustrates how over the years, this has essentially been inverted – today Healthy Start has a range of objectives, ‘foodstuffs’ available through the Welfare Food Scheme has shifted to ‘food’ available as fruits and vegetables were introduced, however less people are eligible to receive the benefit.

**Figure 18 Contrasting the Welfare Food Scheme and Healthy Start**



It remains unclear, exactly why these changes occurred. The value in acknowledging the changes is that it indicates that food welfare provision is a fluid policy area that has historically changed frequently and been influenced by a range of factors. This finding compounds the need to look in detail at what influenced the formation and implementation of Healthy Start.

The issues that emerge from looking at the background to food welfare for women and children in the domestic sphere highlight the historical tension between conceptualising and forming food welfare policy and the issues around how welfare food operates on the ground. Now that historical tensions within the Welfare Food Scheme have been identified, they will inform aspects of the policy analysis of the formation and implementation of Healthy Start.

### 3.3 Healthy Start specific literature

This section presents literature that specifically addresses Healthy Start. Table 9 highlights the limited published research focused on Healthy Start and emphasises how the small literature being reviewed is made-up of different types of literature, from a policy briefing written by an NGO policy officer (Mynard 2006) to guidance and advice for health professionals (More 2003; More 2004; Walker 2007). The available literature on Healthy Start is a hodgepodge of academic conceptual papers, papers aimed at practitioners and briefings/reports that aim to influence policy direction.

#### 3.3.1 Literature that assesses the proposal and implementation for Healthy Start

Although there is not a large literature, or indeed much literature, from peer reviewed academic journals, there is literature that critically assesses the proposal for Healthy Start. Table 9 summarises the literature on Healthy Start that was identified through searching online databases and the British Library database.



**Table 9 Healthy Start literature**

Author	Author background	Date	Publication	Type of publication	Type of article	Intended readership
<b>Belton</b>	Biochemist from the University of Edinburgh's Department of Child Life and Health	2005	Nutrition and Food Science	Peer reviewed academic journal	Conceptual paper	Academic
<b>Mynard</b>	Citizen's Advice Bureau Policy Officer	2006	Citizen's Advice Bureau Policy Briefing	Memo from independent charity that aims to provide advice to people and improve social policies.	Policy briefing	Policy makers and other charities that support families.
<b>More</b>	Dietitian and then chair of the BDA Paediatric group in the UK	2003	Journal of Family Health Care	Peer reviewed journal for community health professionals concerned with infants and young children	Opinion piece	Health professionals
<b>More</b>	Dietitian and then chair of the BDA Paediatric group in the UK	2004	Community Practitioner	Journal of the Community Practitioners' and Health Visitors Association	Opinion piece	Health professionals
<b>Walker</b>	Civil Servant on Healthy Start Unit	2007	Journal of Family Health Care	Peer reviewed journal for community health professionals	Case study	Health professionals

Thus literature from this period reflects on the evidence base for Healthy Start and forewarns of issues that might emerge when Healthy Start is implemented. Although literature specifically pertaining to Healthy Start from this period is not extensive, the literature from Belton (2005), and the Citizens Advice Bureau (Mynard 2006) both contain warnings about the potential challenges the proposed Healthy Start may be faced with. This section of the literature review will outline the key arguments and the issues some recognized might hinder the impact of Healthy Start.

Neville Belton, a biochemist with an interest in the nutrition of young children, from the University of Edinburgh's Department of Child Life and Health, published a conceptual paper in *Nutrition and Food Science* (2005) with the specific purpose of critically assessing the proposal for Healthy Start. He provides an overview of the proposed changes to the Welfare Food Scheme, specifically assessing the review of the Welfare Food Scheme undertaken by the Panel on Maternal and Child Nutrition of the committee of the medical aspects of food and nutrition policy (COMA. 2002). Belton, had previously undertaken research on the relationship between social class and nutrient uptake among school children in Scotland (Ruxton, Kirk and Belton 1996) and therefore was concerned with how the diet of vulnerable populations could be improved.

Belton (2005) acknowledged that Healthy Start was an improvement on the Welfare Food Scheme, however his main criticism of the proposed scheme revolved around the financial cost:

...the new proposals still fall short of what is desirable. Perhaps this is because of the desire to keep any expenditure within what is being spent by the government at present (p79).

Belton deduces that the disconnect between the recommendations for the new scheme based on the scientific review of the Welfare Food Scheme (COMA 2002) and the proposal for the new scheme (Department of Health 2002) are due to a fundamental undervaluing of the public health benefit of welfare food schemes.

Belton (2005) further speculated that in order for Healthy Start to be deemed a success, appropriate monitoring of the scheme would need to be in place to

demonstrate its value to improving the health of low-income mothers and families. Belton's article addressed a different angle of the theory presented by Riche (1997) that food welfare was being depoliticised. As opposed to focusing on the role of the third sector in the depoliticisation of food welfare, Belton looked at it through perceived fiscal undervaluing of food welfare by the State. The issue of 'undervaluing welfare food schemes' presented by Belton, denotes a theme that could be further unpacked to address the research objective of this thesis.

Although the conceptual paper from Belton (2005) does not present original research, it provides insight into concerns about Healthy Start that were strong enough to voice in a peer reviewed journal. Concerns were also raised by a prominent NGO. A policy briefing from the Citizens Advice Bureau (Mynard 2006) drew on the experiences the Citizens Advice Bureau had of the Welfare Food Scheme. Specifically of the administrative issues that people had come to them with for support. Thus this briefing is written based on experiences of a specific aspect of the Welfare Food Scheme – admin, and does not address wider issues regarding the reform of the Welfare Food Scheme such as nutrition.

The main concerns in the briefing focused on the structural flaws of the Welfare Food Scheme that were preventing beneficiaries from receiving the Welfare Food Scheme benefit, and the implications of the perceived structural flaws in Healthy Start (Mynard 2006). For example, Mynard (2006) reported evidence of beneficiaries waiting between 4 weeks and 16 months to receive their milk tokens and attributed this delay to a range of factors including: beneficiaries not being informed about their entitlement at the appropriate time, beneficiaries not having clear information on who to contact if they do not receive their tokens, Job Centre Plus, HMRC and Department of Health failing to understand which department is responsible for specific parts of the claim process and HMRC only sending tax credit claimant information to the Department of Health on a 4-weekly schedule causing delays for beneficiaries. Significant concern based on the experiences of CAB are expressed, however it is unclear how and whether these concerns fed into the development of Healthy Start or indeed if they were addressed by the relevant Government Departments.

The theme of general confusion over responsibilities across government departments comes through the Citizens Advice Bureau report (Mynard 2006). Concerns about the administration of Healthy Start were also voiced predicting Healthy Start would experience the same administrative issues that prevented eligible people from accessing the Welfare Food Scheme (Mynard 2006). As with Belton's (2005) paper, this briefing does not provide original research on Healthy Start, rather it provides insight into the concerns from the perspective of an NGO that provides support to families that are eligible for Healthy Start.

As well as the perspectives of an academic and an NGO, a Department of Health Civil Servant and a dietitian wrote additional literature that provides commentary on the proposal or implementation of Healthy Start (More 2003; More 2004; Walker 2007). Both focus on the new role and responsibilities of health professionals delivering Healthy Start and are written for practitioners (More 2003; More 2004; Walker 2007). On the theme of responsibility, the role of the health professional in delivering Healthy Start was raised before (More 2003) and shortly after the scheme rolled out of the scheme (Walker 2007).

Walker (2007), who at the time was a Civil Servant in the Healthy Start Unit within the Department of Health published two case studies from the health professionals involved in the original pilot scheme for Healthy Start. The case studies were based on findings from the evaluation undertaken by Hills (2006) and promote the new role of health professional. This article enabled the findings of the initial evaluation of Healthy Start to be disseminated.

As Walker was a Civil Servant, it can be assumed that the article published is representing a government viewpoint on the expectation of health professionals delivering Healthy Start. The article is aimed at health professionals, and outlines considerations for health professionals delivering Healthy Start.

Don't take for granted that your clients will find out about the scheme for themselves. And when they do, they may not have the necessary cooking skills. It's no use just giving them the box to tick and saying 'Off you go', As professionals we have to give them the ideas and the tools to allow them to develop new skills. (p 54)

There needs to be thinking and planning to encourage mothers to prepare fruit and vegetables...Try to link up with other organizations in your area that can deliver this kind of training (p 55).

The case studies suggest that the onus is on the health professional to make connections within their local area to maximize support for Healthy Start beneficiaries. The lack of direct statements about the responsibilities of health professionals in this article and the emphasis on suggestions about ‘thinking and planning’ indicate that perhaps the role of the health professional is not clear-cut.

More (2003; 2004) a dietitian and then chair of the BDA Paediatric group in the UK who was seconded to the Department of Health to support the roll out of Healthy Start also published articles in practitioner journals that, as opposed to promoting the new role of the health professional as Walker (2007) did, critically assessed the new role of health professionals in delivering Healthy Start. More wrote these articles before being seconded to the Department of Health.

In response to the new intended role of Health Professionals outlined in the proposal for Healthy Start (Department of Health 2002), More questioned who would be responsible for training health professionals and supporting their already busy workloads. More essentially raised very practical concerns regarding the new intended role of health professionals and asked questions that were not addressed in policy literature, such as how health professionals would learn about Healthy Start and how the new scheme would be delivered

Returning to this literature helps contextualise some of the issues that emerge from the recent evaluations regarding support for health professionals (McFadden et al. 2013, Lucas et al. 2013).

Thus, literature aimed at practitioners charged with delivering Healthy Start highlighted the areas that could present challenges; the importance of health professionals in delivering Healthy Start and the need for engagement between health professional and client (Walker 2007, More 2003).

From synthesizing the very limited amount of literature on Healthy Start it is clear that Belton (2005), More (2003) and Mynard (2006) were all presenting concerns

with the proposal for Healthy Start (Department of Health 2002) based on either practical experiences (More 2003 and Mynard 2006) or forecasting based on the fiscal value of the new scheme (Belton 2005). Specifically, themes around responsibility for delivery of the scheme and concerns about measuring the impact of Healthy Start are illustrated. There is a lack of literature that considers the actual implications of shifting from the Welfare Food Scheme to Healthy Start. Specifically there is a lack of scholarly literature that explores and considers the feasibility of Healthy Start and critically assesses the policy literature.

### **3.3.2 Research on Healthy Start**

As part of a wider project ‘Changing Families, Changing Food’, a research team from the University of Sheffield undertook a before and after study of the effects of Healthy Start in Sheffield over seven months (Mouratidou 2010). Thus attempting to look at the impact of Healthy Start. Throughout the study the team published multiple papers (see table 10).

**Table 10 University of Sheffield publications on Healthy Start before and after study**

Authors	Date	Publication	Title	Data source
<b>Ford, Fraser, Wademan and Mouratidou</b>	2008	Proceedings of the Nutrition Society	Preliminary Results of the effect of 'Healthy Start' a new food benefit, on the dietary behaviour of women during pregnancy and post partum in Sheffield, UK	University of Sheffield research project that ran between April and November 2007.
<b>Ford, Mouratidou, Wademan and Fraser</b>	2009	British Journal of Nutrition	Effect of the introduction of 'Healthy Start' on dietary behaviour during and after pregnancy: early results from the 'before and after' Sheffield study	
<b>Ford and Fraser</b>	2009	Chapter in 'Changing Families, Changing Food' (Ford, Fraser 2009)	Off to a Healthy Start: Food Support Benefits of the Low-income Woman in Pregnancy	
<b>Mouratidou, Ford, Wademan and Fraser</b>	2010	Maternal and Child Nutrition	Are the benefits of the 'Healthy Start' food support scheme sustained at three months postpartum? Results from the Sheffield 'before and after' study	

The study looked at the nutritional behaviour of women in receipt of the Welfare Food Scheme (n= 176) and compared it to the nutritional behaviour of women in receipt of Healthy Start (n=160) (Ford et al. 2008). Dietary intakes were assessed through a questionnaire that was administered by members of the research team and therefore the data is based on self-reported food intakes in a relatively small population group. The study found that women in receipt of Healthy Start vouchers reported eating more fruits and vegetables and were consuming more calories daily, primarily from increased milk consumption, however they also ate more 'chocolate bars, cakes and buns, puddings, cheese, sausages and burgers, and crisps' (Ford and Fraser p.30). In both groups, a 'significant proportion' of women did not meet the recommended intake for iron, folate, calcium and vitamin C.

Mouratidou et al. (2010) recognise the limitations of their study, primarily that results are based on crude dietary intakes and that there is likely to be a degree of misreporting that will impact results. They do however conclude that 'in the short

term, the question whether participation in the Healthy Start scheme contributes to healthy eating patterns is confirmed as positive' (p.335). However it is imperative to recognize that like the 2006 Hills evaluation, discussed in section 2.6, the scale of this study prevents it from being evidence of Healthy Start in a wider context and that it does not look at the impact of advice from the Health Professionals delivering Healthy Start nor consider the processes involved in accessing Healthy Start. It is in a sense, a case study from which the authors recognize the need for more work in the area.

The conclusions of the study in Sheffield suggest the long-term public health impact of Healthy Start is uncertain. In arriving at this conclusion the ambiguity of the purpose of Healthy Start is reiterated, as it is unclear from the background in chapter 1, whether there is an intention for Healthy Start to have a long term impact on public health, or whether Healthy Start is a 'nutritional safety net' that is meant to supplement nutrition for an allotted time period.

Writing about the study in Sheffield, in 'Changing Families, Changing Food' (Ford, Fraser 2009) take a historical perspective and look at the key food support programmes for women and children in the 20<sup>th</sup> century. They identify a key tension that runs through the 20<sup>th</sup> century and into the 21<sup>st</sup> century as the tension between giving advice to women about how to make nutritious food within their financial means or to supplement the diets of those who cannot afford to buy healthy foods for their family. Ford and Fraser (2009) underscore the importance of Healthy Start by arguing that Healthy Start presents an opportunity to provide both advice and supplementation for the first time since the WW2 (p.28). This further highlights the important role that 'information' theoretically plays in Healthy Start. Given Ford and Frasers conceptualisation of Healthy Start as bringing together information and supplementation, it is unclear why the study they are reflecting on, does not pay more attention to the information beneficiaries received.

Both Ford (2007), Ford and Fraser (Ford, Fraser 2009), Mouratidou (2010) and Hills (2006) present findings that indicate how Healthy Start works in specific geographic areas of England, Healthy Start as a national scheme operating in Northern Ireland, Scotland and Wales. Healthy Start is not addressed on a national level by either study and although the findings demonstrate impacts among specific groups in specific



areas, this information cannot be extrapolated to contribute to a national picture of Healthy Start. It is therefore appropriate to view each of these studies as isolated case studies; one which looks at the benefit of Healthy Start in a single area (Mouratidou et al. 2009) and one which assesses the mechanics of the scheme in a different single area (Hills 2006).

The focus of the very small literature on Healthy Start in practice focuses on local areas. There is a lack of literature which critically examines the role of the Department of Health within Healthy Start, despite the forewarnings regarding the schemes design (Belton 2005, More 2003, More 2004, Mynard 2006). The studies that exist look at Healthy Start in terms of an intervention, but neglect to look at the scheme in terms of welfare or food policy.

Dyson et al. (2007) argue that the way Healthy Start was launched nationally prevented a systematic approach to take place on the largest possible scale, consequently preventing a national picture of the impact of Healthy Start from being assessed. The design of Mouratidou et al.'s (2010) comparative before and after study was to address this research gap presented by how Healthy Start was rolled out and the lack of baseline data.

Mouritadou (2010) reflects 'the challenge of measuring impact', a theme that Mynard (2006), Belton (2005), Hills (2006) and Dyson (2007) all raised. The Sheffield study demonstrates the reality of how challenging it is to measure the impact of Healthy Start.

There are a small number of academic articles that consider Healthy Start vitamins, however the main focus is Healthy Start as a vitamin D intervention policy, not Healthy Start as food welfare (Moy et al. 2012, Leaf, RCPCH Standing Committee on Nutrition 2007). A recent evidence review from NICE (National Institute for Health and Clinical Excellence (Great Britain) 2014b) that is considering existing guidance on vitamin D, draws on the articles which reference Healthy Start solely in connection with vitamin D. The significance of this literature is that it emphasises how the majority of publications that have referenced Healthy Start in recent years have been about vitamin D, not about food welfare or the other associated topics.

### 3.4 Broader topical literature

The lack of quality literature that critiques the formation of the scheme or considers Healthy Start as welfare food policy indicates that research in this area could contribute to the general understanding of Healthy Start. Before undertaking research it is important to consider literature that addresses themes of Healthy Start that have not been addressed in the Healthy Start specific literature. This section will present literature that critiques food welfare schemes for low-income women and children, the influence of North American food welfare schemes for women and children, behaviour change and social policy and influencing dietary change among low-income women and their young children. The chapter concludes by introducing the research questions that have been informed by the former chapters and the literature review.

#### 3.4.1 Critiques of food welfare for mothers and children in the UK

As indicated in the policy literature in chapter 1 and the first part of this chapter, there is very little historical context to help understand why the UK developed the Welfare Food Scheme or Healthy Start. The literature and therefore context on the impact of welfare food schemes within the domestic sphere in the UK is lacking. Elwood et al. (1981) present a study in the BMJ which emulates a milk token system akin to the old Welfare Food Scheme. The study aimed to assess the relationship between ‘entitlement’ to milk tokens and impact, not the impact of milk itself. The study recruited 951 families with a new born child and followed them for five years; half the families were given a weekly milk token and the other half were not. The findings indicated that although the amount of milk purchased increased, the amount consumed by the children only slightly increased and there was no impact on child growth. Thus the biggest difference between the two groups was the amount of milk purchased. This study provides some insight into creating financial access to food, however neglects to consider the complexity of food access which is discussed by McEntee (2008). McEntee highlights how food access is multifaceted and addressing better access to healthy food requires consideration of physical and financial factors as well as access to knowledge. It will be of value to further consider how these components of food access were considered in the development of Healthy Start.

D'Souza et al. (2006), present a concise overview of many of the food based issues that face low-income women in the Western World. This report solidifies the evidence links between low-income women and nutritional risk by synthesising a number of small scale studies. In doing so, the need for larger scale studies is emphasised and the lack of substantial evidence on the impact of supplemental nutrition programmes is highlighted. It is of value to review the 2006 report as this was published as Healthy Start was rolling out and therefore helps contextualise the formation of Healthy Start. This review was updated in 2013 as part of McFadden et al.'s (2013) evaluation of the scheme. McFadden et al. state:

The updated review still does not provide strong enough evidence to support the premise that food support in the form of vouchers or food packages has an impact on health status of babies born to low-income and socially disadvantaged women (2013 p.27)

The systematic review of evidence on food support programmes for low-income and socially disadvantaged women in developed countries (De Souza et al. 2006) indicates that most of the academic work in this field is based on government supplemental nutrition programmes in North America. The WIC (Women Infants and Children) programme which began in the 1960s is the focus of a plethora of studies weighing-up the pros and cons of the scheme on a local and national level. D'Souza rightly points out that although both schemes in North America and the UK are designed to support the nutrition of low-income women and families, the contexts are very different and thus lessons learnt from America may not be applicable to the UK.

From D'Souza's review it is clear that there is scope to reflect on the processes, success and failures of North American schemes to critically examine the future development of UK systems. A key critique from the review is the relative lack of academic work on issues impacting low-income women and families and food support programmes in the UK. The fact that this point has been made in the original review, and the updated review, suggests the original recommendations were not considered.

### **3.4.2 Influence of North American food welfare schemes**

Drawing on Prattala, Roos, Hulshof and Sihto's (2002) assertion that comparative studies are of value when looking at food welfare, it is clear that there is literature that pertains to food welfare for low-income women, infants and children outside of the UK. The US Women, Infants and Children (WIC) programme has come up as a point of reference (DeSouza 2006; Leather 2006). This section will review WIC policy literature and academic literature that synthesises the themes that emerged from the Healthy Start review of literature. However, firstly an overview of the key features of WIC is presented in Table 11.

Table 11 Comparisons between Healthy Start and WIC voucher systems (authors own)

	Healthy Start	WIC
<b>Established</b>	2006	1972
<b>Managing government department</b>	Department of Health (DH) (this is a UK wide scheme but managed from the English Health Department for all 4 regions of the UK)	Department of Agriculture's Food and Nutrition Service (USDA-FNS)
<b>Administration</b>	DH and Department of Work and Pensions (DWP) which is a UK wide Government department.	State Health Departments
<b>Gatekeepers</b>	National Health Service (NHS) health professionals	Local WIC agency and clinic staff
<b>How clients access programme</b>	Routine NHS clinic appointments or through community child care or support settings	WIC Programmes do outreach. Clients make WIC appointments.
<b>Client participation requirements</b>	10 weeks+ pregnant; or a child under the age of four; individual or family must be receiving income support, income-based job seekers allowance, or income-related employment support allowance, or Child Tax credit and annual family income of £16,190 (\$26,250) or less; All pregnant teenagers under the age of 18 are eligible.	Pregnant, breastfeeding, postpartum woman, infant, or child up to age 5; At least one nutrition risk; Income at or below 185% of the Federal Poverty Line; or demonstrate enrollment in the Supplemental Nutrition Assistance Programme (SNAP), Temporary Assistance for Needy Families (TANF), or Medicaid
<b>Benefit Form</b>	Weekly voucher for food and 6 weekly vouchers for vitamins sent by post	Monthly checks or monthly electronic benefits (EBT) cards
<b>Benefits</b>	Vouchers for healthy food; Maternal and infant vitamins	Checks/EBT cards for healthy food; Nutrition education; Breastfeeding education and support; Referrals to health care and social services
<b>Annual Cost</b>	£99.5 million (\$149 million) <sup>1</sup>	\$7.046 billion <sup>2</sup>
<b>Food available</b>	Non prescribed but limited to: fresh/frozen fruits and vegetables; milk and infant formula	Prescribed: milk; eggs; cheese; juice; peanut butter; whole grain cereal; whole wheat bread/ whole wheat tortilla; brown rice; canned fish Non-prescribed: fruits, vegetables
<b>Evaluation</b>	First evaluation published in 2013	History of longitudinal studies starting in 1972
<b>Number of clients</b>	Approximately 550,000 pregnant women and children, monthly <sup>3</sup>	Nearly 9 million mothers and young children, monthly <sup>4</sup>
<b>Participation rate</b>	80% <sup>3</sup>	62.6% of eligible mothers and young children; 70.8% of eligible pregnant women, 80.6% of eligible breastfeeding and non-breastfeeding postpartum women, 84.8% of eligible infants, and 52.4% of eligible children <sup>5</sup>

<sup>1</sup> 2010/2011 data from Freedom of Information request to DH 09/11/11 Ref:DE00000653517

<sup>2</sup> FY2013 allocation

<sup>3</sup> Department of Health 2013

<sup>4</sup> FY2013 data from U.S. Department of Agriculture. WIC Programme Monthly Data. [http://www.fns.usda.gov/pd/37WIC\\_Monthly.htm](http://www.fns.usda.gov/pd/37WIC_Monthly.htm). Accessed September 24, 2013.

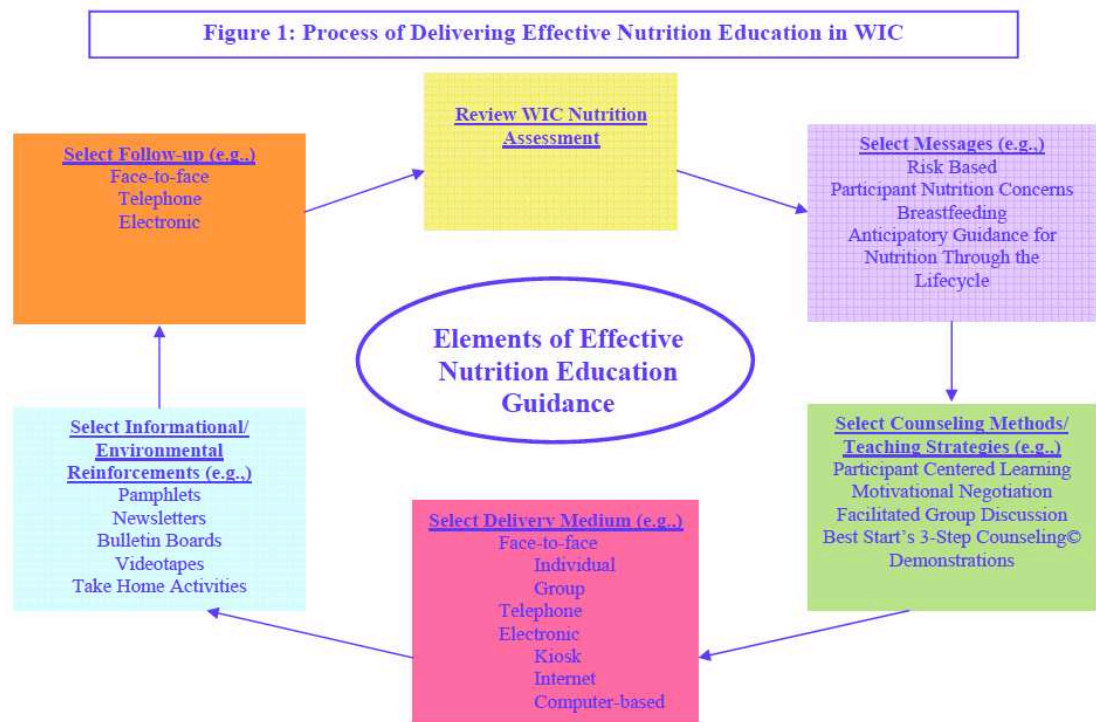
Leather (1997) argues that UK food welfare for low-income pregnant women and children was in need of a system akin to the USA's WIC programme to ensure adequate levels of nutrition are met and malnutrition avoided. The WIC programme was also referenced by COMA in the 2002 review of the welfare food scheme as an example of a successful welfare food scheme that uses vouchers.

It is apparent that Healthy Start and WIC operate on very different financial scales, and that WIC is a more established programme, having started in the 1970s with a clear objective of reducing iron deficiency among nutritionally vulnerable women and children. Thus, although the schemes are similar in that they operate around a retail voucher, and serve nutritionally vulnerable women and children, the features are different. As the 'role of the health professionals delivering Healthy Start' came up as a theme in the literature, a point of comparison that might aid investigation of Healthy Start by offering a different perspective, could be the role of nutrition counselling in WIC. In their evaluation of the WIC programme, Besharov and Germanis (2001) indicate that 'Local WIC agencies are required to spend at least one sixth of their administrative funds on nutrition education' (p.15). Training materials for health professionals produced by the USDA outline the clear process of engaging WIC beneficiaries and tailoring a nutrition education programme to the individual or families' nutritional needs (USDA 2012) (See figure 19).

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<sup>5</sup> U.S. Department of Agriculture, Food and Nutrition Service, Office of Research and Analysis. National and State-Level Estimates of Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Eligibles and Program Reach, *2010*. 2013.

Figure 19 Process of delivering effective nutrition education in WIC



It is apparent from the policy literature (USDA 2012, FRAC 2012) that WIC demonstrates features of successful nutrition intervention (Caraher, Coveney 2004, Anderson, Campbell and Shepherd 1995, Anderson 2007, Davies, Damani and Margetts 2009) by combining upstream intervention through tailored nutritional counselling, and downstream intervention through the voucher.

However there is evidence that the nutritional counselling provided in WIC does not necessarily change behaviour – Rossi's (1998) evaluation of the impact of WIC indicates there are gaps in nutrition knowledge among the schemes participants.

The literature from the UK which refers to WIC as an example of good practice (Leather 1997, COMA 2002) does not acknowledge some of the issues with WIC. Besharov and Germanis (2000) point out, the scheme is not without flaws. Central to Besharov and Germanis's argument is that the impact of WIC has essentially been romanticised without robust enough methodologies being used in evaluation.

All of us would like WIC to be successful as claimed. And it makes common sense that providing food packages and nutritional counseling to the poor ought to improve

their diets. The plain and almost undisputed fact, however, is the following: Beyond modest reductions in anemia and modest increases in the intake of selected nutrients, there is little research evidence about the effectiveness of almost 90% of the funds expended under the WIC programme (page 136)

Thus, WIC is not a clear cut model for an effective food welfare scheme. Rather it is an established one that is continuously developing to respond to the nutritional needs of low-income women, infants and children. As DeSouza (2006) suggests, using the WIC model to identify processes that are transferable may be useful, but the contextual differences need to be considered.

Midgley (2008) theorised that the role of US social policy has been influential in the development of welfare in other western countries and that welfare development was shaped by an exchange of welfare ideas in the west. Although Midgley does not specifically refer to food welfare, using his theory as a framework can help unpick the somewhat uneven foundation that is the basis for Healthy Start. Midgley points out the influence of President Bill Clinton's 1996 Welfare Reform on the New Labour government under Prime Minister Tony Blair and draws on Dolowitz and Marsh's theory of policy transfer (Dolowitz, Marsh 2000a). Dolowitz and Marsh argue that policy transfer from the US to UK has been prominent in British policy making due to common language and common ideologies (Dolowitz, Marsh 2000a).

Despite the impact of WIC being debated, as an established programme WIC has a history of collecting routine monitoring and evaluation data (Johnson, B., Thorn, B., McGill, B., Suchman, A., Mendelson, M., Patlan, K.L., Freeman, B., Gotlieb, R., and Connor, P. 2013, Colman S, Nichols-Barrer IP, Redline JE, Devaney BL, Ansell SV, Joyce T. 2012). In addition, WIC is the subject of a range of academic studies that address specific aspects of the programme such as its impact on breastfeeding (Jiang, Foster and Gibson-Davis 2010, Mickens et al. 2009) or whether or not WIC can be used to deliver other interventions such as smoking cessation (Edwards et al. 2009). Thus, WIC is the focus of a broad range of research projects that produce new data on a regular basis. To contextualise the amount of data that exists on the WIC programme, the USDA recently published a report that summarised new research on the programme (Colman et al. 2012), and in addition routine reports are published that outline WIC participant and programme characteristics (Johnson 2013), these



are derived from routine monitoring and reporting that are built into the policy that governs WIC (Federal Register 7 CFR part 246).

Although many of the academic studies are criticised for being small scale or addressing a local issue (Germanis 2001), having both a wide range of academic studies and a consistent monitoring and evaluation data provides scope for the US government to use data in a formative process of continuous programme development.

As outlined in Table 10, although both WIC and Healthy Start operate around a similar structure in that central government provides funds to eligible beneficiaries via a voucher that can be spent on nutritious food at participating retailers, there are fundamental differences in context, administration and goals. The transfer of WIC to the UK would not be an appropriate transfer as the ‘economic, social, political and ideological contexts’ (p.17) have not been considered.

From reviewing literature on WIC and policy transfer, more questions emerge regarding what influenced the formation of Healthy Start. It is clear that aspects of WIC have been drawn upon, however it is unclear to what extent and with what intentions. There are currently no comparisons between any aspects of WIC and Healthy Start. Anderson (2007) also argued that there were examples of successful interventions in the US that the UK could draw upon to influence policies that not only changed eating habits of nutritionally vulnerable women but also engaged them in the process. Thus indicating that there may be value in looking toward the processes that govern the North American government funded nutrition programmes while taking into account contextual differences.

### **3.4.3 Behaviour change and social policy**

As chapters 1 and 2 indicate, although the specific objectives of Healthy Start are somewhat vague, as part of creating a ‘nutritional safety net’, the scheme intends to promote breastfeeding, encourage increased consumption of fruits and vegetables and promote maternal and infant vitamin take-up. There is a clear emphasis on changing behaviour or at least promoting behaviour change through policy. This section of the literature review builds context on using policy to change behaviour. Evidence that behaviour can be changed through vouchers and vitamins is considered.

Dallison and Lobstein (1995) argue that the reality of the nutritional inequalities that poor women face, are not realised in social policy. They presented a small study that looked at accessing an adequate diet while on benefits in 1995 and concluded that the level of benefit received was not enough to ensure pregnant women on benefits could access adequate nutrition. Specifically, the report recommends supporting better nutrition advice from health professionals, enabling milk tokens to be exchanged for a wider range of products and for the Department of Social Security to conduct research into the amount of money spent on food by women on benefits and the amount of money necessary to access an adequate diet. In 2007 Anderson, continued this critique of the governments role in welfare food initiatives, by arguing a ‘dearth of research’ (p.30) existed in the area of nutrition interventions for low-income women in the UK.

Dowler, Turner and Dobson (2001) review and reflect on activities taking place to address food poverty in the UK. They argue, ‘the welfare state and the cheap food policies aimed at ensuring people have sufficient resources to buy enough food have not prevented food poverty’ (p.1) and describe how although the Welfare Food Scheme exists many of the impacts of food poverty are being left to civil society to address, as Dowler and Caraher (2003) also conclude in their work. This reflects some of the issues presented in the evaluations of Healthy Start (McFadden et al. 2013; Lucas et al. 2013) which describe the challenges of delivering a national scheme on a local level – recommendations suggest linking with more community based activities to support delivery. In addition, this reflects the suggestions from Walker (2007) who was representing the government as a Civil Servant.

Dowler (2008) highlights the challenge of designing policy initiatives that do not generalize the factors impacting low-income households. The arguments presented by Dowler underscore the challenge of designing a welfare food scheme that does not generalise issues which are in reality complex and vary across populations:

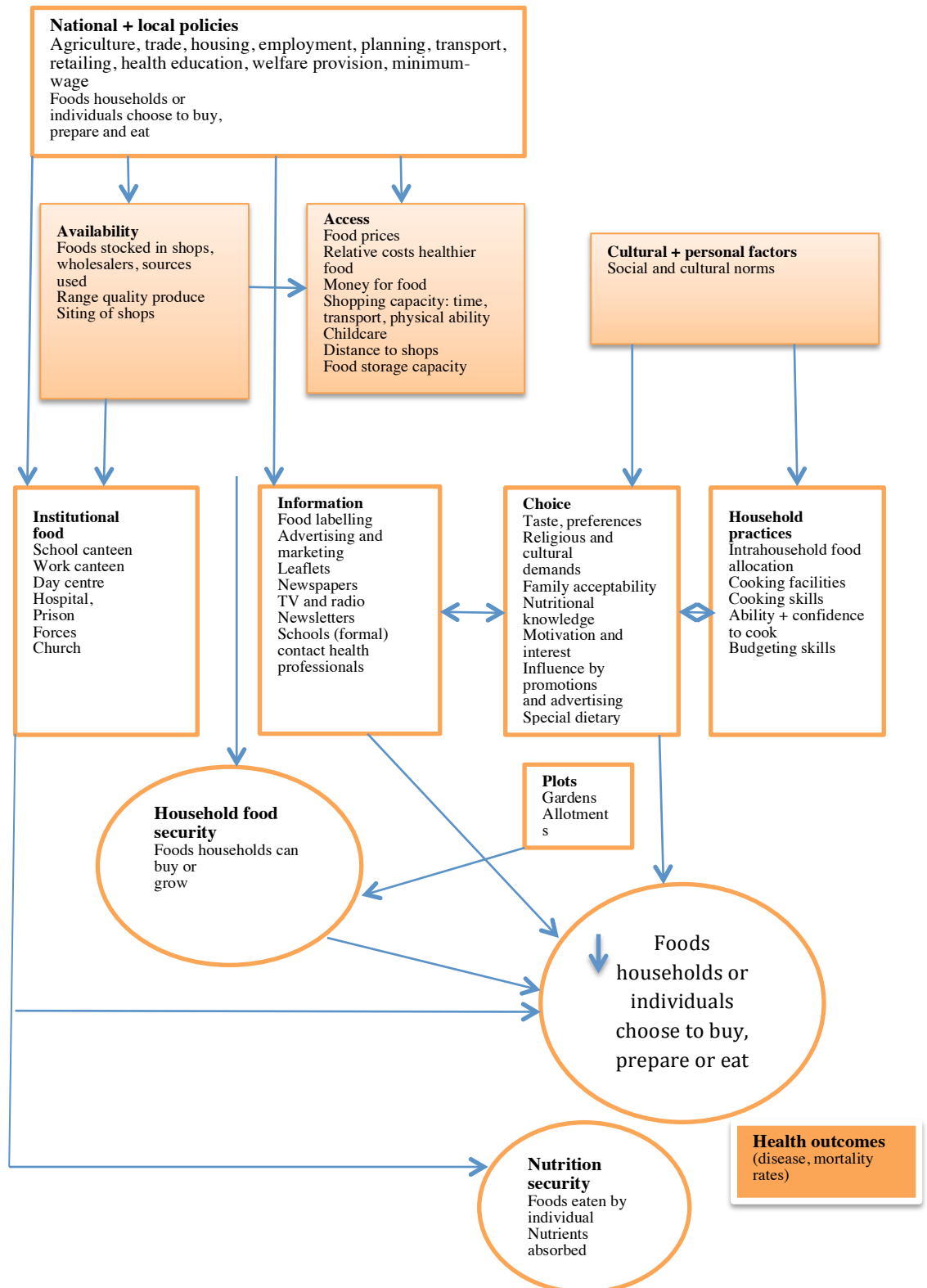
There are further complexities to teasing out the relationships between food and nutritional outcomes and factors such as money, skills, cultural or social capital, in that effects might vary depending on whether they pertain to the individual or to the household; intra-household management of, and access to, resources of various

kinds may not be equal, and this factor may be more important for outcomes in some circumstances (2008 p.291).

The concept of complexity within designing effective food welfare policies further suggests that the influences on the formation and design of Healthy Start should be considered through original research in this thesis. Dowler echoes literature on food access (Wrigley 2001, Whelan 2002, McEntee 2008) by explaining that the existing knowledge on food issues in low-income households stems from a plethora of small scale studies that document the challenges of diet in low-income household.

However Dowler looks at the qualitative findings of these studies and focuses on distinguishing the varying elements of low-income households in the UK. The adapted model of *Main determinants of food and nutritional intake by households and individuals in developed countries* (p 293) marries the themes of food policies and initiatives for low-income households through a flow chart that highlights the complex web of issues that need to be addressed in effective policy design for intervention policies for low-income households (Figure 20). These include availability, access, cultural and personal factors, institutional food, information, choice, household practices (including cooking facilities, skills, budgeting, ability and confidence to cook), household food security and nutrition security.

**Figure 20 Main determinants of food and nutritional intake by households and individuals in developed countries adapted from Dowler et al (2008)**



The model is a broad overview of considerations for policies on a national and local level and demonstrates the necessity of multifaceted food and nutrition policies specifically for low-income households. Dowler (2008) uses the model to illustrate the ‘range of factors and policy arenas’ in food and nutrition policy and the need for initiatives under different policy headings to overlap responsibilities and practices in order for interventions to be effective. Healthy Start operates under the Department of Health and the policy literature (Department of Health 2002, Department of Health 2003b, Department of Health 2004) indicates that ‘cross-cutting’ is a component of Healthy Start. There is however, little guidance on how to successfully cross-cut on a local level to support delivery of Healthy Start. The evaluations of Healthy Start indicate that as a national policy that is delivered on a local level, Healthy Start is not delivered consistently across areas nor is there substantial support for implementation by central government.

