From Food Welfare to Healthy Start:

A Social and Economic Perspective

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List of Exhibits

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Declaration

I declare that the work presented in this dissertation, except for where specifically declared, is all my own work, carried out and finished at City University of London.

Copyright Declaration

Abstract

Healthy Start is a well-regarded food voucher scheme for young children and pregnant women. Despite its popularity with government and charitable organizations, it only reaches half of those eligible, and food insecurity and health inequalities have worsened since its implementation. The significant and steady decline in uptake has focused civil society and the government on increasing uptake and considering modifications to delivery but not on questioning whether the scheme is the best tool to address poor nutrition in young children.

The social and economic impacts of Healthy Start are under-researched and the focus of this dissertation. This research relies on qualitative interviews with parents of young children, health professionals and regional managers of the scheme, as well as on an economic model that was developed to evaluate the scheme's cost effectiveness and financial impact.

The findings indicate that the shortcomings of Healthy Start will not be resolved with minor adjustments or more promotion. The policy is based on an inaccurate assessment of the underlying cause for poor nutrition in low-income families. Parents (usually mothers) at all income levels take seriously their responsibility for their family's nutrition, value healthy food prepared at home, and have a good understanding of the importance of fruit and vegetable consumption. Rather than a lack of knowledge or desire to feed their children healthfully, mothers describe the challenges of limited budgets, the relatively high cost of fruit and vegetables, and the preferences of family members as obstacles to their food provisioning. The restrictions imposed by the Healthy Start voucher reflect and perpetuate the widely accepted perception, among both those that receive benefits and those that do not, that low-income parents lack the knowledge and/or desire to feed their children healthfully. This message reduces participation in Healthy Start as health professionals are less likely to promote the scheme for fear of offending patients and potential recipients are less likely to apply. The vouchers compound the stigma of needs-based welfare undermining personal resilience and contributing to social division.

The findings of this research illuminate the benefits of making the scheme universal for all pregnant women and children under 4 years old, of changing the restrictions on purchasable items, and of increasing the voucher amount. All three changes, or a combination thereof, result in positive economic returns. There is also a significant opportunity to align the policy with other policies and objectives and support local economies, food security, UK farming, and environmental sustainability.

Acronyms

COMA, Committee on Medical Aspects of Food and Nutrition Policy

DEFRA, Department for Environment, Food and Rural Affairs

DHSC, Department of Health and Social Care

DWP, Department for Work and Pensions

MIS, Minimum Income Standard

NHS, National Health Service

NICE, National Institute for Health and Clinical Excellence

SNAP, Supplemental Nutrition Assistance Program (US)

USDA, United States Department of Agriculture

WFS, Welfare Food Scheme

WHO, World Health Organization

WIC, Special Supplemental Nutrition Program for Women, Infants, and Children (US)

Introduction

What is Healthy Start

Healthy Start is a relatively small government scheme that provides vouchers to low-income pregnant women and those with children under 4 years old who receive other means-tested government benefits. The vouchers can be used to purchase cow's milk, fresh or frozen fruit and vegetables and infant formula. All pregnant women under the age of 18 years are eligible regardless of income. The vouchers are currently £3.10 per week for pregnant women and those with children aged 1–4 years and £6.20 per week for those with infants under 1 year old. Approximately 250,000 women and children benefit from the scheme, with an average monthly benefit of £14.40.

The scheme has been in operation since 2006, but enrolment has consistently and significantly declined. This has occurred despite growing recognition of the problem of food insecurity and poor nutrition in low-income families, and attempts to increase the visibility of the scheme and promote its use. While the scheme has been presented as a solution to health inequalities, child nutrition and obesity, prior research has focused on the operations and efficiency of the scheme rather than its potential to address these larger social and economic issues (Lucas *et al.*, 2013; Griffith, von Hinke and Smith, 2018; Scantlebury *et al.*, 2018).

There is an opportunity to study the scheme from a broader welfare economics perspective that attempts to quantify the costs and benefits of the scheme to society while allowing for consideration of the health, social and environmental impacts. This dissertation fills that gap in the belief that considering all of the potential impacts of the scheme, and determining how it is perceived by parents and the health providers that serve as its gatekeepers, can help to explain the disjunction between the assumed effectiveness of Healthy Start and its declining popularity even in the face of growing food poverty and health inequalities.

Personal Motivation

A lifelong interest in politics and the importance of food led me to London to pursue an MSc degree in Food Policy. My MSc dissertation compared food voucher schemes in the US and the UK, and led me to question why the Healthy Start scheme was declining in uptake despite increasing need. My background included an MBA and corporate finance, and so I felt I could analyse the economics of Healthy Start in a PhD. However, my real interest was in the social impact of the scheme. As a mother I understood that feeding children is about much more than food, and I wanted to better understand the social and cultural issues that appeared to have been largely overlooked by prior studies of the scheme.

Why Study Healthy Start?

The importance of a healthy diet in early life is uncontested, and the Healthy Start scheme is the primary policy that the UK government uses to support nutrition in very young children from low-income families. The UK historically has not provided food welfare except in limited circumstances, and this is the only UK government scheme that provides money for food in the home. More is known about other forms of food support, with recent research focusing on food banks and school meals. However, there is a

gap in the knowledge about the social and economic aspects of Healthy Start. Despite the lofty goals of the scheme, it has had a precipitous decline in popularity and impact.

Contribution to Food Policy

This dissertation sets out to contribute to better food policy by researching the impact that Healthy Start has on those who are eligible, and the challenges and opportunities it provides to improve nutrition in young children. The findings will assist in the development of an inclusive food policy that incorporates the lived experiences of parents and considers the economic and social impact of the scheme.

Methodology

The research methodology is primarily qualitative. A wide-ranging literature review establishes the context of the scheme. Qualitative interviews with parents, health professionals and managers in two urban areas provide a rich source of data on the everyday lives and beliefs of families with young children. Observations of parents with their children add depth to the research findings. The development of an economic model helps to measure the cost effectiveness and potential for policy improvement based upon suggestions derived from the findings.

Epistemological Approach

This research project uses an interpretive approach, allowing meaning to arise from the analysis of the discourse and practices observed. The goal of this research is not to test a hypothesis or discover a solution to a problem, which would be more suited to a positivist approach. Rather, the goal is to learn more about the lives of families with young children and the challenges they face and how families and health professionals perceive Healthy Start and its goals and impact. This approach allows for broader social questions and is consistent with the primarily qualitative methodology undertaken.

Conclusion

There is a large gap between the lofty goals set out for the policy and its actual impact. More than a small voucher is needed if the scheme is to be a response to health inequalities and food insecurity. Families face many challenges, and food cannot be separated from housing, utilities and other needs, emphasizing the need for a welfare system that supports people when they need it. This makes economic as well as moral sense. The discourse of personal responsibility and choice reinforces class inequalities and ignores the reality of people's lives and the struggle to meet societal expectations on a low income. The scheme reinforces these inequalities by perpetuating this discourse and deflecting responsibility from the government, placing it instead on low-income parents. One could argue that if the problem is a lack of material resources, then Healthy Start provides a solution. However, this overlooks the role that Healthy Start plays in reinforcing the stigmatization of low-income mothers while absolving the government of the responsibility to address the problem in a meaningful way.

Structure of the Dissertation

The following is a brief summary of the structure of the dissertation. There are eight chapters. Chapters 1 to 3 provide the background, set out the problem to be researched and detail the research methodology

undertaken. Chapters 4 to 6 present the findings, and the final two chapters discuss the findings in relationship to the prior research and identify opportunities for future research.

Chapters 1-3: Context, Literature Review and Methodology

The literature review has been separated into two chapters, followed by the research methodology.

Chapter 1 presents a broad review of the background literature, which sets the context for Healthy Start, and is divided into the following themes: historical and political; health; economic; social; and environmental.

Chapter 2 continues with a detailed analysis of what is known about the Healthy Start Scheme. It covers the policy formation, design and operations. It includes an analysis of prior research on the scheme's impact on nutrition, the role of health professionals, and what is known about how the vouchers are spent.

Chapter 3 identifies the research aim, with supporting objectives and research questions, and explains and justifies the research methodology.

Chapters 4-6: Findings

The findings in this section are organized according to the research questions.

Chapter 4 reviews the food practices of those interviewed, their perceptions of healthy eating, the obstacles they face in achieving this diet, the responsibilities in the home for food provisioning, and finally, the reality of their diet.

Chapter 5 analyses the perceptions and experiences of parents and health professionals with Healthy Start, including its goals, its visibility, its effectiveness. It also examines how recipients are perceived in an attempt to determine if stigma is a barrier to participation.

Chapter 6 provides an overview of the economic impact of the scheme. First an economic benefit/cost analysis model is developed to determine the current and potential economic effectiveness of the scheme under many different scenarios. Second, the financial impact to families, farmers, retailers and infant formula producers is calculated.

Chapters 7-8: Discussion of Findings and Conclusion

The final section of the dissertation is a discussion of the findings presented in Chapters 4 – 6, followed by a conclusion.

Chapter 7 relates the findings to the literature analysed in Chapters 1 – 2, identifying weaknesses in the policy design and operations. It considers the social impact of the policy design and economic impact of the scheme

Chapter 8, the conclusion, provides a summary of the key research findings, the policy implications of these findings and their contribution to food policy, areas for future research, and reflections on my research journey.

Chapter 1: Background and Policy Context

1.0 Introduction

This chapter provides insight into the political, health, economic, social and environmental context that Healthy Start operates within as well as impacts. The argument is that an integrated approach – which is consistent with the 2015 Sustainable Development Goals acknowledging the need for all policymaking to integrate economic, social and environmental considerations – may better answer the crucial question facing policymakers: Why does the scheme appear to be failing?

On the surface the Healthy Start scheme appears to be a logical and efficient policy that targets those who need nutritional support with a voucher for healthy food (fruit, vegetables, milk and infant formula) at a particularly important developmental stage. It seems efficient because it is restricted to those most in need and does not waste resources on those who can afford better nutrition, even if they choose not to, and because the focus on young children provides a unique developmental opportunity to affect long-term health and life chances.

However, there are questions regarding the scheme's success at addressing health inequalities and providing a nutritional safety net for young children. Health inequalities have grown since its implementation in 2006, and the budget for the scheme has fallen from an estimated £125 million at the start to just £50 million in 2020. Uptake of the scheme has consistently declined and is currently only about half of those eligible. This has led to calls to increase registration and uptake through increased visibility. The approach taken by advocates has been to increase promotional materials and local support, while convincing policymakers of its importance. However, advocates and policymakers have not questioned the underlying reason why the uptake is low.

This dissertation interrogates the implicit and explicit assumptions upon which the scheme is based, and assesses their usefulness by comparing these assumptions with the knowledge and food practices of target families and the constraints they face in achieving their ideal healthy diet. The designers of Healthy Start made a number of assumptions about low-income families: that they suffered health inequalities due to a lack of funds to buy healthy food; that they lacked knowledge about healthy eating; and, due to preferences or poor budgeting, they could not be trusted to make healthy food choices if the vouchers were not limited to specific foods.

Utilizing an integrated approach as an organizing structure for this chapter provides a mechanism for identifying assumptions and consequences of the policy that may not have been considered before. Prior research on the scheme has largely focused on its operations and perceptions of its efficiency and effectiveness in improving diet, rather than on determining if the policy design is fit for purpose – improving early nutrition and minimizing health inequalities. This project takes a broader approach by considering all aspects of the food system, including not only health, but also the social, economic, political and environmental issues that could affect the success of the scheme. This organizing framework has provided a way to look at the scheme through many lenses, identifying interactions and relationships.

However, the lines between these broad political, health, economic and social categories can be hard to draw. Some issues belong in several categories and there are linkages between categories that cannot be ignored. Such complexity is a strength of the integrated approach and although it made writing this dissertation more difficult it offers the best possibilities for new insights. It is not the absolute categories that matter, but rather the expansive thinking that the categories required. Using a broad integrated framework consistent with a food systems methodology encourages thinking about the linkages, synergies and potential conflicts of policies in traditionally different areas such as health and agriculture (Parsons and Hawkes, 2018). This has provided an organisational scheme that allows the research to rethink cause and effect and relationships, to question the nature of the problem that Healthy Start is designed to solve, and to assess whether Healthy Start is the right solution to that problem. For example, the health lens looks at the impact of food insecurity and Healthy Start on nutrition, whereas the social lens contemplates stigma and the impact on social cohesiveness. The economic lens focuses on financial means and impacts but excludes social welfare. Finally, the political lens thinks about the power structures, political agendas, and ideas that affect policy formation and change.

This approach is consistent with a belief that the scheme is part of the food system, a "complex network of economic and societal relations which organizes how food is grown, processed, retailed, cooked and consumed" (Lang, 2020, p. 16). While historically not considered to be part of the food system, food welfare programmes are now seen by many as an integral part of food access (Thompson *et al.*, 2013; Cummins *et al.*, 2020). As a response to wartime rationing, Healthy Start's origins implicitly recognized some of these access issues. However, after the war as supplies increased and prices declined, the focus of food policy shifted from supply to consumption (Lang, Barling and Caraher, 2009).

Widening the pool of relevant knowledge also results in better public health policy making, by considering all of the effects of the policy and thus avoiding the linear policy analysis that has been typically employed in evidence-based policy analysis (Rutter *et al,* 2017). Rather than seeing policy makers as dispassionate observers of objective scientific evidence, this acknowledges that policymakers are people who draw on emotions, habits, and their own beliefs to understand policy problems and evidence. This is particularly important for Healthy Start because evidence from marginalized groups, such as the poor, is especially suspect to the imposition of judgement in the analysis of evidence (Cairney, 2018). As this dissertation will demonstrate, the values, perceptions and judgements of policymakers, health professionals, and parents, both recipients and non-recipients, are absolutely crucial to understanding the Healthy Start scheme.

1.1 Political

This section begins with a brief summary of the UK government's response to health inequalities since 1942 which situates the formation of Healthy Start within the historical and political context. The more specific analysis of the foundation and formation of Healthy Start is given in Chapter 2. Then follows an overview of the history of food welfare in the UK, the role of food vouchers and food banks, and a look at the current political environment.

1.1.1 History of the UK Commitments to Reduce Health Inequalities

The origins of the current welfare system date back to the 1942 Beveridge report on "Social Insurance and Allied Services" (Beveridge, 1942). In this report, Beveridge put forth a vision to address what he saw as the five giants of social ills – want, disease, squalor, ignorance and idleness – through a universal benefit plan that would expand public housing, provide free education, achieve near full employment and provide benefits for the poor. Led by this vision for a better society after the trauma of World War II, the Labour Party won the election in 1945 and passed the sweeping National Assistance Act of 1948. Since that time, the government has repeatedly committed to address health inequalities, including the availability and accessibility of an affordable, nutritious diet. The following is a timeline outlining significant research or policy milestones.

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).

1945: The Conservative party loses in a landslide, ushering in a commitment to full employment and the welfare state. Income inequality was reduced substantially due to rationing and full employment, nearly eliminating poverty (Zweiniger-Bargielowska, 1994).

1951: Conservatives return to power as a reaction to the shortages and rationing of the post-war years (Kynaston, 2007).

1954: Wartime rationing ends as the last meat rations were eliminated (Zweiniger-Bargielowska, 1994).

1965: The Child Poverty Action Group (CPAG) meets for the first time with founders Brian Abel-Smith and Peter Townsend, whose work *The Poor and the Poorest* drew attention to the growth of poverty in the UK in the late 1950s (Gazeley *et al.*, 2014).

1967: The Whitehall Study of British civil servants focused on the morbidity of civil servants and found a significant inverse relationship between higher grade employees and the risk of death. Whitehall I only included men, but 20 years later Whitehall II included women and focused on social issues (Marmot *et al.*, 1991).

1979: Townsend's *Poverty in the United Kingdom: A Survey of Household Resources and Standards of Living* is published which examines relative deprivation based upon a range of aspects of living standards, exposing a significant level of poverty. He describes those in poverty as those who fall well below the ability to participate in activities deemed normal in society (Townsend, 1979).

1980: The Black Report "Inequalities in Health" found that although overall health had increased, significant health inequalities remained. The report was commissioned by the Labour government, but at the time of its completion the Conservatives had been newly elected, and the report was largely overlooked (Department of Health and Social Security, 1980).

1996: Suzi Leather's report *The Making of Modern Malnutrition* is published, drawing attention to the impact of low income on nutrition (Leather, 1996).

1996: The Rome Declaration on World Food Security, which the UK signed, stated:

> *We will implement policies aimed at eradicating poverty and inequality and improving physical and economic access by all, at all times, to sufficient, nutritionally adequate and safe food and its effective utilization* (Food and Agriculture Organization, 1996).

1998: The Acheson Report entitled "Independent Inquiry into Inequalities in Health" found a correlation between social class and health, highlighting a widening health gap between social groups. It focused on the social determinants of health and gave a particular priority to mothers and children, while calling for a reduction in food poverty and obesity (Dowler and Spencer, 2007).

1999: The introduction of the Working Families and Sure Start programmes, National Minimum Wage, and benefit changes to reduce childhood poverty.

2002: The Committee on Medical Aspects of Food and Nutrition Policy (COMA) is commissioned to review the Welfare Food Scheme (WFS) in light of then-current nutritional information (Committee on Medical Aspects of Food and Nutrition Policy, 2002). This was the foundation of Healthy Start and will be discussed in detail in Chapter 2.