The passing reference in policy documents to ‘enabling better access’ for low-income or vulnerable consumers usually means in practice more volunteer led food cooperatives, rather than ensuring that individuals have sufficient money to buy food and decent places that are reachable for its purchase. (Dowler 2008 p.296).

The above quote suggests the complexity of food policies that address food access or nutrition insecurity are undermined by those creating policy. This argument is developed in the work of Leat. In 1998, Leat published a chapter in *The Nation’s Diet* (1998) entitled *Food Choice and the British System of Formal and Informal Welfare Provision*. The chapter argues that the complexity of both welfare and food make food welfare doubly complicated and without substantial research on food and welfare it will be challenging to build an effective and efficient food welfare system in the UK.

Dowler and O’Connor (2011) suggest that it is typical for neoliberal states to lean on models of ‘informed choice’ as the basis of their food welfare (p. 3). A primary goal of Healthy Start is to reduce nutritional inequalities by encouraging mothers to choose healthier diets in pregnancy and for their families (Department of Health 2002). Unlike other food welfare schemes in western countries, Healthy Start is not about addressing hunger and food insecurity (Riches 1997), rather it is addressing nutritional insecurity that can result from living on a low-income. The focus on

‘individual choice’ in Healthy Start sets the scheme apart from other forms of welfare and government food interventions such as free school meals.

Leat (1998) categorizes government food interventions as either direct or indirect. Using the criteria presented in the paper, the proposed Healthy Start scheme would be classified as both a direct and indirect formal state intervention as beneficiaries are entitled to a voucher from the government to be spent on specific types of foods and milk, however the educational component proposed indicates an indirect benefit. Attree (2006) refers to the indirect benefit aspect of Healthy Start as the ‘added value’ (p.71) of the scheme, however there is no published work at present that is able to actually value or measure the impact of any advice given to Healthy Start beneficiaries.

Wilson (1989) further explores this concept by looking specifically at the macro and micro power struggles between food policies, in particular health promotion and the responsibility of the individual and of the state. In light of this area of tension presented by Wilson (1989), Healthy Start could be seen as a scheme that in design crosses the ideological divide by being a macro level scheme i.e. state funded and operated, however success is down to individual choices made on a micro level. The paper from Wilson clearly criticises the way in which the state relies primarily on social marketing of health messages as the main way of trying to influence diet in a positive way. Thus leading Wilson to remark that there is a difference between policy and implementation (p.168). Wilson’s work reflects aspects of Healthy Start specific literature that highlights how unique Healthy Start is because it combines both upstream and downstream intervention (Fraser and Ford 2009). Research in this thesis should therefore consider the relationship between policy design and implementation of policy.

In a small scale study (Wilson 1989) looks at the structures preventing low-income household from accessing a healthy diet;

Present policy improves the health status of the majority, but it stresses individual responsibility and ignores the structural factors...It can only increase the health divide between classes. It is therefore time that policy makers recognized the limitations, as well as the success, of health education and turned their attention to

the structural factors that still prevent certain groups of the population from benefiting from the knowledge which is now common to virtually everyone. (1989 p.184)

Given that the above quote was written in 1989, it provides some substance for a line of inquiry – have policy makers recognised and factored in structural factors in the design of Healthy Start? Wilson (1989), Attree (2006) and Leat (1998) all indicate the considerations that should be taken into account when policy makers develop welfare food policies.

Prattala et al. (2002), review nutrition interventions and policies aimed at addressing socioeconomic inequalities in diet, specifically looking at the differences between universal and selectivist approaches. Key to the argument is that selectivist interventions fail to tell us anything about the distribution of inequalities in society. Prattala et al. emphasise the need for ‘comparative analysis on the impacts of food and nutrition policies on nutritional inequalities’ (2002 p. 118). The two examples of interventions they give, one in the Netherlands and one in Finland, which affect socioeconomic inequalities in diet were both based on a universalist approach.

In synthesising the critics of food welfare in the UK, some clear themes emerge. Firstly the tension between food welfare policies in theory and how they translate into implementation, secondly the complexity of relationships between policy, poverty and nutritional outcome and thirdly the tension between offering nutritional advice and offering ‘handouts’. Within the topic of Healthy Start, it is clear that these themes could be considered within research to add to the research gap and contribute to the understanding and knowledge on food welfare.

#### **3.4.4 Influencing dietary change among low-income women and their children**

The previous section of this literature review explored the complexity of forming effective food welfare policies. To unpack this issue, this section explores in more detail what some of those complexities are. Key to Healthy Start is supporting low-income pregnant women, lactating women and children up to the age of 4 to consume a more nutritious diet. Thus considering the experiences of these groups in relation to accessing an adequate diet is of considerable value. There is an academic

literature with a focus on the broader issues affecting diet in pregnancy and the early years.

Anderson, Campbell and Shepherd's (1995) *The influence of dietary advice on nutrient intake during pregnancy* builds on the theme of nutrition advice in welfare by discussing 'nutritional advice and support'. Anderson presents a study aimed to see if increased information on nutrition during pregnancy affects food choice and dietary change. The study found that although pregnant women's knowledge of nutrition and healthy eating may increase, their diet did not change. They were however more likely to change alcohol consumption patterns, reducing the amount of alcohol consumed in pregnancy.

Anderson et al. (1995) looked at different ways of presenting food education. Another theme that emerges from Anderson's work and aligns with the questions facing Healthy Start is the 'confusion between diet for pregnancy and diet for long term health' (1995 p.164). Furthermore Anderson utilises a theoretical framework that focuses on the features that enable dietary change: the relationships between beliefs, attitudes, intentions and behaviour, and food choice. This in part reflects the *Main Determinants of Food and Nutritional Intake* model (Figure 20). This work will apply to the study of the experiences of beneficiaries using Healthy Start and speak to the concept of food welfare and mobilisation (Riches 1997).

Earlier work (Anderson 1991) looked at creating opportunities for long term dietary change for pregnant women by suggesting that 'relating healthier eating to health maintenance and family concern might assist behavioural change' (p 164). This recognised that 'attitudes' and 'knowledge' toward behaviour change, diet and health may impact the effectiveness of an intervention. One issue with relating this work to Healthy Start is the target group used in the study, were described as 'well motivated', 'interested in health education' and 'seeking health information' (p173). The wider literature on the experiences of low-income families and food suggest that the issues, challenges and motivational factors for food choice vary considerably among low-income women (Whelan 2002). Thus although Anderson's study provides insight into how to frame healthy eating messages to low-income women, the participants in the study entered it with some interest in healthy food, whereas it is probable that would not be the case for all beneficiaries of Healthy Start.



Baird, Cooper, Margetts, Barker, Inskip and the Food Choice Group at the University of Southampton (2009) conducted a review to look specifically at the features of effective health behaviour change. From their review they acknowledged four key components to a successful health intervention: an educational component, continued support, peer support and family involvement. This presents a theoretical framework to assess the potential effectiveness of Healthy Start.

interventions to change the health behaviour of women of child-bearing age from disadvantaged backgrounds will require an educational approach delivered in person by professionals or peers and should provide continued support after the initial consultation. (2009, p.203)

Davies, Damani and Margetts (2009) emphasised the complexity of understanding what motivates food choice.

There are a variety of factors that influence what individuals eat and why, which include: social pressures to eat, which have to be negotiated and reconciled with dietary recommendations; the social importance of certain foods such as red meat, religious rules, strong cultural influences and a desire to eat food that helps retain a sense of identity; other recognised constraints or factors, such as family eating patterns, family commitments, habit, health beliefs, environment and finances. (Davies, Damani and Margetts 2009 p.211)

Thus the literature suggests that policies are presented as theoretical concepts and are not necessarily effective in practice. In order to fully understand the reality of policies aimed at enabling better access to an adequate diet, parallel investigations into the policy development process and practice would enable the most robust investigation to be undertaken. In theory Healthy Start depends on cross-cut and integrated approaches in order to fulfill its mandate from the Department of Health, Dowler (2008) emphasises that in reality this can be challenging. This picks up the theme drawn from the policy literature that Healthy Start in theory may in fact differ from the scheme in practice.

The role of community food initiatives delivering national schemes on local levels is unpacked in Dowler and Caraher's work on local food projects (Dowler and Caraher 2003). Their focus is on the role of the state and the role of civil society in delivering

food and inequality agendas and the tension that exists as a result of the state placing the responsibility of delivering food based issues on local projects.

The role of the government is seen to be twofold; first, to create the conditions for people to make healthy decisions, and second, to support individuals in making healthy choices. (Attree 2006 p.75)

Attree (2006) recognizes that the second component of the role of government is highly challenging within the policy frameworks that are set of food welfare schemes such as Healthy Start. Attree draws on evidence that highlights the context of many low-income families, which indicates that educational programmes can have a positive impact on food choice in low-income families, however they remain low-income and still face challenges. Attree's key point in synthesising policy documents with experiences of low-income families is that often policy makers undermine the wider challenges of living on a low-income and focus too much on enabling individual choice and empowering consumers (p.75). Attree concludes by arguing that there is evidence to suggest that the way to improve nutrition among low-income families is to focus policy on alleviating poverty instead of blindly encouraging healthier choices with disregard for the structures preventing long term health.

The depoliticising of food welfare can be linked to Healthy Start through the intended role of the third sector set out in the policy framework and the focus on individuals and local communities being responsible for delivering the scheme and supporting individuals to make healthier choices. The commoditisation of entitlement is an issue facing Healthy Start as beneficiaries are also consumers and thus intrinsically linked to industry. Mobilisation of low-income families is an area of food welfare in the UK that demands more attention. From the policy literature it is unclear if Healthy Start is a 'public health intervention' aimed to increase nutrition at specific key points in childhood development or a scheme intended to mobilise low-income families to make long term dietary changes.

There is consensus across the literature, that support from both health professionals and peers are identified as important and effective features of nutritional interventions for mothers and children. This adds to the theme across the literature regarding the role of those delivering food welfare schemes for low-income women

and children. Effective interventions combine upstream and downstream interventions, thus combining structural change and advice (Herman 2008). The most striking feature of the topical literature review is a general lack of literature that explores domestic food welfare programmes for low-income women and children in the UK. Although there is a lack of Healthy Start specific literature, there are a plethora of issues that have emerged from the topical literature review that could be researched and used to develop a conceptual framework.

Consideration of the literature on behaviour change raises questions regarding how Healthy Start was designed to be a nutritional safety net. What aspects of behaviour change, if any, were considered?

### 3.5 Developing research questions

From synthesising the key findings from across the topical literature an overarching theme emerges, which is the lack of clarity over what was considered in the formation of Healthy Start and what was driving the formation of both the policy and implementation. The literature outlines the complexity of designing food policies, and provides a number of issues that in theory should have been considered in the formation of Healthy Start, such as the features of successful nutrition interventions for low-income women (Davies, Damani and Margetts 2009) and the capacity of health professionals to be able to deliver Healthy Start in its entirety.

From reviewing the literature it is also clear that a significant research gap exists which research for this PhD could address, contributing to the field of food policy.

In addition to questioning the drivers behind Healthy Start, the literature presents the different ways that food welfare is conceptualised and some reflections on the challenges of food welfare within the domestic sphere. Wilson's (1989) point that 'policies' are distinctly different from 'implementation', could be used to conceptualise the differences between the policy aspirations for Healthy Start – outlined in the background and policy context and the findings of the most recent evaluations. A significant issue therefore, that has not been addressed is the difference between the intentions for Healthy Start as a policy and the operational reality of Healthy Start, in other words – the potential tension between making policy and implementing policy.

The body of literature that does exist essentially on food access and low-income pregnant women and young children, paints a complex picture of the challenges facing low-income families and the tensions between effective intervention and the role of the state. The overview of Healthy Start and the literature review indicate the complexity of designing an efficient welfare food scheme that is also implementable, again suggesting it is of value to look at the development of Healthy Start as a policy.

The literature review isolates the development of Healthy Start as a specific phenomenon that requires scholarly interrogation. Bearing in mind the plethora of issues that emerged from the background, policy context and literature review, the following research questions have been developed as a starting point to address the objectives of this PhD.

**Figure 21 Research questions**

- 1. What were the influences on the initiation, formation and implementation of Healthy Start?**
- 2. What are the barriers and enablers for Healthy Start, a national scheme from being delivered on a local level?**

In addressing these research questions both policy and practice will be engaged and thus provide a framework for robust interrogation of the research objectives which are: consider the initiation, formation and implementation of Healthy Start and consider how Healthy Start as a policy relates to Healthy Start in practice.

The first part of this literature review chapter presented topical literature that has supported the development of research questions. The following chapter further justifies the research questions and considers different analytical lenses and theoretical frameworks to consider the initiation, formation and implementation of Healthy Start.

## Chapter 4: Methodological literature review

### 4.0 Introduction

The theoretical literature review is organised into four sections. The first section outlines the approach to developing a conceptual framework, the second section considers how theories of food policy can be used to ground research on Healthy Start, the third section explores literature that discusses the complexity of policy making and the final section looks at how the complexity of policy making is addressed through models for policy analysis. Specifically the final section, considers the value of the policy analysis triangle (Walt et al. 2008) and the policy streams approach (Kingdon 2003).

As in the topical literature review, literature for the theoretical literature review was accessed through a range of methods including:

- Social policy text books
- Guides to policy analysis
- Bibliographic leads
- Online database searches

### 4.1 Approach to developing a conceptual framework

The study of Healthy Start can be approached through a number of conceptual lenses, for example: nutritional science, social welfare systems, public health intervention, food poverty and political science. It is therefore pertinent to situate the research for this thesis within a conceptual approach that allows the research questions to be interrogated while remaining situated within food policy.

In order to address the research questions that have been informed by the topical literature review, conceptual/theoretical frameworks need to be considered. As mentioned in section 3.0, Hart (2001) states that a robust literature review, examines both topical literature – to identify what needs to be studied and methodological literature to identify *how* to study the topic. To develop conceptual frameworks that will ground the research, Maxwell (2005) suggests identifying the concepts that emerge from the topical literature review and considering how they relate and whether they can be used to ground the research.

From the topical literature review it is clear that a number of concepts emerge. Five key concepts are defined below:

- **Concept 1:** Complexity of influences on food and nutrition consumption among low-income women and children
- **Concept 2:** Tension between making policy and implementing policy
- **Concept 3:** Multifaceted nature of designing implementable food welfare policy
- **Concept 4:** Lack of context on Welfare Food Scheme and Healthy Start
- **Concept 5:** Lack of clarity around what it is Healthy Start is aiming to achieve.

It is clear that all five of the above concepts relate to the policy design that informed Healthy Start and further justify focussing on this phenomena through research. The concepts interrelate as they each consider policy, implementation and practice. The relationship between concepts indicates social policy research will be at the core of research for this PhD. Policy, implementation and practice are three core features of social policy (Alcock in Becker, Bryman 2004). Social policy is concerned with ‘understanding social issues and social problems, social policies and actions in the social world more generally’ (p.14). In addition to defining social policy, Alcock (2004) distinguishes between research *for* policy and research *of* policy. It is important to distinguish that research in the context of this PhD is research of policy as it is not informing any stage of the policy development, rather it is concerned with aspects of *how* a policy developed.

There are different theoretical/conceptual frameworks that can ground research concerned with policy (Cairney 2012, Exworthy 2008, Walt et al. 2008). It is therefore appropriate to consider different theoretical frameworks that will enable a greater understanding of the processes, influences, drivers of the policy design of Healthy Start. In addition, it is of value to recognise the parallels between the concepts that emerge from the topical literature review and food policy thinking. It is necessary for a theoretical framework in this instance to integrate concepts from both the topical literature review and food policy. Theoretical frameworks that are

prevalent in food policy thinking will ensure research is situated within, and contribute to, food policy. The following section of theoretical literature review will explore concepts of food policy thinking and policy analysis that will impact upon the research design outlined in the following chapter.

#### 4.2 Considering food policy

Food policy is complex and multifaceted. As a field, it is broad and explores the enablers and barriers for a range of local, national, international food policies (Lang, Barling and Caraher 2009). Thus food policy considers tensions between different actors and how those influence the development of policies that pertain to food. The background, policy context and topical literature review of Healthy Start has demonstrated that there is contested terrain both in forming and implementing Healthy Start – the disparity between the aspirations for Healthy Start as a policy and the reality of how the scheme operates on the ground presents a clear area of tension that will be explored. The range of actors involved in implementing Healthy Start, health professionals, Department of Health, retailers, community projects and beneficiaries, also present potential areas of tension that can be assessed through the lens of food policy. The concept of ‘contested terrain’ will underpin the research and ensure the implications for food policy theory are considered. In addition to being contested terrain ‘food policy’ is frequently described as ‘complex’ (Lang and Heasman 2004). As a result of the complexity of food policy, multi-method approaches are often adopted for research in the field (Murcott, Belasco and Jackson 2013). This will be considered in the research design. The *Main Determinants of Food and Nutritional Intake* (figure 21) highlights the range of necessary considerations in making effective food policies.

#### 4.3 Complexity of policy analysis

Cairney (2012) states: ‘Policy making is a complex and far reaching process that involves individuals, groups and institutions’ (p.22). Cairney goes on to suggest that the challenges of making sense of policy making can be overcome through the use of theories, models and frameworks. Thus the benefit of using a model/theory/framework in policy analysis is that they can make the process of studying policy more ‘manageable’ (Cairney 2012).

Although there is a substantial literature that highlights the importance and value of policy analysis (Cairney 2012, Sabatier 1991, Marjone 1989), Walt et al (2008) argue that there is little guidance on how to practically undertake policy analysis and apply conceptual frameworks. Yanow (2007) describes the expectation of policy analysis:

We expect policy analysis to provide both policymakers and citizens with an intelligent basis for discussing and judging conflicting ideas, proposals and outcomes (Yanow 2007 p.3).

This is a broad brushstroke definition of the point of policy analysis. Rist (1994) in Denzin and Lincoln) notes that there is often not enough time to conduct qualitative research within policy analysis as policy research is often driven by deadlines for legislation, votes etc. with the objective of influencing policy decisions or reforms. Policy analysis is often reduced to modelling and statistical analysis (Rist 1994). Thus, real world policy analysis is often constrained by time, resources and agendas.

#### 4.4 Making sense of the policy process – models of policy analysis

Before exploring approaches to policy analysis, it is necessary to consider what aspect of the policy needs to be analysed. The issues that emerge from the literature review suggest that the formation and implementation of Healthy Start as part of the policy process have not yet been considered through academic research. In addition, beyond the COMA review there is little consideration of why Healthy Start was formed when it was.

As previously explored, making policy is complex (Miller and Brewer 2003, Walt et al. 2008, Kingdon 2003), therefore analysis of public policy needs to be driven by a clear objective. Walt et al. (2008) reflect that a common error in health policy analysis is only asking ‘what happened’ and not asking ‘what explains what happened’ (p. 309). The research questions aim to address a ‘what explains what happened’ within the context of the formation of Healthy Start.

There is a broad literature on analysing policy development and implementation. This section will critically assess the theory that underpins analysis of policy formation and assess the potential for two different policy analysis models that could be utilised to ground research in the formation and implementation of Healthy Start.



The two policy analysis approaches that will be explored are the policy analysis triangle (Walt and Gilson 1994) and policy streams (Kingdon 2003).

There is an argument from Cairney (2012) suggesting that the most efficient process for analysing public policy is two-fold. Firstly mapping the process or timeline of events in the formation of policy provides a direction of travel for research. Initial mapping of the policy formation of Healthy Start has been undertaken through initial policy scoping and policy document review in chapter 1. Thus the objective of policy analysis is to add a new dimension to what is already known regarding the formation of Healthy Start. Policy analysis by only mapping what has happened has been criticised for oversimplifying a complex process (Sabatier 1991).

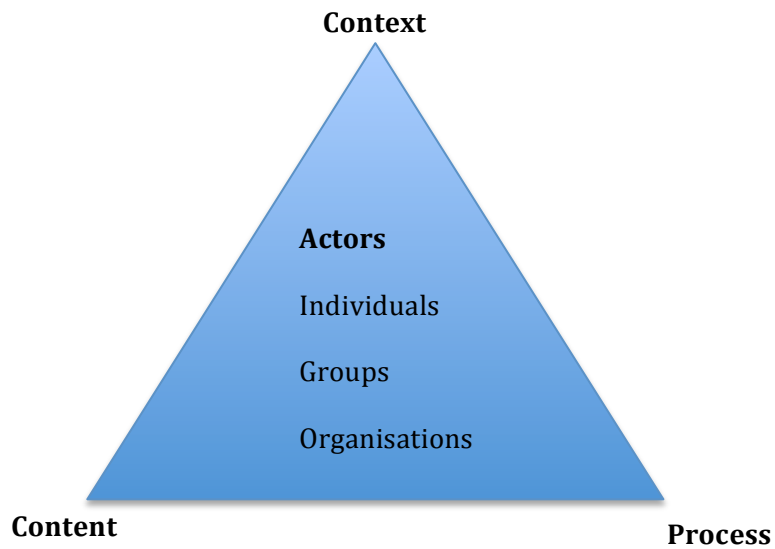
The policy analysis triangle (Figure 22) presents a model for looking at the process, content and context of a policy through the views of policy actors. Actors are organised into individuals, groups and organisations. The model is credited for providing a 'road map' for organising analysis of policy (Buse, Mays and Walt 2005). As a key concept from the topical literature review (Chapter 3) was the complexity of forming welfare food policies, there may be value in adapting this model as a theoretical framework. The same authors who credit the model as a road map, however, suggest it does not provide analytical depth in policy analysis.

While the policy triangle is useful for helping to think systematically about all the different factors that might affect policy, it is like a map that shows the main roads but that has yet to have contours, rivers, forests, paths and dwellings added to it.  
(Buse, Mays and Walt 2005 p.9)

Although the model is specifically developed to consider the actors within health policy formation, there is literature that indicates its applicability across disciplines (Walt et al 2008).

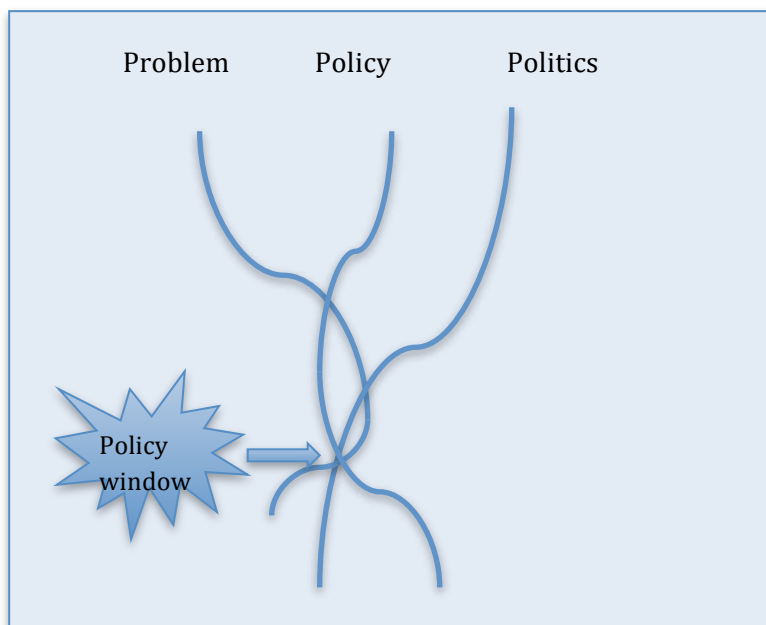
In a sense the topical literature review (Chapter 3) and the policy context in chapter one (Section 1.4) have identified and mapped the factors that may have influenced the formation and implementation of Healthy Start.

Figure 22 Policy analysis triangle, adapted from Walt and Gilson 1994



The initial policy scoping and literature review highlight the lack of clarity around the formation of Healthy Start. Kingdon's model of policy streams (figure 23) offers an organised approach to studying the influences on public policy formation (Cairney 2012). Analysis grounded in policy streams could provide a depth of understanding.

Figure 23 Kingdon's Multiple Streams



Drawing on Lindbolm's theory of 'muddling through', Kingdon's approach assumes that policy making is not a linear process, rather that policy decisions are made as a result of 'organised anarchy' (Cohen et al. 1972). Thus Kingdon challenges earlier conceptualisations of policy making as being a neat or straight forward process with clearly defined stages. Kingdon's research with policy makers established that it was common for policy makers to not have a clear understanding of why certain policy proposals emerge and 'where policies come from' (Kingdon 2003, p487). This theme of a lack of clarity around the policy drivers resonates with findings from the topical literature review regarding the lack of clarity around the development of Healthy Start. To make sense of organised anarchy within institutions, Kingdon (2003) identifies three independently flowing streams that converge to create a policy window or policy opportunity in which a new policy can be formed and implemented. Features of each stream are summarised in Figure 24.

Figure 24 Multiple streams overview

*Problem stream*

The problem stream is multifaceted. Within this stream problems are defined by a number of factors – policy communities, focussing events, crisis, feedback in the form of research and evaluation and budgets. Kingdon argues that some problems remain prominent while others fade and this is largely due to whether or not the problem stream combines with the policy and politics stream simultaneously. Kingdon argues that key differentiating factor between problems that get addressed through a policy response and problems that go unaddressed, is budget.

*Policy stream*

The policy stream is where proposals for solutions to problems are presented and debated by the policy community. Policy proposals need to be technically feasible – i.e. implementable; compatible with the values of prominent players in the policy community; equitable and efficient; acceptable to the public and present an available alternative. The available alternative means providing a clear path for addressing a defined problem.

*Politics stream*

Kingdon argues that unless the politics stream aligns with the aforementioned problem and policy stream, new policy proposals will not come into fruition. The political stream comprises swings in national mood, changes of government, pressure group campaigns and lobbies, values of elected officials.

Kingdon's (2003) approach acknowledges the chaotic and unorganised reality that often surrounds the development of new policy – 'a departure from comprehensive rationality' (p.240) further suggesting that policy making is not a linear process.

Drawing on the comparative work of Zahariadis (2003), Cairney argues that the strength of the multiple streams approach to understanding policy decisions is in its 'explanatory power' (Cairney 2012 p.240). It is for this reason that Kingdon's approach could be a valuable theoretical framework. Interrogating the problem, policy and politics stream that converged to form a policy window in which Healthy Start was formed, will enhance the depth of analysis and help address the objectives of this PhD. Sabatier (1991) offers some criticism of Kingdon's multiple streams approach, contending that it 'neglects the intergovernmental dimension in both (policy) formation and implementation' (p.151). This implies that there are limitations to how Kingdon's approach might be applied to the analysis of the formation of Healthy Start.

Kingdon's approach builds knowledge around unknown phenomena of policy making and agenda setting. It assumes that new policy is made when 'an ideas time comes', however Kingdon argues that it is more than the idea that makes it policy, it is also dependent on timing and the coming together of policy, politics and problems. Bearing this in mind, Cairney (2012) suggests that two concepts central to Kingdon's approach are inevitability and uncertainty – good ideas or solutions to problems will inevitably occur, however it is uncertain when the policy window will open and new policy can be formed and implemented.

The purpose of the multiple streams approach is to build on knowledge not to test a hypothesis, thus, as there is substantial context missing from what is known about the development of Healthy Start, a policy streams approach may provide a model for building an understanding of the policy context. The approach is not expected to explain in detail exactly how and why Healthy Start was formed, rather it can be used to develop context on an unexplored process and provide insight into an otherwise unexplored topic. Cairney emphasises that in policy analysis tracing the foundation of 'ideas', which is essentially what policies are, is a near impossible feat with little value. A deeper understanding of why and how a policy was formed can be found from approaches that explain influencing factors.

Beyond Kingdon's original work, the policy streams approach has been used to explore different types of public health focused policy in different countries, for example: health insurance in the USA (Larraway and Jennings 2002); health care associated infections in the USA (Odum-Forren and Hahn 2006); the social determinants of health in the UK (Exworthy 2008); public health in Sweden (Guldbrandsson and Fossum 2009). Kingdon's multiple streams approach is therefore a recognised method of policy analysis that can help bring understanding to the formation of policy within the area of public health. As there is a lack of research on the formation of Healthy Start, Kingdon's approach provides a method for defining a process that has not previously been defined.

The policy streams approach enables some consideration of 'implementation' as well as policy formation. The 'policy window' that is formed by the convergence of policy streams has implications for how policy is implemented. Kingdon suggests that 'policy windows' are often only open for a short period of time, therefore time-pressure is created for those tasked with designing and implementing policy. The lack of clarity defined in the topical literature review regarding what was considered in the roll-out of Healthy Start could be explored by using the concept of a pressurised policy window.

Cairney (2012) summarises why policies often fail or are only partly successful in seven key features of 'good' policy making (p.35).

- The policy objectives are clear, consistent and well communicated and understood.
- The policy will work as intended when implemented
- The required resources are committed to the programme
- Policy is implemented by skilful and compliant officials
- Dependency relationships are minimal
- Support from influential groups is maintained
- Conditions beyond the control of policymakers do not significantly undermine the process.

In summary, from developing the concepts that emerged in the topical literature review and considering their connections through social policy and food policy,

conceptual frameworks for developing new knowledge and greater understanding of the concepts identified in the topical literature review have emerged.

#### 4.5 Implications of methodological literature review

Maxwell (2005) suggests that the value of a theoretical framework within the research process is to essentially show how research adds to what is already known about a topic and to illustrate how research contributes to a topic field. Drawing on both Kingdon's policy stream approach and theories around the complexity of all the considerations for policy makers in the formation of food policies, creates a theoretical framework that will situate research within social policy, respond to the research objectives and develop implications for food policy that add to the field and address unexplored issues within food welfare.

#### 4.6 Summary of literature review chapters

Chapter 3 began by summarising Hart's (2001) purpose of a literature review: to identify relevant work; prevent duplication of work; to avoid the errors of previous research; help design methodology by identifying key issues and data collection techniques and finally to identify research gaps (p. 3). From undertaking the literature review it is clear that this chapter has demonstrated the need for research to consider what influenced the development of Healthy Start – specifically policy formulation and implementation. Although there is a small literature on Healthy Start, there are many issues that could be considered. As many of the concepts that emerged from the topical literature review pertain to the policy design and how the scheme was implemented, research questions have been developed to interrogate this aspect of Healthy Start. Deciding that the initiation, formation and implementation of Healthy Start would be the foci of research, enabled a conceptual framework to develop through the theoretical literature review that combines concepts of policy analysis and food policy thinking.

## Chapter 5: Methodology

Methodology is concerned with how knowledge will be generated through lines of social inquiry (Miller and Brewer 2003). Daly (1998) argues that methodologies are two fold – firstly providing a set of rules and procedure for a line of enquiry and secondly, a way of communicating the legitimacy of one’s research. Schwant (2007) describes methodology as ‘the theory of how inquiry should proceed’. How research should proceed is established by the context and background of the subject being researched. The background, context and literature review in this thesis indicate that there is a lack of understanding and knowledge on the relationship between the aspirations of Healthy Start as policy and how it operates in practice.

This chapter is concerned with *how* the research questions will be addressed to fulfil the objectives of this thesis, which are: to consider the initiation, formation and implementation of Healthy Start and to consider how Healthy Start as a policy relates to Healthy Start in practice.

Designing legitimate social research to address this issue and produce new knowledge, demands a number of considerations, for example: What new research will add to the existing data highlighted in the previous chapters? How can existing data be used to say something new?

In considering these questions, the background, context and literature review the following research was designed and undertaken. The next section provides a summary of the research and is followed by a detailed overview of methods.

### 5.1 Summary of research

Research began by undertaking analysis of the policy documents that relate to the initiation, formation, and implementation of Healthy Start. These include: the proposal for Healthy Start (Department of Health 2002), consultation documents (Department of Health 2003), response from government (Department of Health 2004b). Documents were analysed to identify and develop an understanding of what was happening in the policy, politics and problem streams, inline with Kingdon’s (2003) multiple streams approach. A number of questions emerged from the analysis of policy documents regarding what was considered and what was influential

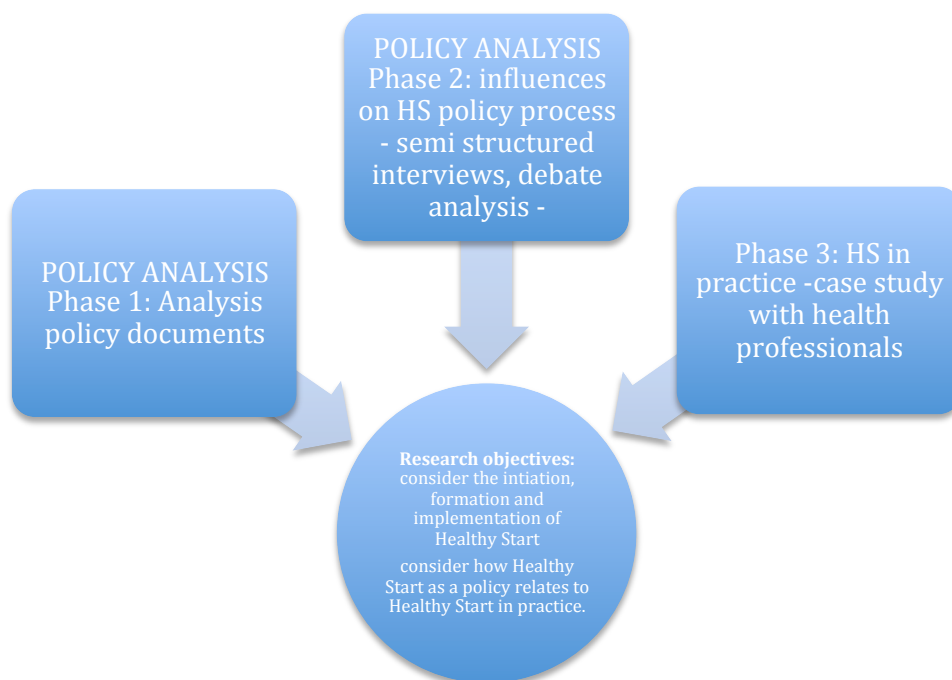


throughout the Healthy Start policy process. These questions informed questions asked to policy participants in the second phase of research – semi-structured interviews with Healthy Start policy participants.

Across the literature review and policy analysis, the role of the health professional emerged as contested terrain and therefore a case study was undertaken to glean insight into the barriers and enablers that impact how health professionals deliver Healthy Start.

The objective of this methodology chapter is to detail the methods undertaken in the research process outlined above.

Figure 25 Research design



Exworthy (2008) stressed that the way policy decisions are made – in a non-overt or non-observable nature of policy making - can cause challenges for researchers trying to analyse why a policy has emerged. It is therefore pertinent to design a methodology that uses a clear line of inquiry. Green (2005) suggests ‘diverse methods enable better understanding of the complex, multifaceted, real-world social phenomena evaluators aim to understand.’ (p.256).

## 5.2 Policy Analysis Phase 1: Policy document analysis

This section will firstly present the methodology of phase 1, secondly outline data collection methods and ethical issues, and finally present how data was analysed.

The guiding research question for this first phase of research is: *What influenced the policy initiation, formation and implementation of Healthy Start?*

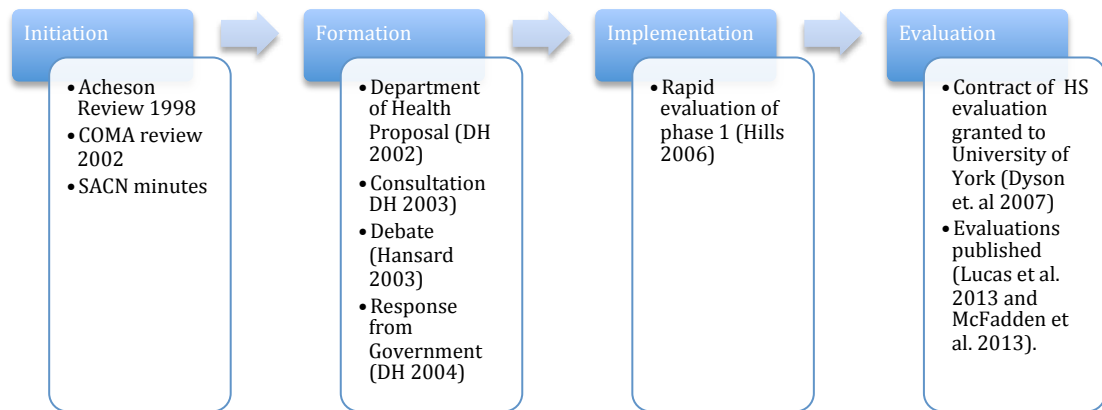
### **Objectives of study 1**

- Add to the mapping of Healthy Start policy development, formation and implementation.
- Identify themes that advance the understanding of the original policy framework of Healthy Start.
- Identify issues/grey areas within the policy context

#### **5.2.1 Methods: Data collection**

The primary data used in this analysis is publically available policy documents pertaining to the development of Healthy Start between 2002 and 2006, including: reports from the Department of Health (Department of Health 2002, Department of Health. 2003, Department of Health 2004b), and COMA (2002), evaluation reports (Dyson et al. 2007, Lucas et al. 2013, Hills 2006). Documents were accessed through the Department of Health online archive. Heywood (2002) identified the four stages of policy development: initiation, formation, implementation and evaluation. Figure 26 illustrates the development process of Healthy Start and the documents that that are analysed using a policy streams approach.

Figure 26 Healthy Start policy development - data analysed



To further contextualise the policy development, additional publically available reports were reviewed (Acheson 1998, Bullock, Mountford and Stanley 2001, Team S.P.M. 1999).

### 5.2.2 Analysis

The objective of the analysis was to identify possible drivers in the initiation, formation and implementation of Healthy Start. The policy documents (Figure 26) were reviewed for themes that can be attributed to, problem, politics or policy then analysed to identify how content fed into the formation of Healthy Start and whether any one of the policy streams was more dominant. This was done through a process of manually coding the policy documents, using policy, problem and politics as initial codes to organise the data and then looking for themes within each category.

To explore drivers of Healthy Start, Kingdon's (Kingdon 2003) approach of multiple streams was utilized to examine what occurred in the policy window in which the Healthy Start programme became a key food welfare policy. Kingdon suggests that policy is made through independently flowing streams: politics, policy and problem, converging to create a policy window. This concept is explored further in the literature review. Using this conceptual approach, this first phase of research aims to

assess what was happening in the policy, politics and problem streams when they converged to create a policy window in which Healthy Start was implemented. Kingdon's approach acknowledges the chaotic and disorganized reality that often surrounds the development of new policy – 'a departure from comprehensive rationality' (p.240) suggesting that policy making is not a linear process. Guldbrandsson and Fossum (2009) describe the policy streams approach as 'a means to reveal the development of the policy process'. Chapter 6 presents the findings of this phase of research.

This first phase of research, is the first phase of a policy analysis, and is inline with Cairney's (2012) recommendation for policy analysis which is to first map the development of policy using available data before undertaking qualitative research to further explore emerging themes. To more fully explore the influences on the initiation, formation and implementation of Healthy Start, semi-structured interviews were undertaken in phase 2 of the policy analysis.