2003: Expansion of Child Tax Credits to reduce child poverty.

2006: Launch of the Healthy Start Scheme, replacing the WFS.

2007: The Foresight Report, *Tackling Obesities: Future Choices*, acknowledges the socioeconomic drivers of obesity, recommending policies to address obesity that focus on structural issues as well as individual behaviour.

2008: The report entitled *Food Matters—Towards a Strategy for the 21st Century* establishes a food policy vision for the future that "promotes public health". It specifically mentions the need for low-income families to increase fruit and vegetable consumption (Cabinet Office, 2008, p. iv)**.**

2010: The Marmot Review, *Fair Society Healthy Lives* highlights persistent health inequalities, calling for a government response that is proportional to the level of disadvantage (Marmot, 2010).

2011: The Responsibility Deal relies on industry to make voluntary reductions in calories in their food. The government's response to obesity and health inequalities is to focus on education and information, including improved labelling and some restrictions on advertising during children's programmes. Healthy eating advice was provided on government websites.

2014: The Department for Environment, Food and Rural Affairs (DEFRA) report entitled *Household Food Security in the UK: A Review of Food Aid* determines that low-incomes, unemployment and benefit delays have combined to trigger increased demand for food banks among UK's poorest families. "A broader approach to sustaining food access, which takes account of longer-term and underlying dimensions to household food insecurity is needed." The reasons given for food bank usage were low wages, benefit sanctions, and high energy and housing costs (Lambie-Mumford *et al.*, 2014, p. xi).

2015: The UN Sustainable Development Goals articulated many goals directly relevant to nutrition including "ending all forms of malnutrition" by 2030 (United Nations, 2015)**.**

2015: A House of Commons committee report calls for "brave and bold" action on childhood obesity (Health Commons Select Committee, 2015). The report notes that a significant number of deprived children are obese when they begin school, and that this is a significant contributor to health inequality. The trend shows a widening of inequality over time.

2016: The *Childhood Obesity Strategy* is substantially weaker than campaigners had hoped, calling for a voluntary 20% reduction in the sugar added to certain foods by 2020, but none of the hoped-for restrictions on advertising or unhealthy food promotions (HM Government, 2016).

2020: *Health Equity in England: The Marmot Review 10 years On* describes the last decade as a lost decade because health inequalities are widening and health is declining for the whole population. This is described as a direct failure of government policies (Marmot, 2020).

But despite the awareness and stated concern, the issue of health inequalities has not just persisted but widened in the UK. As shown above, it seems that each decade the impact of poverty on health is rediscovered. Marmot notes, in the past ten years austerity has increased child poverty and insecure work and has led people to increasingly rely on food banks. Although the research is just emerging, this has been exacerbated by Covid-19 which disproportionately impacts those at the lower end of the social and income gradient (Loopstra, 2020; Power *et al.*, 2020).

1.1.2 Role of the State in Reducing Health Inequalities, or the Right to Food

> *The right to food is the right of every individual, alone or in community with others, to have physical and economic access at all times to sufficient, adequate and culturally acceptable food* (De Schutter 2014, p. 3).
>
> *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* (De Schutter 2011, p. 3).

Is there is a fundamental human right to an adequate diet? The UK government's stated goals imply an answer in the affirmative because the state has committed to reducing health inequalities, making it explicitly a governmental responsibility to ensure that everyone has access to healthy food. A number of influential researchers have argued along these lines "[S]tates have a duty to protect the right to an adequate diet" (De Schutter, 2011, p. 3) see also Poppendieck (1999), Riches (2011), Dowler and Lambie-Mumford (2015) and Caraher and Furey (2017). This places the role and responsibility to ensure access to a sufficient diet with the state rather than the individual (Dowler and Spencer, 2007). Yet, these commentators agree that there is little evidence that the UK is meeting its right to food obligations for all (Dowler and O'Connor, 2012). This stems from tension in government's understanding of food as a basic human right or as an economic imperative that views public health interventions to improve nutrition as a solution to an economic problem. The latter, described as a human capital rather than human rights

approach, was first articulated by Boyd Orr and recognises the economic efficiency of a healthy working population (Orr, 1936).

The idea that a right to food is the government's obligation has been eroded and is being replaced by the view that the private sector, primarily charity working with industry, should take over the responsibility. The rapid growth of emergency food provisioning through food banks is evidence of this change. There are signs of this also in the Healthy Start scheme as private charity and industry have initiated voucher enhancing programmes.

The friction between these competing theories of ensuring access to food as a government or private sector obligation is at the heart of understanding the UK policies to address hunger and health inequalities. A related issue is whether the vision for policy is to right health inequalities as a matter of social justice or as an efficient means of increasing productivity in a society. From a right to food perspective, the transition from imagining food as an entitlement, to framing it as an object of charity, is problematic (Lambie-Mumford, 2015). For example, Riches argues that "charitable food banking is very much a part of the problem of hunger in rich societies… it is no guarantee of meeting demand, nor of ensuring nutritious or culturally appropriate food" (2011, p. 768). For Riches, the only way to eliminate hunger in wealthy states is to return to the belief that food is a basic human right and the responsibility of government:

> *If there is to be a strong public commitment to eliminating hunger and reducing poverty in the wealthy states, there is an urgent need for governments to think outside this charitable food box. The human right to adequate food offers an alternative approach* (2011, p. 768).

Others concur, as in Dowler and O'Connor's claim the following year that "[s]ystematic failure in the obligation to fulfil people's rights to sufficient food for a healthy life is perpetuated by State reliance on voluntary sector responses, to feed people who are hungry or without the means to purchase food in the short or longer term" (2012, p.46). A human rights-based campaign that posits the obligation of the state to provide its citizens with enough nutritious food would acknowledge the State's failure to fulfil its obligations (Poppendieck, 1999; Donald and Mottershaw, 2009; Riches, 2011). These approaches ultimately require the state to focus on the root causes of poverty rather than its manifestations. Sen (2009) redefines food poverty as not a lack of food, but a lack of entitlement to access food. One solution to improve food security would be for the state to guarantee an income that is sufficient to secure food against other expenses (Lambie-Mumford and Dowler, 2015).

The moral or economic basis for policymaking may not matter in practice, as the goal is the same: dictating similar policy interventions. A potential advantage to the economic argument that an investment in healthier and more productive citizens results not only in healthcare and welfare savings but also in increased tax receipts is that it may be more compelling to policymakers. The economic analysis presented in Chapter 6 makes such an economic argument based on the human capital approach.

1.1.3 History of Food Welfare in the UK

The inception of food welfare began in the Second Boer War as the government was forced to acknowledge that malnutrition was limiting the productivity of the working classes. The concern that the

British empire was weakened caused public alarm that created support for better nutrition, particularly for children.

1899-1902: The Boer War exposed the poor health of the working-class men recruited for military service.

1904: Report of the Committee on Physical Deterioration of recruits to the Boer War documented this "widespread physical weakness among the working class" (Gilbert, 1965, p. 144).

1905-1909: The Royal Commission on the Poor Laws was established to review the adequacy of the existing Poor Laws.

1906: The Education (Provision of Meals) Act of 1906 passed

1907: Medical checks in schools were introduced

1908: Pensions were introduced in a limited way

1909: Royal Commission on the Poor Laws—Majority and Minority Reports were published drawing attention to the destitute and inadequacy of the current laws. The majority determined that the existing laws should be enhanced to provide better protection for the sick, children and the elderly (the deserving poor), but believed that others (the undeserving poor) were responsible for their own poverty and required the supervision and discipline provided by the poor law guardians. However, a vocal minority led by Beatrice Webb highlighted the inadequacy of the existing system by documenting an unacceptable prevalence of poverty caused by structural and social conditions (Wallis, 2009). While it has been described as the foundation of the modern welfare system, the Minority Report stopped short of recommending free services, as "any grant from the community to the individual… ought to be conditional on better conduct" (Minority Report, p. 673 in Woodroofe, 1977 p. 159).

1909/10: Lloyd George's the People's Budget was introduced to Parliament which raised new taxes from the wealthy to support new programmes for old age pensions, national insurance and employment assistance (George, 1909).

1913: *Round About a Pound a Week* by Maud Pember Reeves was published by the Fabian society (of which Webb was a member) to detail a charitable response to the 1909 reports. The purpose of the study was to show the impact of food welfare for low-income mothers and young children. In response to the higher infant death rates in poor London areas compared to more affluent areas, members of the Fabian Women's Group initiated a four-year study of working-class Lambeth families, studying their food practices and providing food subsidies and medical support. Forty-two mothers received a stipend of five shillings a week for the last three months of their pregnancy and for the first year of their child's life. The stipend was financed with private donations. Families were required to record how the money was spent, which caused some families to drop out of the programme. The report of the study concludes that lack of income was the primary barrier to better nutrition and health, arguing for better support for children including child benefit and the provision of school meals (Pember Reeves, 1913).

During the first half of the twentieth century there were significant strides in nutritional research as well as the increased recognition that a large portion of the British population lacked the means to purchase sufficient healthy food to become productive citizens. Boyd Orr's 1936 report, *Food, Health and Income*, calculated that a third of the UK population was unable to afford a healthy diet (Orr, 1936). He was the first of many to call upon government to adopt a food policy that focused on nutrition (Lang, Barling and Caraher, 2009). There was concern in particular that citizens consumed too little milk and cheese and too much sugar (Hammond, 1954). Milk consumption in particular was encouraged as a means to promote nutrition for vulnerable groups.

However, the Ministry of Health, responsible for the nation's nutrition, did little to offer a remedy for this until the Ministry of Food proposed wartime food rationing. The threat of rationing and concern about the supply of milk led to the public health concern that consumption would fall in mothers and children, which prompted the Minister of Health, Walter Elliot, who was himself medically trained and an advocate of food welfare, to take the opportunity the war presented to improve the nation's nutrition. It is important to note that the impetus for change was not the information on nutrition and public health inequalities, but the supply challenges presented by the war. Elliot proposed a plan to subsidise milk for all pregnant women and young children. The plan was not supported by the Treasury, which was funding the war effort and concerned about inflation. The Treasury opposed any extension to social welfare during the war (Hammond, 1954). However, the objections were overruled due to the increased power of the Labour Party following the 1940 election combined with the emotional impact of the war. The WFS was quickly implemented.

Upon application, the WFS provided parents of children under 5 years old and pregnant women (if their pregnancy was certified by a health professional) with one pint of milk a day at a reduced price from any retailer. The government paid the difference upon receipt of claim from the retailer. Rapid introduction led to implementation and administrative issues, including problems with unclear responsibility for the scheme and an inefficient application process. It was ultimately abolished in 1943. After that time anyone in possession of a children's ration book was automatically entitled to reduced price milk. The delivery of the scheme evolved from a ration book to tokens that could be exchanged for a specific amount of milk or infant formula at retail outlets. The tokens were distributed by Benefit Centres in conjunction with other benefits.

In 2002, a review of the WFS was undertaken by the Panel on Maternal and Child Nutrition of COMA (Committee on Medical Aspects of Food and Nutrition Policy, 2002). Based on the recommendations of the committee, the Welfare Food Scheme was expanded to include fresh fruit and vegetables and rebranded as the Healthy Start Scheme. Healthy Start inherited many of the problems of the WFS. Eligibility and the value of the voucher were limited to avoid increases in overall programme costs. The scheme provided weekly vouchers for £2.80 (twice that for infants under 1 year old) that could be exchanged for milk, infant formula, fruit and vegetables. This amount was increased in 2009 to £3.10, where it has remained until a proposed increase to £4.25 in April 2021 due to increased awareness of children's food insecurity due to Covid-19. It is unclear if the original goal of the scheme was to provide

a nutritional safety net for a specific time period or to have a long-term impact on public health (Machell, 2014).

Historically, the British government has not intervened in food provision except in times of war, or for the benefits of children (Hills, 2017). The only food welfare programmes in the UK are small and limited to pregnant women and children. The belief that individuals are responsible for their own choices and health has made it politically unpalatable to implement policies that constrain choices. Healthy Start is a notable exception to this, justified because it offers healthy food vouchers for children, and because it has been framed as an economic investment in productivity. The discussion around Healthy Start in the literature and in the press does not focus on the "right to food" aspect of food welfare, and the scheme is perhaps best viewed through the framework of food as a public health intervention serving as an investment in "human capital."

In addition to the Healthy Start Scheme, other existing food programmes for children include school meals, the Nursery Milk Scheme which provides milk for children in licensed day care facilities, and the School Fruit and Vegetable Scheme which entitles every child aged 4–6 years in state schools to a serving of fruit and vegetables daily. The School Fruit and Vegetable Scheme was introduced in 2004 as part of the 5 a day campaign to reinforce messaging about improving children's diets. Its stated goal was to minimize health inequalities.

1.1.4 Food Vouchers

When targeted economic benefits are given, an important question becomes: What is the best way for benefits to be given? Is a voucher more effective than a cash transfer? A voucher provides a financial incentive to purchase a certain item. Vouchers are often implemented to promote desired outcomes that may not be accomplished by cash welfare transfers. There may be greater public support for in-kind versus cash assistance because supporters believe that providing vouchers for food will encourage healthy eating and recipients will not be able to use the support funds for other, less socially desirable purchases.

However, economic theory suggests that if recipients are infra-marginal, that is the value of the food they purchase is worth more than the vouchers they receive, then cash and vouchers should lead to the same outcomes (Griffith, von Hinke and Smith, 2015). The fungibility of money is central to the economic theory of consumer choice.

The evidence is mixed. Studies in the US on the introduction of the Supplemental Nutrition Assistance Program (SNAP) confirm that people do behave as economic theory predicts. Vouchers were found to lead to an increase in overall food expenditures, but infra-marginal households respond similarly to cash or voucher benefits (Hoynes and Schanzenbach, 2007). However, other studies of vouchers have shown that people may spend more when the voucher is "labelled" for a certain use, showing that people may not treat money as fungible (Kooreman, 2000; Abeler and Marklein, 2016). A UK study of the winter fuel payment found an increase in spending even in infra-marginal households (Beatty *et al.*, 2014), and a study in Morocco that provided a cash voucher for education that was not conditional on school attendance had a large impact on school attendance, suggesting that just the label changed behaviour in that circumstance (Benhassine *et al.*, 2015).

1.1.5 Food Voucher Programmes

In contrast to the UK, food welfare is the primary source of welfare in the US. There is a long history of well-studied programmes. The Special Supplemental Nutrition Program for Women Infants and Children (WIC) is similar to the Healthy Start scheme, but the eligibility is much broader. Half of the infants born in the US are eligible. The benefit amount is much greater (£27 per month), the list of allowed foods includes everything required for a nutritious diet, and administrative costs are quite high (40%) because of mandated nutrition education, preventative healthcare services and promotion of breastfeeding and immunization (USDA Food and Nutrition Service, 2021). These substantial differences make comparisons of WIC and Healthy Start difficult. However, it is worth noting that WIC is widely considered a success and research has shown that it has a positive impact on families, improving nutrition, increasing the use of healthcare, prolonging breastfeeding, and improving retail environments (Chiasson *et al.*, 2013; Langellier *et al.*, 2014; Rose *et al.*, 2014; Ng *et al.*, 2018; Nianogo *et al.*, 2019). Despite this success, participation rates are low; with only about half of those eligible participating (52% for 2017) (Gray *et al.*, 2019). Participation is greatest at the lowest income levels, and less at higher levels (Powell, Amsbary and Xin, 2015) which suggests that those at higher income levels may choose not to participate. A study of barriers to participation found that perceived stigma was a major reason cited by those who chose not to participate (Powell, Amsbary and Xin, 2015).

1.1.6 Food Banks in the UK

Another form of food assistance that provides a source of relevant research is food banks. As the state has reduced its commitment to the social safety net, civil society has stepped in to help (Lambie-Mumford *et al.*, 2014; Garthwaite, Collins and Bambra, 2015). The proliferation of food banks has largely been lauded by politicians and society, because it is consistent with the role of the "active citizen." Those that volunteer in food banks are seen as generous, morally superior and honoured by society (Poppendieck, 1999; Lambie-Mumford, 2013; Wells and Caraher, 2014).

Despite the intentions of these charities, by providing a short-term solution they may be undermining food access in the longer term by giving the government an excuse not to address the underlying conditions. Nor can we rule out the possibility that corporations are the true beneficiaries of food bank charity, as they provide an avenue for the disposal of food waste in an inexpensive and apparently socially responsible manner.

The change from government entitlement programmes to charity has brought increased conditionality and stigma for users of food banks (Silvasti, 2014). Food bank users are associated with poor financial management, cooking skills, and lifestyle choices such as drug and alcohol use (Wells and Caraher, 2014; Garthwaite, 2016). While research has shown that food bank usage is often a last resort of those who are the most food insecure due to benefit sanctions and cuts to services (Poppendieck, 1999; Riches and Silvasti, 2014), the perception is that those that use food banks are to blame for their situation.