### 5.3 Policy Analysis Phase 2: Semi-structured interviews with policy participants

The goal for this phase of research was to add qualitative accounts of the policy process to the existing policy context to tease out the influencing factors on the development of Healthy Start and develop understanding of the current policy context for the scheme. Walt et al. (2008) reflect that a common error in policy analysis is only asking 'what happened' and not asking 'what explains what happened' (p. 309). This phase of research aimed to address a 'what explains what happened' question within the context of the development of Healthy Start. As the overarching methodology adopts an interpretive approach, the research aims to address a 'how do different actors explain what happened?' question.

Qualitative research allows for different interpretations of the same event to be explored. In gathering a range of interpretations, a more well-rounded and balanced understanding of the issues can be developed. Rist (1994) notes that there is often not enough time to conduct qualitative research within policy analysis as policy research is often driven by deadlines for legislation, votes etc. with the objective of influencing policy decisions or reforms. Policy analysis is often reduced to modelling and statistical analysis. Thus, real world policy analysis is often constrained by time

and resources and agendas. The objective of this study is to conduct policy analysis that fully explores issues that have emerged in the background, context, literature review and first phase of research by using semi-structured interviews.

### **5.3.1 Methods**

Semi-structured interviews focussing on the areas that emerged as vague from the policy analysis were used to develop interview guides to explore the influences on the policy formation of Healthy Start (See appendix 2 – Interview Schedule).

Walt et al. (2008) state that within health policy analysis, ‘it can be difficult to ‘tell the story’ without getting immersed in the detail’ (p. 310). As the background and literature review section emphasised, Healthy Start is multi-faceted as a scheme, academic area of study and as a policy, so having a clear line of inquiry, but maintaining flexibility was essential. The interview guides were used to ‘guide’ the topics covered in the semi-structured interviews, but the flexibility of semi-structured interviews allowed participants to not be constrained by the interview-guide, they were encouraged to bring-up topics that they considered important to the initiation, formation and implementation of Healthy Start.

Semi-structured interviews were chosen as the research method. Semi-structured interviews allow for flexibility and emphasis ‘is on how the interviewee understands issues and events’ (Bryman 2004, p321). The objective for this phase of research was to glean insight into different actors understanding of the influences on the formation of Healthy Start.

Policy initiation and formation often happen behind closed doors and the lack of existing detail on the influences on the initiation, formation or implementation of Healthy Start outlined in the literature review and background, indicate that interviewing people who were present in the Healthy Start policy participants from that period, could greatly add to the context and help address the research question. In this phase of research ‘policy participants’ are defined as individuals that fed into the initiation, formation and/or implementation of Healthy Start.

The following sections outline how participants were selected, ethical considerations and reflections on the process.

### 5.3.2 Participant selection

The criteria for participating is that each professional either had input to the implementation of the Healthy Start scheme and/or participated in the initiation, formation or implementation of the scheme. Initial participants were selected based on their roles identified through the literature review, case study and policy analysis. A range of interviewees were selected to provide a range of interpretations of the same issue (See Table 12).

**Table 12 Semi-structured policy participants interviewees**

<b>Interviewee</b>	<b>Interview status</b>
Civil Servant, Department of Health	Complete
Healthy Start commissioner Department of Health –	No longer employed at Department of Health after April 1 <sup>st</sup> 2013
Six MPs that participated in the debates in the policy formation process of Healthy Start	6 MPs have been contacted, 4 no responses and 2 declined
Former social policy manager of the Maternity Alliance	Complete
Tavistock Institute – evaluator of HS phase 1	Complete
Nutritionists commissioned to develop HS training for phase 1 (Nutrition <sup>4</sup> )	Complete – conducted small group interview with 2 people
Public health nutritionist employed at DH when HS was being formed	Complete
Former DH civil servant	Tentatively agreed, then changed-mind
NGO Child Poverty Advocate	Complete
Dairy industry	Invited twice. No response

### *Snowballing (Morse 2002)*

Participants identified through the literature review, case study and policy analysis were asked if they recommended interviewing any other professional individuals that might add to the context of the research, thus utilising ‘snowballing’ a method of identifying participants. If individuals were identified by the interviewees, initial contact was made through work email addresses and/or phone numbers.

### **5.3.3 Ethical considerations**

As the researcher is engaging with individuals to conduct qualitative research, there are a number of ethical issues to consider (Bryman p.509). Bryman references four principles to consider:

1. Whether there is harm to the participant
2. Whether there is a lack of informed consent
- 3 Whether there is an invasion of privacy
- 4 Whether deception is involved.

In addition to these principles, consideration was also given to the safety of the researcher and the protection of data generated.

Ethical approval was given by the City University School of Arts and Social Sciences Ethics Committee (See appendix 3) to conduct and record semi-structured interviews. The interviewee information sheet and consent form can be found in Appendix 4 and Appedix 5.

All interviews were recorded and transcribed manually, by the researcher (see appendix 6 for example transcription). The process of transcribing provided an opportunity to familiarise with the data before coding.

### **5.3.4 Reflection on the semi structured interview process**

In total 7 interviews took place. All interviewees gave written consent to be interviewed and identified by their job title, in line with the Ethical Approval granted by the City University School of Arts and Social Sciences ethics committee.

It proved challenging to recruit MPs or civil servants to be interviewed as part of the research. Out of six MPs contacted, two declined and four did not return emails or calls. To glean insight into the role of government and MPs in the development of

Healthy Start, parliamentary transcripts of two key debates were included in the analysis of qualitative data in phase 2 of the research. Transcripts were identified through Hansard (House of Commons, Hansard (Debate) 2003, House of Commons, Hansard (Debate) 2005). The parliamentary transcripts, provide qualitative data that gives insight into the role of MPs in developing, forming and implementing Healthy Start.

Two interviewees requested they reviewed interview transcripts before quotes were used in publication. Initially, there was concern regarding how this might affect the research process and the requests were unanticipated. After consulting with a City University ethics specialist, it was agreed that the interview transcripts would be analysed and quotes intended for use in the thesis would be sent to the two interviewees. Interviews were transcribed and analysed, and quotes were emailed to the interviewees for review. One interviewee saw no need to change the quotations beyond ‘tidying’ some of the language, the meaning of the quotes were not lost. The other interviewee had to get the quotes approved by a communications team, who did remove a few of the quotes that pertained specifically to defining Healthy Start and the purpose of the scheme. A few of the other quotes were reworded to slightly change the focus. Enough quotes remained for the interview material to still be valuable and contain important findings.

Throughout the semi-structured interview process, participants volunteered unpublished documentary data from the policy formation period. This was not anticipated, but provided deeper context into the issues that emerged from the semi-structured interviews. To include additional policy literature provided by interviewees in the policy analysis, written consent was granted through email communication. Documents included are shown in Table 13.



**Table 13 Unpublished policy documents provided by interviewees**

Document	Date	Supplied by
<b>Notes of Welfare Food Policy Forum meeting</b>	10 <sup>th</sup> May 1999	Maternity Alliance Archive
<b>Report of the Welfare Foods Consultative Conference</b>	7 <sup>th</sup> December 1999 (Report dated 2001)	Maternity Alliance Archive
<b>Welfare Food Scheme brainstorm</b>	31 <sup>st</sup> October 2001	Maternity Alliance Archive
<b>Notes Open Space Conference</b>	25 <sup>th</sup> November 2002	Maternity Alliance Archive
<b>Policy Briefing from Royal College of Nursing and Maternity Alliance on proposed changes to the Social Care Bill</b>	2002	Maternity Alliance Archive
<b>Industry responses to Report of the Welfare Foods Consultative Conference – one major supermarket and the National Dairy Council</b>	10 <sup>th</sup> and 11 <sup>th</sup> January 2000	Maternity Alliance Archive
<b>Tender for Evaluation of phase 1 of Healthy Start</b>	August 2005	Tavistock Institute
<b>Report on training to Health Professionals in Phase 1 of HS including training resources</b>	November 2005	Nutrition4

Consideration was given to whether or not the unpublished documents provided by policy participants should be included in the analysis of policy documents in the first phase of research to distinguish between documentary data and interview data. However, it seemed pertinent to distinguish between data that was outward facing and publically available (official policy documents) and data that was adding to the context of policy making and was acquired through the process of semi-structured

interviews. Many of the documents acquired through the semi-structured interview process are supporting documents that can validate some of the interview content. Essentially the data in the first phase of policy analysis and the second phase of policy analysis were accessed through different methods and are therefore being analysed separately and presented as separate findings.

### **5.3.5 Analysing data**

Thematic analysis is the analytical approach taken to ‘make-meaning’ from the qualitative data both collected and generated in this phase of the policy analysis. As an approach thematic analysis allows qualitative data to be mined for meaning and for interpretations to be developed.

It is not a research method in itself but rather an analytic approach and synthesizing strategy used as part of the meaning-making process of many methods (Lapadat 2010 p.926)

#### **5.3.5.1 Objectives for analysis**

The analysis of data collected in phase 1 of research, is to identify influences on the formation of Healthy Start by using Kingdon’s (2003) multiple streams approach to draw out the activities that were in the politics, policy and problems streams. The objective of analysis in phase 2, is to derive themes that have emerged across the data and respond in some way, to the research question. This was achieved through concept driven coding of a qualitative data. Participants were not informed about the theoretical approach, a general information sheet was provided (See appendix 5). It was important that participants reflected the issues they identified as important and were not led by the questions.

Coding for this thesis was conducted manually, without the use of analytical software packages. Manual coding was chosen for two reasons – the relatively small number of interviews that took place meant that the amount of data was manageable, and manual coding provided an opportunity to engage with data as part of the analysis process. Using software was not deemed necessary. As transcription was also conducted manually, this provided an opportunity for the researcher to further familiarise with the data. After transcription, a summary sheet of initial striking themes from the interview was saved with each transcription. The purpose of the

summary sheet is to create frames of reference for each interview that can be used when initially considering the range of issues that emerged across the data.

To ensure the data is thoroughly mined, the analyses of the semi-structured interviews will be triangulated with the analysis of parliamentary transcripts, policy documents, and literature. In doing so, a range of interpretations of the influences on forming Healthy Start should emerge.

In reviewing parliamentary transcripts, the view of MPs will be captured. As the researcher was unable to secure any interviews with MPs, the analysis of parliamentary debates will provide a valuable point of view.

#### **5.3.5.2 Concept driven coding framework**

Concept driven coding is being used as the starting point for analysis. In concept driven coding, concepts derived from relevant literature are used as an initial framework for analysis (Gibbs 2007). Authors who promote the use of concept driven coding emphasise the iterative nature of this coding method. As analysis deepened, more codes emerged.

Meaningful findings emerged by process of manual concept driven coding. Manual coding began with concept driven codes that reflect Kingdon's (2003) model of policy streams. With the concept driven codes, specific themes emerged that reflect what aspect of the policy, problem or politics were drivers in the formation and implementation of Healthy Start as well as more general themes that cross cut the policy process.

The following tables (Tables 14 and 15) illustrate the key themes that emerged within each concept driven code across the semi-structured interview transcripts.

Table 14 Coding framework 1

	Concept driven code	Code	Definition	
<b>Developing and forming Healthy Start</b>	Problem stream	New evidence	Reference to the COMA review or Acheson Inquiry	
		Politics stream	Budget pressure	Reference to policy limitations due to budget
			Time pressure	Reference to policy limitations due to time
			Agenda alignment	Reference to decisions being made to reflect other agendas
			Compromised role of civil servants	Reference to the role of the civil servant being primarily administrative and not concerned with public health
			New Labour best practice	Reference to following a process for policy making
	Policy stream	Welfare Food Scheme assumptions	Unsubstantiated statements about the Welfare Food Scheme	
		Ambiguity over objectives of HS	Statements of issues HS will address	
		Silent actors	Reference to formative information shared with DH	
		Expectation of Healthy Start in practice	Reference to how HS will/does operate in practice	
		Intended role of the Health Professional	Reference to intended role of Health Professional in delivering Healthy Start	

In addition the semi-structured interviews provided a lot of data on the implementation of Healthy Start – the activity which takes place within the ‘policy

window’ (Kingdon 2003). The following table (Table 15) is the coding framework for data pertaining to ‘implementing Healthy Start’.

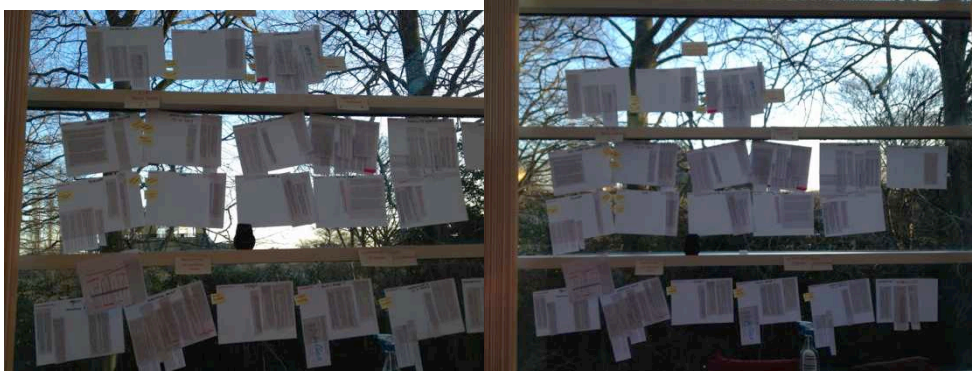
Table 15 Coding framework 2

	Themes	Codes	Definition
<b>Implementing Healthy Start</b>	Process	Commissioning	Reference to process of DH commissioning consultants as part of implementation
		Piloting	Reference to how pilot/phase 1 was organised
	Role of Health Professionals	Knowledge of Healthy Start	Reference to it being important that HP can provide nutrition advice and knowledge about HS to beneficiaries
		Accessing knowledge/training	Reference to importance of training HP to deliver HS
		Lack of training	Reference to the lack of training available
		Administrative role	Reference to HP having a primarily administrative role
	Tensions	DH and evaluators	Reference to communication issues between DH and evaluators
		Pilot v. Phase 1	Reference to ambiguity over whether HS had a pilot or if it was a phased roll out
		DH and trainers	Reference to communication issues between DH and trainers
		Expectation and reality of training health professionals	

The process of manual coding was undertaken by first colour coding themes across the interview transcripts, then organising the data from each interview by code in a table in Microsoft word. Tables of themes were then created and relevant quotes organised into the relevant table (see appendix 7 for an example from this stage of coding). This was undertaken using a manual process of cutting and pasting. This

enabled all the data to be laid out, after it was coded, presenting a ‘big picture’ made-up of detail, that could be considered (see Figure 27).

Figure 27 Manual cut and paste



To fully and fairly analyse the data, Seale (2012) suggests a number of questions to ask of the data throughout the process of analysis (Seale 2012 p.373). Specifically the following questions (adapted from Seale 2012) enhanced the depth of analysis:

**Context:** When does the participant raise a topic? Does it relate to anything else?

**Internal consistency:** Are topics talked about differently at different times? Can this be related to anything?

**Frequency:** Why are some things repeated more frequently than others? Does this reflect their significance to the participant, and is this because they have problems coming to terms with something, or because they wish to be seen in a certain light? Is it significant that a particular topic is rarely mentioned, avoided or missing?

**Extensiveness:** How much coverage is given to specific topics?

**Big picture:** What major trends or topics are there that cut across cases?

Chapter 7 presents the findings of this qualitative research.

#### 5.4 Case Study with health professionals

A dominant theme across the findings from phase 1 and 2 of the research, as well as the literature review, is the role of health professionals in delivering Healthy Start.

To more fully understand why this appeared as a point of contention, a single community case study with health professionals was undertaken to explore how Healthy Start as a policy translates into practice.

Drawing on Yin's definition of a case study, the rationale for a case study approach is to 'investigate a real life phenomenon in-depth and within its real life context, especially when the boundaries between phenomenon and context are not clearly defined' (Yin 2009, p.18). Thus a case study approach will add an aspect of reality to the research, which until this point has considered the development of policy, but not how the policy operates on the ground. The case study enabled the second research question: what are the barriers and enablers of Healthy Start, a national scheme from being delivered on a local level?

The aim of this case study is to help clarify the boundary between phenomenon and context (Yin 2009)– the phenomenon being the development of the Healthy Start scheme and the context being how the scheme currently operates in reality, or, Healthy Start as policy and Healthy Start in practice.

The research question for this case study is:

‘How do health professionals in one local area of England understand the Healthy Start scheme and what is their role in delivering the scheme?’

#### **5.4.1 Methods**

Semi-structured interviews with a range of health professionals within one London Borough is the primary method for this case study. Statistics on the take-up of Healthy Start within the borough were used to contextualise the community the health professionals work in. As in the semi-structured interviews with policy participants, the semi-structured interviews enabled a level of flexibility in the interview process for the interviewee to interpret issues and draw on their own unique experiences as practitioners.

The recent evaluations (Lucas et al. 2013, McFadden et al. 2013) do capture some views of health professionals, however there is a lack of inquiry into the tensions that have emerged around the role of the health professional in the background, literature review and first two phases of research. Specifically, how they understand their role in the scheme, the type of support they can provide to families and challenges or

enablers for Healthy Start being delivered in the way it is described in policy documents i.e. health professionals providing bespoke nutrition and food advice, helping families link to community food projects and informing families how and where Healthy Start food vouchers can be spent.

#### **5.4.2 Participant selection**

The term ‘health professional’ is an umbrella term for a range of professions working within community health services. To glean insight into the different roles different health professionals have in the case study borough, different types of health professionals were interviewed. These were:

- 1 Community nursery nurse
- 1 midwife
- 1 infant feeding coordinator
- 1 family support worker
- 1 Public Health nutritionist
- 1 Health visitor

Participants were recommended by the local areas public health strategist and invited to participate in the research. An information sheet and consent form were sent to all participants before the semi-structured interviews took place.

The semi structured interviews focus on six key areas that emerged from the literature and policy analysis as areas that require further investigation (see appendix 8 for interview schedule):

- 1 the role of the health professional
- 2 guidance and advice health professionals give to beneficiaries
- 3 relationship with beneficiaries
- 4 support for voucher use
- 5 the shift from the Welfare Food Scheme to Healthy Start
- 6 background and policy design

The rationale for scoping these six areas of Healthy Start in practice, essentially is to add to the knowledge gap in the policy literature and policy analysis and scope how engaged health professionals are with different aspects of the scheme.



### **5.4.3 Ethical approval**

Ethical approval was given by City University London School of Health Sciences Ethics Committee in June 2012 (See appendix 9). All participants were given an information sheet at least one week before the interview (Appendix 10) and signed consent forms (Appendix 11).

Interviews were recorded, manually transcribed (See appendix 12 for an example of transcription) and then manually coded to draw out any emerging themes. Themes were then organised.

### **5.4.4 Analysis**

Across each area of the six areas of the semi structured interviews, the themes that emerged were manually coded. Two key concepts are predominant across the interviews, these are the role and responsibility of the health professional and the knowledge of the health professional. Concepts pertaining to the role and responsibility of the health professional and their knowledge are presented in Table 16.

Table 16 Coding framework 3

Coding framework 3	
<b>Role and responsibilities</b>	Time dedicated to delivering Healthy Start
	Time dedicated to administration associated with Healthy Start
	Supporting beneficiaries use vouchers
	Supporting vitamin take-up – scheme is compartmentalised on a local level
	Process
	Difficult conversations – sensitive topics
<b>Knowledge</b>	Confusion over the main purpose of Healthy Start.
	Professional knowledge obvious to interviewee
	Process of delivery
	Questions about practice – lack of knowledge
	Knowledge of participants

Interview transcripts were manually coded. The findings of this case study are presented in chapter 8.

### 5.5 Summary

To address the research objectives of this work, original research has drawn on a range of methods to develop new data and look at existing data in a new way.

## Chapter 6: Phase 1: Policy streams analysis

As the ‘outputs’ of the political process, it reflects the impact government has upon society; that is the ability to make things better or make things worse.

(Heywood 2000)

### 6.0 Introduction

Heywood (2000) argues that policy is the output of the political process. Furthermore, he highlights it is commonly understood, that policy is made in four distinct stages: initiation, formation, implementation and evaluation. Heywood also suggests the process of forming policy is often seen as the most crucial stage in the policy process as this is when actions are developed in response to an agenda and it is these actions that will either ‘make things better or make things worse’ (Heywood 2000, p.32). This chapter will therefore focus on the context of the initiation, policy formation process, implementation and evaluation of Healthy Start to develop a strong policy context. The policy context is crucial to developing the line of enquiry for this thesis as it will illuminate the areas of the policy process that are unclear and/or require further investigation. This chapter reports on phase 1 of the research design (See Figure 25, p. 139).

### 6.1 The problem stream – an out of date Welfare Food Scheme and new evidence

A policy problem is defined as the ‘perceptions of problems as public matters requiring government action’ (Buse 2005). Kingdon (2003) argues that an indicator or focusing event needs to occur to get the issue onto the political agenda. The indicator in the instance of Healthy Start was the Review of the Welfare Food Scheme (COMA 2002) and the Acheson Review on health inequalities (Acheson 1998). The problem impacting the public was threefold: an out of date policy, a growing evidence base for optimum nutrition during pregnancy and the early years (Dallison and Lobstein 1995, Robinson 2001, Acheson 1998) and a raised awareness of health inequalities in the UK (Shaw 1999).

Studies from the years before Healthy Start was proposed in 2002, evidence the social problem occupying the problem stream. Reports conclude that insufficient nutrient consumption by pregnant and lactating women could be linked to chronic disease experienced by their offspring in later life (Barker 1998; Dallison and Lobstein 1999; Robinson 2001; Acheson 1998). Acheson (1998) suggests that differences in nutrient consumption between low-income pregnant women and higher income pregnant women would perpetuate social inequalities as poor health could prevent low-income children from reaching their potential.

### **6.1.1 Review of the Welfare Food Scheme**

The Welfare Food Scheme was an established programme that already aimed to address poor health in low-income populations, and therefore provided a policy mechanism for addressing the problems identified. In 1999 a Scientific Review of the Welfare Food Scheme was undertaken by the independent Committee on Medical Aspects of Food and Nutrition Policy (COMA) for the Department of Health, and reported in 2002. The review recognised that a problem with the Welfare Food Scheme was that it did not offer a broad range of foods and was being seen to incentivise bottle-feeding infants as the amount of infant formula available through the scheme was higher than the amount of cows' milk that could be exchanged for a token (COMA 2002). Whilst the evidence base for changing the Welfare Food Scheme to include vouchers for fresh fruit and vegetables was clearly derived from data reporting that lower income households had a poorer diet and poorer nutritional health, the evidence for how the new policy would work in practice was not provided in the COMA review (2002).

The COMA review (2002) concluded that in light of new data on the value of diet in pregnancy the Welfare Food Scheme was no longer a sufficient response to the social problem of poor diet in pregnancy and the early years and could be significantly enhanced.

The timing of the Review of the Welfare Food Scheme by the Committee on Medical Aspects of Food and Nutrition Policy (COMA), disbandment of COMA and the formation of the Scientific Advisory Committee on Nutrition (SACN) is of interest when considering what fed into the formation of Healthy Start. The shifts in scientific bodies responsible for in part informing public health policies that relate to

food and nutrition and their changing remits, presents a unique context in which Healthy Start was formed.

The Review of the Welfare Food Scheme was published in 2002 after COMA was disbanded in March 2000, and replaced by SACN. The remit of COMA was to relate existing medical and scientific evidence to policy, and advise the Chief Medical Officer (CMO) who would thereby inform government (COMA 2000B). Essentially, COMA focussed on risk management, by suggesting amendments to policy based on existing scientific evidence. The scope of food and nutrition policy changed in 2001 with the Development of the Food Standards Agency.

The Food Standards Agency (FSA) was implemented in 2001 as a non-ministerial department of government with the vision of ‘safer food for the nation’ (FSA 2014). The FSA focuses on providing transparent and independent advice to Ministers on issues that relate to food safety and hygiene. Thus a new body was needed that could provide expertise to both the FSA and Department of Health on issues pertaining to food and nutrition. It was recognised that food and nutrition cross-cut policy areas such as food safety and health. Thus, the context for making food and nutrition policy was changing. The remit of SACN reflects the new context for policy making:

‘The Scientific Advisory Committee on Nutrition (SACN) will inherit essentially the same remit as COMA but will be part of a more complex policy making machinery’ (COMA 2000B p.3)

Additionally, the remit of SACN was to recognise the need for a coordinated approach to advising food nutrition and policy that acknowledges the broad reach of food nutrition across both food safety and nutrition. Thus the remit of SACN differed to COMA as ‘risks and benefits’ of evaluating scientific evidence and different policy options became the focal objective:

SACN’s remit is to assess the risks and benefits of nutrients/dietary patterns, food or food components to health by evaluating scientific evidence and to make dietary recommendations for the UK based on their assessment.

Conclusions drawn from any evidence considered are those that are applicable to the UK population, including any vulnerable groups which have been identified. (SACN 2012 p.1)

SACN maintains a framework for evaluating scientific evidence (SACN 2012). A key differentiating remit of SACN from COMA is that SACN considers the implications of different policy options.

In the final annual report from COMA (2000B), it is stated that SACN (The Committee):

‘The committee would be asked to provide scientific advice together with advice on the implications of that advice on a range of policy options which then can be fed into the broader policy process undertaken by Ministers and contribute to the policy decisions being made by Ministers and then implemented.’ (COMA 2000B p.10)

The implication of the timing of the Scientific Review of the Welfare Food Scheme is that it was the last report written by the Panel on Maternal and Child Nutrition of the Committee on Medical Aspects of Food and Nutrition Policy and thus was focussed on COMA’s remit to consider the medical and scientific evidence of a subsidised nutrition policy for women and children. It is clear why COMA undertook the review. The last annual report produced by COMA (2000B) indicates that the review was undertaken in 1999 as the government saw it was timely because the Welfare Food Scheme had not been reviewed throughout its 60 year history and there was ‘accumulating evidence on the influence of early nutrition on risk of developing non-insulin dependent diabetes, hypertension and coronary heart disease’ (COMA 2002 p.iii). Additionally, COMA (2002) also indicate that the review of the Welfare Food Scheme was also driven by the Acheson Review (1998) which ‘outlined how inequalities in nutrition in women and children influence health and recommended that a high priority be given to policies aimed at improving the health and nutrition of women of childbearing age and their children’ (COMA 2002 p.iii). However, as the review was written and published after COMA was disbanded, it limited the scope for discussion with the COMA panel. Due to the timing, the Review of the Welfare Food Scheme (COMA 2002) and the proposal for Healthy

Start (Department of Health 2002) did not fall within the purview of SACN and implications of policy suggestions were not considered, as they would have been, had the review been undertaken by SACN.

From considering the proposal for Healthy Start (Department of Health 2002) it is clear that the majority of policy suggestions made by COMA were taken on board. The suggested amendments to the Welfare Food Scheme included (from COMA 2002 page 118):

### **Pregnant women**

- Choices other than milk should be offered to address dietary inequalities more effectively.
- The composition of vitamin supplements be reviewed. A supplement providing vitamins D, C and Folic Acid would be preferable to the current preparation.
- The scheme should ensure that pregnant women of all ages have equitable access to Welfare Foods

### **Mothers**

- An incentive to breastfeed should be considered, replacing the allowance of cows' milk.

### **Infants**

- Liquid cows' milk should not be provided for infants under 12 months of age.
- At 6 months of age the allowance of infant formula should halve in favour of providing tokens to purchase complementary food.
- Low birth weight babies should be entitled to receive formula until at least 1 year from expected date of delivery, not the date of birth.

### **Young children**

- Mothers should be offered an equal volume of infant formula as an alternative to cows milk until the child is at least 18 months of age.

- Consideration should be given to extending the provision of free vitamin supplements to groups who are not beneficiaries of the current Scheme, particularly children from ethnic minority groups.

### *SACN Sub-group on Maternal and Child Nutrition*

The implications of Healthy Start being informed by a report that was written by a body that was disbanded, was highlighted in minutes from the SACN Sub-group on Maternal and Child Nutrition.

From reviewing minutes from the Sub-group on Maternal and Child Nutrition, it is clear that Healthy Start was reported on to SACN through a Department of Health representative that would attend meetings. It is less clear, how SACN influenced Healthy Start initially.

Like COMA had, SACN has a Subgroup on Maternal and Child Nutrition. Minutes from meetings of this subcommittee indicate that it was unclear what the role of SACN would be in the formation of Healthy Start and whether they would be consulted with by the Department of Health.

“The range of foods and vitamins to be included in Healthy Start were under discussion and it was unclear at this stage whether SACN / SMCN would be asked to address this issue at a later stage.” (SACN 2003 Point.40)

After the initial rollout of Healthy Start, the subgroup expressed interest in the training that Health Professionals received in phase 1:

“16. Members expressed their interest in the training provided to health professionals in Phase 1 of Healthy Start. Members were informed that training/information sessions were provided through contractors at a local level to a selected group of midwives and health visitors. Approximately 95 to 100 health professionals have been trained in Devon & Cornwall. Information/training for Phase 2 is expected to focus mainly on the practicalities of delivering the Healthy Start interventions – understanding the mechanisms and processes underlying Healthy Start, although elements



of nutrition and healthy eating advice will form part of this process.”  
(SACN 2006)

In multiple meetings of the Sub-group on Maternal and Child Nutrition, the issue of evaluation was discussed. The Sub-group raised concerns that it wasn't clear what was meant by evaluation and how meaningful evaluation would be undertaken without evaluation measures considered before the roll-out of Healthy Start.

“24. The Chair asked whether the aim of the evaluation was intended to be observational rather than a comparison between Healthy Start and the former Welfare Food Scheme. Members noted a previous review of the Welfare Food Scheme undertaken by COMA and suggested that this evaluation should take a similar format. It was agreed that ultimately the evaluation should identify the nutritional outcomes of Healthy Start.”  
(SACN 2007)

In addition, the sub-group also pointed out that there was a lack of definition over some of the terminology the Department of Health were using to describe the objectives of evaluating Healthy Start. For example in minutes from a sub-group meeting on 19/05/08, it is stated:

“The *enhancement of nutrition* has never been defined, although it can be defined in terms of process and of outcome. The aims and objectives of the evaluation need to be clear.” (SACN 2008 Point 28).

Practical concerns about the implications of Healthy Start were also raised by the subgroup on maternal and child nutrition. For example minutes from a subgroup meeting in 2008 highlight the lack of clarity around the implications of providing vouchers for fruits and vegetables through Healthy Start:

“There are potential problems with evaluating the uptake and usage of vouchers. For example, recipients who buy fruit and vegetables with the vouchers they receive might therefore purchase less fruit and vegetables with

their household income, and the total fruit and vegetable purchase could potentially be unchanged.” (SACN 08 Point 27)

In highlighting the lack of clarity around the implications of Healthy Start, the lack of clarity around the schemes objectives are underscored and the missed opportunity of SACN undertaking the review of the Welfare Food Scheme emphasised. Had SACN undertaken the Review of the Welfare Food Scheme, instead of COMA, it is likely that these types of issues, which focus on the implications of the policy, would have been more fully considered.

The minutes from the sub-group provide valuable context on the policy process that informed the formation of Healthy Start. The minutes highlight how the timing of the COMA review of the Welfare Food Scheme in relation to the disbandment of COMA and formation of SACN meant that the initiation of Healthy Start was out of the purview of SACN and thus the relationship of this body with the consequent policy process was more distant than COMA’s may have been, had it not been disbanded.

The analysis of the ‘problem’ indicates that there are macro problem streams – health inequalities, and also a micro problem stream - issues with the status quo of the Welfare Food Scheme.

## 6.2 The politics stream – the political climate was ripe

Three themes emerge from analysing the policy documents that pertain to politics: the new political context for policy making, proposed breadth of Healthy Start and budgetary efficiency.

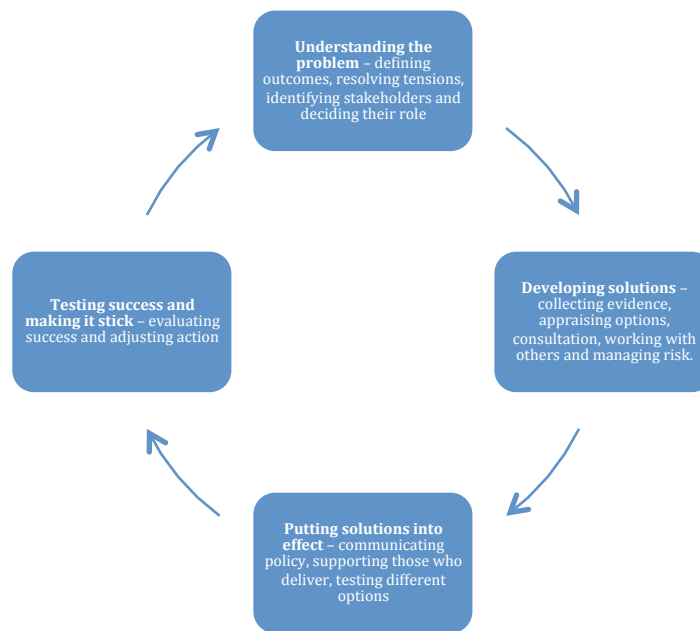
### 6.2.1 Political context for policy making

In 2002 the political stream was flowing with New Labour agendas, specifically the Early Years/Sure Start agenda (TSO 2003) and the Inequality agenda (Acheson 1998, Dowler 2007, Hills and Stewart 2005) which created a platform and policy window for a review of the Welfare Food Scheme. In parallel to these agendas, New Labour were also redefining a modern approach to policy making driven by a new logic and belief that good policy making and reform could be more efficient in terms of delivery and outcomes (Team S.P.M 1999, Bullock, Mountford and Stanley 2001).

The new political sphere focused on reducing the gap between rich and poor and creating long term change for children born into poverty. A number of policy reports were produced during the first seven years of New Labour which outlined priorities for the health and inequality agendas (Acheson 1998, Lives 1999, Department of Health 2000, Department of Health 2004a). Donald Acheson's report 'Inequalities in Health' highlighted the social value of ensuring health interventions in the early phases of the life cycle, primarily pregnancy, the first year of life and between the ages of 1 and 5, and the first steps towards developing the SureStart programme aimed at providing integrated support for families with children under 5 was taken in 1998 (Pugh, Pugh and Duffy 2006).

The message coming from central government, stressed a new level of 'good practice' (Figure 28) and systems of due diligence to ensure effective policy design. The significance and impetus given to what became Healthy Start as an essential nutritional intervention (Department of Health, 2002), suggests the process which informed it was engaged with the new principals of good practice in public policy development (See Figure 28). The process illustrated in Figure 28, is simple, it represents best practice in a national approach to policy making, but perhaps not the reality. Cairney (2012) draws on the earlier work of Lindbolm (1959) that opposes policy making as a linear process, rather likening policy making to a process of 'muddling through'. In addition, Figure 28 contrasts to the complicated process of food policy, which is described as a messy process due to continuous tensions between various factors such as public health and the industrialised food system (Lang, Barling and Caraher 2009). Therefore, food policy development itself may be at odds with the new modernised policy process.

Figure 28 Core policy process from Team S.P.M 1999 2.6



While the development and implementation of the Healthy Start scheme clearly followed the New Labour agenda for modernising the policy process, analysis of the documents suggests inconsistencies from the original objectives of the scheme and support Kingdon's (2003) argument that 'Policy proposals are developed according to their own incentives and selection criteria, whether or not they are solutions to problems or response to political considerations' (p.201). Thus the complex problems Healthy Start is charged with responding to - health inequalities and optimum nutrition at key stages of development may have not been fully considered.

### 6.2.3 Budget efficiency

When Healthy Start was proposed by the Department of Health in 2002, it was stated in the proposal (Department of Health 2002) that the budget allocated could not exceed the previous budget for the Welfare Food Scheme. Central to the new scheme was 'efficiency' and making 'the most effective use of resources' (Department of Health, 2002 p14). However, the general tone of the proposal was more ideological than pragmatic, in that there was little discussion of the practical aspects of the scheme such as how it would function and optimise resources beyond unspecified efficiency savings. Rather there are broad statements about the agendas Healthy Start will contribute to without elaboration on how it would be feasible to deliver a more

complex scheme without additional budget. A recent evaluation of Healthy Start (McFadden et al. 2013) indicates that economic feasibility has not received attention

to date there has been no systematic review of economic studies on the impact of vouchers within the context of supplementary feeding programmes. (p.15)

#### 6.2.4 Cross-cutting agendas

Interestingly, the proposal document (Department of Health 2002) claims Healthy Start will help address a wide range of issues from the future of farming and food industries, reducing levels of obesity and child poverty (p.9). It seems that links to the proposed output of the scheme goes beyond the scope of the evidence provided. The proposal draws on reports that have been referred to in the policy context section of chapter 1. Yet, there is little explanation of how the issues that emerged from Acheson (1998), the Currie Report or the Foresight Report will be practically addressed and measured through Healthy Start.

The link between agendas and evidence comes across as politically contrived rather than practical and outcome focused, reflecting Kingdon's (2003) suggestion that policy proposals are often driven by the politics and not the problem. It is curious to note the information from the COMA review (2002) that is included and excluded from the proposal. The proposal adopts a singular message from the review and neglects some details that demand further exploration, such as the fact that the Welfare Food Scheme had never been formally evaluated.

#### 6.3 The policy stream – visible and hidden participants

Kingdon (2003) argues that within policy formation there are influential 'visible' actors and 'hidden' less influential actors who focus on alternatives to the policy being formed. Within the formation of Healthy Start the knowledge of the hidden actors, such as potential beneficiaries of the scheme and academic researchers with a wealth of evidenced knowledge in the area of the food poverty for low-income women and children, are overlooked in favour of the political 'visible' actors. Those who can make and implement policy have more influence than those who are affected by the policy or who can offer alternatives (Kingdon 2003).

Analysis of themes that pertain to the policy stream have been organised into four sections: the proposal, the consultation, the response from government and policy transfer.

### **6.3.1 The proposal**

The ‘Context for Change’ section of the proposal for Healthy Start (Department of Health 2002) sets the context for shifting the Welfare Food Scheme to Healthy Start by listing ten reports that all refer at some point, to the importance of nutrition in pregnancy and the early years. Although the COMA (2002) review is referred to as an evidence base, contextual information to support the development of Healthy Start is missing. For example, specific information on factors affecting the dietary choices of low-income pregnant women, how food choice impacts on nutritional status, birth outcome and child health and development and the varying needs of different low-income groups is not considered, although there is an academic discourse that offers small scale studies indicating the barriers that different groups of low-income families are faced with when choosing food.

An example of such a study is research from Leeds, a city in the north of England, that identifies a range of structural barriers and issues around generalising ‘low-income’ households (Whelan et al. 2002). There is little acknowledgement of the structural barriers beyond the cost of food and nutritional knowledge. It is perhaps possible that the lack of discussion around what it is like to be a mother on a low-income, an area that has been researched by academics such as Dowler (1997) and Attree (2005), enables larger claims to be made about the proposed scheme:

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. (Department of Health 2002)

### **6.3.2 Consultation**

Cook (2002) argues that within policy development ‘consultation is a crucial, yet deeply problematic process’ (p. 517) and that with New Labour, consultation within the policy process shifted from being somewhat ‘tokenistic’ to being ‘progressive’. Reports from both Bullock, Mountford and Stanley (2001) and The Cabinet Office (1999) laid out new measures of best practice in policy making, including the

important role for consultation with appropriate actors. The first consultation of Healthy Start was undertaken in 2002 and in total, 500 written responses were received in the two-month long consultation period (Figure 29). As well as written responses, a number of events were held around England to gauge responses to the proposal, however data from the events is not readily available (Department of Health 2003b).