1.1.7 Current Policy Environment

When the coalition government took power in 2010, the country was reeling from a global recession, rising food and energy prices, and an unacceptable level of unemployment. The government response was

a policy of austerity to reduce government debt, which resulted in the restructuring of welfare programmes. This significantly changed the safety net for low-income people (Ridge, 2013). Eligibility rules for benefits were tightened and many forms of benefits were combined into one: Universal Credit. This has resulted in reduced benefits overall. Unfortunately, these cuts disproportionately affected infants and young children (Ridge, 2013), and have exacerbated inequality (Hastings *et al.*, 2015). The most deprived local authorities have seen cuts of £220 per head per year, while the least deprived have only experienced cuts of £40 per head (Hastings *et al.*, 2015). One of the consequences of these cuts has been a rapid rise in the use of food banks in the UK (Loopstra *et al.*, 2015). It has been estimated that for each 1% cut in spending on central welfare benefits there has been a 0.16 percentage point rise in the distribution of food parcels (Loopstra *et al.*, 2015). Yet, private food aid has been unable to meet the demand for all of the families facing food poverty (Dowler and Lambie-Mumford, 2015).

In addition, the coalition believed that more power and funding should rest with local governments and increasingly relied on them to provide services that had traditionally been controlled by the state. This resulted in many health and social programmes becoming the responsibility of local areas (Department of Health, 2015). This has been criticised because often the funding provided has not been sufficient to implement the programmes, resulting in a diminution of services (McKenna and Dunn, 2015).

The changing political structures as a result of Brexit and devolution provide opportunities as well as challenges to public health at the sub-national level that may not have been possible on a UK or EU level. This provides an important window to consider how changing political circumstances create the opportunity to reassess policy commitments, including the commitment to reducing health inequalities and developing food policy goals. It is an ideal time to ask the big questions: What are the underlying problems, what are the optimal policy solutions, which political institutions are most relevant, and which are the areas where interventions are likely to be the most effective? (Katikireddi *et al.*, 2016).

1.2 Health

The link between nutrition and health has long been understood. The costs to the economy of poor nutrition are outlined in the economic section. The UK has largely relied on a narrative of personal responsibility with regard to nutrition, relying on dietary recommendations. This section begins with an overview of these guidelines in comparison to the current diet. This is followed by the impact of low income on nutrition and finally the importance of nutrition in early life.

1.2.1 Background on UK Nutrition Guidelines and Current Diet

In the 1980s an increasing body of health research identified the importance of fruit and vegetable consumption in preventing disease. This prompted the World Health Organization (WHO) in 1990 to launch a “5 a day” campaign to encourage countries to recommend increased fruit and vegetable consumption. The Department of Health in the UK responded in 2003 with their own 5 a day campaign.

Following an initial rise in consumption after the launch overall consumption has remained relatively steady since, with less than a third of adults achieving the target of five or more portions of fruits and

vegetables per day, and children even less likely to achieve the target (Health and Social Care Information Centre 2014, NatCen Social Research and UCL, 2019).

The 5 a day campaign has not disappeared, but the current guidance according to the guide recommendations is seven portions of fruit and vegetables a day (Scarborough *et al.*, 2016). The empirical evidence for the precise amount of fruit and vegetables underlying the recommendations is lacking, but there is a well-established link between consumption of more fruits and vegetables and health (Lalji, Pakrashi and Smyth, 2018). Current research suggests that the optimum level of consumption for good health may be much more than the recommended amount, or four or five portions of fruit and five or more portions of vegetables (Lalji, Pakrashi and Smyth, 2018).

The Eatwell Plate was developed as the UK's national food guide by the Food Standards Agency in 2007 to reflect the increased interest and research in nutrition at the time. The plate visually represented the proportion of the five major food groups that contributed to a healthy diet. Responsibility for nutritional guidelines passed to Public Health England in 2013. In 2016, the Eatwell Guide modified the earlier recommendations to incorporate the latest recommendations of the Scientific Advisory Committee on Nutrition's Carbohydrate and Health report, which recommended reducing sugar intake and increasing fibre intake (Public Health England, 2015). The guide did not consider the cost or affordability of the recommended diet, which is discussed in more detail in Chapter 6.

1.2.2 Nutrition and Low Income

Although poor nutrition exists at all income levels, it is exacerbated at lower income levels, most likely due to the higher cost of a healthy diet (Bernstein *et al.*, 2010; Lee, Ralston and Truby, 2011; Green *et al.*, 2013; Rehm, Monsivais and Drewnowski, 2015) and the lower cost of less nutritious, energy-dense foods (Drewnowski, 2010; Jones *et al.*, 2014). As the food budget is discretionary whereas many other expenses are fixed, food is often sacrificed in times of financial hardship.

When people are asked about barriers to eating a more healthful diet, financial barriers are most frequently cited, including lack of income and the relatively high cost of healthy food, particularly fresh fruits and vegetables. (Attree, 2006; Church, 2007; Nelson *et al.*, 2007; Haynes-Maslow *et al.*, 2013, 2014; Lucas, Jessiman and Cameron, 2015; Fisher and Dwyer, 2016). It is not only perceived as more expensive to eat fresh foods (Nathoo and Shoveller, 2003; Kamphuis *et al.*, 2006) – and per calorie it is incontestable that fruits and vegetables are more expensive than high fat and sugar processed foods (Drewnowski, 2003) – but fresh foods may also be seen as wasteful because of the possibility of spoilage or of children not liking them (Roux *et al.*, 2000; Dibsdall *et al.*, 2003; Attree, 2006; Yeh *et al.*, 2008; Haynes-Maslow *et al.*, 2013). Low-income parents are reluctant to purchase food their children may reject (Daniel, 2016). In this way children's taste preferences shape food decisions in families with a low income. Unfamiliar foods, particularly those that are not sweet, may take many introductions to be accepted, and low-income families do not have the financial resources to withstand the cost of food waste (Daniel, 2016). At the lowest income levels the lack of funds goes beyond sacrificing quality and diversity to worrying about the availability of food and skipping meals.

It has also been suggested that the shopping habits of low-income people may be the result of other issues such as nutritional knowledge or health attitudes (Turrell and Kavanagh, 2006; Aggarwal *et al.*, 2014; McKinnon, Giskes and Turrell, 2014), but this is difficult to confirm from quantitative data. An indicator that the reason is likely financial is that subsidy schemes which lower the price of healthy food have the effect of improving diet (Ni Mhurchu *et al.*, 2010; Waterlander *et al.*, 2012; An *et al.*, 2013; Klerman *et al.*, 2014) but education schemes alone do not affect purchasing behaviour (Ni Mhurchu *et al.*, 2010; Le *et al.*, 2016).

On average, low-income families consume fewer healthy, minimally processed foods and higher levels of fat, sugar and salt compared to higher income families (Attree, 2006; Adams and White, 2015). Accordingly, the link between poor diet and poverty is clearly visible (Attree, 2006; Khanom *et al.*, 2015). Even in preschool children, differences in knowledge and preference for eating fruits and vegetables is correlated with income (Hansen *et al.*, 2015). However, it is crucial to note that at every income level the consumption of fruits and vegetables is below recommended amounts (Darmon and Drewnowski, 2008; Giskes *et al.*, 2010; Appelhans *et al.*, 2012; Pechey *et al.*, 2013; Pechey and Monsivais, 2015). The Health Survey for England reports consumption of fruit and vegetables by index of multiple deprivation quintile, showing that the mean number of portions consumed varies from 3.8 portions for men and 4.0 portions for women in the least deprived quintile to 3.1 portions for men and 3.3 portions for women in the most deprived quintile. As previously noted, consumption reached a peak in 2006 and following a decline has remained fairly consistent in recent years (Roberts, 2013). Children consume less than adults, as boys eat only 1.6 portions per day and girls 2.0 portions (Nelson *et al.*, 2007; Lucas *et al.*, 2013). Those at the lowest income levels spend the same proportion of their food budget on fruit and vegetables as those in the highest income levels, yet the food budget of more than half of the UK population is insufficient to purchase a healthy diet (Scott, Sutherland and Taylor, 2018). An analysis of shopping habits in the UK by income level follows in Chapter 6.

1.2.3. Food Insecurity

Since the 1996 World Food Summit, food security has been defined as "when all people, at all times, have physical and economic access to sufficient, safe and nutritious food to meet their dietary needs and food preferences for a healthy and active life" (Food and Agriculture Organization, 1996). The main components of food security are availability, access (including affordability) and quality of food. The quality of food includes its safety, nutrition, taste and social acceptability (Kneafsey *et al.*, 2013). Food insecurity, by contrast, can be framed as a lack of appropriate food or as a lack of the resources necessary to obtain it. For Poppendieck (1998), the problem is best defined as poverty, and this will be discussed in more detail below in the Economics section of this chapter.

Food security can be thought of as a national issue or a household issue. As a nation the UK relies on others to produce much of its food. Nearly half of the UK's food is imported from other countries (Lang, 2020), including 84% of our fruit and 47% of our vegetables (Byrne, 2020). Since the UK relies heavily on imported food and functioning supply lines, it is vulnerable to shocks such as Covid-19, climate change, Brexit and future trade deals. It is impossible to have household food security without national

food security, so it is important to consider these elements in policies that address household food security.