Figure 29 Consultation respondents (Department of Health, 2003 p.24)

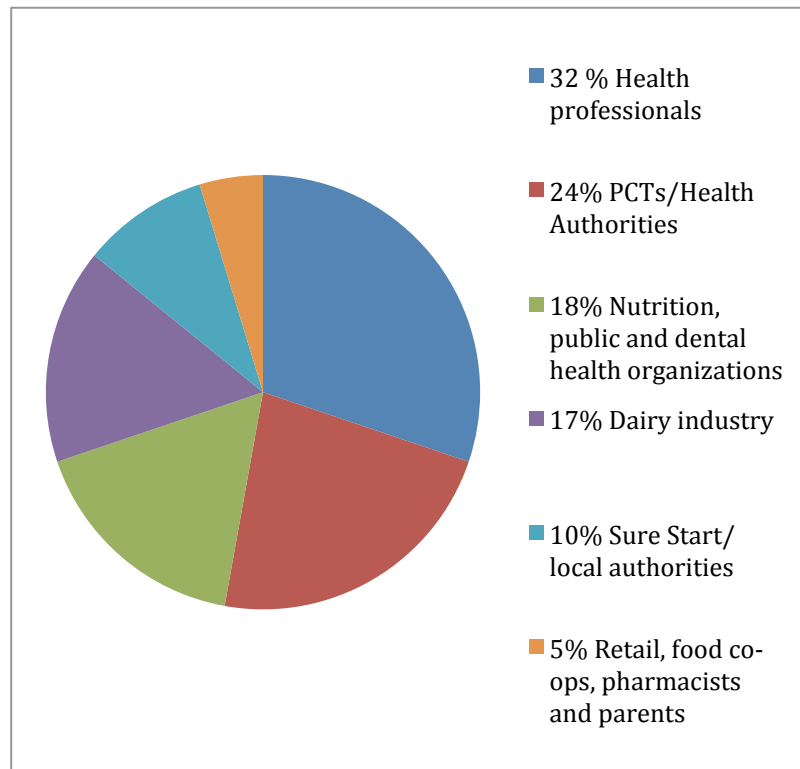


Figure 27 indicates the range of documented responses from the first consultation period. Less than 5% of written responses came from parents who would be eligible for the scheme, suggesting potential beneficiaries of Healthy Start may have been ‘hidden participants’ in the policy formation. The significant number of responses from the dairy industry in this part of the policy formation raises questions about the policy goal of the scheme and the role of one industry lobby group in the policy process. Although focus groups are documented as having occurred ‘with 70 parents in Morecombe, Newham, Bolsover, Ilfracombe and Halifax’ (Department of Health, 2003 p.24), information on the structure of these focus groups and the specific findings are not available alongside the written responses, thus it is unclear how they fed into the development process of the scheme.

The consultation appeared to lack a robust methodology to gather formative views on the proposed scheme and a clear flaw is the lack of input from potential beneficiaries of the scheme and representatives from the fruit and vegetable supply chain. This indicates the narrow scope of the consultation and suggests priority given at that stage to how Healthy Start may impact health professionals and how it may impact on the dairy industry if vouchers allowed foods other than milk to be purchased.

Some respondents participating in the consultation felt the proposal claims were too ambitious and that it should have been made clear that the ‘problems facing low-income families in relation to nutrition would not be solved by the scheme itself’ (Department of Health 2004 p.8). In both the proposal and the consultation document it is unclear how Healthy Start would link to wider agendas to deliver the proposed scheme or how the consultation connected with the context of the policy process or the wider agendas set. This could be suggested to expose a wider issue in policy making which is political pressure to reflect agendas and achieve deliverables (Majone 1989, Buse 2005).

### **6.3.5 Government response**

In 2004, the Department of Health published the Government response to the consultation exercise. This report provides valuable insight into the parliamentary discussions that shaped the current scheme. The report outlined three areas that generally supported the new scheme and four areas of concern. The areas supported were; reform of the Welfare Food Scheme, support for removing disincentive to breastfeed and providing extra help for babies with low birth weight. The four areas of concern were: the potential impact on the dairy industry, eligibility requirements, a lack of evaluation of the schemes effectiveness, and potential fraud (Department of Health 2004 p.3).

The 2004 Government Response report indicates confusion over the point of the scheme – ‘providing extra help with low birth weight’ is not a target of the scheme and as there was never an intention to remove formula milk entitlement from the scheme, Healthy Start could be viewed as a continued disincentive to breast feed.



The previous section has presented findings from analysing policy documents. The following section presented considers whether the US programme – WIC, was influential throughout the policy process.

### **6.3.6 Policy transfer**

The 2002 COMA review did provide some insight into how the format of the Welfare Food Scheme might be reformed to become more efficient. One aspect of the review considered food welfare schemes in other countries. Specifically, information on the Supplemental Nutrition Programme for Women and Children (WIC) was presented. In 2008 Midgley theorised that the role of US social policy has been influential in the development of welfare in other western countries and that welfare development was shaped by an exchange of welfare ideas in the west. Although Midgley does not specifically refer to food welfare, using his theory as a framework can help unpick the somewhat uneven foundation that is the basis for Healthy Start.

Applying this theory to food welfare, it is plausible that the Department of Health under New Labour were influenced by elements of the Special Supplemental Nutrition Programme for Women Infants and Children (WIC). Although both WIC and Healthy Start operate around a similar structure in that central government provides funds to eligible beneficiaries via a voucher that can be spent on nutritious food at participating retailers, there are fundamental differences in context, administration and goals. Dolowitz and Marsh (2000) would argue that the transfer of a WIC based model for food welfare to the UK would not be successful as there is no evidence that the ‘economic, social, political and ideological contexts’ (p.17) have been considered. However, reference to the WIC programme in the Scientific Review of the Welfare Food Scheme (COMA 2002) does indicate that Healthy Start was influenced by the WIC model (See section 3.4.2 in Chapter 3).

In summary, within the policy stream the public health aspect of Healthy Start and consideration of the schemes functionality appear to have been overlooked. The focus is on developing a ‘policy package’ that is appealing to visible actors, but does not however, fully consider the viewpoints or needs of those with expertise on the issues Healthy Start is tasked with addressing or beneficiaries of the scheme.

#### 6.4 The policy window: Phase 1 of Healthy Start roll out

The culmination of the multiple streams converging is a policy window in which the regulations for Healthy Start were drafted by the Department of Health and laid before parliament in 2005 (Department of Health 2005a). The draft regulations enabled the consequent roll out of phase 1 of Healthy Start. Piloting and evaluation are considered key aspects of health policy development before policy approval (Cook 2002). It is important to note, that Healthy Start did not have a pilot per se, rather, the first phase of the national roll-out was evaluated. The draft regulations enabled the first phase of the scheme to be rolled out and evaluated in Devon and Cornwall in Autumn 2005. The goal for evaluating the first phase of Healthy Start were:

to demonstrate whether, how and the extent to which the new Healthy Start processes are working smoothly, and meeting government, NHS and wider stakeholder expectations and to contribute to the smooth roll out of the scheme across England, Scotland and Wales in Autumn 2006. (Hills 2006 p. 2.)

The evaluation of the first phase of Healthy Start (Hills 2006) included interviews with different stakeholders including: health professionals, retailers, beneficiaries and other local services. Similarly to the Healthy Start consultation (Department of Health 2003b), beneficiaries of the scheme appeared underrepresented. A total of 17 beneficiaries were interviewed for the evaluation out of a total of 112 interviews (Hills 2006 p.6). It was recognised that issues with accessing interviewees were in part due to ‘the absence of a Healthy Start Coordinator’ (Hills 2006 p.7) on the ground who could connect evaluators to the desired interviewee groups.

It is clear that, when the evaluation began, Healthy Start had not been well implemented across Devon and Cornwall. Hills et al commented on the challenge of implementation and evaluation occurring in parallel:

The team (evaluation) also became aware of how much we became part of the process of implementing Healthy Start – in some cases we were the prime providers of information about Healthy Start to local health professionals. (Hills, 2006 p.8)

It is not clear how this was addressed before the scheme was rolled out nationally under an amendment made under the Social Care Act in 2006. The timeline of

Healthy Start rollout appears to undermine important processes of implementing and evaluating public health interventions. It is well documented in evaluation theory (Rossi, Lipsey and Freeman 2004) that evaluation designs need to be considered before a programme is launched. There is little justification for why the roll out of the scheme was not phased in a more structured way. Dyson et al. (2007), wrote 'Policy-related factors and timing limited options for evaluation from the start' (p.14). Then describe how at an initial meeting to discuss evaluation protocols of the scheme with the Department of Health, it was made clear that phased rolling out would not be possible:

Both the most robust approaches to evaluation, a randomised controlled trial or a prospectively planned before-and-after-study, were therefore ruled out from the start. Identifying suitable comparison groups, which we see as fundamental to evaluation, has been a serious challenge as a result. (Dyson et al., 2007 P.14.)

Previous to this report, SACN had discussed the importance of evaluating Healthy Start. Minutes from a meeting in 2004 state:

11. Members questioned the extent to which the evaluation would be of process or outcome and were informed that the intention was to evaluate both process and outcome. It was agreed that evaluation of an intervention was critical and should encompass both the process and all steps towards the outcome. (SACN 2004 p.3)

Thus, actors in advisory roles were aware of the importance of evaluation and this was clearly communicated to government.

This indicates a clear flaw in the formation of the scheme and highlights an area that needs further examination as the decision not to collect sufficient baseline data is unjustified in the policy literature and distinctly clashes with the new clean and modern approach to policy making as set in the agenda by New Labour. The primary features of the policy window appear to be policy expediency.

In summary, the findings of analysis of the three policy streams that influenced Healthy Start indicate that public health objectives defined by the problem stream and the aspirations laid out in the policy stream were not as influential as the constrictions presented in the politics stream.

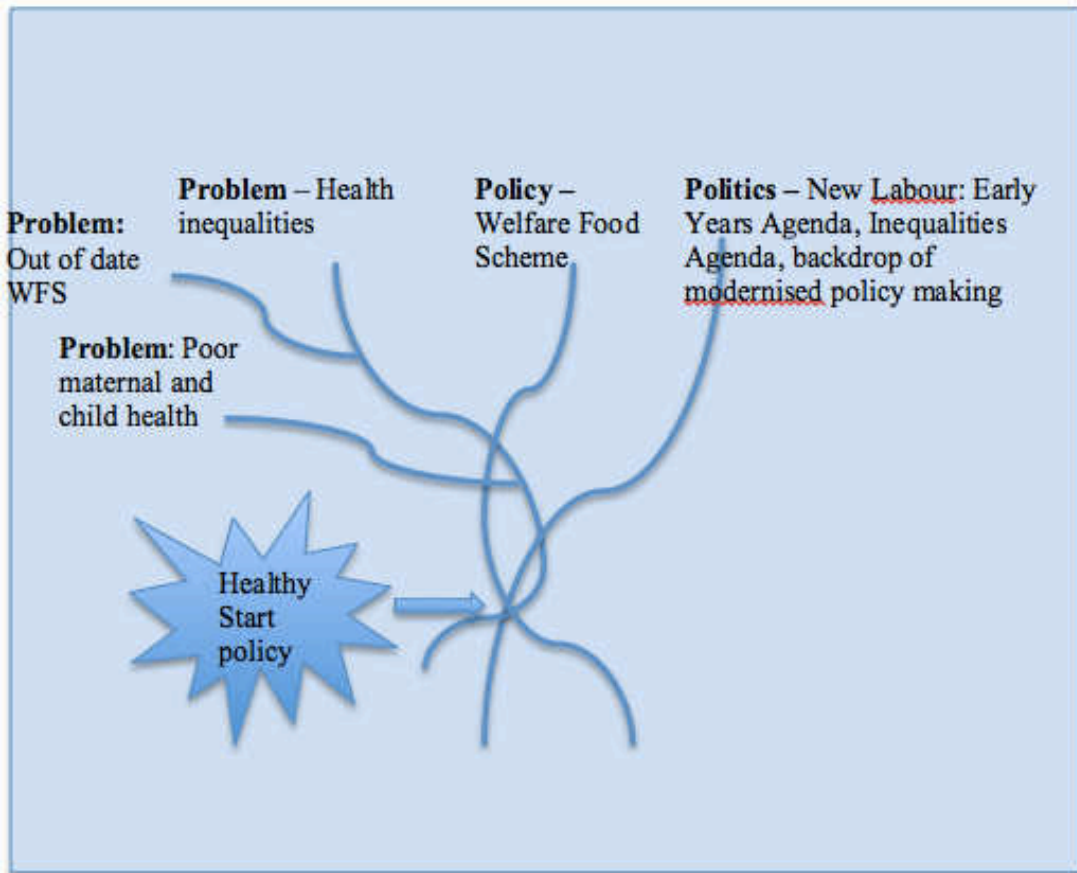
## 6.5 Summary of policy streams analysis

The point at which the convergence of policy, politics and problems occurs creates a policy window that is open for a short period of time, putting pressure on the Department of Health to complete the process of policy formation while the window remained opened. This may have been to the policy's detriment as it is clear that although there was a New Labour emphasis on 'the process of good policy making' aspects of the development of Healthy Start were less than robust and neglected to address the reality of the challenges of food welfare. It is therefore possible that within the policy window, the policy opportunity is not addressed, that is when politics, policy and problem converge the ideal social outcome is second fiddle to the political outcome. This provokes larger questions about the policy formation process and whether it is sufficient to be driven by politics as Kingdon (2003) suggested it was or whether policy should be formed based solely on problem. Figure 30 illustrates the convergence of policy, politics and problem that informed the formation of Healthy Start.

The most prominent actor throughout the policy, problem and politics was and continues to be the Department of Health, which appears to have been under pressure to create a scheme based on financial efficiency and long term health impacts. It is possible that tensions within central government may have added to the complexity of developing Healthy Start effectively. Concerning, is the lack of engagement with beneficiaries as actors throughout the process and the lack of measures built into the design of the scheme to measure whether desired outcomes were met.

It seems that after the policy window occurred, the streams did not continue to move in convergence, instead returning to the separate streams of politics, problems and policy reconnecting through the development of a Healthy Start scheme that was well intentioned but which failed to reflect its original public health purpose (See Figure 30).

Figure 30 Healthy Start policy streams



This initial analysis of the Healthy Start policy formation indicates a number of potential issues. Firstly, within the context of the scheme the convergence of a policy problem, politics at that time and the availability of a policy ‘solution’, appeared to create pressure to create the new policy before the three streams cease to converge. Not only does this put pressure on the visible actors to create policy, within doing so the formation of Healthy Start clashed with the concept of more efficient modern policy design (The Cabinet Office 1999). The consultation and roll out of phase 1 as a pseudo pilot, appears tokenistic which is unsurprising considering the pace at which Healthy Start was created and initially rolled out.

The design of the scheme itself can in part be explained by the influence of WIC and policy transfer theory (Dolowitz, Greenwold and Marsh 1999) – the evidence for looking towards America’s WIC programme is clear; the majority of literature that exists on food welfare for low-income pregnant or lactating women and children under the age of 5 originates from schemes in North America (D’Souza and National

Institute for Health and Clinical Excellence 2006). Thus adapting some form of voucher based food welfare scheme was a somewhat predictable. However the vouchers are one aspect of a much wider and substantially better funded and organised system in North America and thus transferring one aspect of a scheme is a risk that Dollowitz and Marsh (2000) would suggest inappropriate as this is based on an assumption of success, and not evidence.

Finding data on how much the government spend on Healthy Start required a Freedom of Information question to be formally submitted. The lower than budgeted expenditure for the scheme (See Figure 9, p.49) undermines the social value the scheme has been charged with and indicates that there is likely to be a significant percentage of eligible people not accessing the scheme. Regardless of the aspirations for the policy stated in the proposal, starting the policy development process with a fixed efficiency budget restricts the scope of what Healthy Start can deliver and presents a challenge to it being substantially different from the Welfare Food Scheme. It is therefore not surprising that the limited data on how Healthy Start is used from the infant feeding survey suggest Healthy Start vouchers are most commonly used to purchase infant formula (McAndrew et al. 2012)– continuing the spending patterns of the Welfare Food Scheme (COMA 2002). However, as previously mentioned in chapter 2, there are limitations to this data and there remains a lack of ‘big picture’ data on how Healthy Start vouchers are used.

In summary, given the analysis of politics, problems and policies around food welfare, health inequality and early years agendas, it seemed fairly predictable that a new food welfare scheme would emerge as an obvious policy window was created. However, the question emerges – was it open long enough to form a policy robust enough to address the problem? Kingdon’s (2003) model of policy streams converging to create a policy window highlights how a ‘policy moment’ was created to form Healthy Start. However, the dominance of the politics stream overshadowed the problem itself and although it addressed the problem of the Welfare Food Scheme not being efficient, it has not reformed the policy in a way that will enable outcomes to be measured effectively or for the complexity of food poverty and nutrition insecurity to be fully realised.

These issues will be addressed in detail in the discussion and synthesised with the findings that are presented in the following two chapters.

## Chapter 7: Phase 2: Initiating, forming and implementing Healthy Start – results from analysing primary data

### 7.0 Introduction

This chapter presents research findings that pertain to research question 1 -**What were the influences on the original policy framework for Healthy Start?** The findings presented develop narrative knowledge on what took place to develop, form and implement Healthy Start, as well as themes that add to the understanding of what influenced the development, formation and implementation of the scheme. The implications of the findings are discussed in chapter 9 and triangulated with the findings from the literature review (chapter 3) and initial policy analysis (chapter 6) to address the research question.

Three sources of data were analysed to generate the findings presented in the chapter: semi-structured interviews with policy participants, parliamentary transcripts and unpublished documents acquired throughout the semi-structured interview process. As the methodology (chapter 5) indicated, throughout the process of undertaking semi-structured interviews with policy participants, a number of interviewees offered to provide unanticipated and unpublished data including – tenders for contracts with the Department of Health, briefs from the Department of Health, reports to the Department of Health, and minutes and correspondence between actors. Written consent was provided by the interviewees to use this data. It was clear that providing these additional details on the development of Healthy Start was important to these individuals as they were compelled to share printed information that was not in the public domain in order to ensure this research illustrated clearly the issues that they experienced throughout the process of initiation, forming and implementing Healthy Start.

In addition to the semi-structured interview findings and the unpublished documents provided by interviewees, parliamentary transcripts have also been analysed (this is outlined in the methodology). The parliamentary debates provide a political dimension that was missing across the policy participant interviews due to the lack of success in getting MPs to participate in this research. Thus, the parliamentary



transcript analysis provides additional data and another dimension to the narrative and themes presented in this chapter.

This chapter presents and illustrates the narrative and thematic findings from manually coding the aforementioned data sources. The chapter is structured by first presenting the findings from semi-structured interviews, followed by the findings from documents provided by interviewees and finally the findings from parliamentary debate transcripts.

The range of data analysed provides a clearer picture of what was considered in the development and formation of Healthy Start, as well as what the constraints were on implementing Healthy Start. Consistent issues emerged across the different data sources (semi-structured interviews; parliamentary transcripts and policy documents not in the public domain), thus validating the findings.

Throughout the policy process of Healthy Start, there is evidence of three independently flowing streams at different stages of the policy process, this chapter will discuss each stream in detail. However, the research findings indicate that the independent streams are not as clear-cut as Kingdon (2003) describes. Specifically, the problem stream is particularly confusing. As the problem stream is associated with the initiation of a policy, the issues that emerge at this stage of the policy process linger throughout the formation and implementation of Healthy Start, ultimately having implications for how Healthy Start operates in practice.

## **7.1 Findings from semi-structured interviews**

### **7.1.1 Ambiguity of the objectives of Healthy Start**

A finding that cross-cuts all phases of the policy process is confusion over the objectives of Healthy Start. When asked to describe the purpose of Healthy Start, interviewees did not provide a consistent objective of the scheme or indeed one that aligned with the policy literature explored in chapters 2 and 3.

The following quotes illustrate that although the importance of having a clear objective was seen as important in theory, in practice the objectives of Healthy Start are unclear.

The civil servant interviewed suggested that a key objective of Healthy Start is about addressing hunger – as the quote below illustrates:

*It's a two part objective. One is the here and now, making sure there is food in a tummy and the longer term bit on dietary change is alongside that, although we have tried to really push that longer term dietary change (Civil Servant, Department of Health)*

The Maternity Alliance interviewee described the scheme focussing on the intervention aspect of Healthy Start and promoting early access to Health Professionals:

*(the objective is) to promote early access to health professionals for pregnant women and women with new babies and to provide access to necessary vitamins and to promote healthy eating through health advice from health professionals and the vouchers. (Social Policy Manager, Maternity Alliance)*

The evaluator commissioned to evaluate the first phase of Healthy Start described the point of the scheme as follows:

*the whole point of the scheme was to create an opportunity for a conversation about healthy eating. (Evaluator, Tavistock Institute)*

Thus a key finding is that from the initiation to the implementation of Healthy Start there has been no clear or consistent definition of exactly what it is that Healthy Start is supposed to do. This is an issue that will also be picked-up in the findings from parliamentary transcript analysis and document review.

In addition to the consistent unclear objectives/descriptions of Healthy Start another topic that repeatedly appears across the policy initiation, formation and implementation, is the role of the Health Professional. Although at each stage of the process, the issues around Health Professionals are different, the role of health professionals has been a constant topic since Healthy Start was initiated.

### 7.1.2 The role of the COMA review of the Welfare Food Scheme

Data from the initiation period of Healthy Start illustrates how the COMA review was an initial driver for considering changes to the Welfare Food Scheme. An interview with the Maternity Alliance found that COMA was the starting point for discussions on the Welfare Food Scheme. The interview also highlighted how no one seemed to question the content of the COMA review or the processes involved in writing the review.

*COMA was there to look at the nutritional angle and this was everybody else, bringing context to that COMA report, but clearly COMA had separate nutritional verdict on the scheme and that was the absolute starting point for everyone and nobody was going behind that. (Social Policy Manager, Maternity Alliance)*

*The COMA maternal subgroup did a review of the welfare food scheme and that very firmly confirmed that there was a need for a scheme like that but it could be improved. (Civil Servant, Department of Health)*

A dietitian who was seconded to the Department of Health to support the formation of Healthy Start, reflected on the value of the COMA review and suggested that although the COMA review highlighted a need, the content of it was not necessarily going to be influential to the formation of new policy as political direction ‘is more important’.

*The information that comes from the recommendations in the scientific body, it is something to be considered but not necessarily acted on because the political consideration were more important. (Freelance dietitian, seconded to Department of Health)*

Thus suggesting, in order to identify policy drivers, it would be of value to look at the COMA review and identify the political issues that emerge or issues that could be politicised, for example the government being seen to promote the use of infant formula feeding as opposed to breastfeeding is politically bad. The extent to which this was concerning groups within the policy community was expressed in the interview with the Social Policy Manager from the Maternity Alliance:

*One of the really big issues was that the breast feeding advocates really struggled with this scheme and some of them even tried to get it closed down, as some of them felt it incentivised bottle feeding. (Social Policy Manager, Maternity Alliance)*

The COMA review was a catalyst to mobilise stakeholders in the Welfare Food Scheme to start considering what a reform should include. The interview with the Maternity Alliance highlighted the number of groups and organisations that had an interest in how the COMA review might spur reform of the Welfare Food Scheme:

*We heard that DH were thinking about doing the review and we got together with people like RCM and CPHEA, some of the breast feeding orgs and NGOs in the food world to form a little group to brainstorm the potential issues that might be coming up. (Social Policy Manager, Maternity Alliance)*

This indicates that a policy community was engaged with the potential a reform of the Welfare Food Scheme presented.

### **7.1.3 How expert recommendations fed into the policy process**

After the COMA review was published, the Maternity Alliance took a lead role in coordinating stakeholders to discuss how the Welfare Food Scheme should be reformed and what would be necessary to reform the Welfare Food Scheme into a more effective scheme. The Maternity Alliance interviewee emphasised the importance of relaying information back to Department of Health on what the full range of stakeholders considered to be important in regards to reform of the Welfare Food Scheme:

*the idea was to discuss all the issues in a very open minded way and present the results back to DH so that they knew what everybody was thinking. (Social Policy Manager, Maternity Alliance.)*

### **7.1.4 The role of the Dairy Industry**

The role of the dairy industry was something that came-up as an area of tension. The interview with the Maternity Alliance, Social Policy Manger provided some insight into the position of the Dairy Industry:

*National Dairy Council were defending milk at all costs and didn't want the scheme to become diluted by including – at that time people talked about fruit, veg and*

*cereals and possible things that might go in. They were very opposed to the idea that it would stop being a milk scheme and start becoming a food scheme.*

It transpired, that although the National Dairy Council had vested interest in the reform of the Welfare Food Scheme, they were not seen as part of the group of stakeholders made-up of NGOs and public health bodies. Thus, from the initial conversations on what a new Welfare Food Scheme might look like, there was a tension between what the National Dairy Council wanted and what other stakeholders wanted. The interview with a Child Poverty NGO Advocate elaborated on the tension between the dairy industry and other stakeholders:

*They (the National Dairy Council) were always kind of uh, persona non grata I guess is the best way of putting it. And whilst I didn't mind some industries, I didn't come from the food sector so I didn't understand the dynamic of those relationships at the time, I do now I work a lot on EU food policy and they're perceived to be the bad sectors, particularly bad parts of the food industry and obviously they were a vested interest. I guess in hindsight but I don't remember them being participants in the meetings.*

#### **Policy formation 2002 – 2005**

In the policy formation stage, the Department of Health published the proposal for Healthy Start and followed the New Labour model of making policy, consequently publishing consultation results and the response from government (as outlined in Chapter 6). Reforms to the Welfare Food Scheme and the draft regulations for Healthy Start were debated in Parliament.

Political drivers were prominent in the policy formation, specifically New Labour best practice and timeframes. More general themes that emerge in the policy formation are concerns regarding the proposed role of the health professional, concerns regarding how Healthy Start would be administered; the lack of public health knowledge of the Department of Health; concerns over the role of the dairy industry.

#### **7.1.5 New Labour Best Practice**

The interview with the civil servant emphasised the policy making framework that the Department of Health was working within. The quote below illustrates how best practice for making policy changes with government changes.

*The process that was followed reflected what the government of the day regarded as the due process. (Civil Servant, Department of Health)*

The following quote illustrates how the policy making process did not allow for public consideration of *how* Healthy Start was going to be actualised. The process identified the need, but ‘backroom stuff’ is where practical considerations were made.

*Ministers had the final decision. But this team had to explore and put up recommendations to them: it's part of the normal policy-making process that starts with the principles which are consulted on, modifies them in response to the consultation and then explains what Ministers will do. The policy principle didn't really change from then on – the focus was about how we were going to make this happen. (Civil Servant, Department of Health)*

Although the political process is followed, responses to consultations only need to be ‘considered’ by those making policy. The content of the responses to consultations are not as important as the process of completing consultation.

## **7.1.6 Aligning with other agendas**

### **7.1.6.1 The influence of 5-A-DAY**

The broader policy environment, specifically other agendas such as 5-A-Day were also influential in the policy formation. As the emergence of 5-A-Day was happening at a similar time and also being managed by the Department of Health, the two schemes had cross over.

The Civil Servant suggests that the 5-A-Day agenda directly influenced the content of the Healthy Start scheme. Although other foods such as whole grains, were being considered in the scheme, fruits and vegetables were the only new foods to be included. The Civil Servant suggested that as 5-A-Day was already underway and being implemented, it made it simpler to just include fruits and vegetables in Healthy Start, despite recommendations that other foods should be included.

*5-A-Day agenda was building and we had more information than we had before about people's dietary habits in relation to fruit and vegetables- it wasn't looking good. We added fruit and vegetables to the scheme to respond to that agenda and*

*also because in practice it is also quite a simple thing for retailers to deal with.*

(Civil Servant, Department of Health)

The synonymous nature of the formation of Healthy Start and 5-A-Day is illustrated in the following quote by a Child Poverty Advocate.

*I'm probably confusing some meetings with meetings for 5-A-DAY and this scheme.*

(NGO child poverty advocate)

#### **7.1.6.2 The influence of Choosing Health**

The influence of 'choice' in behaviour change was demonstrated though the emphasis put on enabling beneficiaries to choose a healthy diet.

In a parliamentary debate in 2003, Secretary of State for Health, Hazel Blears emphasised the importance of choice. This debate was happening as the *Choosing Health: Making Healthy Choices Easier* report was being written by DH. Thus, it is pertinent to question how the new 'choice' agenda played into the formation of Healthy Start. It is also interesting to consider how 'choice' is a component of domestic food welfare programming but not in institutionalised food welfare, this dichotomy will be explored in the discussion.

When asked about why Healthy Start does not prescribe specific foods based on individual needs as in the US model for WIC, the Department of Health Civil Servant responded:

*The process for achieving this would have been a burden to a publically funded health service.* (Civil Servant, Department of Health)

Thus having 'choice' at the core of Healthy Start, not only aligns with the 'Choosing Health' Agenda, it is a more financially efficient model, raising questions about the influence of budget as a key driver in the formation of Healthy Start.

#### **7.1.7 The role of civil servants**

Interview data found that the role of the Department of Health was somewhat paradoxical as they were on the one hand, the policy actors who were proposing Healthy Start, yet other actors clearly felt that the Civil Servants charged with forming Healthy Start did not have a strong grasp of the problems Healthy Start was supposed to address or understand the best way of addressing those problems.

The following quote from a freelance dietitian who was seconded to the Department of Health to advise on vitamins while Healthy Start was being formed suggests that primarily the policy process and completing tasks rather than the public health issues drove the Civil Servants.

*I think they had a job to roll out Healthy Start and you get a tick for that and that's what they wanted to do. (Freelance dietitian , seconded to Department of Health)*

The freelance dietitian strongly expressed concern that civil servants were not engaged with the public health issues Healthy Start aims to address.

*It was completely different to working in the scientific world, where if you see some evidence then you feel obliged to act on it because you know that other people's health depends on it. (Freelance dietitian, seconded to Department of Health)*

The Maternity Alliance also indicated that Civil Servants expertise is in completing the policy process efficiently and they are not necessarily engaged with public health. In addition the interviewee described how isolated the Healthy Start Unit within the Department of Health was, by drawing on the concept of 'silos'.

*The Healthy Start unit are a little silo all on their own and their energy has to go into these extraordinarily complex logistical systems and they have massive expertise on these systems but they are not public health people. (Social Policy Manager, Maternity Alliance)*

Not only did actors think the Department of Health did not have significant grasp of public health issues, the Social Policy Manager at the Maternity Alliance further suggests that although Department of Health were driving Healthy Start, they did not understand the benefits system and, as Healthy Start traverses both public health and welfare, this was problematic.

*It was entirely driven by the Department of Health and they didn't involve their colleagues and in fact they were really clueless about the wider benefit system. (Social Policy Manager, Maternity Alliance).*



The evaluator of the first phase of Healthy Start also suggested that the main objective of Civil Servants is to get the job done and not necessarily engage with the policy or promote it:

*Policy makers implement policy but don't need to champion it. (Evaluator, Tavistock Institute)*

### **7.1.8 Expectation of Health Professionals**

Throughout the formation of Healthy Start a recurring issue was what Health Professionals would be expected to do in order for Healthy Start to function. A tension emerged as Civil Servants and the Secretary of State for Health expected that Health Professionals would be able to offer bespoke nutrition advice to pregnant women, sign off on Healthy Start application forms and tell women how to access Healthy Start vitamins – essentially making the Health Professional the gatekeeper of the scheme. The onus of being the gatekeeper of the scheme was vehemently opposed by the Royal College of Nursing and the Maternity Alliance (See section 7.2.3 p.193).

The Department of Health Civil Servant describes the sort of conversations they expected Health Professionals to be having with beneficiaries of Healthy Start. The following two quotes illustrate the expectation by Department of Health.

*It's a combined approach – we have the scheme materials/ user guides which tell families what they need to do and we have a customer helpline, although that tends to be more functional rather than 'should I buy cabbage, is that good?' - that kind of thing is really part of the on-going discussion they should be having with their health visitor and their midwife about healthy diet That's where we really need the health professionals and children's centres to be quite actively giving information. (Civil Servant, Department of Health)*

*There is the "this is what you're allowed to spend them on" conversation, but then there's the conversation about 'well your child is 6 months old, have you thought about weaning? well you can buy these foods with your vouchers.....'. That's a conversation the health professionals should be having. (Civil Servant, Department of Health)*

The Department of Health Civil servant also suggested that Healthy Start actually helps Health Professionals to address diet with beneficiaries.

*We want the scheme to be a tool for health professionals to give them the opportunity to have a discussion around healthy eating in a non confrontational way. (Civil Servant, Department of Health)*

The interviewee from the Maternity Alliance described what the issues were with having a Health Professional as the gatekeeper of Healthy Start and appeared frustrated at the misconceived capacity of health professionals, by policy makers. The interviewee highlights how the Royal Colleges were not on-board with the concept of putting Health Professionals in the position of Gatekeeper:

*We shared the perspective that the royal colleges had, that this was completely misconceived and in fact people were very opposed even to the idea that you'd have to get health professionals signing the form in terms of how that's worked out. That does seem to have created a lot of logistical problems in terms of implementing the scheme but we weren't so worried about the logistics as the practical change that that meant, you couldn't get food which you might need unless a health professional had done this procedure with you. (Social Policy Manager, Maternity Alliance.)*

The policy community were therefore, concerned about the moral consideration with necessitating vulnerable families to see a health professionals in order to access an adequate diet.

The amount of advice that health professionals would be expected to provide was also strongly opposed:

*It was felt to be a really big change and step in the wrong direction and the health professionals also advised us that also that rationale for it was that women would therefore receive special health advice because the health professional is signing the form. 100% of health professionals that discussed this with us said, 'no' they'll get the same health advice that we already give everybody so far as we have time to give it to anybody. (Social Policy Manager, Maternity Alliance.)*

The range and types of advice some health professionals are able to provide to women was also outlined by the Maternity Alliance.

*And to some midwives that might be very superficial like handing somebody a leaflet and in others it might be a bit more detailed, but essentially they said this is absolutely just a waste of time and its not going to make the slightest bit of difference to the advice we already give pregnant women so we felt from a practical*

*point of view this is actually to no ones advantage except the presentational issue which it did seem to be the focus of it. (Social Policy Manager, Maternity Alliance.)*

The interviewee from the Maternity Alliance suggests that although early access to Health Professionals is a core point of Healthy Start in policy, it was never going to work in practice. The following two quotes juxtapose the intention of early access with a health professional and the reality.

*We want health professionals to use the application to identify the people they might want to engage with or sign-post to other local programmes. (Civil Servant, Department of Health)*

*All the publicity about Healthy Start still has to say it's a scheme that's about promoting early access to health professionals but everybody knows that that is fictional and health professionals treat that as fiction. People come in to see a midwife because they are pregnant not because they want to get Healthy Start. (Social Policy Manager, Maternity Alliance.)*

In addition to the opposition to the role of health professionals from the Maternity Alliance, NGO advocates were also concerned about the unrealistic expectation that the government had for health professionals within Healthy Start. In an interview with an NGO Child Poverty Advocate, they stated:

*They'd (health professionals) been undermined for years and years under the previous government and it was this idea that what role could they play and they were there saying, we couldn't do very much or people had unrealistic expectations about what could be done because you know they would often only ever see the mother once maybe, you know it was down that they should be monitoring this and doing that they said you know we only see a mother once and if everything is okay, we never see them again even if they're considered to be low-income (NGO Child Poverty Advocate)*

*It was remarkable the extent to which they did not have the royal colleges on board (Social Policy Manager, Maternity Alliance.)*

In summary, the findings illustrate that throughout the formation of Healthy Start, political drivers such as budget, timelines and best practice of the government in

power, were influential on the formation of Healthy Start. In addition to political drivers, tensions emerged regarding the competence of the Department of Health Civil Servants to be the key actors driving Healthy Start. In addition, tensions about the intended role of the Health Professional were dominant in the period of policy formation. The next section will look at themes and issues that emerged in the implementation of Healthy Start.

#### **7.1.9 Policy implementation: Relationship between Department of Health, evaluators and trainers**

The policy implementation stage involved commissioning training for health professionals and commissioning evaluators to evaluate the first phase of Healthy Start which was rolled out in Devon and Cornwall.

The findings indicate that the implementation of Healthy Start was problematic. A key issue was that there was a lack of clarity between DH and those commissioned to train health professionals and evaluate the scheme as to whether or not the scheme was in fact a pilot, or indeed the first phase of the national rollout. The implication of this being, that some actors thought that the first phase/pilot was a testing process and generating formative lessons before Healthy Start rolled out nationally and other actors saw it as the first step of fully implementing the scheme. Thus a tension emerged.

The Department of Health Civil Servant interviewed, was adamant that it was not a pilot, therefore indicating that Healthy Start was never piloted.

*Devon and Cornwall wasn't a pilot, it was the first phase. There was never going to be any going back. (Civil Servant, Department of Health)*

Not only does this quote illustrate the fact that there was no pilot, it also illustrates the drive of the Department of Health to rollout Healthy Start – “there was never going to be any going back” is a strong statement that indicates that the ‘first phase’ of Healthy Start was less about providing formative lessons and more about getting the scheme rolled-out.

When questioned further about the issues that did come-up in the evaluations of the first phase of Healthy Start – political timelines were influential.

*Issues emerging from evaluation weren't ones that would stop the roll-out, they were just ones that needed to be addressed. (Civil Servant, Department of Health)*

The Civil Servant further indicated that from the 'first phase' of Healthy Start, there had been no problems identified that would hinder the national roll out of the scheme.

*We set ourselves a timetable of rolling it out within a year and we did that: there weren't any problems identified that would have made that impossible, but we would have taken longer if needed and that would have been perfectly fine. (Civil Servant, Department of Health)*

However this experience contrasted significantly to the experiences of the evaluators and the group commissioned to provide training in the first phase of Healthy Start. Both the evaluators and the trainers understood the first phase to be a pilot and that the scheme would be further developed in light of the evaluation findings. This differing understanding of an important aspect of the policy process, demonstrates a level of confusion between key actors in the policy implementation:

*The whole point of the pilot phase is generate lessons for the roll out. (Evaluator, Tavistock Institute)*

*The pilot was the first 6 months in Devon and Cornwall. (Evaluator, Tavistock Institute)*

The evaluator from the Tavistock Institute was clear when interviewed that the scheme that they had been commissioned to evaluate had not been implemented properly:

*Even in that early phase, the pilot phase, there was supposed to be a local development officer, whose job was to have oversight of the whole process, engage with all the relevant partners and have oversight of the training and that appointment broke down so there was never, even in that initial pilot phase, it wasn't actually implemented in a way. (Evaluator, Tavistock Institute)*

The following two quotes – the first from the evaluator and the second from a Department of Health Civil Servant support the idea that policy expediency, rather than evidence was driving the roll out of Healthy Start. Additionally, the first quote

raises issues about how Healthy Start was not being driven by evidence and differed to the best practice model for making policy under New Labour (see Figure 28). If other policies were following the model of best practice, this quote indicates how Healthy Start may differ:

*I think there was a good evidence review done before and the whole programme was designed based on the evidence review, but then the implementation was influenced very much by policy expediency rather than, you know several of the elements that were there, I mean evidence was lost. (Evaluator, Tavistock Institute)*

*We set ourselves a timetable of rolling it out within a year and we did that: there weren't any problems identified that would have made that impossible, but we would have taken longer if needed and that would have been perfectly fine. (Civil Servant, Department of Health)*

It was clear in the interview with the evaluator that they did not believe Department of Health to have a firm grasp of how to influence behaviour change and that budgetary restrictions and timing were limiting the scope of Healthy Start. In addition, it is clear that how Department of Health interpreted the findings of the evaluation was different to how the evaluators intended them to be understood.

*You want to make sure beneficiaries are getting advice as well as vouchers, so what might need to be in place to make sure that happens? And that was the bit of the evaluation they (Department of Health) seemed to be really uninterested in, mainly because it didn't fit with the policy imperative. I think they lost the budget or the budget was cut down so the budget for roll out was fairly minimal. Any budget that was available for this kind of input – rollout and training development – some kind of development roll, there was no budget for it, so there was nothing to support that side of the programme. (Evaluator, Tavistock Institute)*

The evaluator appeared cynical about the experience of evaluating the first phase of Healthy Start, at one point summarising the process of evaluating government programmes by saying:

*It's normal policy process; you commission an evaluation and ignore it. (Evaluator, Tavistock Institute)*

It was clear that the evaluator felt that the way in which the pilot or first phase of Healthy Start was rolled out, undermined the public health rationale of the scheme:

*The whole point of the scheme was to create an opportunity for a conversation about healthy eating. That was the rationale, and that rationale got lost basically. (Evaluator, Tavistock Institute)*

This raises questions regarding the tokenistic quality of the policy process – was the evaluation a box-ticking exercise?

#### **7.1.10 Developing training for health professionals**

Training for health professionals was a feature of the first phase/pilot of Healthy Start that appears to have also been affected by budget and timing.

The semi-structured interview with two trainers from Nutrition<sup>4</sup> highlighted the chaotic nature of the roll-out of Healthy Start. There were a number of elements of the scheme that they had expected to be in place, which, when they started working in the field, they found out were not. One of the features the trainers were expecting was the presence of a Healthy Start coordinator:

*There was no coordinator for anything and so really it was like picking a name out of a hat, and ringing a lot of people up to find out who is the person we should contact and they would put names forward. (Nutrition<sup>4</sup> A).*

The short timeframe between being commissioned and being expected to start training was very short and appeared to add pressure to the training.

*Trainer A: we had to do everything. We had to organise venues and they had no training materials, well they had some leaflets. It was a bit dodgy because they would say yes you deliver it, but you were lucky if you got you know the little leaflet that we could hand out to the health professionals and some of them arrived the day we were delivering the training, it was very...*

*Trainer B: It was a very tight schedule because we only got awarded the contract, we found out about it in August, we got awarded it sometime end of September the National roll out went live at the end of November, so we had to put this whole thing together in two months.*

Despite the short time frames, the training was valuable and well received. This is backed-up by the evaluation report undertaken by the Tavistock Institute (Hills 2006).

*It was just so so quick and we were so time short and even getting the resources together, my feeling was they were very happy someone had gone down to give them training. (Nutrition<sup>4</sup> B)*

The semi-structured interviews with trainers commissioned to deliver Healthy Start training to professionals in the phase 1 area indicates that there were issues with implementing training due to rapid timelines and a lack of coordination.

#### **7.1.11 Not rolling training out nationally**

It was to the surprise and disappointment of the trainers who had been commissioned to roll out the training in the pilot/ phase 1 of Healthy Start, that the cascade training they had developed, would not be rolled out nationally when Healthy Start rolled out across the UK in 2006. The following quote describes how Nutrition<sup>4</sup> pitched their concept for rolling-out training for health professionals across the country. Although they were not certain, they initially presumed the large cost of their proposal may have prohibited the national roll-out of training. The impression that they described, was that ideas for a national roll-out of training for health professionals were quashed rather abruptly by the Department of Health and without clear explanation.

*What we did was take our knowledge and figure out how many we would have to train to cascade down in each region so how many people we would have to train in each region and cost it. The costing was mega -, it was almost like a road-show. That's how I would describe it and we would go to key cities, I know we pitched for two in London, then Birmingham, Liverpool and Manchester and we didn't get it because they never went ahead and did it. (Nutrition<sup>4</sup> B)*

In the interview with two trainers, it became clear that they were sceptical about why the training was implemented in phase 1/pilot and were not clear why the Department of Health decided to not roll out training to Health Professionals despite the fact that the training had been well received and considered an extremely important component of Healthy Start by both the trainers and the evaluator from the Tavistock Institute.



*It would be interesting to know whether they ever intended to or whether they just looked at the costs and feasibility of it and said we're not going to do it this way. Everyone will be so interested in doing this, that they won't need that. That sounds like a sarcastic remark but I think there is the temptation to say well this is a new initiative, updating the welfare food scheme and people will be interested in doing it, but not realising that they did need some background skills to do it. (Nutrition<sup>4</sup> A)*

*We don't know what went on in the background, but basically they said – it was out of any budget that had been set aside and the other issues we had, we were not registered contractors or providers we weren't on the official register for DH, it must have been because our contract they said although we'd been awarded phase 1 and a logical assumption would be for us to do phase 2 they'd have to put it back out to tender. (Nutrition<sup>4</sup>B)*

#### 7.2.0 Findings from unpublished documents provided by policy participants in semi-structured interviews

This section adds details to the findings from the previous section, drawing on documents that were provided when undertaking semi-structured interviews with policy participants. The findings in this section develop the themes from the previous section and build a more detailed narrative of the process of initiating, forming and implementing Healthy Start. As in the previous section, this section is structured according to the policy development narrative, thus it begins with a report detailing a conference on the initiation of the scheme and concludes with reports regarding the implementation of Healthy Start.

##### 7.2.1 Maternity Alliance conference documents

A conference report written by the Maternity Alliance in 2000, was provided by the interviewee from the Maternity Alliance and shows that the need for clear objectives of the scheme was highlighted early on in the policy process. The Maternity Alliance conference discussed reform of the Welfare Food Scheme and the key question the conference aimed to address was: ***How can a welfare food scheme meet the health needs of mothers and babies today?*** (p.1). The conference report indicates that it was unilaterally agreed by stakeholders in 2000 that there should be clear objectives for the Scheme.

The Scheme should have explicit public health objectives in the context of a public health strategy. The objectives should be printed on all literature about the Scheme.

The report from the Maternity Alliance conference opens with:

The Welfare Food Scheme is of great importance in our society where so many pregnant women and young children are, through poverty and other factors, at risk of serious nutritional vulnerability. This was accompanied by a strong sense that just as the Scheme has evolved over the past 60 years, to truly meet the needs of the target population today it must leave behind the baggage of the past and become far more flexible. (Maternity Alliance 2000, p.1).

It is unclear what the above quote is based on. Chapter 6 highlights, there was no evaluation of the Welfare Food Scheme, which is why it is interesting that the Welfare Food Scheme is discussed as if there were data that proved its value. The only information that can be drawn on is the COMA review which largely uses proxy data to predict what the impact/value of the Welfare Food Scheme was.

In the initiation of Welfare Food Scheme reform, the experts who gathered at the Maternity Alliance Conference highlighted a need for research before significant and effective improvements to the Welfare Food Scheme could be made. Including research on the contribution that the Welfare Food Scheme might make to improving maternal and child health:

The Government should carry out an analysis to establish the long term cost of poor birth outcomes and sub-optimal infant nutrition, and to evaluate the contribution that the Scheme can make to improving maternal and child health. The research could inform future decisions on how best resources can be spent to reduce inequalities and improve outcomes. (Maternity Alliance, 2000)

There is no evidence that the Department of Health commissioned any research of the kind. It is therefore important to consider how formative the suggestions were from the series of meetings and conferences held by the Maternity Alliance.

In addition delegates at the conference raised the issue of the role of health professionals in delivering Healthy Start. This is particularly noteworthy as the role of health professionals consistently comes-up across the formation and implementation of Healthy Start. The following is an extract from the Maternity Alliance conference report:

The conference recognised that health professionals were not particularly engaged with the Welfare Food Scheme and that in any new schemes, measures would need to be taken to raise awareness of why maternal and infant nutrition is important.

‘It was felt that health professionals’ lack of engagement with the Scheme potentially undermines its effectiveness (for example by contributing to low uptake of vitamins), as they are an important source of information for individuals who would be eligible.

The following suggestions were made to improve the awareness of health professionals and health care workers:

- Promote the Scheme to health professionals as a targeted intervention within the context of a public health strategy to reduce inequalities and improve the health of children.
- Promote understanding of long-term benefits of maternal and infant nutrition.
- Provide clear evidence-based information on subjects such as who needs which vitamins and when, to assist health professionals to promote Scheme benefits confidently and enthusiastically.
- Include benefits and Scheme information as part of basic professional education.
- Update information regularly as part of Continuing Professional Development training.
- Mail shots to GPs.
- Training to enable health professionals to recognise women’s unspoken information needs – for example, pre-conceptually – and incentives for identifying and conveying this information e.g. discretionary points (entitling health professionals to higher pay).
- Production of a Department of Health training pack or publication for health professionals.

It was also suggested that it would be valuable to research the attitudes of health professionals to the Scheme and whether they feel it is stigmatising to suggest it to clients.’ (Maternity Alliance 2000 p. 26)

To summarise, early on in the initiation stage of the Healthy Start policy process, detailed suggestions on the role of the health professional were recorded and

presented to the Department of Health. It is unclear how, or if, they fed into the policy formation.

The conference report from the Maternity Alliance also provides information about who attended the conference. This indicates who the 'interested' policy community were. Table 17 outlines the attendees, their policy ideas and associated interests. This information is derived from the policy literature and interviews with policy participants.

Table 17 Policy communities

		Policy ideas	Agenda
<b>Health Professionals</b>	RCN; RCM; Independent midwives	Remove incentive for infant formula Promote 5-A-Day	Health promotion
<b>Government departments</b>	DH, DSS	Rebrand Welfare Food Scheme	Multiple
<b>Breast feeding advocates</b>	UNICEF UK Baby Friendly Initiative; Baby Milk Action	Focus on breastfeeding support, peer support.	Infant feeding, inequalities
<b>Child Poverty advocates</b>	CPAG; The Children’s Society;	Support wellbeing vulnerable children	Health inequalities
<b>Welfare advocates</b>	Family Budget Unit;	Unclear	Meeting needs of families on low-incomes
<b>Food Poverty advocates</b>	Sustain; Sandwell Community Foods; Food Commission;	Support food skill development Make healthy food affordable	Inequalities
<b>Dairy Industry</b>	National Dairy Council	Exclusively maintain the foods available in the Welfare Food Scheme – milk and infant formula	Profit: Maintaining milk as fundamental to welfare foods
<b>Retailers</b>		Keep new policy simple	Profit
<b>Maternity rights advocates</b>	Maternity Alliance; Pregnancy and Parenthood International; NCT	Removing conditionality from the scheme	Inequalities
<b>Special interest groups</b>	Travellers Health; Blackliners; National Council of One Parent Families	Make welfare foods available to travellers, single parents, families impacted by AIDS and HIV	Special interests

It is notable that the least represented groups throughout the formation of Healthy Start appeared to be potential beneficiaries and nutritionists or dietitians.

### **7.2.2 Comments from the National Dairy Council**

Although an interview was not secured with a representative from the National Dairy Council (now Dairy UK), in the unpublished policy documents from the Maternity Alliance, there was a document that contained comments from the Nutrition Manager at the National Dairy Council. This gives a sense of the positions held by the National Dairy Council throughout early discussions on what a new Welfare Food Scheme might look like. The document indicates that the National Dairy Council did not originally welcome discussions of including foods other than milk:

Re-naming the WFS the 'Healthy Food Scheme' is unwise. There are no healthy or unhealthy foods, only healthy and unhealthy diets.

It is extremely difficult to obtain adequate calcium if milk and dairy products are excluded from the diet without taking supplements.

Large quantities of vegetables need to be consumed to absorb the same amount of calcium from one portion of milk. (National Dairy Council 2001 p.1).

As attempts to secure an interview with a Dairy UK representative were unsuccessful, the review of this document adds a valuable dimension to the research on the influences on Healthy Start

### **7.2.3 Policy memo from the Maternity Alliance and Royal College of Nursing**

In 2002, the Maternity Alliance and the Royal College of Nursing wrote a policy memo with objections to some of the proposed changes to the Welfare Food Scheme. The document provides data from the formation of Healthy Start. They provide four objections, which they categorised as: philosophical objection, human rights objection, practical objection and Nurse-client relationship.

The unpublished documents, further add to the understanding of tensions between policy participants during the formation of Healthy Start. During the formation of the scheme, it was proposed that beneficiaries receive Healthy Start only if they agreed to a number of conditions, for example mandatory vaccinations of their infants and mandatory medical examinations for both women and children and to allow health professionals into their home. The Maternity Alliance and Royal College of Nursing

saw it as morally wrong, that a family should be required to a level of conditionality in order to receive needed food. A policy briefing provided by the Maternity Alliance and Royal College of Nursing demonstrates their issues with the proposed scheme. They suggest that the proposed conditions:

may contravene the Human Rights Act, in particular Article 8 (the right to respect for private and family life). (Maternity Alliance and Royal College of Nursing 2002 p.2)

The practical objections are founded in the concept of coercion and the lack of evidence to suggest ‘financial coercion will increase service uptake’. They acknowledge the external barriers that can prevent families from accessing welfare foods.

Many known obstacles to service uptake lie outside of the control of the individual and the proposals in the Bill therefore risk doing nothing to “improve access” (Maternity Alliance and Royal College of Nursing 2002 p.2)

Further concerns were raised that if the health professional became the ‘gatekeeper’ of the scheme, that it may impede the important relationship between health professional and parent.

The relationship between health visitors, midwives and families is a very important aspect of the maternal and child health care, in that a level of mutual respect and trust is necessary so that parents feel able to confide any issues they might have. If the health professional is forced to act as a “gatekeeper” controlling access to food benefits, this relationship of trust will be severely undermined. (Maternity Alliance and Royal College of Nursing 2002 p.2)

Thus, this document provides important demonstration of the tensions between those making policy and those supporting the actors who were being proposed as gatekeepers.

#### **7.2.4 Report to the Department of Health from trainers contracted to train health professionals in phase 1 of Healthy Start**

A number of unpublished documents pertain specifically to the implementation of Healthy Start and were willingly shared by policy participants to demonstrate the issues that both the evaluator of the first phase of Healthy Start and the trainers

commissioned to train health professionals in the first phase of Healthy Start experienced.

The process of commissioning trainers to develop and provide training was affected by timing. Nutrition<sup>4</sup> – a collaboration of freelance nutritionists and dietitians, won the contract to develop and provide training to health professionals in the pilot/phase 1 area. The next section presents findings from their final report to the Department of Health and an interview with two of the trainers.

Nutrition<sup>4</sup> provided a copy of their report to the Department of Health (Nutrition<sup>4</sup> 2005), outlining how the training was undertaken, how it could be cascaded across the country and why it is an integral component of making Healthy Start an effective programme. This report provides data on the implementation of Healthy Start.

The introduction to the training report illustrates the short timeframe in which the trainers were working in:

In late August 2005, the Department of Health invited tenders for delivering the training programme to inform Health Professionals about Healthy Start, Phase 1. Nutrition Four tendered for the Department of Health's Healthy Start Phase 1 cascade training on 7<sup>th</sup> September 2005, were invited to support the tender on 28<sup>th</sup> September and were awarded the contract on 14<sup>th</sup> October 2005 to develop and deliver training of relevant health professionals across Devon and Cornwall before the launch date of 28<sup>th</sup> November 2005. The timeline for delivery of the project was challenging. (Nutrition<sup>4</sup> 2005 p.2).

Nutrition<sup>4</sup> report that the implications of the short time scale between obtaining the contract and dates when training needed to be completed were:

- Key people were missed – e.g. midwives at South Molton, more personnel from Sure Starts, some public health personnel.
- Half term, holidays and part time staff meant delays in identifying key people to attend.



- Resources had to be printed in a very tight time scale and not all relevant people may have had time to comment on drafts. (Nutrition<sup>4</sup> 2005 p.12).

Thus the short time frame and timing of the training was not ideal and essentially meant that Healthy Start could not be properly implemented.

The report also describes a meeting in which Nutrition<sup>4</sup> met with the Department of Health and members from the Royal College of Midwives and Community Practitioners and Health Visitors Association on November 5<sup>th</sup> 2005. The report states:

This meeting was very useful for Nutrition Four as it helped focus on the priorities to cover in the training from the practitioner's perspective as there was minimal time to do needs assessment with those attending the training. (Nutrition<sup>4</sup> 2005 p.12).

Thus, training was being developed without a full needs assessment being carried out.

Concerns from Health Professionals that participated in the initial training are outlined in the report and include:

**'Timing and cross over** – short notice for training and close to deadline for start of implementation, so difficult to cascade before the start date

**Promoting and raising awareness of Healthy Start scheme** – needs advertising, education, how to reach those who are eligible, availability of resources to promote.

**Nutrition education** – losing contact with clients who come for formula milk, not sure if enough time for cascading

**Fruit and vegetables** – no frozen fruit and vegetables, allowed with the voucher, lack of skills/knowledge to prepare fruits and vegetables.

**Others** – what are we actually piloting (has it not already been decided anyway)?

(Nutrition<sup>4</sup> 2005 p.7)

As well as the report Nutrition<sup>4</sup> provided to the Department of Health, to demonstrate the level of detail in the training they designed, after the semi-structured interview took place, the interviewees provided a copy of the training pack that they had developed. It was a very detailed programme that was clearly written and designed to

be easily used in a number of settings that work with Healthy Start eligible families. The training was designed to be an off the shelf training package that could be cascaded within local areas. Specifically, it included key nutrition messages, ideas for promoting the scheme, breastfeeding and nutrition messages, suggestions for promoting the scheme widely, ideas for promoting directly to clients. It included PowerPoint presentations, session training plans, a CD rom with resources on and a template for developing bespoke cascade training plans. Interestingly, the example certificate (Figure 31) in the training pack states the ‘the training was designed with the involvement of the Royal College of Midwives (RCM) and the Community Practitioners and Health Visitors Association (CPHVA)’. This clear demonstration for the need to train health professionals, further juxtaposes the decision not to rollout training nationally.

Figure 31 Certificate for completing Healthy Start training



The main priority recommendations from Nutrition<sup>4</sup> (2005) were to allow for more than one month from the time of starting organisation of training to completion and have a local Healthy Start coordinator in post before organising any training to facilitate logistics and to be available for follow-up/on going support. Additional recommendations were to prioritise training in nutrition information, the recommendation specifically states ‘nutrition information is crucial to delivery of Healthy Start’.

### 7.2.5 Brief from the Department of Health to the evaluators of Phase 1

A further document that was provided by an interviewee was the brief from the Department of Health to the commissioned evaluators of phase 1 of Healthy Start – the brief outlines the expected scope of the evaluation. The brief states the outcomes of the evaluation on page 4:

1.11 The overall policy outcome of this project is to demonstrate whether, how and the extent to which the new Healthy Start processes are working smoothly, and meeting government, NHS and wider stakeholder expectations, though an assessment of early impact on beneficiaries, health professionals, retailers and contractors. The evidence and learning from the evaluation of the Phase One introduction of the Healthy Start voucher scheme will be used to help ensure the smooth roll-out of the scheme across the rest of England, Scotland and Wales in mid-2006 (Phase 2). (Department of Health 2005, p.4).

This description of the role and purpose of evaluating the first phase of Healthy Start, is at odds with the experience described by the interview with the evaluator of the first phase of the scheme and to an extent the report of this evaluation.

The Brief from the Department of Health to the evaluators further states how the evaluation will be used:

The Department of Health will use evaluative evidence for example to:

- Inform improvements to Healthy Start policy and operational processes;
- Inform reports to Parliament/Ministers on Phase One introduction of Healthy Start;
- Inform DH policy communications with key Healthy Start stakeholder groups, including beneficiaries, the NHS, retailers and contractors;
- All smooth transfer of policy learning (and intellectual capital) from Phase One into the evaluation of Phase Two implementation of Healthy Start; and
- Understand the initial impact of Healthy Start in retailers. (Department of Health 2005, p.5).

Again, this is at odds with the experiences both the evaluator of phase one and the trainers described.

The control of the Department of Health is outlined in the briefing to the evaluators. The Department of Health reserves the right to publish reports and that any spin-off publications (including articles and conference papers) would be subject to the Department of Health's permission to publish, copyright and standard confidentiality conditions.

### 7.3.0 Findings from parliamentary debate transcripts

To add a further dimension to considering the influences on the development of Healthy Start, parliamentary transcripts of two debates were accessed via Hansard and analysed as detailed in Chapter 5 (Methodology).

Like the policy participant interview findings – the purpose of Healthy Start was not clear among politicians either. Politicians confuse the purpose of scheme. Hazel Blears, the Secretary of State for Health at the time when Healthy Start was proposed and initially being formed suggests that Healthy Start is about family behaviour change.

*The whole purpose of the healthy start scheme is to augment the diet of low-income families, which includes mothers and their children. (Hazel Blears, 2003 Col. 764)*

Whereas Andrew Lansley, highlights the confusion over the point of the scheme – it is not clear if it is about behaviour change or supplemental nutrition.

*I was, if anything, worried by the Under-Secretary's assertion that this is a supplement to the diet of low-income families as distinct from being focused on the nutritional requirements of children, which is what I understood the scheme primarily to be about. (Andrew Lansley, Hansard 2003 , Column 768)*

One MP went so far as to express anxiety over changing the Welfare Food Scheme as it has worked 'fairly well'. Again, raising the issue that the Maternity Alliance conference report identified – there is little evidence that the Welfare Food Scheme was effective, yet it is described with an element of nostalgia that assumes its success.

*I hope that my hon. Friend the Under-Secretary will recognise that there is anxiety. We do not want to move from a scheme that has worked fairly well for 60 years to one that could be subject to change on a popular fashion or whim. I hope that she can assure us that any changes will be subject to reasonable consultation and will take people's anxieties into account. (Stephen McCabe, Hansard 2003 Col.766)*

As in the semi-structured interviews and analysis of unpublished documents, the issue of budget came-up in analysis of parliamentary transcripts. Concerns were raised in Parliament regarding how the scheme would meet aims without increasing budget.

*I hope that the Under-Secretary will answer all our points and will explain how the new system can possibly meet all the aims of the Department of Health within the current budget. (Patsy Calton, Hansard 2003, col.756)*

The response suggested that money in the Welfare Food Scheme had not been spent effectively and that Healthy Start would be more financially efficient, yet it is not indicated how it would be designed to be more efficient.

*The scheme costs about £142 million and, as we said in the NHS plan, we want to ensure that we spend the money more effectively and on ensuring that we get more nutritional value out of it. (Hazel Blears, Hansard 2003, col.762)*

The practical issue of cost was pursued by Ms. Patsy Carlton.

*My concern is that the Government are planning a series of schemes that add up to no more than the current provision. If the Minister can tell me that more flexibility and money will be available and that we are talking about adding on to what we have at present, I might go away satisfied. (Patsy Carlton, Hansard 2003, col.762)*

Hazel Blears does not draw on evidence in her response, she explains what she ‘believes’ but provides no reason for her belief.

*We are not in the business of enlarging the scheme in monetary terms, but I believe that we can get better value out of the money that we spend. (Hazel Blears, Hansard 2003, col.762)*

Thus, very little evidence or practical reasoning was provided how Healthy Start would provide more without increasing budget. Budget was however a clear issue area for politicians.

The issue of choice was also raised in the parliamentary debates. Hazel Blears, ironically describes ‘choice’ as if it is the only option for Healthy Start.

*Based on scientific evidence and the consultation responses that we have received, we are genuinely attempting to introduce an element of choice. (Hazel Blears, Hansard 2003 Col. 762)*

*We are not only widening the range of foods but introducing a fixed value voucher to give people an element of choice in the system. (Hazel Blears, Hansard 2003 Col.761)*

However concerns were raised that it was unfair to ask parents to choose how to spend their Healthy Start vouchers.

*It is sufficient to say that there is widespread concern that parents on low-incomes should not be asked to make a choice between milk or fruit and veg for their children. (Stephen McCabe, Hansard 2003 Col.766)*

As in the semi-structured interview findings and the analysis of unpublished documents, evidence of the National Dairy Council having a role in influencing Healthy Start was demonstrated.

The Hansard transcripts provide evidence of how the National Dairy Council participated in the policy process and it appeared to be through private meetings with individual Ministers and MPs invested in the Welfare Food Scheme. Thus, the National Dairy Council mobilised lobbying efforts throughout the policy process to protect and maintain milk as a key part of the scheme. The following quotes indicate how the National Dairy Council were operating:

*It is no secret that several members of the Committee were approached by the dairy industry and the National Dairy Council to express their concerns. (Hepburn, Hansard 2003 Col. 766)*

*Milk will continue to be an essential part of the scheme. I have met representatives of the dairy industry on several occasions and have emphasised to them how important I feel milk is to the young children's nutrition. It will be retained while we introduce the measure of choice. (Hazel Blears, Hansard 2003 Col. 763)*

*Changing a system involving only milk to one that involves milk and food will have an impact on the dairy industry. Has the Minister or her Department made any evaluation of that impact? (Mr Burns, Hansard 2005 Column 11)*

The above quotes represent a clear pressure from the Dairy Industry that may have been influential in the formation of Healthy Start.

Concerns were also raised regarding the administrative challenges of actually shifting the Welfare Food Scheme to Healthy Start had been recognised in the formation phase of Healthy Start:

*I fear that, with something as significant as the changes to the welfare food scheme proposed in clause 167—and in light of the points that a number of hon. Members on both sides have made during our debates on the clause—there is the potential for considerable problems and mistakes with the fine tuning and final decisions that the Government will make on the nuts and bolts of any new scheme. (Mr Burns, Hansard 2003 Col. 767.)*

*In passing, I want to say that I am always suspicious of any politician, regardless of political colour, who says that they are bringing in a bureaucratic scheme in which the paperwork is very simple to fill out (Simon Burns, Hansard 2003 Column 11)*

As in the semi-structured interviews with policy participants, the expected role of the health professional was a theme that was displayed in the parliamentary debate transcripts.

*We want to have maximum consultation with the public and with the health professionals involved, who have a serious job to do in providing nutritional advice to families. (Hazel Blears, Hansard 2003, Col.770.)*

*We are also linking the entitlement and the take-up of the foods and benefits to the registration process. That is an important element of the new scheme, because we are seeking to ensure that pregnant mums have access to good nutritional and health advice. (Hazel Blears, Hansard 2003 Col.761)*

Two years later in a parliamentary debate to approve Healthy Start regulations the new Secretary of State for Health, Caroline Flint defended the new role for health professionals, stating:

*We want to expand that application process under the healthy start scheme to all beneficiaries. The reason for that is not to introduce a bureaucratic exercise—some sort of gateway process—but is to provide opportunities for health professionals to*

*engage with mums and dads and their babies about a healthy start in life. Someone like a health visitor will sign off the application, which will give them the opportunity to engage with the family about the benefits of good diet and nutrition. (Caroline Flint, Hansard 2005 Column 8)*

Although the point of parliamentary debates is to raise issues and concerns, and many issues were raised in the parliamentary debates in the formation of Healthy Start, it is however not clear how concerns were addressed before the policy was rolled out. There is a sense that these debates were part of the political process and not necessarily formative.

#### 7.4.0 Summary of findings

The findings add to the general knowledge of how Healthy Start was initiated, formed and implemented. In addition, the findings start to indicate what influenced the development of Healthy Start at each stage in the policy process.

Specifically, the findings indicate that the process of initiating, forming and implementing Healthy Start was driven by a number of different factors. Throughout the process there appears to be confusion over exactly what it is that Healthy Start is trying to do and there is little evidence of how the suggestions and advice provided to the Department of Health throughout the policy process were used in any formative capacity. The influence of political drivers such as time, budget, agenda alignment and frameworks of best practice in policy making appear to have been more influential than the suggestions and information provided by actors with expertise in child nutrition, welfare, evaluation and training. This is most evident from the findings that address how the role of the health professional was considered or not considered at each stage of the policy process.



## Chapter 8: Phase 3: Case Study – the role of health professionals delivering Healthy Start

### 8.0 Introduction

This case study explores the role of the health professional, an area that emerged from the policy context, background and literature review as an area that little is known about, yet is theoretically crucial to the success of Healthy Start. The research question for this case study was:

How do health professionals in one local area of England understand the Healthy Start scheme and what is their role in delivering the scheme?

The rationale for this research question lies in the role of the health professional being identified as crucial to the successful implementation of the scheme and the disconnect between policy aspirations and practice that the findings in chapter 7 indicate. The Healthy Start policy literature stresses the value of beneficiaries making better links with the NHS and primary care (Department of Health 2002, p18) and the introduction of public education and professional training schemes to ‘help get the best out of the contacts between the primary care services and the users of the scheme’ (Department of Health 2002 p.20). The second point is based in evidence from the COMA review which indicated some health professionals lacked knowledge of the Welfare Food Scheme (COMA 2002). The importance of engagement between Healthy Start and health professionals is described in the following quote:

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... Information about the role of the scheme will also need to be included in basic professional education and continuing professional development. (Department of Health 2002, p.22)

From the development of the policy, it is striking that health professionals were the majority of respondents in the consultation (Department of Health 2003b). In the response, they emphasised the need for ‘coordination, information and guidance in the area of nutrition’ (Department of Health 2003b, p.8) to facilitate successful

delivery of the scheme. From the literature alone it is unclear how much of the intended role of the health professional has manifest into the reality of practice.

Thus, in theory health professionals are the gatekeepers that connect Healthy Start as a policy to the delivery of the scheme. How this is happening is relatively unknown.

### 8.1 Background on Local Area

The case study area has 200,000 residents and has the second highest rate of child poverty in England, with around half of the case study area's children living below the poverty line. The rationale for choosing the case study area was that it presented a diverse geographical area with high levels of poverty and an above average take-up of the Healthy Start scheme.

In 2012 the national average for Healthy Start take-up was 80% (Department of Health 2011). Within the case study area, the Department of Health estimates that between 87 and 92% of eligible healthy start beneficiaries are engaged with the scheme, which means that they are signed-up and receiving Healthy Start vouchers. It does not reflect the number of vouchers that are redeemed, this information is not known. Therefore it is an area where statistically the Healthy Start scheme is both necessary and utilised. Within this case study area, the take-up statistics suggest that there should be examples of best practice in Healthy Start delivery.

Within the case study area, Healthy Start is managed by a Public Health Strategist who is responsible for monitoring the Healthy Start vitamin uptake, promoting the scheme generally and reporting to the Department of Health. The management of Healthy Start within the local area revolves around 3 pathways: ordering, distribution and promotion. Within those three pathways different professionals within the NHS and Local Authority have different roles and responsibilities.

### 8.2 Case Study Findings

This section will present the issues from the interview data and provide examples from the interviews to support the concepts that emerged from the semi-structured interviews.

Although the roles of Health Professionals varied in terms of when and how they would interact with families, the common responsibilities remained the same, as

outlined in figure 32. There was no Healthy Start specific training offered for health professionals that deliver Healthy Start within this local area.

**Figure 32 Role of health professionals from case study findings**

1. Ensure beneficiaries are signed-up to the scheme and receiving vouchers.
2. Sign-off application forms
3. Make sure beneficiaries know where the vitamin coupon is on the Healthy Start letter and where they can collect vitamins
4. Promote the scheme in general

The interviewees highlighted how identifying beneficiaries was the first challenge in making sure eligible families are registered for Healthy Start. To the health professional, figuring out who was eligible was uncomfortable as it often involved a ‘difficult conversation’ about eligibility:

*I'd say to them 'oh I see you're unemployed' that's the hardest thing, is actually saying to somebody, basically are you on income support because there's lots of people who actually very proud that they are on benefits or they should be on benefits and they're not. So that's quite a minefield, actually who do you have the discussion with and who do you not. (Midwife)*

Some health professionals inferred that they themselves were confused by the eligibility criteria for the scheme:

*I guess I'm not entirely clear what the thresholds are, I know how you can claim – if you're on income support or child tax credit, but the cap – so most parents have got the internet so I tell them why don't you go on the website and you can fill out your details and it will then tell you for definite whether you can apply or not.*

(Community Nursery Nurse)

With Health Professionals that experienced both the Welfare Food Scheme and Healthy Start, it was clear that Healthy Start was administratively more complicated and therefore frustrating at times. The emphasis on how hard it can be to understand Healthy Start is demonstrated in the following quote:

*I think that it's (Healthy Start) not as easy to understand now, and I think the way that the application form and the processes are not as easily understood and I don't think they're consistent as they could be. But from talking to the recipients, there are some frustrating things that happen and I don't think it is well understood. (Health Visitor)*

A number of interviewees asked for clarification on aspects of the scheme during the interview:

*One question, is it one of these vouchers per family or is it per child? (Health visitor 1)*

*Are you allowed to use them on dried fruit? (Community Nursery Nurse)*

*I thought it was tinned and frozen from something that came through. But um, not that long ago but that might be me giving them false information. (Family support worker)*

Language barriers were identified as a challenge in delivering the scheme:

*Some parents with English as a second language, it may be something that is a bit misunderstood talking about that with them. (Health Visitor)*

*Don't forget we have lots of families for whom English is not their first language and they're not necessarily going to be able to understand what the text is saying so sometimes you have to break it down to very simple terms and sort of say to them – you are entitled for this, its going to be very good for your baby to receive this, very good for mum to receive these vitamins, if you fill in the application we will sign-it for you. (Midwife)*

There were reports of beneficiaries getting signed-up to the scheme and not receiving their vouchers, resulting in health professionals having to repeat the process of signing-off a Healthy Start application form:

*The difficulty is that when we do sign the application forms for families and send them off, we get people who keep repeat coming in because for some reason we could sign maybe four or five applications for one family and then they've missed out on 6 - 7 months of vouchers. So we don't understand why some people are getting them and some people aren't when the applications are the same and we always check the application forms. (Health Visitor)*

*This one woman I spoke to she sent off forms and didn't hear anything for ages and they had to fill them all in again. She must have been about, well it was her 28 week check-up and she still hadn't got anything. And this is a woman with an under 4 as well, so she should have been receiving for him too. (Family Support Worker)*

Accessing the vitamins was identified as a challenge to the scheme as they can only be distributed from NHS buildings, however this requires a member of administrative staff to be responsible for handling and banking cash, coupons and the vitamins.

*I think its confused and I think that the confusion is more about how parents can get the vitamins, because there was a time when you could come along and get your vitamins, but we didn't have the supply -- the stock, so it was about what other places where you could access them from – obviously we know how important vitamins are in terms of diet, nutrition, minerals etc. and we know that there are families who are needy who need to purchase them or to get hold of them. But we were asking them to travel quite long distances to get them, so having them all accessible in other places would be beneficial, and you would see your numbers rise from that. (Family Support Worker)*

The above quote also emphasises that the health professional relates the success of the scheme with vitamin take-up statistics – ‘you would see your numbers rise from that’.

There was some confusion over where the vitamin coupon is situated on the letter that contains the food vouchers. A few health professionals had not seen what the voucher letter looked like or knew that beneficiaries also received leaflets from the Department of Health with their vouchers:

*I think the most frustrating thing is turning families away, the most frustrating thing for us and saying we don't have any and we won't have any for a while and then sign-posting them to someone else that we thought had them but obviously they've run out so there's no communication really, so we sending families to another centre and they wouldn't have any so then they were having to go somewhere else...*

(Health Visitor)

The big challenge to promoting the scheme generally was the lack of knowledge about components of the scheme apart from vitamins, specifically the assumption that the support and delivery of food vouchers was being done by the Department of Health.

*I definitely see it as the vitamin part because that's what we're delivering, I just assume that they're getting the vouchers and using them for whatever they should be used for, so yeah... I've never really sat down with a family and said how are you using your vouchers and you know what are you doing with them? Its just never come-up, I mean they all say they use them, but I've never really checked out how they use them. (Family Support Worker)*

*I probably talk to parents more about their vitamins if they are getting their vouchers because generally if they are getting their vouchers they are getting their fruits, their veg and their milk. (Health Visitor)*

*So like the full food side of things, that's all managed by them (The Department of Health) (Public Health Strategist)*

*I don't know they may do this, we don't see the letter but perhaps giving out healthy recipes or how to make healthy meals on a budget, how to use your vouchers to get fruits and vegetables. Maybe something like that could go in with the letter so that parents are given an idea and not just sort of having to buy fruit or a bag of peas, you know doing something more creative maybe. (Community Nursery Nurse)*

When one health visitor was asked to clarify what she meant by 'voucher' her response was:

*Yeah, sorry I'm always going to go to vitamins because I don't think of the food. (Health Visitor)*

Different professionals had different understandings of the purpose of Healthy Start.

*So that families buy foods that are healthy but affordable because they've got the money off, rather than buying unhealthy foods that are cheaper. Obviously to encourage them to take milk for calcium, um so yeah – probably, really just to encourage a healthy diet and make that more possible by having money off healthy foods. (Community Nursery Nurse)*

*I would say it's there to, so the aim of the scheme is to improve the nutrition of mothers and families on low-income. But I would just say it is there as a help to support you with respect to fresh fruits and vegetables, milk, fresh milk and vitamins as well. (Midwife)*

*It's about health promotion, to be honest I don't really go into how nutrients work, you know vitamins A, B, C and the benefits, we sort of don't go into that at all – well I haven't. I don't think you really have the opportunity go to into it in depth. (Health Visitor)*

Within the workloads of the health professionals' minimal time was dedicated to Healthy Start inferring that there isn't time to have a supportive role beyond ensuring those that are eligible are signed-up to the scheme.

*It's a tiny piece of work and its usually done at booking, and that's an hour and half appointment already and Healthy Start, that's not included because you may not need to talk to somebody about that, so its not included per say in the timing of the interview. (Family Support Worker)*

Health professionals have indicated mixed experiences of the Healthy Start resources published by the Department of Health - some did not know certain pamphlets existed and suggested literature on specific aspects of the scheme would be useful. In fact pamphlets on the issues they were suggesting (using the vouchers, entitlement, etc.) do exist, however they were not being accessed by the health professionals in this case study.

The confusion experienced by Health Professionals trying to access Healthy Start resources from the Department of Health was demonstrated in the interview with an Infant Feeding Coordinator.