Around the world there have been many studies focusing on the magnitude, risk factors and consequences of household food insecurity (Marques *et al.*, 2015). The UK has not consistently measured food insecurity, which has complicated research efforts to study the risk factors and consequences as well as assessments of intervention programmes. The Low-income Diet and Nutrition Survey (LIDNS) from 2003–2005 surveyed the lowest 15% of the population in terms of material deprivation. About 30% of the households in this survey were food insecure and only 51% had the type and quality of food they wanted to eat (Nelson *et al*., 2007). The Food Standards Agency has included food insecurity questions in the biennial Food and You surveys since 2016, the Department for Work and Pensions (DWP) will collect food insecurity data in the Family Resources Survey, which will be available from 2021, and the Food and Agriculture Organisation of the United Nations has also collected data for 140 countries, with about 1000 adults participating in each survey. The most recent Food Standards Agency data showed that 20% of adults in Britain face food insecurity annually, with half of those reporting low or very low food security and about 4% reporting going without food (Food Standards Agency, 2019). Families with children are nearly twice as likely to be food insecure: 30% compared to 16% of those without children and 5% of adults over 75 years old (Food Standards Agency, 2019). As discussed below, this is particularly detrimental to health, as early nutrition has long-term health consequences.

Due to differing methodologies the results from the different surveys are not directly comparable, making it difficult to analyse trends. Studies that have used indirect methods such as the use of food aid indicate that household food insecurity exists and appears to be worsening in the UK. Trussell Trust, which operates the largest system of food banks in the UK, reported that over 1.6 million food parcels were given out in 2018–2019, which represents a 73% increase in the past five years (Trussell Trust, 2020). This expansion in private food aid suggests that emergency food assistance is a growing necessity. However, measuring food insecurity through indirect means such as the rise of food banks offers only one window into the problem. People employ multiple strategies to combat and live with food insecurity and only the most insecure turn to aid (Riches and Silvasti, 2014), which is at best a temporary solution. Potential reasons for the increasing rates of food insecurity are welfare reform, precarious jobs and the elimination of support structures such as the Sure Start children's centres.

Early research indicates that the Covid-19 pandemic has caused significant hardship and increased food insecurity (Caplan, 2020; Loopstra, 2020). The virus-related economic downturn and the possibility of rises in food prices post Brexit is likely to further exacerbate the problem (Barons and Aspinal, 2020; Power *et al.*, 2020).

It is widely recognized that those living in low-income households are more likely to have poor health outcomes both in the short and longer term and are at risk of premature death as a result of their dietary intake (Dowler, Turner and Dobson, 2001; Dowler and Spencer, 2007; Men *et al.*, 2020). For the food insecure, price is the primary criterion in food selection, and dietary quality suffers as a result (Hansford and Friedman 2015). In the US, participation in food voucher programs has resulted in significant

declines in medical costs that have been attributed to improved food security (Sonik, 2016; Berkowitz *et al.*, 2017).

Food insecurity necessitates that families employ creative strategies to procure food, but the lower down the socioeconomic scale the less control people feel they have to influence their nutritional health (Attree, 2006). Strategies to procure food include a reliance on the generosity of others, careful budgeting and shopping, eating inexpensive, monotonous meals with few fruits and vegetables, relying on processed and frozen food rather than fresh, and, as a last resort, skipping meals (Goode, 2012; Dowler and Lambie-Mumford, 2015; Edin and Shaefer, 2015). In a qualitative study, low-income families reported buying "much cheaper food (which they usually also regard as of poorer quality or unacceptable to cultural patterns) or so-called 'fast food' because it requires no cooking" as a main food management strategy (Lambie-Mumford and Dowler, 2015, p. 420). Parents cannot afford the waste that comes from trying new foods and report buying familiar food they know their children will eat (Daniel, 2020; Shinwell and Defeyter, 2020).

Children who experience food insecurity show signs of stress and depression (Darling *et al.*, 2017), increased absenteeism from school (Peltz and Garg, 2019) and higher rates of asthma (Mangini *et al.*, 2018). This is despite the protection from the effects of poverty by sacrifices made by the mother in a well-documented phenomenon referred to as "maternal sacrifice." This acknowledges that women carry an uneven burden and often go without food themselves in order to privilege their children's as well as their male partners' needs (Attree, 2006; Goode, 2012). This comes at a cost to the mother's nutrition and potentially risks the health of future children (Attree, 2006).

Poverty can be defined in many ways. The UK government measures poverty both in relative and absolute terms. The annual report on the Households Below Average Income considers families living below 60% of the median UK household income to be living in poverty (Shale *et al.*, 2015). An absolute measure uses the relative rate of poverty determined in 2011 updated for current prices, ignoring changes in the overall wealth of the country. Neither of these measures consider the cost of an acceptable standard of living which is the foundation of this definition by Townsend (1979):

> *Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong.*

This definition of poverty encompasses the social and cultural elements that are necessary to participate in society. Based on this, researchers have calculated a minimum income based on a social consensus of the cost of a minimally acceptable standard of living that meets an individual's physical, psychological and social needs (Morris *et al.*, 2000; Davis *et al.*, 2012).

A key component of this minimum income is the cost of an acceptable diet that not only meets the requirements for health, but also encompasses the social and cultural acceptability of food (Anderson *et al.*, 2007; Caraher and Furey, 2018). The most recent example of this is the study and calculation of the cost of a consensual food basket undertaken in Northern Ireland (MacMahon and Weld, 2015;

MacMahon, Thornton and McEvoy, 2019). The calculation is based on research with focus groups and nutritionists to determine what is deemed necessary for the minimum essential and socially acceptable food basket. This basket has been priced using supermarket price data that is updated periodically. In 2016, a family with two adults and two children, one in pre-school and one in primary school, would need to spend £115 for food each week, which represents 33% of a family's income if they rely on state benefits or 24% if one of the adults earns minimum wage (MacMahon, Thornton and McEvoy, 2019). For the same family, the cost of the Eatwell Guide has been estimated to be £96.92 per week and actual average household expenditures are £84.07 per week (Scott, Sutherland and Taylor, 2018; Office for National Statistics, 2020). On average the current food budgets of less than half of households are sufficient to meet the government's recommendation for a healthy diet and even fewer have sufficient funds to meet the minimally acceptable diet from a social and cultural perspective.

1.2.4 The Effect of Nutrition on Early Life

The relationship between food insecurity and poor health in children has been well documented (Cook *et al.*, 2004; Anderson, 2007; Hanson and Connor, 2014; Drennen *et al.*, 2019). The results are long lasting, with low socioeconomic status as a child being significantly associated with adult disease (Lynch *et al.*, 1996; Power and Matthews, 1997). Food insecurity is linked to an increased risk of birth defects, anaemia, asthma, cognitive problems and depression (Cook *et al.*, 2006). Children under 3 years old in food insecure households are more than twice as likely to be in poor health than children in food secure households (Cook *et al.*, 2006). The impact goes beyond physical health as even marginal levels of food insecurity are associated with adverse behavioural, academic and emotional issues (Shankar, Chung and Frank, 2017). Even in cases where the child is protected from food insecurity through the mother's sacrifice, children with food insecure mothers are more than twice as likely to have behavioural problems (Whitaker, Phillips and Orzol, 2006).

Preconception and pregnancy, as well as infancy and early years, the first 1000 days, have been recognized since the early twentieth century as especially critical periods of human development with tremendous impact on health outcomes in later stages of life (Webb and Webb, 1927, British Medical Association, 2009, Mameli, Mazzantini and Zuccotti, 2016; Dinenage, 2019) "Much of human development is completed during the first 1000 days after conception" (Barker, 2012, p. 186). There is substantial evidence of the causal link between adversity in childhood and the risk of poor health throughout life, which may not be overcome by future life experiences (Turner, Thomas and Brown, 2016). Good nutrition is critical to the health of pregnant and breastfeeding women – maternal nutrition is particularly important for infant cognitive development (Emmett, Jones and Golding, 2015) – as well as the normal growth and healthy development of young children (Westland and Crawley, 2012; Wen *et al.*, 2013; Kaiser and Campbell, 2014; Baskin *et al.*, 2015).

There are several hypotheses, but little evidence, on the causal reasons for the importance of early nutrition on the developing body. It seems intuitive that severe deprivation of early life nutrition makes it difficult for children to learn and therefore affects their long-term success. But it is also possible that a lack of nutrients in early life reprograms the body to expect deprivation throughout life, in what is referred to as the "thrifty phenotype" or Barker hypothesis. This theory suggests that if and when

nutrition is plentiful later in life, the body will not be equipped to process it, and the result is an increased risk of obesity, high blood pressure, type II diabetes, and cardiovascular disease (Barker, 1990).