Figure 33 Accessing Healthy Start resources

During an interview with an Infant Feeding Coordinator, it became clear that she was unaware of a number of Healthy Start pamphlets that are published by the Department of Health. Specifically ‘the quick guide for under 18s’ and ‘the quick guide for first time mums’.

To try and order some copies to distribute to Health Visitors in the borough where she works, she logged onto the Department of Health ordering site ([http://www.orderline.dh.gov.uk/ecom\\_dh/public/home.jsf](http://www.orderline.dh.gov.uk/ecom_dh/public/home.jsf)), where publications can be searched for and ordered by health professionals to support the delivery of various public health initiatives and campaigns. The search term ‘Healthy Start’ was entered and a handful of publications were returned, however the publications she was looking for did not come up. She went onto the Healthy Start website and looked at the resources page (<http://www.healthystart.nhs.uk/for-health-professionals/healthy-start-resources/>) and saw the publications she was trying to find. She clicked on the link to order publications and it took her back to the Department of Health publication search page –where she began, however this time she knew the publication number as she had seen it on the Healthy Start website. She entered the publication number into the search field and the publication she was looking for was found. When she tried to order it, a message popped-up stating she had reached her monthly limit for ordering publications and that her ordering limit was zero. She called the number on the page to speak with someone at the Department of Health. The DH informed her that she could only order 40 of the pamphlets. The Infant Feeding Coordinator commented that she was ordering to distribute to all of the Health Visitors within a borough that has over 3000 births a year and that there would be little point in only ordering 40 pamphlets. The Department of Health informed the Infant Feeding Coordinator that an order of more than 40 pamphlets would need to be approved by the head of the ordering department and that a reason for ordering more than 40 would need to be supplied.

The reason she did not know about the pamphlets to begin with is that they did not return on the original search on the Department of Health Order line when using the term Healthy Start. She had assumed that all the relevant material for Healthy Start would be held in the Order line database, however it became clear that some material was only available if the publication code was entered into the search. Thus if Health Professionals are of the understanding that you can find out what literature is available by searching Healthy Start on Order line, they are in fact not learning about all the information that is available.



## 8.2 Summary of Case Study

The case study differs from the research undertaken with Health Professionals in the 2013 evaluations (Lucas et al. 2013 and McFadden et al. 2013), as the case study findings illustrate the tension between practitioners within a local area and the Department of Health. Given that the evaluations were undertaken for the Department of Health, the evaluators may have been restricted in their capacity to pursue this line of inquiry. Additionally, the design of the case study allowed for specific issues that emerged from the initial policy analysis to be pursued, such as the perceived rationale for the shift from the Welfare Food Scheme.

This case study indicated that the Healthy Start scheme in its entirety is not acknowledged within this local area. Rather the local area services take responsibility for delivering the vitamin component of the scheme and there is a general assumption that the Healthy Start food voucher component of the scheme is delivered by the Department of Health. The lack of knowledge on the food aspect of the scheme and the lack of support beneficiaries reported receiving in recent evaluations suggests that Healthy Start is compartmentalised in practice. In compartmentalising, it detracts from the overall point of the scheme, making it unclear to health professionals and potentially resulting in confused and mixed messages in delivery. What remains unknown at this stage, is whether or not the Department of Health have the same understanding of the role and responsibility of the local area. It is clear that within this case study, the original intention for the role of the health professional for delivering Healthy Start, has not been realised. There were no reports of Healthy Start specific training, thus indicating a tension between the original intent of the Health Professionals' role within the scheme indicated by the policy literature (Department of Health 2002, 2003, 2004), and the reality of how the scheme operates in practice.

It is unclear how the Department of Health would know that there were issues regarding the experience of the health professional in delivering Healthy Start as statistically the scheme appears to be working as the take-up statistics are above the national average (Department of Health 2011). However the case study findings indicate that there are issues and tensions which may prevent the scheme from being

successful in its entirety. These issues are explored further in the following discussion chapter.

## Chapter 9: Discussion

*Policy change at the top will not necessarily translate into change at the bottom. (Cairney 2012 p.37)*

### 9.0 Introduction

The objectives of this thesis were to consider the initiation, formation and implementation of Healthy Start and how Healthy Start as policy relates to Healthy Start in practice. By undertaking original research, combining historical research, qualitative research and policy analysis, new information on an unexplored topic in food policy has been developed. This chapter synthesises the research findings (chapters 6, 7 and 8), literature reviews (chapters 3 and 4), policy context and background information (chapters 1 and 2) and discusses the relationships and tensions that have emerged.

The chapter begins by discussing the initiation of Healthy Start, this is followed by discussion of the formation and implementation of the scheme.

### 9.1 Initiation – catalysts in the policy process

The policy streams analysis of Healthy Start policy documents in chapter 6, indicated that ‘timing’ was an important factor in the initiation of Healthy Start – the political climate was ready, there was evidence that the Welfare Food Scheme could be improved and there was new evidence on the importance of diet and nutrition. This section triangulates the policy streams analysis with the literature review and findings from interviews with policy participants to fully consider the influences on the shift from Welfare Food Scheme to Healthy Start. In addition, influences on how problems with the Welfare Food Scheme were interpreted and influenced the problems Healthy Start aimed to address are also considered in this section.

Initial background and historical document review in this thesis, demonstrated the importance of the COMA review (2002) – it was the first report that considered the Welfare Food Scheme since its inception in 1940. The review of historical documents indicates that although the COMA review (2002) presented valuable

context, there is still a dearth of research on the Welfare Food Scheme and it is striking that the scheme was unevaluated. COMA acknowledged the lack of research and emphasised the need for more research in the recommendations. The main role of COMA was to ascertain whether or not the Welfare Food Scheme was addressing the needs of beneficiaries, and whether there was scientific need for the Welfare Food Scheme. However as this happened alongside other developments in the policy context (outlined in chapter 1), the needs of beneficiaries were also changing in the eyes of policy makers, for example, the 5-A-Day agenda.

The research in this thesis indicates that little research was undertaken to follow-up on the 2002 COMA recommendations. As the semi-structured interviews with policy participants emphasise, the government was not tied in any way to do what COMA recommended. Thus, the initiation of Healthy Start was limited to the context presented by COMA (2002), which COMA acknowledged was not sufficient. Thus although the COMA review arguably initiated reform of the Welfare Food Scheme, the report emphasised the ‘uncertainty’ around the impacts of the Welfare Food Scheme. However, the interviews with policy participants show that the level of uncertainty was not acknowledged, or deemed a problem in itself. Literature on forming policy suggests ‘good policy making’ draws on evidence (Cairney 2012). There is little evidence from the findings that suggests available information or expertise was consulted and acted upon. Although little research existed on the Welfare Food Scheme, there is a literature on the issues that are interlinked with food welfare for women and children – these are outlined in the literature review (chapter 3). The literature stresses the multifaceted nature of improving nutrition and behaviour and consideration of this literature would have enabled policy makers to connect a theoretical policy idea with demonstrated realities.

The role of the COMA review and the role of COMA in general was to advise policy makers by drawing on existing scientific evidence. This did not necessarily provide the scope that is necessary to address a social welfare policy. As welfare food as a policy area cross-cuts both public health and social welfare, the COMA review does not provide the scope for the ‘social’ aspect of welfare foods. Thus, the review was of the Welfare Food Scheme as a targeted public health intervention, not as a welfare benefit. Additionally, findings from the semi-structured interviews with policy

participants indicated concern over the Department of Health's ability to translate scientific evidence into social policy. Specifically, the Social Policy Manager from the Maternity Alliance, Evaluator from the Tavistock Institute and the Dietitian seconded to the Department of Health all voiced concern that the 'science was lost' on the Civil Servants driving the policy. The translation of scientific evidence into policy recommendations may have been different if Healthy Start was only a health policy. Additionally, if the review of the Welfare Food Scheme had been undertaken by SACN, as opposed to COMA, there may have been more practical considerations within the suggestions for reforming Healthy Start (See section 6. 1.1). As Healthy Start traverses health and welfare policy areas, the demand for civil servants in the Department of Health to understand both health policy and social policy were additionally complicated.

The number of problems presented in the policy streams analysis in chapter 6, reflect Kingdon's (2003) assertion that policy ideas are rarely clear-cut. The semi-structured interview findings reflect another of Kingdon's ideas - that policy officials tend to focus on a singular issue and that defining a policy problem is interpretive. Thus, despite there being many issues with the Welfare Food Scheme, it is likely that the primary issue was simply in replacing it. The details on exactly how this would be done to address the broader social and public health concerns raised in Acheson (Acheson) were secondary to that.

In considering the influence of the COMA review in light of the semi-structured interview findings with policy participants, it appears that the issue interpreted as being the most pressing, and justifying a need to change the Welfare Food Scheme was the fact that the government was providing women with the means to purchase more infant formula than cows' milk, thus going against the recommendation from the government that breastfeeding is always preferable. In both the interviews with health professionals and the interviews with policy participants, interviewees heavily focussed on the idea that the Welfare Food Scheme had to end due to the biased promotion of infant formula feeding over breastfeeding.

As the lack of literature on the Welfare Food Scheme in chapter 3 and the interview findings from health professionals in chapter 8 indicate, although there was little concrete evidence on the impact of the Welfare Food Scheme, there was concrete

understanding that the scheme was politically unpopular because of the incentivising of infant formula feeding. Kingdon (2003) talks of the ‘great political stakes in problem definition’ meaning when policy is initiated, the problem defined may be more likely to become policy if there is a political imperative as well as a social one. Thus, the findings suggest that the imperative was on *not* having the Welfare Food Scheme and a new health focussed scheme needed to be created to positively correct the mistakes of the Welfare Food Scheme and address the issues that were becoming prominent in both health and social policy, namely, inequalities and a focus on the early years (Pugh, Pugh and Duffy 2006, Acheson 1998).

From synthesising analysis of the COMA review with policy participant interview findings, it appears that much of the reason for shifting welfare foods into public health, was to rebrand, or reframe, what was considered an archaic scheme that was tied to benefits into something that was focused on health. The policy streams analysis in chapter 6 highlights how the policy context of the time was very much focussed on addressing inequalities through health based programming. Other issues that were presented in the COMA review did not appear to be as pressing to the policy participants interviewed or the health professionals interviewed in the case study. In an interview with a dietitian who was seconded to the Department of Health to advise on the rollout of Healthy Start, the interviewee emphasised that the COMA review was just guidance, and that policy makers could pick and choose which recommendations they wanted to address, again emphasising the interpretive nature of policy making in the initiation phase of the process. Additionally, this also raises issues regarding the role of COMA and the role of evidence that was presented to the Department of Health throughout the policy process. Evidence on the scientific basis for welfare food programming was presented, yet there was little evidence collected on the social components.

There is a tension between the types of problems that may have initiated reform of the Welfare Food Scheme. There was the problem with the actual scheme itself, as outlined above, and this could be defined as both a social problem potentially preventing women from breastfeeding, and a political problem, potentially embarrassing the government. There is also the social problem that the Welfare Food Scheme aimed to address, and a reform would continue to address, in terms of

providing a nutritional safety net to ensure vulnerable women and children had adequate nutrition. The concept of a nutritional safety net is not clearly defined and as the review of historical documents in chapter 3 indicates, had been changing over the sixty year period, prior. There is a lack of clear definition of the ‘nutritional safety net’ across food welfare and a review of the recent evaluations of Healthy Start demonstrated this concern. The concept is complicated, and Dowler (2008) suggests that complex issues within food policy often get generalised by policy makers. The historical overview of the Welfare Food Scheme in chapter 3 illustrates how at times the nutritional safety net was targeted to specific populations, and at times it took a population approach, – intervening to ensure that ‘the average health of the population’ was satisfactory. Thus, although not defined explicitly, the findings indicate that the concept of a nutritional safety net was somewhat fluid, and shifted throughout the 20<sup>th</sup> century.

In the initiation phase of the policy process for Healthy Start, interviews with policy participants indicate that there was the general problem of low-income groups having a poor diet and the specific issue that the Welfare Food Scheme had been promoting formula feeding. In the initiation, an interview with a civil servant indicates that it was clear early on that a policy response would need to promote and support breastfeeding, and continue to provide a nutritional safety net, which as a concept, remained undefined. This could be suggested as meaning that the risk of low income families using a less safe alternative to formula milk if they chose not to breastfeed could not be taken.

In reflecting on how Kingdon (2003) depicts the policy process, with three streams converging to create a window in which a new policy can be made, in the instance of Healthy Start, it appears that within the streams there are multiple sub-streams. This is clear in the consideration of the policy stream specifically as multiple problems were identified.

#### *Linking with other agendas*

The policy context in which the COMA review was published indicates that food, health and early years were growing policy areas under the New Labour Government. From the interviews with policy participants, it became clear that reforming the Welfare Food Scheme was an opportunity to create a policy that integrated a number

of growing agendas into one programme/scheme. Thus, initiating a reform of the Welfare Food Scheme was timely as the policy streams analysis in chapter 6 indicated the political climate was ripe. Although, there is evidence to suggest reform of the Welfare Food Scheme would create a scheme that responds to other agendas, there is little evidence that suggests how the reform would benefit women and children and respond to the nutritional and practical needs to supplement nutrition. The literature review highlights how providing social policy that responds to the needs of low-income populations is complex and often the complexity of issues become generalised (Dowler 2008). The findings, reflect aspects of Exworthy and Hunter's (2007) argument that although New Labour promoted the concept of 'joined-up government' to address health inequalities, the reality is that this rarely happened successfully as integrating aspects of government is complicated. The lack of involvement from the Department of Work and Pensions in the initiation, formation and implementation of Healthy Start, is an illustration of the lack of joined-up governance.

More robust consultation with eligible families, and consideration of the existing literature that describes the barriers and enablers of some low-income families from accessing an adequate diet could have helped policy makers understand whether or not the decisions made in the reform were in the best interest of the beneficiaries.

#### *Interpretation of the problems with the Welfare Food Scheme and the problems facing low-income families*

From the policy participant interviews, the findings suggest that problems that initiated the reform of the Welfare Food Scheme were primarily the issues with the Welfare Food Scheme and secondly the social and public health issues which were being discussed in reports such as Acheson's (1998). Thus, from the beginning there is a sense that policy participants recognised that there was evidence that adequate diet throughout pregnancy, while breastfeeding and in the early years, could have long term impact on health but there appeared little consideration of how to address this issue practically.

Thus in the initiation stage there is an argument or interpretation of/from the data that the reform of the Welfare Food Scheme was based on creating a new scheme that would be health focussed and connected with other agendas that were prominent to



the New Labour government of the time. What this scenario neglects is how a new scheme would provide and respond to the needs of low-income women with young children. Thus from an early stage in the policy process, the role of the beneficiary feeding-into the policy design appeared lacking.

It is interesting that within the problem stream, there is no evidence of policy participants recognising issues with the source of the ‘problem’, namely the quality of data in the 2002 COMA review. Analysis of the COMA review (2002) in chapter 6 indicates that much of the data is based on proxies, yet this was not recognised as an issue by the wider policy community. Analysis of the COMA review (2002) reflects the findings in the historical research that there is a dearth of research on the Welfare Food Scheme.

#### *Welfare food scheme not well defined*

The historical overview highlights how the issues that the Welfare Food Scheme addressed changed throughout the 20<sup>th</sup> Century and indicated that there is a sense that food welfare became a malleable policy over time, possibly due to the ambiguity around its aims and objectives. As a policy area, domestic food welfare has shifted focus, beneficiaries, government departments, eligibility and content. It is therefore understandable that as a policy area, food welfare is poorly defined and the foundations of food welfare appear somewhat shaky. Yet, the findings from interviews with policy participants signify that the fluid history of the welfare food scheme is not recognised. The loose definition of Healthy Start indicated in the semi-structured interviews with both Health Professionals and policy participants, could also be related to the inconstant history of food welfare, as the policy objective has changed throughout the history, and was not clearly redefined in the last version of the scheme. Although the scheme proved challenging to define, it has not prevented people from discussing it, in ways that are beneficial to their cause, reflecting the concept that uncertain policies are open to manipulation (Cairney 2012). The ambiguity around the definitive purpose of the Welfare Food Scheme makes it a policy area that had the potential to cross-cut other agendas and issues.

Some agendas were mentioned in the initiation of Healthy Start, but were then silent through the other phases of the policy process. For example, ‘obesity’ was originally stated as something that Healthy Start would address, but this was rarely mentioned

as the process went on. This further supports the argument that in the initiation phase a range of policy outcomes are often presented, but not necessarily followed through. There is a sense from the initiation that the objective was to create an attractive ‘policy package’ and the dominance of obesity within discussions of public health at the time, indicates why it was included in the initiation phase.

The initiation of Healthy Start, or any policy, requires a policy issue to be brought to the attention of those in charge of making policy (Kingdon 2003, Majone 1989). Cairney (2012) suggests that policy problems tend to either have ‘uncertainty’, meaning not enough information or evidence to clearly define the problem, or ‘ambiguity’, meaning there is enough information on a problem, but the problem itself can be manipulated to fit the specific objectives of a policy participants.

Despite the lack of research into the Welfare Food Scheme beyond the COMA review (2002), the findings in chapter 7 indicate that policy participants spoke very highly of the importance of the Welfare Food Scheme and took pride that this was a scheme that had emerged in Wartime Britain, seemingly heightening its social value because of its long existence. Returning to the broader discussion of why governments provide welfare food (chapter 1) from synthesising research findings with the policy context there is little sense that welfare food provision is being driven by strategy as Churchill supposed, or ideology as Deakin (1994) suggests. Instead it was a continuation of what had already been done, but with a new focus and shift toward ‘health promotion’ as opposed to benefits and welfare.

The concept of the nutritional safety net at this stage of the policy process, appeared to be focussed on a targeted population and preventing those who were deemed ‘vulnerable’ or ‘at risk’ from nutrient insufficiencies. The concept of the nutritional safety net is developed throughout this chapter.

The implications of food welfare shifting toward health, are discussed in the formation and implementation section of this chapter.

## 9.2 Formation – Solutions chasing problems

The ‘formation’ phase is often described as the most crucial phase in the policy process as it is this phase where theoretically decisions are made that can determine whether a policy will succeed or fail (Heywood 2000). The findings chapters

illustrate the range of issues that were considered. When the findings are synthesised with the literature review, the range of issues that were not considered in the formation also become clear. This section will discuss the influencing factors on the formation of Healthy Start, these include:

- The range of views from policy participants
- The appeal of budget efficiency
- The constraints of models of best practice for policy making
- The lack of behaviour change considerations
- Influence of ‘choice’ agendas
- Influence of the dairy industry
- Implications of straddling health and welfare policy areas

To look at policy formation, or the development of a policy, Kingdon (2003) suggests that it is important to look toward the policy community as there are often a range of solutions to problems floating around in what is described as a ‘policy primeval soup’. This suggests that solutions to problems evolve and percolate, floating around until a policy window opens, when policy, politics and problem streams converge. The interviews with policy participants and analysis of policy documents (chapter 7) emphasise the range of issues and responses from different policy participants, and how in the formation phase of the policy process, this was politically positive.

From analysing the interviews with different policy participants and data from the Maternity Alliance conference that discussed what a new Welfare Food Scheme could look like, it is clear that the problems with the Welfare Food Scheme were interpreted widely depending on the context from which the policy participant was coming from. For example, the infant formula promotion was a significant issue for breastfeeding advocates, and some suggested removing infant formula from the scheme completely. The administrative issues with the Welfare Food Scheme were key problems for representatives from the Citizens Advice Bureau, and concerns over human rights were concerns for the Maternity Alliance. Thus, after different views were brought forward, the Department of Health then had the challenge of synthesising all the issues and proposed solutions into the proposal for Healthy Start (Department of Health 2002).

Within food policy, often making a unified policy response is challenging (Lang, Barling and Caraher 2009, Lang, Heasman 2004). This is exemplified in the proposal for Healthy Start in which it was suggested that Healthy Start would address issues ranging from inequalities, obesity, farming, low breast feeding rates and 5-A-Day. From looking at the policy participants it is clear that these are agendas that were presented by specific interest groups (see Table 17 in chapter 7). Despite, the solutions being wide-ranging and not having a clear singular policy objective, the benefit, Cairney (2012) would argue, is that support for the proposal was broad across the policy community and different members of the policy community engaged with the issues that affected them. Having the support of a policy community is a feature of successful policy making as defined by Cairney (2012). Thus, in the formation phase of Healthy Start, demonstrating support and gaining support was politically important and perhaps explains why issues such as obesity were prominent in the proposal and initiation of phase of Healthy Start, then faded in prominence throughout the subsequent phases of the policy process.

This does indicate a tension as the proposal could be interpreted as being more about rallying support from key stakeholders in food welfare, as opposed to proposing a practical policy solution. The proposal for Healthy Start could be explained by drawing on Kingdon's thesis (2003) that policy proposals are a theoretical starting point. Although this may be true as evidenced through the broadness of objectives, from interviews with policy participants it was clear that the proposal was not theoretical, but the intended policy solution to problems they had identified with the Welfare Food Scheme. Throughout this phase of the policy process the analysis of policy documents in chapter 6 and interviews with health professionals in chapter 8 indicate that practical and logistical views of health professionals such as midwives and health visitors, who would be responsible for operating the scheme, were not fully considered in the proposal. However, health professionals still supported the reform of the Welfare Food Scheme as a theoretical idea.

Based on triangulating the findings, policy streams analysis and theoretical literature, another influencing factor on the success of Healthy Start being formed, was the proposed 'efficiency' of the scheme. Kingdon (2003) dedicated a large section of his text to the role of budget as an influence in policy formation, stating:

Budgetary considerations prevent policy makers and those close to them from seriously contemplating some alternatives, initiatives, or proposals. Kingdon p.106.

Kingdon (2003) suggests that attractive budgets may be influential in turning a policy idea into a reality. The fact that the budget for Healthy Start was to stay the same as the budget for the Welfare Food Scheme, was attractive to policy makers. The proposal suggested that they could ‘do more’, without spending more (Department of Health 2002) but did not explain how. Thus, from synthesising Kingdon’s consideration of budget with the findings in chapters 6 and 7, it is clear that this proposed ‘efficiency’ was an influential factor.

Budget efficiency also provided a tension however, and one of the few academic articles on Healthy Start warned that without significant budgetary increases, Healthy Start would not be able to fulfil its remit. The proposal for Healthy Start was a far more ambitious programme than the Welfare Food Scheme, but no analysis of potential costs appeared to have been undertaken. This concern was also raised in parliamentary debates as outlined in chapter 8. Yet, the interview with a Department of Health Civil Servant clearly indicates that budget was never going to change and that ‘budget efficiency’ was a focal point of Healthy Start. Thus, the two-edged sword of an efficient budget, described by Kingdon was realised i.e. it appears that the efficient budget prevented other policy options from being considered. This is problematic when the complexity of public health and diet illustrated in the literature review is contemplated.

It could be argued that the public health potential of Healthy Start was undermined by budget constraints, and that the proposal was in fact a new scheme with features which had not previously existed in the Welfare Food Scheme, such as information and support for individuals regarding diet and nutrition. Civil Servants ‘believed’ that all the proposed features of the new scheme could be achieved but were not required to explain how.

This could be seen as undermining the intricacy of behaviour change and public health. Thus Cairney’s (2012) third out of seven factors of good policy making is not fulfilled as many policy participants would argue, that the resource allocated was not sufficient to respond to the social problems associated with poorer maternal, infant

and early years nutrition among low-income populations. The literature review of Healthy Start specific literature clearly highlights that concerns were raised that without more financial resource a new scheme would be limited.

The findings presented in chapter 8 indicate that the policy process was largely dominated by the pressures that comprise the political stream. This reflects the dominant influence of political pressures in the policy process, above policy or problem. Interviews with other policy participants indicated that the fact that the budget was non-negotiable was seen to undermine the social value of providing a nutritional safety net. The rigidity of the budget suggests that it was less of a reform in the sense that it was looking for a new way to address a public health problem, rather the task was to address a problem with the way the Welfare Food Scheme was being perceived as a scheme that promoted formula feeding over breastfeeding, within a set budget and timeframe. The concept of 'reframing' the issues emerges again.

The process of forming Healthy Start is at odds with some of the concepts presented by Kingdon (2003). Kingdon suggests that a policy proposal survives and prospers if it is technically feasible, acceptable within the policy community, has tolerable anticipated costs and is acceptable to the public. In these circumstances there is a reasonable chance elected officials will support it. In synthesising Kingdon's theoretical reasons why ideas become policies with the research findings of this thesis, it is apparent that the five reasons do not take into account the context and any preferential weighting. For example, the findings indicate that forming a cost neutral policy was central to the formation of Healthy Start, thus the costs are tolerable from the start. However, there is little evidence on the 'technical feasibility' of Healthy Start being put to the test and, there are many technical questions which remained unanswered. Yet, this did not appear to be problematic to the forming of policy in this case, suggesting, that in the policy process more importance, or weight, was given to forming a policy that was within budget as opposed to being technically sound. Thus, it appears that the policy idea for Healthy Start, survived despite that fact it doesn't reflect Kingdon's criteria. The implementation section in this chapter further discusses the practical issues that were lacking in the policy formation.

The literature review surmised that policies are often presented as theoretical concepts, and the reality of the scenarios are not always fully considered, especially when the realities are complex. Within food policy, Dowler (2008) suggests that complex issues are often ‘generalised’, which can prevent an effective policy response from being reached.

As well as budget efficiency, the research findings indicate that policy expediency was also influential in the formation of Healthy Start. Cairney states that ‘policy solutions take time to develop and refine’ (p.234). The findings from interviews with policy participants indicate that there appeared to be an influential time pressure in the formation of Healthy Start. Thus, there is a clear tension between the notion that good policy solutions take time to develop and form, and the manner in which Healthy Start was developed. Some policy participants suggested in interviews that there wasn’t enough time to ‘do things properly’ and a number of the policy participant semi-structured interviews, essentially suggest that much of policy making is a ‘box ticking exercise’, without ‘quality control’.

The process of forming Healthy Start clearly followed the model of best practice for policy making laid out by the New Labour government of the time (Bullock, Mountford and Stanley 2001), however the emphasis on following the best practice appears to have constrained the consideration of evidence and expertise. The semi-structured interviews indicate that the Civil Servants at the Department of Health who were responsible for driving Healthy Start, had little insight into the public health and practical considerations for Healthy Start. A dietitian who was seconded to assist with the formation of Healthy Start, mentioned multiple times how the Civil Servants working on this policy were driven by getting the job done, not necessarily getting the job done effectively. This interview highlighted a number of tensions between the Department of Health and other policy participants who felt the Department of Health were not equipped to create policy that addresses such multifaceted issues as behaviour change among low-income women.

Different policy participants enter the policy process with different objectives, depending on their own backgrounds, context and goals. The unified food policy response that is understood as necessary to make ‘good’ food policy is challenged in reality by the different objectives, or vested interests, of policy participants.

The reality is that making good policy that responds to a complex set of social issues is resource intensive and to a certain degree, bespoke. Not knowing how long a process might take clashes with the model of best practice in policy making. Does this suggest that the best practice was in-fact wrong or does it suggest that best practice trumps quality control? The parliamentary system is supposed to act as quality control for policy making, and indeed many concerns were raised as evidenced in the findings from parliamentary debates in chapter 8. However it assumed the policy process leading up to the point of parliamentary debate has been conducted robustly. Thus an emerging consideration is that the model for best practice for policy making may not have been sufficient for a policy that has objectives as ambitious as Healthy Start.

In addition to the range of social issues Healthy Start addresses, the fact that the policy area cross-cut both health and welfare added complexity, despite the formation being primarily driven by the Department of Health. Issues that were brought-up in the literature review illustrate how there were concerns regarding the administration of the Welfare Food Scheme (Belton 2005; Mynard 2006) and it was unclear how these administrative issues would be addressed in moving the scheme to the Department of Health. There is little evidence that the Department of Health interacted extensively with the Department of Work and Pensions throughout the policy process. Concerns were raised in the semi-structured interview process regarding the knowledge Civil Servants had of the welfare system, emphasising a lack of joined-up Government in practice.

From considering the initial overview of Healthy Start in chapter 1, and the findings from policy participant interviews, an additional challenge of forming Healthy Start was the differing needs of beneficiaries. Elements of Lister's (2006) argument outlined in the policy context (chapter 1), that New Labour did not fully consider the needs of mothers, and prioritised investment in young children, are reflected in the findings. The fact that in the formation of Healthy Start, it was not considered problematic that women would not be able to access Healthy Start vitamins until after their first trimester, the stage in their pregnancy which is most crucial to foetal development, reflects a lack of regard for the needs of the mother. It could also be argued that concern over giving women benefits too early in a pregnancy, to which



they might not be entitled should the pregnancy not advance, puts concern over eligibility criteria before public health objectives.

Healthy Start addresses a wide range of issues: nutrition and diet in pregnancy, nutrition and diet while breastfeeding, infant feeding, complementary feeding and early years diet and nutrition. Each of these areas differs and this highlights the scale of policy ambition which may not have been fully understood by civil servants..

Cairney's (2012) seventh and final feature of good policy making - *Conditions beyond the control of policymakers do not significantly undermine the process*, is not realised in Healthy Start. The positioning of Healthy Start as both welfare and public health leaves it vulnerable to external changes to the welfare system, and the NHS, both of which are beyond the control of the policy makers that influence Healthy Start.

Throughout the process of undertaking the research for this thesis, external debates on the future of welfare and government responses to food insecurity have been prominent in the British media. The number of people using food banks is on the rise, and although the reasoning behind this phenomenon is debated it has brought food insecurity into the realm of public interest. Thus the role of government in ensuring people have access to an adequate diet has been under scrutiny and attention has been drawn to how governments support people who cannot access an adequate diet. Interestingly Healthy Start has not been addressed throughout these debates in parliament or in the media

A justification for moving to the Department of Health according to the findings of policy participant interviews, was that the new scheme wanted to engage more with other agendas of the time that were focussed on healthy eating and encouraging dietary behaviour change.

During the policy formation phase, Healthy Start was envisioned as having a two part remit: to provide dietary supplementation and to provide information and support for women and families to help them 'change their behaviour'. 'Behaviour change' was new terrain for food welfare, making Healthy Start more than just a hand-out in the form of food, but essentially a health intervention. Although, the term

intervention is not used to describe Healthy Start the descriptions of the scheme from interview participants outline what could be described as a public health intervention.

Aspects of the literature review contextualise the considerations that would have needed to take place in order for the complicated task of designing and implementing an intervention. Four key components to a successful health intervention are presented in the literature review and it is suggested they should include: an educational component, continued support, peer support and family involvement (Baird et al. 2009). An educational component was proposed as part of Healthy Start as the new scheme required the signature of a health professional and this was a manufactured opportunity for the health professional to discuss diet and health with a mother or family. It was also suggested that Healthy Start could link-up with other local health promoting activities. The policy context in chapter one, and tables 4 and 5 in chapter 2, indicate the range of investment and initiatives occurring on a local level. This again emphasises how the policy itself is theoretical, with the findings from interviews with policy participants and health professionals emphasising that the proposal for Healthy Start was about behaviour change despite the fact that there was little realism about how behaviour change intervention would be implemented or supported. .

Throughout the formation of Healthy Start, the findings indicate a tension between combining upstream and downstream interventions. This was an important feature of Healthy Start as it differentiated it from the Welfare Food Scheme. As the literature review indicated there are parallels between upstream and downstream interventions and combining direct or indirect benefits. Leat (1998) categorises government food interventions as either direct or indirect. The proposed Healthy Start scheme would be classified as both a direct and indirect formal state intervention as beneficiaries are entitled to a voucher from the government to spend on specific types of foods and milk, however the educational component proposed indicates an indirect benefit. However when the reality of practice is considered, drawing on the research findings and recent evaluations, there is little evidence of the downstream intervention being implemented.

Findings suggest that the role of the health professional was not practically considered in the formation phase of Healthy Start and this has been the main reason

that the health promotion part of the scheme has not been fulfilled. Despite policy participants clarity that health professionals were unlikely to have the time to do everything that the policy was asking of them, this aspect of the policy was not changed. Training for health professionals had been commissioned as part of the implementation phase, but not rolled-out for reasons that are not clear but may well have been budgetary. Questions therefore arise about the intentions for Healthy Start to be about behaviour change, or whether, as the interview with the Civil Servant demonstrated there was a general emphasis on linking with other food agendas at the time that were focussed on behaviour change.

Throughout the policy process, expert advice was provided about resources that would be necessary to enable behaviour change to be a central component of Healthy Start. As the interview findings indicate, the evaluators, nutritionists responsible for training health professionals and the wider policy community all voiced their concern that without resources Healthy Start would not change behaviour. Changing behaviour is a resource-intensive, multifaceted undertaking. In the initiation phase, the COMA review looked towards the US at an example of a welfare food scheme for women, infants and children (WIC) that was seeing demonstrable impact (COMA 2002). Key to models of behaviour change is education and information. The WIC model shows that education and information are most effective when built into the policy and are a mandated component of programme delivery. In Healthy Start, the information education component is more of a suggestion or recommendation with regards to delivery, and there are no formal structures for ensuring it occurs or for monitoring if it has occurred.

It is highly likely that the WIC model was influential to the formation of Healthy Start, however the contextual and structural differences meant that the reasons why WIC is generally considered to be a success are not transferable to the UK context. For example, as the literature review indicated, the WIC model is routed in three key objectives: to increase breastfeeding, reduce the number of low birth weight babies and educate families about the importance of a healthy diet, facilitating skill development. Theories of policy transfer (Dolowitz, Greenwold and Marsh 1999, Dolowitz, Marsh 2000b) present a clear framework that explains why policies cannot transfer seamlessly from one country to another.

Despite this, from considering the literature on WIC, there do appear to be practical lessons from WIC that could have enabled the behaviour change component of Healthy Start to be considered in more practical terms in the formation period. For example, it is arguable that the success in WIC is a result of the clear objectives of the scheme, routine monitoring and data collection and emphasis on support for the beneficiary. It is understood in WIC that behaviour change will not happen without an educational component, hence WIC parents are required to attend nutritional counselling or some form of education, depending on their individual needs. This is clearly a more resource intensive scheme as the cost comparison in chapter 3 indicates, however the processes and considerations of behaviour change models could have been more thoroughly considered in the formation of Healthy Start.

In addition, a distinguishing feature of Healthy Start is the element of choice: a family must choose how to spend their Healthy Start food voucher. This further reflects the argument from Lister (2006) that families were being made responsible for the success of government investment in the Early Years, without receiving adequate support or any acknowledgment of the structural components of poverty. Throughout the policy process this was a point of contention as some felt that making a family choose between fruits, vegetables, milk and infant formula was unfair. This concern was a prominent feature of the parliamentary debates. Dowler emphasises that within food policies, the complexity of 'choice' is often overlooked and undermined. As there is little evidence of prior research being considered in the policy process of Healthy Start, it is likely that Dowlers' (2011) assertions were realised in the forming of Healthy Start. On the other hand, research findings show that advocates for reforming the Welfare Food Scheme such as the Maternity Alliance, were opposed to the idea of having a prescribed food voucher, like the WIC model in the US, as it was seen to impinge on human rights, thus choice became contested terrain.

Including 'choice' as a component without providing support for making choices, reflects the prominent NHS/Department of Health agenda for individuals taking responsibility for their own health. This clashes with the concept of 'welfare' in which governments provide support for vulnerable people. The challenge of Healthy Start, straddling both welfare and health, becomes very apparent when the concept of

‘choice’ is considered. Food choice literature describes the range of factors that influence what people decide to choose. For example: social pressures, social importance of certain foods, cultural influences, family eating patterns, family commitments, habit, health beliefs and environment (Davies, Damani and Margetts 2009 p.211). If the objective of Healthy Start is to influence behaviour change through empowering people to choose specific foods, consideration of the above list would have been valuable.

Literature on food access also suggests some low-income consumers need to have a combined approach to influence purchasing and consumption habits. This means, in order for people to purchase fruits and vegetables a number of considerations are needed. Numerous studies indicate that more than financial access is necessary to influence behaviour change. For example McEntee (2008) suggests that in order for an adequate diet to be accessed, people need: to want to eat a healthy diet (and thus some education on why this is important), the means to buy an adequate diet and the physical access to shops where you can buy healthy food. Additionally, some argue that cooking skills are also components of food access. The relevance of this in discussing the formation of Healthy Start, is that the only type of access that the scheme provides is financial, which arguably is not enough to change behaviour.

The evidence on how the issue of choice plays out in practice is mixed. The 2010 infant feeding survey suggests Healthy Start vouchers are primarily exchanged for infant formula. However, as indicated in Chapter 2, this is based on a sample of Healthy Start beneficiaries with children aged 4 months – 18 months. The other limited data that exists on how families use their Healthy Start vouchers is to choose fruits and vegetables that they wouldn’t otherwise purchase because they are expensive, such as strawberries and grapes (McFadden et al. 2013). Although it is positive that families are broadening the foods they taste, it is unclear how this relates to the purpose of Healthy Start, or indeed how it will encourage behaviour change. The findings of the interviews and the recent evaluation data leads to the question – what did the policy makers expect families to do with Healthy Start vouchers?

In a semi-structured interview, the Department of Health Civil Servant said the reason for ‘choice’ being a central component of Healthy Start, was that prescribing specific foods as in the WIC model would be too resource intensive, and it aligned with the

other ‘choice’ agendas of the time. Thus the decision making behind introducing choice appears to have been influenced by political factors rather than the necessary considerations of evidence and models of behaviour change. This concurs with one of Kingdon’s (2003) five reasons policy ideas thrive – because it was politically appealing. Many of the policy actors interviewed also suggested that the Department of Health simply did not have the necessary background and knowledge to be able to form and implement an effective Healthy Start programme that incorporated a behaviour change component. From considering the research findings in light of both the theoretical and topical literature, there remains uncertainty over whether the influence on addressing behaviour change through reforming the Welfare Food Scheme was politics or public health.

An implication of ‘choice’ being a central feature of interventions is that the responsibility for demonstrating behaviour change is clearly on the individual. This increases the potential for blaming the individual if behaviour does not change or if behaviour is perceived to be unhealthy (Crawford 1977). In chapter 1, a newspaper article defined Healthy Start as a scheme that could easily be taken advantage, suggesting that low income families were ‘feckless’ in their decision making. The article did not pursue a line of inquiry which questioned how and why retailers were letting women exchange vouchers for anything other than fruit, vegetables, milk or infant formula or why, despite Healthy Start trying to influence behaviour, this behaviour had been observed. The article demonised beneficiaries, as has been the case with other welfare benefits, where ‘victim blaming’ has not considered the wider context of why a family is in the position of needing welfare support.

COMA (2002) originally recommended widening the nutritional basis of the Welfare Food Scheme to include other foods. This recommendation instigated consideration of which other foods might be appropriate. At this stage in the process, the influence of other food policy related agendas such as 5-a-day become apparent. The interview with a Civil Servant, clearly stated that fresh fruits and vegetables were the only foods added to Healthy Start as it would be simplest for retailers to deliver and it fitted in with the other agendas of the time, such as the 5-a-day scheme and the Balance of Good Health. This decision did not have the beneficiary at the centre of the decision making process and reflects a classic tension of food policy between

government, civil society and industry. The influence of the National Dairy Council is not explicitly evidenced in the findings, however there is some evidence that they were threatened by widening the foods available and lobbied to protect milk within the formation of Healthy Start. It is plausible that another reason why only fruits and vegetables were included in the final regulations was due to pressure from the dairy lobby. This scenario reflects a further tension between the policy process and responding to public health or social needs.