Nutrition in the first 1000 days may also affect later health through gene expression or epigenetics. Epigenetic factors are the environmental influences and lifestyle factors that may be transferred to future generations by determining which genes are silenced or activated. These environmental exposures, particularly in early life, may result in changes to the epigenome, or the chemicals that surround the genome which is the sum of the DNA that makes each individual unique (Soubry *et al.*, 2013). Such nutrition programming "suggests that an under or oversupply of a particular nutrient or nutrients at a critical or sensitive period of development may have long term effects on the structure or function of specific organs or systems in the offspring" (Emmett, Jones and Golding, 2015, p. 154). It may be that components in breastmilk are one of the means for epigenetic changes (Verduci *et al*., 2014).

Epigenetics is the likely explanation for why a mother's obesity during pregnancy and the combined effect of hunger followed by obesity may affect the health status of subsequent generations. But recent research has shown that even paternal obesity prior to conception affects the DNA of future offspring (Soubry *et al*., 2013). Obesity and stress, which are both correlated with food insecurity, may result in permanent changes to the genetic code that can be passed on to future generations. One study looked at sperm before and after bariatric surgery to treat obesity. The study found epigenetic differences in the genes that affect behaviours such as appetite control (Donkin *et al*., 2016). It is unclear if these changes would be passed onto future generations, but animal studies suggest the affirmative. Research using rats has shown that male rats fed on a high-fat diet fathered offspring that tended to gain more weight (Ng *et al.*, 2010). This is also true of stress, as male animals exposed to stress produced offspring with a lessened response to stress, suggesting they had been conditioned by their father's adaptation to stress (Rodgers *et al.*, 2013). This could have significant public health implications, but debate remains surrounding the causal link, namely whether the epigenetic changes found actually cause disease or are the consequences of disease (Birney, Smith and Greally, 2016).

A study that mapped later life health outcomes with policies that affect very young children found that increasing resources available in utero and in early life had a significant impact on adult health, educational attainment and economic self-sufficiency (Hoynes, Schanzenbach and Almond, 2016). Although the benefits were largely attributed to improved nutrition, additional research has suggested that the reduction in stress that results from additional income could also play a role (Evans and Garthwaite, 2014; Aizer, Stroud and Buka, 2016).

There is a critical window of opportunity in early life to ensure optimal physical development, but also to establish healthy food preferences that may have a lasting impact on diet and health (Marmot, 2010). Beyond the biological preferences present in all humans at birth, for sweet over bitter, for example, the dietary preferences established in infancy and early years are largely socially constructed (Lioret *et al.*, 2015). Since food preferences are a learned process, early exposure to a variety of healthy foods, particularly vegetables which often have bitter flavours that children are less predisposed to like (Fisher and Dwyer, 2016), enhance the likelihood of a varied diet throughout life (Birch and Marlin, 1982; Lawrence and Barker, 2009; Yeomans, 2010; Ahern *et al.*, 2013; Fisher and Dwyer, 2016). Breastfeeding

also likely expands the taste preferences of young children, since the flavour of breastmilk is affected by the mother's diet and can provide a diversity of flavours that increases the acceptance of a variety of foods (Fisher and Dwyer, 2016). The sooner children are introduced to a variety of flavours, the easier it is for them to accept them. It may only take an infant one exposure to develop a preference for a particular food (Birch *et al* 1998), whereas older children may require 8–10 exposures (Birch and Marlin, 1982; Birch *et al.*, 1987; Sullivan and Birch, 1990) and adults many more (Pliner, 1982).

There is a significant body of evidence indicating that breastfeeding is critically important to infant health in low- and middle-income countries but less agreement about its importance in high-income countries (Victora *et al.*, 2016). In high-income countries breastfeeding has been associated with a reduction in sudden infant deaths and higher performance on intelligence tests (Victora *et al.*, 2016). However, it is difficult to isolate the effects of breastfeeding from the effects of the underlying qualities that make a mother more likely to breastfeed, such as income and education. More research remains to be done, but it has been suggested that components in breastmilk provide the opportunity for epigenetic changes that affect the future health of the infant (Verduci *et al.*, 2014). Beyond this, infants fed formula are significantly fatter than breastfed infants at 1 year old, perhaps because of the mother's tendency to overfeed if she can measure consumption rather than rely on the child's own hunger (Dewey *et al.*, 1993; Victora *et al.*, 2016). This continues into at least early childhood, as formula-fed infants are more than twice as likely to be obese at 2 years of age (Gibbs and Forste, 2014), although it is unclear whether this difference in body composition persists into adolescence and adulthood (Butte *et al.*, 2000; Victora *et al.*, 2016). In addition to potential benefits to the child, benefits also accrue to the mother in reduced rates of breast and ovarian cancer as well as the potential for birth control (Victora *et al.*, 2016).

1.3 Economic

This section begins with a discussion of the relationship between food insecurity and poverty and follows with an overview of the economics of household food expenditures in relation to the dietary guidelines and the cost of malnutrition to the State.

1.3.1 Food Insecurity and Poverty

Food insecurity is one of the many consequences of poverty, but food insecurity is not the same thing as poverty. Poverty is measured annually in the UK and both relative and absolute poverty are published by the DWP based upon annual survey data. Yet, people need to eat every day. Therefore, economic shocks such as a job loss, divorce or delays in benefit payments can result in the inability to purchase food. It has been estimated that only half of children experiencing food insecurity live in households with incomes below the poverty line (UNICEF, 2017). Further, the recent coronavirus outbreak has highlighted food insecurity from causes other than financial, such as the fear of going to shops (Loopstra, 2020). The uncertainty of supply lines due to Brexit and the stresses caused by climate change will provide the next challenges to food security (Lang, 2020).

Food, therefore, has the potential to fluctuate in abundance and quality when poverty demands that a diverse range of household needs be met. It is safe to say that although evidence of the drivers of food aid use in the UK is lacking, the most important factor is household income (Lambie-Mumford *et al.*, 2014).

The Trussell Trust reports that the primary reason given for food bank usage is benefit delays, and some of the recent drivers of poverty are the tightening of welfare benefits and rules amidst stagnant earnings and increasing housing costs, job insecurity, and temporary contracts (Trussell Trust, 2016). Along these lines, characteristics that increase the risk of food insecurity because they exacerbate the circumstances of poverty include the inability to work (whether because of age, disability, or caretaking responsibilities) and susceptibility to negative financial shocks due to poor health, debt or insecure employment. These circumstances are especially urgent when combined with weak public support systems (Bartfeld *et al.*, 2015).

Children in the UK are more likely to be living in poverty than adults. Using the commonly accepted definition for poverty in the UK, which is income below 60% of the median, in 2017-2018, 34% of children in the UK, or 4.6 million, lived in poverty (O'Leary, 2019). A Food Foundation report found that more than 4 million children are living in poverty and unable to access a healthy diet (Scott, Sutherland and Taylor, 2018). This relative definition of poverty assumes that standards of living change over time, and where someone fits into society is important, as has been persuasively argued by Townsend (1979), a specialist in the economics of poverty, in his definition of poverty:

> *Individuals, families and groups in the population can be said to be in poverty when they lack the resources to obtain the types of diet, participate in the activities and have the living conditions and amenities which are customary, or are at least widely encouraged or approved, in the societies to which they belong.*

Another method is absolute poverty, defined in the UK as those with an income less than 60% of the median from 2011 adjusted only for inflation. Using this measure, 13% of children suffer from low income and material deprivation, and 4% from severe low-income and material deprivation (O'Leary, 2019). Another measure of poverty sometimes used is receipt of income-related welfare benefits such as free school meals (Wickham *et al.*, 2016). Under any definition of poverty, the ability to access food is central to the definition.

Growing up in a low-income household is the biggest factor of food insecurity in children, but other factors that play a role are social class, the primary caregiver's mental and physical health and age, residential stability, and the time of year (because there are no school meals in summertime) (Pilgrim *et al.*, 2012; Gundersen and Ziliak, 2014). It is worth flagging at this stage that socioeconomic status is the result of not only income, but also education, occupation and social environment. While discussing nutritional inadequacies in low-income families, it is important to note that not all low-income families are food insecure. Social capital, which comprises the available resources that are based on community networks, provides a buffer for many families. Higher social capital leads to lower food insecurity (Martin *et al.*, 2004). Human capital, often a result of education, increases resiliency and enables the confidence and stamina to employ creative solutions, which can mitigate the frequency and circumstances of food insecurity. Yet, those living at or below the minimum wage or on state benefits are unlikely to have sufficient money to meet basic needs including food, however skilful they are at budgeting, shopping and cooking (Caraher and Dowler, 2014).

1.3.2 Household Food Expenditures

The government did not consider the cost of the Eatwell Guide. A subsequent analysis compared the cost of the Eatwell Guide with the Eatwell Plate and the actual British diet. It found that the cost of the Guide was similar to the cost of the current mean diet per day and the Eatwell Plate recommendations (Scarborough *et al.*, 2016). However, the average masks the fact that half of the UK population do not currently spend enough to purchase the recommended diet (Scott, Sutherland and Taylor, 2018). A further analysis of the cost of the recommended diet and current food expenditures is contained in Chapter 6.