It appears that the least influential actors in the political transaction were beneficiaries or potential beneficiaries, the group for whom Healthy Start exists. It appears decisions on what to include, were being made with the retailers in mind, and not necessarily public health. There is little information on why other foods were not included in Healthy Start, despite recommendations from public health and nutrition professionals in COMA and the Maternity Alliance conference. This emphasises that the role of COMA was powerful in initiating policy change, but less influential in the policy formation period. Given the changes that were happening in the policy context, specifically COMA transitioning to SACN and the development of NICE, it is worth considering how Healthy Start may have developed if the initiation had happened a little later in the policy process or if NICE was already in-place. The role of NICE is to provide guidance and risk assessment across different aspects of public health. Whereas, COMA/SACN were focussed specifically on the medical aspects of food and nutrition issues and in particular risk to population health, broader public health considerations are deliberated by NICE. The current role of NICE in considering aspects of Healthy Start such as universalising Healthy Start supplementation to improve population vitamin D status (NICE 2014) illustrates that although NICE were not influential in the initiation of Healthy Start, they have become a key actor.

Throughout the literature review, there are calls for more research into the food and nutrition issues that affect low-income women and children and concerns raised about the point of reforming the Welfare Food Scheme without increasing the financial resources available in the budget for the scheme (Belton 2005, Mynard 2006, More 2003). The qualitative research with policy participants further indicates that there was expertise provided in the initiation of Healthy Start. However, the interview with a member of the Maternity Alliance indicated there were so many different points of

views coming from experts who were all advocating for their issue areas to be represented in the policy. The range of issue areas presented in the Welfare Food Scheme at this stage in the policy process reflects the ‘ambiguity’ which Kingdon associates with defining a policy problem. The ‘ambiguity’ of the policy problem is apparent as the broad objectives of the Welfare Food Scheme are able to be manipulated in varying directions. The report from the Maternity Alliance Conference which aimed to discuss how a new Welfare Food Scheme might address the needs of low-income women and children reflects this. The ambiguity of what became Healthy Start is contextualised in the findings in chapter 6 and 8, when both health professionals and policy participants were asked to describe the point of Healthy Start and varying answers were given, from helping families ‘get some money off their shopping’ to ‘help with low birth weight babies’. It is clear from synthesising the findings with the initial policy scoping that the objectives of the reform of the Welfare Food Scheme were ambiguous.

An additional component that is generally considered in the policy formation, which in Healthy Start appeared not to be, is evaluation. Theoretically, evaluation is usually considered in the formation phase of the policy process. The recent evaluations (Lucas et al. 2013, McFadden et al. 2013) reflect the issues presented in a report from 2007 that scoped the options for evaluating Healthy Start (Dyson et al. 2007b). As there is little data collected by the Department of Health on Healthy Start it is very challenging to gauge whether or not Healthy Start impacts on behaviour change. McFadden et al. (2013) describe how Dunhumby, a market research company, do hold retail data on how Healthy Start vouchers are spent, however the Department of Health has not accessed that information, possibly because transparency about the purchase of infant formula may not be seen as politically advantageous.

Although the evaluations drew on qualitative research to explore the ways Healthy Start vouchers are used, there was a sense that it was all they could do, because evaluation had not been considered in the formation of Healthy Start. The fact that measures were not in place, makes it more confusing that Healthy Start should be about behaviour change, as policy literature stresses the importance of having measurable policy outcomes. This raises questions as to whether or not the promotion of behaviour change as an underpinning concept of Healthy Start, without



clear guidance on how behaviour could change, or ways of knowing if behaviour does change, may have been somewhat tokenistic.

From considering the Welfare Food Scheme and Healthy Start, the defining features of Healthy Start are the ‘soft features’ of the policy i.e. features that are not strictly governed in any way such as advice, choice, support. These concepts are central to Healthy Start promoting behaviour change, yet there is a lack of understanding on how these features of Healthy Start should play-out. The recent evaluations indicate that these soft features of Healthy Start are challenging to evaluate. Within the context of behaviour change literature, including these soft policy features without clear strategy or guidance is not going to change behaviour and if it did, we wouldn’t know as there is so little data.

In considering the issues that appear unconsidered in the formation of Healthy Start, it appears to illustrate Kingdon’s (2003) ‘idea’ that is summarised in the following quote:

An idea ‘whose time has come’ captures a fundamental reality about an irresistible movement that sweeps over our politics and our society pushing aside everything that might stand in its path. Kingdon 2003 p.1

From the interviews with policy participants, it is clear that a number of things were ‘pushed aside’ in order for Healthy Start to be formed within the boundaries set by the government at the time. Evidence and expertise was reportedly disregarded as the objective of those responsible for forming the policy reportedly was getting Healthy Start formed and rolled-out. From synthesising the findings with the literature and background information, there are clear tensions emerging from the policy formation phase and clearer indicators as to what influenced the formation of Healthy Start. Central to the formation was financial and political efficiency

The clear driving of Healthy Start policy formation by the Department of Health indicates that the process took a top-down approach to policy making. In taking this approach, it is common for policy makers to not fully connect with issues that are ‘on the ground’ (Cairney 2012). Therefore, the disengagement between policy drivers at the Department of Health, and people with expert knowledge, could be argued as predictable.

Throughout the semi-structured interviews with policy participants and health professionals, descriptions of the intentions for Healthy Start varied – some suggested it was a ‘tool’ to help health professionals talk to women about healthy eating, others described it as a ‘policy’ that makes sure women and children get vitamins, it was also described as a scheme to help families on a low-income afford a healthy diet. Thus, the lack of clarity over the objectives of Healthy Start are reflected in the wide range of descriptions of the scheme.

At the end of the formation period, regulations for Healthy Start were approved indicating that policy streams converged and a policy window was open, however this does not signify that Healthy Start was ready to be rolled out, it signified that the decision had been made that Healthy Start had to be rolled out. Kingdon (2003) states:

There is no irresistible momentum that builds for a given initiative...participants may feel they have addressed the problem through decision or enactment, even if they have not, the fact that some action has been taken brings down the curtain on the subject. p.169.

Thus, the timing of streams coming together often undermines the effectiveness of the policy as the political necessity to follow-through with an idea takes centre stage. It may be that in the eyes of the policy maker, the policy has been a success as regulations have been approved and plans for implementation can be put into action, however the success of the policy to the broader policy community will depend on the impact Healthy Start makes on the lives of beneficiaries. This again, emphasises the interpretive nature of policy making.

Parsons (2002) discusses how often ideology and policy are incompatible concepts, making policies that address welfare challenging. The findings indicate that the ideologies that underpin Healthy Start are multi-faceted and at times, unclear. In considering the actors throughout the policy process, it is clear that some are more influential than others, and the influential actors are not necessarily the actors with the most expertise in the social/public health issues Healthy Start aimed to address.

Thus, the tension between ideology and policy can also be seen as the tension between actors. There are those that are ideologically invested in what Healthy Start

could be and also understand the factors that should be considered in order to achieve the ideological objective, and those that may have vested interests for other reasons, but know how to influence policy.

This is exemplified when considering the National Dairy Council's role throughout the policy process. They did not attend meetings with other stakeholders, they met with policy makers in private and lobbied. Actors who participated in the outward facing policy process may not have been listened to as much as actors who participated in a policy process that occurred behind closed doors. Lang, Barling and Caraher (2009) recognise this as a feature of food policy and discuss the tensions that occur between policy communities comprising of policy makers and industry and policy actors with ideological objectives.

There are a number of practical issues that do not appear to have been considered in the policy formation. These were identified in the background section and literature review. The lack of consideration of such factors mean that Cairney's second feature of good policy making – 'the policy will work as intended when implemented' is challenged as it is unclear how the policy was intended to be implemented due to the lack of practical details proposed throughout the formation of Healthy Start. There remain many undefined issues about Healthy Start, many of the issues link policy and practice and will be picked-up in more detail in the following section on implementation.

### 9.3 Implementation – linking policy to practice

*Quite often they've not really thought it through right to the end.*

Infant Feeding Coordinator, Case Study.

The above quote from a semi-structured interview with an infant feeding coordinator in the case study area (chapter 8) summarises a theme that emerges from synthesising the research findings, with literature review and policy context. The theoretical literature on policy process and policy analysis helps to understand why certain practical considerations get overlooked throughout the policy process. As the policy streams analysis in chapter 6 demonstrates, much of the policy process is driven primarily by political drivers.

The research findings demonstrate some of the implications of the policy process in practice, the clearest example of this being the misconceived role of Health Professionals delivering Healthy Start. This section will discuss the role of the health professional within Healthy Start as policy and Healthy Start in practice. This section of the discussion begins by considering how Healthy Start was implemented and the issues that emerge from the research findings.

Chapter 6, the policy streams analysis indicates that after Healthy Start was formed, a policy window was created in which Healthy Start was implemented. However, despite this being standard part of the policy process, the issues that Kingdon (2003) suggests often exist with 'policy windows only being open for a limited time' appears to have had implications for the implementation of scheme. The findings from non-published policy documents and interviews with policy participants supports the theory that within the policy window implementation was influenced by time pressure or policy expediency.

Healthy Start was rolled out in two phases beginning in 2006. The first phase implemented and evaluated the policy in Devon and Cornwall before the scheme rolled out nationally. The evaluation of the first phase of Healthy Start (Hills 2006) indicates that in the development of Healthy Start and in the initial phase, training had been commissioned by the Department of Health, developed and implemented with success in the pilot area of Devon and Cornwall. The evaluation of this pilot or first phase of roll-out, further affirmed what the role of the health professional would need to be, to ensure Healthy Start met its objectives:

In order for Healthy Start to be fully effective health professionals need to be clear that they are familiar with the rules, application processes and what is being offered. They also need to understand, secondly, its potential to provide opportunities to discuss healthy eating, diet and nutrition and thirdly, where else in the community these messages might be reinforced. (Hills 2006 p. 16).

The intended role of the health professional was clarified at this stage of evaluation and the importance of training for health professionals reiterated. This is inline with the literature from practitioner journals, which made clear that health professionals would be crucial to the policy fulfilling it's two-fold objective to supplement diets and influence behaviour change. The evaluation of the initial training programme

that was part of the pilot indicates that training was welcomed by health professionals. Yet, the importance of training health professionals such as midwives and health visitors appears undermined by the decision to not include training in the national roll-out.

The evaluation report (Hills 2006) and training report presented to the Department of Health emphasised that training health professionals enabled Healthy Start to be implemented more effectively. Both the evaluators of phase 1 and the group who successfully developed and implemented training for health professionals expressed concern that without training the Healthy Start scheme would not fulfil its objective (Hills 2006; Nutrition 4 2006). A major tension that emerged from the findings is the fact that after these recommendations were made, training was then not rolled-out and little explanation for this decision was provided.

The policy analysis literature and policy streams analysis in chapter 6, suggests that throughout the policy process, concepts of public health and welfare were second fiddle to the process of actually getting policy made. Both the evaluator and the trainers emphasised how not rolling-training out, severely undermined the public health aspect of the scheme. This suggests, that the driving factors for the Department of Health, were policy expediency and political direction. In addition, it also reflects the idea that Wilson (1989) discussed that policy and implementation are often very different and Kingdon's suggestion, that the policy is often influenced by politically attractive features, not necessarily practical considerations.

In reflecting on the implementation process itself, the interview findings from policy participants indicate that there was a tension between civil servants and experts participating in the process. The contention between policy participants over whether it was indeed a pilot phase, or the first phase of Healthy Start, demonstrates the level of confusion around the process of implementing the policy. The interview with a civil servant in which the first phase of Healthy Start was defined 'as the first phase' and not a 'pilot' because there was going to be 'no going back' on what was implemented'. The tension is between rolling out a policy quickly and rolling out a policy that has a robust process behind it. The Civil Servant stressed that if there had been issues, they would have delayed the roll-out, but nothing was apparently identified that would have prevented a successful roll-out.

Again, this reflects the importance of ‘timing’ and rolling the policy out. The evaluator stressed the dominance of ‘policy expediency’ and ‘political direction’ over public health and behaviour change. The trainers raised concerns with the Department of Health regarding the short time frame in which they had to develop, deliver and evaluate training. This builds the case that time pressure was a significant driving factor and the earlier comments from other policy participants about the role of civil servants simply wanting to complete a task is reflected. The tension between the ideological aspirations of those making policy, and the practical needs of those implementing policy, is demonstrated.

The findings suggest that Cairney’s (2012) fourth and sixth features of good policy making (See Chapter 4) are not realised ‘Policy is implemented by skilful and compliant officials; and ‘Support from influential groups is maintained’. It remains unclear exactly how Healthy Start was implemented and the support from policy participants was fragmented over the role of the health professional. Both evaluators and trainers suggested in semi-structured interviews that Healthy Start had not been implemented when they began training and evaluation.

Findings from the implementation phase of Healthy Start illustrates a seeming lack of strategy for implementing a complex scheme. The onus was put upon local areas to identify ways of integrating Healthy Start into complementary local programming, health professionals such as midwives and health visitors to offer advice and beneficiaries to choose how best to spend their Healthy Start food vouchers.

#### ***Policy Aspirations vs. Policy realities***

A constant focus across the literature and the research findings is the role of the health professionals in delivering Healthy Start. The intended role of health professionals was a contentious issue within the policy community throughout the policy process. In the formation period policy participants warned the Department of Health that it was unfair for women to have to present to a health professional in order to get food. The Maternity Alliance and Royal College of Nursing went so far as to say it would be a breach of human rights. In addition, concerns were raised that too much was being asked of health professionals and that the reality was that health professionals were already struggling to provide everything that was being asked of them. In one interview with the Social Policy Manager at the Maternity Alliance, the

interviewee went so far to say that the Royal Colleges knew that it was ‘fictional’ that Health Professionals would be able to deliver Healthy Start. Despite the objections from the policy community that making health professionals gatekeepers wouldn’t work, it appears that other options were not considered. This is another example of expertise being ‘pushed aside’ (Kingdon 2003).

One of the key objectives of Healthy Start is to provide early access to health professionals, who can then offer specialised healthy eating and lifestyle support to Healthy Start beneficiaries. The recent evaluations indicate that there is little evidence of this policy aspiration being realised (McFadden et al. 2013; Lucas et al. 2013).

The objections presented in the formation of the policy are realised in the findings from the case study with health professionals. The systems in which health professionals operate are not conducive to providing detailed information and finding out exactly what the needs of each beneficiary are. Health professionals discussed how they do not receive any more time with a Healthy Start beneficiary than they do with a pregnant woman who is not eligible for Healthy Start. Therefore the ‘opportunity’ that was proposed by requiring women to engage with health professionals early on, in most circumstances, doesn’t exist. In addition, findings from the case study with health professionals also indicate that it is usual for a health visitor or midwife to only see a beneficiary once, therefore providing more than general advice is often difficult. These types of practical considerations appear unconsidered in forming Healthy Start. Rose (1985) clearly states:

One thing we have learned in health education at the individual level is that once-only advice is a waste of time. To get results we may need a considerable investment of counseling time and follow-up. (p.430)

This raises questions about how Healthy Start was intended to be a nutritional safety net. A number of local areas such as Birmingham and Tower Hamlets have implemented a universal Healthy Start vitamin policy. The Healthy Start scheme in these areas is therefore quite a different scheme compared to areas that are still doing the targeted approach. The focus on vitamins within local areas however, as the case study indicates, detracts from any focus on the food aspect of Healthy Start.

Health professionals had been present and vocal throughout the initiation and formation of Healthy Start. The consultation report (Department of Health 2003b) indicates their presence, as did the interview with the Maternity Alliance and unpublished policy documents. It is striking that health professionals were the majority of respondents in the consultation (Department of Health 2003b), yet their actual needs appear to have been overlooked in the policy. In the consultation response, health professionals emphasised the need for ‘coordination, information and guidance in the area of nutrition’ (Department of Health 2003b, p.8) to facilitate successful delivery of the scheme. Thus the Department of Health were aware of the potential challenges of utilising health professionals to be gatekeepers of Healthy Start but did not prioritise training for reasons which remain unclear.

As in the formation phase of the policy process, there is a sense that Kingdon’s (2003) ‘visible’ and ‘hidden’ policy participant concept is realised. In the case of Healthy Start it seems that the policy participants who are hidden in the policy process, mainly experts, are hidden by the policy makers, not by any making of their own. For example, expertise is provided to the Department of Health, however it is not acted upon, suggesting that the expertise is not initially hidden, but gets hidden as it conflicts with the intended policy direction.

The findings reflect the concept of an ‘implementation gap’ (Hill and Haube 2009). This essentially means that the policy initiation and formation phases have not effectively considered the realities of how a policy translates into practice. Themes that were present in the formation phase of Healthy Start continue into the implementation phase, primarily time and budget pressures. From synthesising this with the theoretical literature, a lack of ‘technical feasibility’ (Cairney 2012) appears to be realised in the implementation of Healthy Start.

The implications of not rolling-training out nationally cannot be quantified. However the case study findings and findings from recent evaluations of Healthy Start indicate that the role of health professionals within Healthy Start continues to be a contentious issue. The case study illustrated that health professionals have varying levels of knowledge both about the mechanics of the scheme and their role in delivering it.



The policy literature does not address the practicality of delivering the scheme or indeed provide an evidence base for the delivery mechanisms intended for Healthy Start, rather the policy literature describes an aspirational role for the health professional. Again emphasising the conflicting concepts of ideology and policy (Deakin 1994). When disconnect between the policy aspiration and policy reality exists, it is pertinent to question whether the policy formation process was driven by evidence or aspirational agendas and the impact that such policy drivers have on limiting public health impact. This relates back to earlier discussion on the tensions between influences and how political factors such as budget and time appear more influential than the public health or welfare motive of Healthy Start (See sections 3.3.1; 6.2.3; 7.3).

Data from recent evaluations provide an overview of some of the issues experienced by Health Professionals. The key issues that emerged were that health professionals were primarily engaged with delivering the vitamin component of Healthy Start and rarely discussed food vouchers or voucher use with beneficiaries. Although, vitamins were the key focus of delivery, vitamin take-up remains extremely low. Thus, there is little support for Healthy Start families with regards to nutrition and the benefits of spending vouchers on fruits, vegetables and milk. In synthesising the findings from the policy participant interviews with the case study, it is clear that the Department of Health civil servant had a differing view of the role of the health professional in delivering Healthy Start, to the health professionals interviewed as part of the case study.

The relationship between local area health services and the Department of Health needs to be reviewed as the findings indicate a number of areas where, by default, assumptions are being made by both parties regarding roles and responsibilities in delivering Healthy Start. This indicates a possible lack of strategy in how Healthy Start would be used to link with other agendas/programmes in local areas. Although the policy documents analysed in chapter 6 do say that Healthy Start will cross-cut issues, the policy participant interviews and analysis of unpublished policy documents indicate little practical consideration of how this would work in practice. Reflecting the literature that suggests policy makers don't always grasp reality of the situations for which they are forming policy (Dowler 2007).

The epistemological approach to this research has been interpretive. From considering the research findings in light of the background, context and literature review, it is clear that 'policy success' is different to different actors depending on their specific focus and interpretation of the problem. Actors can only consider the problems from their own individual contexts. Thus, although the civil servants developing Healthy Start as policy were constrained by budgets, time, and the model of policy making that was best practice at the time, this was the framework that they were tasked with working within. Their job was to reform the Welfare Food Scheme and roll out Healthy Start. This is at odds with how others within the policy community interpret the role of civil servants and it was clear that actors coming from a public health perspective in particular were dissatisfied with the lack of public health expertise that the civil servants had. The differing perspectives that different actors came from has meant that Healthy Start is successful to one and not successful to others.

The seeming disconnect between central government and local areas has also led to differing interpretations of what the barriers and enablers are to Healthy Start being delivered on a local level. This tension is clearly summarised in the case study with health professionals (chapter 8) in which it became clear that there is an element of assumption from practitioners regarding their role, as well as an assumption from central governments regarding the role of health professionals. The reality is that roles of both are undefined and as a result, a barrier has been created that is preventing health professionals from delivering Healthy Start in the way central government intended it to be delivered.

It is clear that as a scheme Healthy Start is confused. It's not clear to those delivering it what exactly it is supposed to do beyond providing financial assistance for food and tokens for free vitamins. The issues with Healthy Start in practice are the same issues that were apparent throughout the Welfare Food Scheme – low vitamin take-up, concerns that it supports formula feeding as opposed to breastfeeding and a lack of data on the actual benefits of the scheme.

The lack of a support role from health professionals in delivering Healthy Start indicates a crucial area of behaviour change that is not being realised in the case study area. This contrasts significantly with WIC in the USA which stresses the importance

of community nutritionists and dieticians to support beneficiaries to make healthy choices. The extent of support for using Healthy Start food vouchers in the UK appeared to be the pamphlets produced by the Department of Health.

Healthy Start in practice presents a conundrum. It is reported that the take up of the scheme in general is around 80%, however recent evaluations demonstrated that those delivering Healthy Start focus primarily on vitamins and vitamin take-up is very low. If take-up is indeed at 80% this suggests there is nothing to be concerned about with this as a benefit, but research in this thesis and in the recent evaluations of Healthy Start suggest otherwise. There is considerable confusion over the objectives of Healthy Start. The research in this work illustrates the reality of the messy process of forming Healthy Start and explored how issues in the formation of Healthy Start spill over into the ways in which Healthy Start is delivered. The statistic of 80% take-up is not indicative of the success of Healthy Start, beyond the fact that people are accessing it. The recent pattern of decrease in take-up that was outlined in chapter 2 (figure 9) presents an interesting situation, where it is unclear why Healthy Start take-up is decreasing, but no warning bells have rung.

By drawing on the historical document review in chapter 3 and the recent evaluations (Lucas et al. 2013, McFadden et al. 2013) it is striking that although Healthy Start and the Welfare Food Scheme differ on paper i.e. they have different schemes as policies, in practice many of the same issues remain that have existed for decades. For example in a parliamentary debate from 1953, considerable concern was raised that vitamin take-up was low among women eligible for the Welfare Food Scheme. The COMA review (2002) also reported that free vitamin take-up was very low. Vitamin take-up has also been a problem for Healthy Start (Jessiman et al. 2013). Likewise, the issue that arguably was influential in the initiation of Healthy Start, the fact that women chose infant formula over liquid cows' milk in the Welfare Food Scheme (COMA 2002) is mirrored in the most recent Infant Feeding Survey which sampled for the first time a number of Healthy Start beneficiaries. The consistency of issues indicates that the issues which reform of the Welfare Food Scheme was seemingly addressing, have not been addressed effectively in the policy process adding fuel to the argument that the reform was more about reframing the Welfare

Food Scheme as opposed to creating a scheme that was a better and more effective public health intervention.

In applying models of policy analysis to the study of Healthy Start, they indicate that technically Healthy Start should not be defined as a success as it does not meet the criteria of a successful policy. However, the scheme *is* technically successful – the participation rate is in line with other benefits and the issues reported with the scheme have not been defined in any way as failing. However, the case study information and qualitative research highlight that there are in fact considerable issues with the scheme. The question then arises, does the lack of data on Healthy Start enable the scheme to be defined a success, despite the practical issues experienced in delivery? For example, as ‘behaviour change’ is undefined and unmeasured it would be unfair to state Healthy Start does not change behaviour. What can be claimed is that there are few mechanisms in-place that would support behaviour change and there is a lack of data that can explain how and if Healthy Start impacts behaviour.

It is clear from the interviews with policy participants that policy success is an interpretive issue, influenced by the context from which the policy participant comes. Although it is unclear whether or not the policy is a success or not, the research findings indicate that it is fair to say that the scheme was not implemented well. Some participants went so far as to say that Healthy Start was not implemented. Theoretical policy analysis literature presents three possible explanations for a failed implementation – bad policy, bad execution and bad luck (Hogwood and Gunn 1984). From considering the policy initiation and formation, the failure to successfully implement Healthy Start appears to be a result of ‘bad policy’, specifically, a lack of consideration for the practical details associated with the scheme and a lack of definition of the policy objectives.

#### 9.4 Vision

The discussion of research undertaken in this thesis has highlighted a number of moments that occurred throughout the formation and implementation of Healthy Start that could be considered as ‘missed policy opportunities’. This section will consider the opportunities that were not grasped. Specifically, the missed opportunity to cross-cut Healthy Start with other maternity benefits such as the Pregnancy Grant and

policies to promote breastfeeding, the lessons from WIC and the loss of original intentions for the purpose of Healthy Start.

The policy context in Chapter 1 highlights the number of food policy activities that were developing under the New Labour government of the late 1990s and early 2000s. One policy that could have aligned with Healthy Start was the Health in Pregnancy Grant, which gave all pregnant women £190 after their 25<sup>th</sup> week of pregnancy. The scheme began in 2009 and ended in 2011. The SACN Sub-Group on Maternal and Child Health raised concerns that there were no plans to provide guidance to recipients of the Health in Pregnancy Grant (SACN 2008). The Healthy in Pregnancy Grant was managed by the Department of Work and Pensions and there was a lack of evidence of DWP working with the Department of Health to consider how the grant could support the health of pregnant women. The Grant did not ring-fence funds, rather it provided money directly into beneficiaries' bank accounts. Like Healthy Start, the objectives of this programme were largely undefined. In considering both programmes, it is of note to consider whether each programme could have been strengthened if they had been integrated, as both have a common, albeit vague objective of supporting the health of pregnant women. The fact that both programmes did not align, reflects the lack of joined-up working that some argue is typical within food policy (Lang, Barling and Caraher 2009).

Likewise, the current move in policies to support breastfeeding in the UK do not appear to have considered how Healthy Start could be an asset to new policies aimed at promoting breastfeeding. For example, research is currently being undertaken to assess whether women can be motivated to breastfeed if there is a financial incentive. The research is called the Nourishing Start for Health project (NOSH) and is being conducted by the University of Sheffield (University of Sheffield 2014). Mothers will be offered shopping vouchers worth up to £120 if their babies receive breast milk until they are six weeks old and a further £80 if their babies continue to receive breast milk up to 6 months (NOSH Scheme website 2014). This project is based on other studies that have used a financial incentive to change other aspects of behaviour, for example smoking and alcohol consumption, in pregnancy. The pilot project is available to all new mothers living in specific postcode areas of Yorkshire. The NOSH project's aim to increase breastfeeding rates reflects one of the aims of

Healthy Start. Yet, there is little evidence at this stage in the project that consideration has been given to how how NOSH and Healthy Start could be complementary.

The case study with health professionals in Chapter 8 indicates that some beneficiaries are incentivised to register for Healthy Start because the scheme enables them to use the Healthy Start food voucher to lower the cost of food shopping bills. Considering Healthy Start as a financial incentive to support breastfeeding, specifically, is complex as the scheme revolves around the beneficiary choosing what to spend their vouchers on and exists to support the health of pregnant women, breastfeeding women, infants and young children (see section 9.2). The early policy discussions (see section 9.1) indicate that Healthy Start was supposed to encourage breastfeeding by offering support and guidance to pregnant women and young mothers along with the Healthy Start food voucher as a financial resource to purchase food that can supplement the diet of breastfeeding mothers. As Healthy Start beneficiaries can also choose to purchase infant formula with their Healthy Start food vouchers, there is a tension when considering how Healthy Start supports and encourages breastfeeding mothers. The complexity of food choice and behaviour change outlined in Chapter 3 (see section 3.4.3) indicates that more than a financial incentive is necessary to change behaviour. In Chapter 2 (section 2.7.2), the overview of breastfeeding and Healthy Start indicates that much is still unknown about how Healthy Start supports breastfeeding and the limited data that does exist indicates women with infants are using their Healthy Start food vouchers to buy infant formula.

Some key differences between Healthy Start and the NOSH pilots are that Healthy Start ring-fences the financial incentive for spending on specific food items that are considered to be of nutritional value to mother and baby. NOSH vouchers can be spent on ‘food, household items, toys, clothes, books, music, film and much more’ (NOSH Scheme website 2014). Additionally, the NOSH vouchers are financially more valuable. In considering this, questions emerge regarding what impact Healthy Start might have if the value of the Healthy Start food voucher was increased? Or if the financial reward for breastfeeding in the NOSH project ring-fenced the financial incentive to be spent exclusively on food? If the pilots find the NOSH model is successful, there could be lessons for Healthy Start. Regardless, Healthy Start and

programs such as NOSH should aim to work in concert to support breastfeeding women.

Although initiation of breastfeeding in the UK has increased over the past 10 years, low rates persist in lower-income groups and among younger mothers (McAndrew et al. 2012). If new programmes are being considered to promote breastfeeding, is it a sign that Healthy Start is failing to address one of the initiating issues of the policy: a lack of support to promote breastfeeding? By considering the new programming that is being piloted, it is telling of the impact of Healthy Start. If resources were strengthened for Healthy Start, perhaps the original aims of the scheme could be better addressed. This could include more support for education, guidance and training for both health professionals delivering Healthy Start and beneficiaries of the scheme. Throughout the policy process, the need for guidance and education was reiterated by experts in the field (see section 7.2.4). Within the context of Healthy Start, it appears that there is scope to more fully integrate breastfeeding support. The mechanisms to make the connections on the ground between infant feeding coordinators (where these remain in place), health visitors, midwives and breastfeeding support and advocacy groups, however, are not being recognised or supported by central government.

How could support be developed? A valuable resource that can provide examples of an efficient delivery of a welfare food scheme is WIC. The research in this thesis has recognised that there is a lack of support, best practice, data and guidance on Healthy Start. Although contextually very different (see table 11) and with impacts that are debated, WIC has established successful processes for providing support to both gatekeepers and beneficiaries. This has been achieved by using the policy to drive practice. The policy that underpins WIC denotes that before a state receives annual funding to deliver WIC, state agencies have to report on training and nutritional education opportunities. The policy that underpins Healthy Start simply outlines what beneficiaries receive and eligibility criteria. The legislation has little impact on practice. Any guidance that comes from central government on how education should be used to support Healthy Start is simply a suggestion as there is no consequence to the programme should health professionals not deliver Healthy Start in the way it may have been intended to be delivered. The unique context of WIC makes it

possible to integrate training into the model because state and local WIC agencies are required by law to hire nutrition professionals and administer training opportunities and report on their activities.

As an established programme, WIC has a history of collecting routine monitoring and evaluation data. In addition, WIC has been the subject of a large range of academic studies. Thus, there is a lot of data on WIC and there is the ability to use data in a formative process of continuous programme development. Local areas have no reporting requirements for Healthy Start beyond vitamin take-up data. Without both routine data collection and academic research on Healthy Start, it will be challenging to develop and refine the programme based on meaningful evidence.

There are opportunities to improve the relatively new Healthy Start model by looking towards WIC for substantive and formative reflections on practice. While directly transferring aspects of practice is not practical or realistic due to contextual differences, Healthy Start may benefit by considering concepts from the WIC model, such as the role of third party support, distributing the duty of care and incorporating routine data collection into practice.

In reflecting on how Healthy Start began and what is known about Healthy Start today, it is clear that throughout the formation of Healthy Start an original objective of the programme was lost. Childhood obesity was listed in the explanatory memorandum (Department of Health 2005b) that accompanied the Draft Regulations for Healthy Start in 2005 (see section 2.1). Yet, throughout the policy process and in practice, there is little evidence that childhood obesity is an issue that Healthy Start is addressing. It is unclear how Healthy Start was designed to address childhood obesity beyond the manufactured opportunity for beneficiaries to discuss health and diet with the health professional signing-off on their Healthy Start application form. However, information on how central government envisioned that interaction and the reality are quite different, as indicated in the case study (Chapter 8) and the NICE guidance (see Figure 11 in section 2.7.1).

## 9.5 Summary

The opening quote at the top of this chapter *Policy change at the top will not necessarily translate into change at the bottom* (Cairney 2012 p.37), sums-up a large



part of what emerges across the discussion. Although the Welfare Food Scheme changed as policy, there is little to suggest it has significantly changed in practice – similar issues remain – vitamin take-up remains low, it is reported that beneficiaries continue to choose infant formula and little data exists to explain how Healthy Start is providing a nutritional safety net. As the policy process has been primarily driven by political objectives, removing the incentive to breastfeed, staying within budget and rolling a new scheme out quickly, it can be argued that the top-down policy process to reform the Welfare Food scheme reduced the scope of the policy as practical considerations and expertise were ignored.

The chaotic nature of policy making (Lindblom 1959, Parsons 2002) is demonstrated through the combination of research findings and literature. Although the analysis of research findings provide more information than previously existed on the influences on Healthy Start, the picture painted is still muddy. Through the complexity of the policy process, the chaotic nature of policy making emerges and tensions between the linear model of best practice for policy making (Bullock, Mountford and Stanley 2001) and the reality of making policy that addresses complex issues emerges.

Although not all of Kingdon's (2003) concepts ring true across the research findings – more complexity within each of the three streams was found, this chapter has demonstrated that there is clear value in using methods of policy analysis to consider the influences on the policy process. The concept of multiple streams has enabled complicated processes to be better understood and for further questions to be raised to dig deeper into the research objectives of this thesis.

This thesis began by considering why the government is compelled to provide food welfare to women and children. From undertaking a literature review, policy analysis and case study, it is clear that the government sees value in providing food welfare to women and children. The shift from the Welfare Food Scheme to Healthy Start was influenced by a combination of new scientific information on the importance of diet before, during and after pregnancy and the early years, the policy focus of the New Labour government and a political need to reframe what food welfare had become since 1940. However, what the policy analysis research indicates, is that the way in which food welfare was changed, or reformed, neglected to consider a number of practical components and conceptual components that the literature on changing

behaviour indicates are important. In addition, a range of factors that were primarily political influenced the policy.

The research clearly indicates that the initiation, formation and implementation of Healthy Start told through the publically available policy documents, is quite different to the initiation, formation and implementation told by policy participants and unpublished policy documents – highlighting the interpretive nature of policy. By looking at both though policy analysis methods, a deeper context emerged and a clearer understanding of Healthy Start as a topic has been defined.

## Chapter 10: Conclusion

### 10.0 Conclusions

*There is no answer to justify a reluctance to provide essential nourishment at the most critical stages of a child's growth and development.*

Hewetson 1946

It is clear that there has been a longstanding intention to support the nutrition of pregnant women and children. Pressures on policy makers however can prevent clear understanding of how best to deliver 'essential nourishment' in the form of nutrition support and how to identify 'vulnerable' families.

The introduction to this thesis outlined that the epistemological approach taken, was interpretive and therefore hypothesis generating. The research aimed to develop new knowledge on the policy context and formation of Healthy Start and food welfare as little was formally known about what influenced the formation, initiation and implementation of Healthy Start and what the barriers and enablers are to Healthy Start operating on a local level. The research in this thesis has built new knowledge in this area of food policy and integrated policy analysis and concepts from social policy to help develop explanations of what influenced Healthy Start.

In reflecting on the previous discussion chapter, it is clear that the two research questions that directed research in this thesis are interconnected. Responses to the first research question, *what influenced the initiation, formation and implementation of Healthy Start?* in-part answer the second research question, *what are the barriers and enablers of Healthy Start, a national policy, being delivered on a local level?* The influences on the policy process appear to have contributed to barriers to Healthy Start being effectively delivered on a local level. A clear divide between considerations for policy and practice have been illustrated – the research suggests that Healthy Start as policy was driven in part by factors that were defined by features of politics such as timelines and budget efficiency. Conceptual and practical factors were overshadowed. Dowler's (2007) thesis that complicated concepts are often

simplified and not fully addressed by policy makers is realised in the research presented in this thesis. Specifically, the concept of behaviour change was misconceived throughout the policy process. There was little evidence that multifaceted nature of behaviour change was considered and it remains unclear to what extent Healthy Start aims to change or influence behaviour.

This chapter reflects on the research and lays out what this research adds to the understanding of Healthy Start and the subject of food policy, it is structured in 5 sections: the first presents the new understanding of influences on Healthy Start, the second section looks at what the research in this work adds to the ‘big picture’ understanding of food welfare. The third section presents the policy implications of this research. The fourth section reflects on the limitations of this work and the doctoral process. The final section proposes further work to develop additional knowledge and understanding on food welfare and Healthy Start.

### 10.1 New understanding of influences on Healthy Start

Primarily, the research in this thesis has developed a substantial policy context for Healthy Start and considered new ways of interpreting what was already known about the scheme, drawing out the tensions that developed throughout the policy process and developing connections between policy and practice. The findings in this thesis support the following conclusions:

**The Welfare Food Scheme was not reformed; it was reframed as a public health intervention policy.** The evidence presented in this work, highlights the emphasis given to disassociating with the ‘old’ Welfare Food Scheme and moving the scheme into a new more health focussed policy arena. The evidence also suggests that that Healthy Start was not ‘fully’ reformed as there was little consideration of the social or public health needs of the potential beneficiaries and more emphasis on creating a scheme that aligned with other food and health focussed agendas, maintained the same budget as the Welfare Food Scheme and did not promote infant formula feeding over breast feeding. Questions also remain as to whether Healthy Start was a reform of the Welfare Food Scheme as the same legislation remains, it was amended to allow for new distribution methods, a new name and fruits and vegetables to be included.

**The political pressures on civil servants to develop and rollout Healthy Start policy within a predetermined timeframe and budget appears to have constricted the level of robust consideration to feed into the development of Healthy Start.** This affirms a tension between the policy process and recognising the complex factors that are necessary to design effective food policy. The contested terrain over beliefs and interest that underpins most food policy theory is present here.

**The role of health professionals in delivering Healthy Start was not fully considered in the policy process.** The disparate views within the policy community on the capacity of health professionals and their needs throughout the policy process are clearly demonstrated in this research. This is a contributing factor to the confusion around Healthy Start that is experienced in practice. The relationship between policy and practice is demonstrated. The lack of cohesion between those making policy and those delivering policy have implications on practice, for example the findings indicate that those managing Healthy Start centrally, the Department of Health interpret Healthy Start to be a public health intervention. Whereas those delivering Healthy Start on a local level perceive the scheme as health promotion.

**New narrative understanding of how Healthy Start was developed adds to the understanding of why there is confusion in practice today.** The clearest example of this is the support for health professionals delivering Healthy Start. The fact that training for health professionals was commissioned and then not rolled-out, undermines the complexity of delivering public health interventions and further suggests that the need for rolling the scheme out within a specific timeframe and budget was interpreted as more pressing than ensuring gatekeepers of the scheme were equipped to deliver it.

**Visible and hidden participants: There is a tension between policy stakeholders and the policy community.** There were lots of vested groups in the initiation of Healthy Start, however in the formation few groups are evidenced as having a relationship with policy makers, and therefore being influential – visible participants. Thus the issue of policy makers disregarding expertise (hidden participants), which as the discussion denotes, was a feature throughout the formation of Healthy Start, is explained by considering policy participants who were ‘policy stakeholders’ –

meaning the reform of the Welfare Food Scheme was important to them ideologically and socially, and policy participants that were in ‘the policy community’ – meaning they had more influence on policy makers, were more in-tune with the policy architecture and understood how the policy process worked.

Despite not interviewing anyone from Dairy UK, from considering the policy documents and the semi-structured interviews with policy participants, it is clear that the dairy industry had high stakes in the reform of the Welfare Food Scheme and had proficient lobbyists that had the ear of policy makers. Whereas, the concerns raised by academics and practitioners were seemingly less influential. Within food policy thinking, this could be explained through the productionist paradigm (Lang and Heasman 2004), in which industry is more influential than civil society.

**The interpretive nature of policy making adds a further level of complexity to Healthy Start.** The research emphasises the various levels of complexity within Healthy Start. It emerged that much of the confusion and differing opinion of what should be prioritised, relates to the different contexts that actors were grounded in. Different actors within the policy process were operating in differing frameworks – the civil servants were working within the political frameworks of the time and using a model of best practice for policy making which did not fit with the framework for behaviour change that other actors were drawing on, thus interpretations of policy priorities differed.

The interpretive understanding of the findings in this thesis denotes that the context from which policy is made and the context that actors driving policy come from, has a large influence on the content of policy and which factors are prioritised throughout the policy process.

**Individual choice without support, challenges behaviour change via the mechanism of Healthy Start.** The decision to enable beneficiaries to choose how to spend their Healthy Start vouchers presents issues. Firstly, as the literature on behaviour change denotes, without the educational and support component, changing behaviour is a challenge. Secondly, the interviews with policy participants and case study with health professionals indicated that the Department of Health believed support and advice was being provided to beneficiaries, whereas, health professionals

indicated that in reality there is little time and resources to deliver a public health intervention to all low-income pregnant women. Thirdly, there is little support for health professionals delivering Healthy Start. Finally, as the newspaper article in chapter 1 indicates, the ‘choice’ factor makes beneficiaries vulnerable to victim blaming, as they are held responsible for how they choose to spend their Healthy Start vouchers.

**The policy context has changed and continues to change.** The beginnings of Healthy Start were clearly influenced by the policy context of the time. However, since Healthy Start rolled-out, the policy context has again shifted. It is inevitable that policy contexts will change. In uncertain times such as concurrent welfare and NHS reforms, the resilience of Healthy Start is founded in the fact that it does not have a clearly defined and measured objective. The findings indicate a range of purposes for Healthy Start. The lack of definition of objectives, provides some flexibility and allows Healthy Start to be malleable, adapting to a range of issues in changing policy contexts. The review of historical documents in chapter 3, illustrates how this pattern of shifting purpose over time has been a feature of the Welfare Food Scheme.

## 10.2 Developing the policy stream model

This model was chosen as a conceptual framework for much of the analysis in this thesis, as it was expected to provide some explanation of a phenomenon that was previously unexplored: the initiation, formation and implementation of Healthy Start. The multiple streams approach helped make sense of the ‘messy’ process of policy making.

Kingdon’s model of multiple policy streams (2003), assumes that there is only one problem in the problem stream. However, the development of Healthy Start illustrates a scenario where the problem stream was formed from multiple problems in ‘sub-streams’ and it is unclear how much priority was given to each problem and indeed, which problems were flowing in the problem stream when it converged with the policy and politics stream.

Although Kingdon’s (2003) Multiple Stream approach adds to the understanding of the policy process, it also highlights how detailing the content of each stream further underscores the complexity of forming Healthy Start. Use of Multiple Stream

analysis in the future should consider not only the complexity of how each stream interacts, but also how each stream is comprised and whether ‘sub-streams’ exist. Considering these factors may add complexity to the analysis, but it will enable a more robust policy context to be developed.

### 10.3 Big picture findings – what does it all mean?

The aforementioned conclusions focussed specifically on the new understanding of Healthy Start, however it is useful to return to the ‘big picture’ issue that was considered in chapter 1 – why does the government provide food welfare? The findings, suggest the nutritional safety net is not a strategic measure, but a symbolic gesture of the government’s commitment to investment in the nutrition of future generations. There is not enough evidence to suggest that the principle of investing in human capital was a hugely influential concept in the development of Healthy Start, as little consideration was given to exactly how and what investment in human capital would look like, and the government was not prepared to invest more budget in welfare foods. If human capital was driving Healthy Start, one would assume a more strategic approach be taken to supplementing diets. What does exist is the continuation of the idea that government ‘should’ support the diets of vulnerable populations as they have done for many years. Thus, over the years, the ideology behind providing welfare food has become broader, cross-cutting and attempting to address more and more issues whilst the population eligible to receive food welfare become fewer. It is perhaps, the fact that the scheme exists, rather than the output of the scheme that matters politically. Again, promoting the politicisation of food welfare and demonstrating the tension that has been present throughout the discussion: political drivers v. public health.

This is not to say, there is no public health value in Healthy Start. The scheme clearly is beneficial in a range of ways as demonstrated by findings in the recent evaluations. What is also clear is that having a scheme to support nutrition of pregnant women and their young children is a good idea, however designing a comprehensive and effective scheme is hard. It remains unclear if Healthy Start is fulfilling its objectives to supplement nutrition and influence behaviour change. Whether it is being used to its best effect is debatable. What has become clear is that supplementing nutrition and changing behaviour are wide ranging objectives for a single policy to deliver. Each



feature demands different strategies for implementation. Additionally, Healthy Start aims to support a wide range of nutritional needs - pregnant women, breastfeeding women, pregnant and breastfeeding teenagers, infants and children in the early years. Each set of needs is different, yet they are all addressed with a single scheme.

Essentially what this research illustrates is a difference between policy aspirations and policy realities. The theoretical literature indicates that making policy is rarely linear and often messy, and this has been reflected in the policy process that underpins Healthy Start.

The research in this thesis evidences how Healthy Start throughout the policy process was politicised – emphasising the pressure to create a scheme within a political framework. Yet, in practice, the scheme is depoliticised as responsibility for its effectiveness is left to individuals delivering and receiving Healthy Start. The concept of perceiving the individual and not their environment as being responsible for poverty is reflected (McKendrick 2008). The fact that the scheme revolves around choice shifts the responsibility of defining the nutritional safety net to the beneficiaries themselves. The term ‘nutritional safety net’ is therefore flexible in its meaning. It is however, up to the individual to cast their own net, recognise their own needs and seek the guidance and support they need, which as the literature review denotes, can be challenging and not conducive with models of behaviour change.

Confusion around Healthy Start in practice can perhaps be explained through the multiple objectives the scheme appears to have and the lack of clarity around whether Healthy Start is a social policy, public health initiative, health promotion scheme or welfare benefit. Although each of the aforementioned can, and often do, overlap, they are also distinctly different concepts. If the actors managing and delivering Healthy Start cannot differentiate between them, then it seems inevitable that confusion will occur. From this research, it appears that Healthy Start is delivered as health promotion, managed as social policy and perceived by beneficiaries and the wider public as part of the benefits system. From considering the research findings, it appears that a central issue that needs to be addressed is whether Healthy Start is about supplemental nutrition or whether it is about taking an upstream approach to improving the diet of low-income communities and influencing behaviour change.

Clearly combining both approaches would be optimal, both are important, however they are not being integrated in practice.

The fluid history of the Welfare Food Scheme, which has seen the nutritional safety net flip-flop between being a targeted approach to impact the health of vulnerable populations within society and whole population approach which aims to raise the average health of the whole population, has led to Healthy Start being a safety net that is not clearly defined. Part of ‘good policy making’ is clearly defining a problem, so that a clear response can be formed. As discussed in chapter 9, clarity was lacking throughout the policy process.

Today, the low-profile of Healthy Start perhaps goes hand-in-hand with the lack of data on the topic. Food poverty, government hand-outs and food banks are frequently media stories and the subject of academic scrutiny, Healthy Start has remained in the background. One interviewee from the policy participant interviews suggested that drawing attention to Healthy Start now, would upset the status-quo by highlighting the lack of data that exists on the scheme and the low vitamin take-up. The new focus is on maintaining and protecting Healthy Start in this volatile climate where schemes that are deemed unnecessary or not working, are liable to be cut from government budgets. If this is the case, then it indicates acknowledgement that the politics of food welfare cast a long shadow over the public health and social needs of vulnerable families.

#### 10.4 Policy implications

The policy implications of this research are clear. It highlights issues to be aware of in future considerations of policy developments in domestic food welfare and highlights the need for advocacy of these issues, specifically the needs of low-income women and children and active participation in the policy process.

Looking forward, it is known that in 2014 NICE are conducting an economic analysis examining the cost effectiveness of moving the Healthy Start Vitamin programme from a targeted to a universal approach. Although growing numbers of local areas are choosing to make Healthy Start vitamins universal, this analysis will assess whether there is an economic case to change the policy centrally, making it mandatory that all women and young children receive Healthy Start vitamins.

The discussions around vitamin D and Healthy Start raise issues about who Healthy Start is for. It is not only low-income women and their young children at risk of vitamin D insufficiencies, also people with dark skin, those who cover-up and the elderly are at risk. If Healthy Start vitamins do become universally available, the nature of the nutritional safety net will change from one which originally had a targeted approach to address health risks in low-income communities, to a general population approach. This may positively impact population averages for nutrient intakes, but will not necessarily impact the health of vulnerable populations or address health inequalities. Thus, as the shifting history of welfare foods has illustrated and the changing policy context for Healthy Start indicates, the focus and shape of welfare food provision may continually change in response to new evidence and concerns. The benefit of having vague objectives, is that the policy can be maneuvered to fit as a policy response to a range of issues. The initial quotes from MPs in chapter 1 illustrate this in action.

The focus on vitamin D as an area of policy concern and Healthy Start vitamins being hailed as a solution, highlights the fluidity of welfare food policy. Healthy Start, which began as a scheme to promote breastfeeding and counteract the negative connotations with the Welfare Food Scheme, today appears to be largely regarded as a system for distributing vitamin D. The recommendation from the CMO and the economic assessment being undertaken by NICE are valuable, however the food aspect of Healthy Start is getting overshadowed, perhaps because it is unclear what the impact of the food vouchers is intended to be and the lack of data collection or monitoring on how families choose to spend their Healthy Start vouchers.

Bearing in the mind the policy context and dominance of political factors throughout the policy process, the conclusions lead to the question: is it politically valuable to have a malleable policy that can be a response to a range of issues? If so, perhaps there was some intention behind the broad range of objectives – as a policy it can continue to be a response to whatever the public health issue of the moment is – a sticking plaster that will fit over various cuts and scrapes, even if it is not a solution.

From considering these conclusions, the main recommendation to policy makers in charge of Healthy Start would be to consider separating the vitamin and voucher component into two separate schemes. Based on the case study with health professionals and evaluations (McFadden et al. 2013 and Lucas et al. 2013), this appears to have happened unofficially due to the legal remit for local areas to make Healthy Start vitamins available. If Healthy Start vitamins become universal, then they are no longer part of a targeted approach to improving the nutrition of low-income women and children, which Healthy Start is. There is a clear case (Rose 1985) that whole population approaches and targeted approaches can be complementary within public health. Thus, if it is given that all pregnant women will receive Healthy Start vitamins, then perhaps more focus can be on support for using vouchers among eligible families and the scheme can refocus on the ‘food’ aspect of ‘food welfare.’

#### 10.5 Contributions to Food Policy

The research in this thesis has demonstrated a number of concepts that food policy as a subject area promotes: tensions within policy communities, tensions between political motive and public health; contested terrain; food policy sitting on the intersection of other subjects.

The research in this work contributes both subject matter and methodologies to food policy. It has demonstrated how methods for public policy analysis can be successfully used to help better understand the complexities and tensions that are discussed and associated with food policy. This adds a practical and methodological component to food policy. This research provides a practical example of ‘food policy analysis’ – drawing on multi-disciplinary sources to explore a subject that has received little attention from academics or policy makers.

This work indicates that policy analysis methodologies can enable better understanding of the formation of food policies. Developing these methodologies further and applying them to other areas of food policy, exploring other areas of food policy would advance the study of food policy beyond a subject and help elevate it to a discipline.

Subject wise, this thesis adds new detail and considerations of food welfare to food policy as a topic. The introduction and literature review indicate how food welfare although mentioned in food policy, has received little research attention. This thesis both uses Healthy Start to affirm common principles of food policy and uses food policy principles to better understand Healthy Start. The literature on domestic food welfare demands development. This is a clear area of food policy that is rich in concept, but is yet to be mined and developed to provide both academic discourse and important lessons for future policy. In developing work on food welfare, the need could be more clearly defined. There is a plethora of work that touches on subjects that are relevant to domestic food welfare in the UK, but little that addresses it head-on.

### 10.6 Limitations

When research began in 2011, there was very little research published on Healthy Start – although the evaluation reports on the scheme were anticipated for publication in 2012. It was not until 2013 that the reports were published and provided detail on Healthy Start in practice that had previously been lacking. Anticipating the publication of two evaluations but not being sure exactly what they would cover or when they would be published, contributed to the decision to focus on Healthy Start policy development.

Before the evaluations were published and the information gap was very large, the market research company that holds data on how Healthy Start vouchers are spent in Tesco, was contacted with hope that this information would be accessible. The information was not accessed as it cost more than the project budget for the research in this thesis. It was disappointing that this information was not accessed by the Department of Health as part of the evaluation budgets. Not having this information, limited understanding of the context on Healthy Start in practice. This is also reflected in the evaluation report from McFadden et al. (2013).

The number of interviews that took place limits the research in this thesis. Originally, it was hoped that more MPs and civil servants would participate, however turnover at the Department of Health in April 2013 meant a number of potential interviewees were no longer available or felt willing to participate. The lack of interviews with

MPs was somewhat overcome by including data from parliamentary debate transcripts which added valuable political context to the qualitative data.

There were also limitations in the semi-structured interview process with policy participants. Two separate policy participants indicated that in order for data from their interviews to be used, they would need to first approve quotes. One participant approved all quotes, the other removed quite a few and changed others. Thus some qualitative data that had initially been analysed was later unable to be used.

There is a lack of context from the point of view of the Dairy Industry. Although their presence was clear in the consultation documents and Hansard transcripts, it was disappointing that despite efforts to recruit an interviewee, a representative from Dairy UK was not interviewed.

Healthy Start was somewhat of a moving target – in the span of time it has taken to undertake this research, the policy underwent a number of changes and developments, from adding frozen fruits and vegetables and more areas making vitamins universal. With uncertainty around the effects of imminent welfare and NHS reforms, it was unclear from the start whether and how Healthy Start would be affected and change throughout the three years spent undertaking research on the scheme. This impacted the decision to focus on the beginnings of Healthy Start, as it was deemed more beneficial to study something that has happened. In addition, focussing on the policy beginnings provided a new context that any changes to the scheme in the future can be considered within.

### 10.7 Reflection on doctoral process

The fact that Healthy Start is very much a live issue meant researching the scheme was very engaging as the practical implications of research were clear throughout the process. Following a model of policy analysis that was both narrative – telling the story and thematic – making meaning from the story, added to the enjoyment of studying Healthy Start and developing original understanding of how Healthy Start came into being and why the issues that are experienced in practice link to policy.

The iterative process of undertaking doctoral research has led to the consideration of what the synthesis of research findings with literature say not only about what influenced the formation, initiation and implementation of Healthy Start, but, also

what did *not* influence the policy process that, theoretically should have, based on the literature review findings. Looking at both what influenced and what did not influence the policy process provided a more detailed response to the objectives of this thesis.

Throughout the doctoral process, consideration was given to whether or not research on Healthy Start would be acceptable without conducting research with beneficiaries of the scheme. Within the scope of a PhD it would have only been possible to do a small scale study and the issue recognised early on in the literature review was that what was missing from knowledge on Healthy Start was large data sets. It was also anticipated that the evaluation reports would include small scale qualitative data with beneficiaries which they did. The evaluations provided insight into the views and experiences of beneficiaries and the context building research directed the line of inquiry toward the policy process that informed Healthy Start. Further research with Healthy Start beneficiaries would be valuable as it would continue to develop context and insight, however as this is a national scheme, that is being delivered on a local level, data that can speak to the ‘national picture’ would be significant.

It was also anticipated that qualitative research would be undertaken with health professionals as part of the evaluations (McFadden et al. 2013; Lucas et al. 2013). The case study with health professionals as part of this doctoral research focussed on how practitioners interpreted Healthy Start and how their experiences related to the data that existed in the community they were practicing in.

### 10.8 Recommendations for further research

A number of issues emerged throughout this work that could be developed to provide further insight and context into food welfare for low-income women and children.

There is considerable scope to compare aspects of programme delivery between Healthy Start and the WIC programme in the US. Despite the clear point that policies cannot be transferred between countries, there may be valuable lessons from comparing operational issues.

In addition, there is scope to develop the data sources for Healthy Start. It is not sufficient that the only information that exists on how Healthy Start is used is from evaluation focus groups and a sample in the most recent Infant Feeding Survey. The

information exists at market research companies, it has however not been accessed. Analysing this data could provide insight into the type of support advocates in the area of food poverty and nutrition should be promoting.

Continuing to map the development of Healthy Start would provide a clear basis for future policy analysis and to maintain an active record of where this policy has come from which may be useful in reflecting on where this policy is going. Reflecting on the number of changes to welfare food provision since 1940, indicates that there is a level of inevitability that Healthy Start will change, whether in small ways or big ways, keeping track of change could help practitioners, beneficiaries and policy participants to maintain engagement with welfare foods.

Now that the policy process has been mapped, it would be valuable to conduct more in-depth research with policy participants to better understand the role of policy communities – specifically the relationship between government and the dairy industry as the research in this thesis has indicated that influence has been occurring behind closed doors.

The research in this thesis has developed context within the scope of a PhD research project. There is considerably more information that could enable clearer understanding of the issues that govern food welfare for women and children in the UK.



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## APPENDICES

### Appendix 1: Healthy Start resources

**The following resources are available for free download on the Healthy Start website** <http://www.healthystart.nhs.uk/for-health-professionals/healthy-start-resources/> Hard copies can be ordered from the DH orderline [www.orderline.dh.gov.uk](http://www.orderline.dh.gov.uk) or by calling 0300 1231002.

**Delivering a Healthy Start for pregnant women, new mums, babies and young children** A guide to Healthy Start for health professionals explaining about the scheme and nutritional advice for pregnant women, new mums, babies and young children.

**‘Help pregnant women, new mothers and children get their free Healthy Start vitamins**’ A guide to Healthy Start vitamins for health professionals in England. Explains the evidence base for vitamins, what they contain and the ordering, distribution and reimbursement process.

**‘Children’s drops vitamins decision tree: Guidance for health professionals**’ Explains when babies and children should have Healthy Start children’s drops.

**Healthy Start application leaflet (free milk, fruit, veg and vitamins) (HS01)** For clients; please make widely available (please note that the hard copy includes an application form and envelope. Accessible versions of this leaflet (braille, large print and audio) are available to order.)

**Application form** For clients; please make widely available

**Healthy Start application leaflet (free milk, fruit, veg and vitamins) (Welsh Language) (HS01W)** For clients; please make widely available

**Quick guide under-18s (HS506)** Explains the Healthy Start scheme for under-18s

**Quick guide first-time mums (HS507)** Explains the Healthy Start scheme for first-time mums

**Healthy Start user guide (a simple guide to Healthy Start) (HS02)** For families new to

Healthy Start – sent out with their first set of vouchers

**Healthy Start vitamins and why you need them (HS58A)**

A short brochure for beneficiaries explaining what is in Healthy Start children's drops and women's tablets, and why they are important to take

**Healthy Start bilingual quick guide (Urdu) (HS30)** Explains the basics of the Healthy Start scheme in English and Urdu

**Healthy Start bilingual quick guide (Somali) (HS30)** Explains the basics of the Healthy Start scheme in English and Somali

**Healthy Start bilingual quick guide (Bengali) (HS30)** Explains the basics of the Healthy Start scheme in English and Bengali

**Healthy Start A3 bilingual poster (Urdu) (HS31)** For use in clinics and centres to advertise the scheme to those who prefer to read Urdu

**Healthy Start A3 bilingual poster (Bengali) (HS31)** For use in clinics and centres to advertise the scheme to those who prefer to read Bengali

**Healthy Start bilingual poster (Somali) (HS31)** For use in clinics and centres to advertise the scheme to those who prefer to read Somali

**Vitamin Promotional Poster (HS504)** Use to advertise the availability of Healthy Start women's vitamins

**Vitamin Promotional Poster (HS505)** Use to advertise the availability of Healthy Start children's vitamins

## Appendix 2: Interview schedule 1

### Interview schedule

#### The Formation of Healthy Start

What was your job title when involved in the development of the Healthy Start scheme?

How long were you in this position?

#### *Understanding of Healthy Start*

- How would you describe the main objectives of Healthy Start?
- Is HS achieving its original objectives?
- From your experience, what is the biggest benefit of the scheme?

#### *Role in development of HS*

- Why were you involved in the development of the Healthy Start scheme?
- Can you describe your experience during the development process of the scheme?
- Were you involved on any level with the Welfare Food Scheme? If so, how?
- Do you recall how you first learned about the Welfare Food Scheme being replaced?
- What instigated the shift from the Welfare Food Scheme to Healthy Start?
- What do you think were main lessons learnt from the Welfare Food Scheme?
- Why was it replaced?
- What were the main issues with the Welfare Food Scheme that meant it needed to be replaced?
- Do you recall any challenges or barriers to ending the Welfare Food Scheme?
- What enabled the Welfare Food Scheme to be replaced when it was?
- What other schemes, reports or politics were influential in the replacement of the welfare food scheme?
- What are the key distinguishing factors between the Welfare Food Scheme and Healthy Start?
- Who were the main stakeholders feeding into the policy formation process of Healthy Start?
- When HS was being developed and formed, was it considered as part of the welfare state or an aspect of health promotion or intervention?

#### *Actors/stakeholders*

- The policy documents indicate a number of actors/stakeholders present in the development of Healthy Start, did any group of actors/stakeholders influence the development of the scheme more than others?
- Were there any groups that didn't feed into the process that perhaps with hindsight, should have?
- From your experience, can you describe the role of the dairy industry in the development of the Healthy Start scheme? What aspect/aspects of the scheme did they influence?
- What was the roll of the Department of Health in the formation of the scheme?
- What was the role of the Department of Work and Pensions?
- Who were the main supporters of the proposed new scheme? Why?
- Did any groups express concern over the proposed new scheme? Why?

- Can you describe the intended role of the health professional – midwife/health visitor within the HS scheme?
- Who was ultimately responsible for signing off on the current format of the scheme?
- From your experience can you describe any political factors that enabled Healthy Start to be formed when it was?
- From your experience can you describe any political factors that were challenges to getting Healthy Start up and running?
- Were any welfare food schemes from other countries considered in the development of Healthy Start?

### ***Consultation and evaluation***

- Did the development of Healthy Start follow a set process for forming new policy?
- Do you have insight into the level of consultation that happened with health professionals before Healthy Start rolled out?
- Do you know of any factors that influenced the timeline of Healthy Start being rolled out?
- How did the responses to the consultation feed into the development of the scheme?
- How was evaluation of the scheme considered when the scheme was being developed?
- Do you have any insight into the pilot in Devon and Cornwall? How were the findings from the pilot implemented into the final version of the scheme?
- Were there any barriers that prevented a phased roll out of the scheme?

### **The voucher**

- What are the benefits of using a voucher based system within the scheme?
- What sort of support do beneficiaries get for using Healthy Start vouchers?
- How was it decided that a voucher would be the most appropriate vehicle for delivering food welfare?
- Do you have any insight into how beneficiaries use the vouchers?
- Were any other formats considered?
- How was the original price of £2.80 decided?

### **Current political climate**

- What are the biggest threats to the future of Healthy Start?
- Why do you think Healthy Start has received such little attention in the debates around both welfare and NHS reform?
- In light of rising food access issues and food banks becoming more predominant across society, do you think the focus of the scheme may shift to address food security as well as nutrition inequality

## Appendix 3: Letter confirming ethical approval 1



### Undergraduate, Postgraduate & Research Programmes

Music, Culture and Creative Industries  
Economics  
International Politics  
Journalism  
Psychology  
Sociology

Northampton Square  
London EC1V 0HB  
T +44 (0)20 7040 .....  
F +44 (0)20 7040 8580  
[www.city.ac.uk/arts-social-sciences](http://www.city.ac.uk/arts-social-sciences)

25 September 2014

#### To whom it may concern

This is to confirm that the Ethics Committee of the Department of Sociology approved the project 'Food Welfare: the relationship between policy design and practice' on the 6<sup>th</sup> February 2013. The principal investigator of this project is Ms Georgia Machell, doctoral researcher at the Department of Sociology, City University.

Dr Lena Karamanidou



Chair of Ethics  
Department of Sociology  
City University  
Northampton Square  
London EC1V 0HB

Email: 

Tel No.: 

## Appendix 4: Consent form 1



**Project Title:** Food Welfare: A case study to scope Healthy Start

**Principal Investigators:** Ms Georgia Machell, Prof Martin Caraher, Dr. Helen Crawley

- I agree to take part in the above City University PhD project. I have read the Information Sheet and my questions have been answered to my satisfaction.
  
- I understand that my participation is entirely voluntary, and that I can choose not to participate in part or all of the project and can withdraw at any stage without being penalised or disadvantaged in any way.

I understand that agreeing to take part means that I am willing to:

- Be interviewed by the researcher
  
- Allow the interview to be audio taped
  
- Allow my job title to be linked to quotes in publications by the researcher, which will anonymise me by name.

### Data Protection

This information will be held and processed only for the purposes of the evaluation.

**I understand that any information I provide is confidential. I agree for the interview to be tape recorded and I agree for verbatim quotations from the interview to be used in presentations, reports and other publications on the understanding that my job title, but not my name will be connected to the quote. I have received a copy of this consent form for my own records.**

Name of Participant	Signature	Date
_____	_____	_____
Name of Interviewer	Signature	Date

## Appendix 5: Information sheet for policy participants



Georgia Machell  
Centre for Food Policy  
School of Arts and Social Sciences  
Northampton Square  
London EC1V 0HB

Tel: [REDACTED]

I am writing to invite you to take part in an interview about your experiences of the Healthy Start scheme. The research is part of my PhD at the Centre for Food Policy, City University, London. I am carrying out research while being supervised by Prof. Martin Caraher and Dr. Helen Crawley

**Project Title:** Forming and implementing Healthy Start: perspectives from policy actors

**Principal Investigators:** Ms Georgia Machell, Prof Martin Caraher, Dr. Helen Crawley

**Why are you being asked for an interview?** We are asking to interview you because you are currently a professional who has been involved with the formation and/or implementation of Healthy Start.

**Purpose of the interview** As part of this PhD, I am interested in what influenced the design of the Healthy Start scheme. The objective of this interview is to gather different policy actors experiences of Healthy Start.

**Procedure** We have contacted you by email or telephone and a suitable interview time and venue have been agreed. Your participation is entirely voluntary and you may withdraw at any time should you change your mind. The interview will be recorded and will take no longer than 90 minutes.

**Potential Benefits** This will be an opportunity for you to reflect on the current format of Healthy Start.

**Confidentiality** Names will not be used in any project reports or publications, however with your written permission, job title will be used.

The recorded data will be stored as an mp3 file and will be transcribed by the researcher. We will hold the audio data until the end of the PhD (October 2014) and the transcribed data will



be stored electronically on the system, and hard copies in a locked room, at City University premises for seven years (December 2018), then it will be destroyed. Once interviews are transcribed they will be anonymised by name, however job title will be used.

### **University Complaints Procedure**

If there is an aspect of the interview that concerns you, you may make a complaint. City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: Forming and implementing Healthy Start: perspectives from policy actors

You could also write to the Secretary at:

Anna Ramberg  
Research Development Manager  
University Research Office  
City University, Northampton Square  
London, EC1V 0HB

Email: [REDACTED]

**If you have any questions about the interview or the PhD in general, please contact Georgia Machell at [REDACTED] or by email: [REDACTED]**

## Appendix 6: Example transcription excerpt

### Interview 2

GM: Can you describe what the Tavistock Institute is?

I: We are a NGO charity that does research consultancy, we run professional training, particularly group relations trainings and we have a couple of publications. Most of our research is evaluation of government programmes or EU programmes.

GM: How you were involved in the development of the HS programme?

I: The DH issued a tender for the evaluation and there were two stages to it, there was rapid evaluation and then there was the evaluation of the training and Symbia applied for the contract and we'd done work with Symbia before and they brought us in a partner to do the work, they sort of managed the contract really.

GM: What was the tendering process?

I: We wrote proposals, more than one I suspect, I can't really remember it was so far back. I think we probably had an interview, but certainly we wrote a proposal.

GM: Just to clarify – what did they mean by rapid evaluation.

I: It was very short term because the pilot phase was quite short.

GM: And were they clear that was a pilot that you were evaluating.

I: Absolutely, yes. It was just in Devon and Cornwall.

GM: Did they clarify why they chose D and C or was it DH that has chosen DH.

I: D and C was chosen by DH and there were reasons but I can't remember. But it was – I could find out, but I can't remember. But there were good reasons for it.

GM: What sort of background to HS did you have when you came into the evaluation?

I: Oh nothing, but that's the normal process of writing a proposal. I mean my own background is that I've done a lot of evaluation of public health initiatives including healthy eating initiatives and I've also evaluated benefit systems, so that combination of knowledge and my colleague Camilla had a lot of experience of research and evaluation.

GM: What specifically were you evaluating?

I: The initial phase, its implementation and the training we were asked specifically to evaluate the training provided to health professionals. We did a survey of training participants and we also looked at how it was implemented on the ground.

## Appendix 7: Manual coding table

Category	Policy drivers			Mapping formation of Healthy Start	Mapping barriers and enablers to accessing HS
Concept driven code	Problem - orange	Policy - yellow	Politics – blue	Process - pink	Practice/operations - green
	<p>I think there was a good evidence review done before and the whole programme was designed based on the evidence review, but then the implementation was influenced very much by policy expediency rather than, you know several of the elements that were there, I mean evidence was lost.</p> <p>And some of the HS we were speaking to said, they were dealing with some mothers from very deprived backgrounds feeding their kids basically on hamburgers and sweets – some real horror stories. It's very complex.</p>	<p>Did you get the impression that your evaluation did not feed into a process?</p> <p>If it fed in, it had very little influence on it.</p> <p>We had dialogue with the policy makers, but that was always a somewhat uncomfortable conversation because they didn't understand</p>	<p>I mean the whole point of the pilot phase it generate lessons for the role out. The other thing is it was in a time when DH was experiencing quite considerable upheaval – about five years of constant reorganisation and people moving out, so I think even the policy people we were talking to, moved and changed during the period so there was a real lack on continuity.</p> <p>Because its political, when it comes down to it. It's like what the political drivers are at the moment and I think it was always a bit odd in so far as it traversed health and benefit system so I think there was always some tension that was never fully resolved.</p>	<p>The DH issued a tender for the evaluation and there were two stages to it, there was rapid evaluation and then there was the evaluation of the training and Symbia applied for the contract and we'd done work with Symbia before.</p>	<p>The initial phase, its implementation and the training we were asked specifically to evaluate the training provided to health professionals. We did a survey of training participants and we also looked at how it was implemented on the ground.</p>

## Appendix 8: interview schedule 2

### Interview Topic Guide: Health Professionals

#### *Role, guidance and advice*

- How would you describe Healthy Start?
- What is your job and how are you involved with Healthy Start in Islington?
- Did you have specific training before you were able to administer/advise on Healthy Start?
- If so, what did it involve and do you think it was sufficient?
- If not, where have you learnt the information you pass on to beneficiaries, specifically on dietary guidance?
- How do you keep up to date with current guidance on diet in pregnancy and the early years?

#### *Relationship with beneficiaries*

- From the first contact with a beneficiary how often do you have the opportunity to talk about the Healthy Start scheme with them?
- How would you describe the main point of Healthy Start to beneficiaries?
- In general are beneficiaries enthusiastic about the scheme?
- What sort of questions do you get asked by beneficiaries of the scheme?
- Do you have all the information you need in order to answer their questions?
- Are there common questions you are asked?
- If so, what are they and how do you address them?

#### *Vouchers*

- How do you think beneficiaries could get the most out of their Healthy Start vouchers?
- Do all the beneficiaries you talk to use Healthy Start vouchers? If not, do you know what the barriers are that prevent eligible people using the vouchers?
- Do you get any insight into how beneficiaries use their vouchers?
- Do you get any insight into where beneficiaries use their vouchers?
- Have you noticed any common trends in how vouchers are used? i.e. on specific things, for specific family members, where they are used etc.
- 

#### *Shift from Welfare Food Scheme to Healthy Start*

- How has the change from Welfare Food Scheme to Healthy Start been?
- Has it affected your workload?
- Were you aware that the scheme was going to change when it did?
- Do you think it has been well received by beneficiaries?
- How has the shift changed things for beneficiaries?
- How prominently does infant milk feature as a component of Healthy Start?

#### *Background – policy design*

- Do you know anything about the background of the scheme?

- Have you ever been involved with a Healthy Start consultation? If so, what was that experience like?
- Do you know how the Healthy Start scheme operates in other areas of London or the UK?
- Why do you think Healthy Start exists?
- Do you think there are any people who are not eligible for Healthy Start that should be?
- If you could change anything about the scheme what would it be and why?
- What do you think is the biggest benefit of the scheme?
- What do you think are the biggest challenges of the scheme?

## Appendix 9: Ethical approval letter 2



School of Health Sciences

Research Office  
20 Bartholomew Close  
London EC1A 7QN

Ref: PhD/12-13/02

Tel: [REDACTED]

31 May 2012

[www.city.ac.uk](http://www.city.ac.uk)

Dear Georgia / Martin / Helen

**Re: Food Welfare: A case study to scope Healthy Start Working Practices**

Thank you for forwarding amendments and clarifications regarding your project. These have now been reviewed **and approved** by the Chair of the School Research Ethics Committee. Please find attached, details of the full indemnity cover for your study.

Under the School Research Governance guidelines you are requested to contact myself once the project has been completed, and may be asked to complete a brief progress report six months after registering the project with the School.

If you have any queries please do not hesitate to contact me as below.

Yours sincerely

A handwritten signature in black ink that reads "A Welton".

Alison Welton

Research Governance Officer

[REDACTED]

[REDACTED]

## Appendix 10: Information sheet for health professionals



Georgia Machell  
PhD Candidate  
Centre for Food Policy  
City Community and Health Sciences  
Northampton Square  
London EC1V 0HB  
Tel: 0207 040 4302

I am writing to invite you to take part in an interview about your experiences of Healthy Start.

The research is part of my PhD at the Centre for Food Policy, City University London. I am carrying research while being supervised by Prof. Martin Caraher and Dr. Helen Crawley

**Project Title:** Food Welfare: A case study to scope Healthy Start

**Principal Investigators:** Ms Georgia Machell, Prof Martin Caraher, Dr. Helen Crawley

**Why are you being asked for an interview?** We are asking to interview you because you are currently a health professional that participates in the dissemination of Healthy Start.

**Purpose of the interview** As part of this PhD, I am interested in how Healthy Start works in practice. The purpose of this interview is to learn about the experiences health professionals have with the scheme.

**Procedure** We have contacted you by email or telephone and a suitable interview time and venue have been agreed. Your participation is entirely voluntary and you may withdraw at any time should you change your mind. The interview will be recorded and will take no longer than one hour.

**Potential Benefits** This will be an opportunity for you to identify the benefits and challenges of Healthy Start within your community.

**Confidentiality** Every effort will be made to ensure confidentiality. No information that discloses your identity will be used in any project reports and all comments made in the interview will be anonymous.

The recorded data will be stored as an mp3 file and will be transcribed by the researcher. We will hold the audio data until the end of the PhD (October 2014) and the transcribed data will be stored electronically on the system, and hard copies in a locked room, at City University premises until June 2017, when it will be destroyed. Once interviews are transcribed they will be anonymous, as all identifiable information will be removed.

**University Complaints Procedure**

If there is an aspect of the interview that concerns you, you may make a complaint. City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary of the Ethics Committee and inform them that the name of the project is: Food Welfare: A case study to scope Healthy Start

You could also write to the Secretary at:

Anna Ramberg

Secretary to Senate Ethical Committee

CRIDO E214

City University, Northampton Square

London, EC1V 0HB

Email: [REDACTED]

**If you have any questions about the interview or the PhD in general, please contact Georgia Machell at [REDACTED] or by email: [REDACTED]**



## Appendix 11: Consent Form – Health Professionals

**Project Title:** Food Welfare: A case study to scope Healthy Start

**Principal Investigators:** Ms Georgia Machell, Prof Martin Caraher, Dr. Helen Crawley

- I agree to take part in the above City University PhD project. I have read the Information Sheet and my questions have been answered to my satisfaction.
- I understand that my participation is entirely voluntary, and that I can choose not to participate in part or all of the project and can withdraw at any stage without being penalised or disadvantaged in any way.

I understand that agreeing to take part means that I am willing to:

- Be interviewed by the researcher
- Allow the interview to be audio taped
- Allow my job title to be linked to quotes in publications by the researcher, which will anonymise me by name.

### Data Protection

This information will be held and processed only for the purposes of the evaluation.

**I understand that any information I provide is confidential. I agree for the interview to be tape recorded and I agree for verbatim quotations from the interview to be used in presentations, reports and other publications on the understanding that my job title, but not my name will be connected to the quote.**

**I have received a copy of this consent form for my own records.**

\_\_\_\_\_  
Name of Participant                      Signature                      Date

\_\_\_\_\_  
Name of Interviewer                      Signature                      Date

## Appendix 12: Transcript excerpt – case study with health professionals

### Interview 2

**GM:** First question, very simple, can you tell me what your job is and how long you've been in the profession?

**Midwife:** In the profession, well I'm a consultant midwife for public health and I have been in the profession since 1979, so that's is 33 and half years.

**GM:** Okay, so quite experienced.

**Midwife:** That's from qualification

**GM:** And how long have you been in this specific job?

**Midwife:** Seven years.

**GM:** Seven years. Okay. And so were you involved with the welfare food scheme before it changed to Healthy Start?

**Midwife:** Yes.

**GM:** You were, and what did you think of the welfare food scheme?

**Midwife:** The welfare food scheme was completely bias towards women who chose not to breast feed.

**GM:** Okay

**Midwife:** It was completely the wrong way round. And it also, um even though towards the beginning, when I was first in practice, you actually used to give the women the milk tokens and the milk tokens used to pay for a tin of formula feed a week or a pint of milk a day and even then, the cost of a pint of milk a day was costly different from a tin of infant formula. And it was an incentive to bottle-feed, because actually you got more out of it. Now women are a lot more educated maybe about breastfeeding it's still the same lower socio economic white women who tend not to breast feed but in this area you about 80% breast feeding initiation. So its much farer.

**GM:** And what do you think of the welfare food scheme in terms of how it was administered?

**Midwife:** It did use to be administered really by the midwives and health visitors.