1.3.3. Cost of Malnutrition to the State

The cost of not having an effective policy to combat malnutrition is high. Healthcare costs related to poor diet in the UK have been estimated to be £6 billion per year. If the cost of lost productivity due to absences from work and early death due to diet-related illnesses is added to the healthcare costs, the economic costs increase significantly (Scarborough *et al.*, 2011). This means that nutrition investments are a high impact, high return proposition, with a potential benefit-cost ratio of 16:1 (Hawkes and Haddad, 2016, p. 76).

This approach conceptualizes citizens by their productivity to society, and welfare that contributes to the creation of a healthier, more productive society will be economically beneficial to the nation by resulting in healthcare and welfare savings and increased tax receipts (Becker, 2007). Healthy Start originated from the theory that ensuring healthy food at a critical time in the development of a fetus and young child would reduce health inequalities and, crucially, increase future productivity. There is evidence that a small investment in health in the early years yields a lifetime of results in a more productive society. A recent study analysing the long-term impact of the SNAP in the US has confirmed this logic that early intervention is economically beneficial, as it found positive effects on human health and the US economy decades later (Bartfield, 2015). The participants showed increased economic self-sufficiency and reduced rates of obesity, high blood pressure and diabetes (Hoynes, Schanzenbach and Almond, 2016). It is perhaps because Healthy Start has been regarded as an economic investment in human capital that it has survived despite the reductions to the public health and welfare budgets under austerity.

1.4 Social

While statistical analysis shows a link between socioeconomic status, diet, health and mortality, the cultural, social and psychological processes related to these differences also need to be considered. Differences in material resources may result in social comparisons which produce stress and anxiety that affect health (Schnittker and McLeod, 2005; Pickett and Wilkinson, 2007; Wilkinson and Pickett, 2009).

Rather than an objective view of their relative position, the most important determinant may be a person's subjective view of their relative position in society. Failing to meet societal expectations can result in shame and damage feelings of identity and psychological resilience. This section begins with an overview of the personal and social determinants of food practices, and then considers stigma, its sources and the impact it could have on Healthy Start recipients.

"Food not only nourishes but also signifies" (Fischler, 1988, p. 276). Of course, food is much more than a source of nutrients and sustenance. It marks our social status and is a means of social inclusion and exclusion (Cockerham, 2005; O'Connell *et al.*, 2019). Identity and food are inextricably linked. While food practices are often viewed as personal choices, they often reflect social expectations (Attree, 2005). The importance of food to social participation and mental health and well-being has been widely studied in cultural and sociological studies (see Dowler, Turner and Dobson, 2001; Caplan, 2017).

Bourdieu's theorization of the way that social hierarchies are determined by non-economic factors such as "taste" and behaviour becomes important in this context. Bourdieu uses taste as a complex theoretical term to describe an individual's culturally conditioned consumer choices, which "roughly correspond to educational levels and social classes" (Bourdieu, 1984, p. 16). He identifies several types of capital, not just economic but social, symbolic and cultural, and uses the term "social capital" to describe the social orientation that results from a display of taste, or the conspicuous consumption of goods meant to align the consumer with an aspired-to social status (Bourdieu, 1984, p. 466). Food is at the centre of this. While policy is more often evaluated by the economic and health outcomes, considering the importance of food to social inclusion and social class is central to this research project.

One cannot look at what young children eat without thinking of the broader issue of how women perform as mothers and how food is used to show the world their competence as "good mothers." Food is a way to express care and nurturing, and there is perhaps no more visible marker of being a good mother than being able to feed your children socially appropriate food (Skeggs, 1997; Wills *et al.*, 2011). Traditional notions of care are gendered and classed. The responsibility for food provisioning in the family reflects this, as does the existing body of research that has largely focused on the mother's role in the family and her responsibility for managing the family's budget and nutrition. This overlooks the father's role and the societal expectations placed on fathers. As gender roles evolve and normative expectations for care change, hopefully research will reflect these changes.

There is some evidence that middle-class families are the most likely to emphasize the importance of eating healthy foods (Wills *et al.*, 2011) and that in some low-income families (just as in high-income ones) there is a perception that unhealthy food is an affordable treat. Parents do not want children to feel deprived, and they often want them to "fit in" with mainstream tastes and values (Khanom *et al.*, 2015). Providing treats that are socially acceptable is necessary to "keep up appearances" (Attree, 2006).

More recently, popular food authors such as Michael Pollan (2007) have proposed that beyond nutrition, food choice should reflect concerns for ethical consumption or 'voting with your fork' as the way to promote a more sustainable and ethical food system. This compounds the responsibility of the mother, who must consider the impact of her food choices on the well-being of her family and on the environment by purchasing fresh, local and organic food (Cairns, Johnston and Mackendrick, 2013).

The inability to perform the traditional gendered parenting roles of managing finances and feeding children is associated with particularly acute feelings of shame (Skeggs, 1997, 2004; Dowler, 2002; Wills *et al.*, 2011; Sutton *et al.*, 2013). Food insecurity can reinforce feelings of social exclusion in both children and parents (Hamelin, Habicht and Beaudry, 1999; Connell *et al.*, 2005; Brannen, O'Connell and

Mooney, 2013). But often the "cure" for the problem is stigmatizing as well, resulting in a tension between the stigma associated with food insecurity, and the stigma associated with claiming benefits or visiting a food bank.

Societal expectations are important not only for the psychological health and well-being of the mother, but also for the health of her children. Mothers need to feel empowered and in control of their lives or they may lack confidence, leaving them more susceptible to the desires of their children and their environment (Fisk *et al.*, 2011; Jarman *et al*., 2015a). Maternal depression is an independent risk factor for household food insecurity in low-income families with young children (Toy *et al.*, 2016). Even after controlling for maternal education, a mother's level of resilience has been correlated with the amount of time her children spend watching television and sitting at a table, behaviours correlated with diet (Jarman *et al*., 2015a). Changing dietary patterns such as an increase in snacking and fewer family meals has also contributed to lower fruit and vegetable consumption (Fisher & Dwyer 2016). Depressed mothers are also less likely to have the motivation and capabilities to access government and social resources that may be able to help them (Toy *et al.*, 2016), which may explain why some eligible families do not receive government benefits.

1.4.1 Factors that Affect Food Practices

Personal characteristics, family dynamics, social support structures and cultural demands are interconnected and all affect family food practices.

Education

Having confidence to cook healthy food from basic ingredients is more common amongst those with a university education (Khanom *et al.*, 2015). A mother's level of education is a mediating factor that protects her children's diet from some of the effects of living in a low-income household (Lioret *et al.*, 2015). The perception and understanding of the risks of an unhealthy diet, as well as the ability to change, varies by education as well as by socioeconomic status, gender, and ethnicity (Slovic, 2000; Khanom *et al.*, 2015). Higher levels of education are related to an increased sense of control and resiliency. Women with a higher level of education eat more fruits and vegetables, and believe they have the power to control their diet and health rather than seeing it as outside of their control (Lawrence and Barker, 2009).

Psychological Attributes

Psychological factors such as self-efficacy, or perceived control and confidence that an individual can achieve a desired outcome, are predictors of healthy eating (Hardcastle, Thgersen-Ntoumani and Chatzisarantis, 2015). In low-income neighbourhoods, those with a higher perceived self-efficacy consume more fruit and vegetables (Lawrence and Barker, 2009). Those with a lack of self-efficacy are often unable to overcome barriers to healthy eating, and more likely to consider food a low priority. Consequently, they have children with poorer quality diets (Jarman *et al*. 2015a; Pearson *et al*. 2009b). The feeling of lack of control allows other household members, usually the partner or children, to exert dominance over the food choices (Lawrence and Barker, 2009). The lower people are on the socioeconomic scale the less control they are likely to feel they have to influence their health (Attree, 2006) and therefore the less likely they are to be concerned about nutrition. For example, an Australian

study of fruit and vegetable consumption of women in disadvantaged neighbourhoods determined that factors such as ability and motivation were more important in determining consumption than food store access (Thornton *et al.*, 2015). In a related manner, food choice is often based on emotion rather than rational thought (Just, Mancino and Wansink, 2007), so a person's mood can be vitally important. Parents need to be supported and empowered to overcome healthy eating challenges (Jarman *et al.* 2015b).

Nutritional Knowledge and Cooking Skills

Although some studies have found little association between knowledge and diet, other studies have shown a link between dietary knowledge and behaviour (Wardle, Parmenter and Waller, 2000; Turrell and Kavanagh, 2006; Wrieden *et al.*, 2007). The inability to cook compounded by a lack of time to plan and prepare meals can be a barrier to healthy eating (Khanom *et al.*, 2015).

Preferences

Within the constraints of availability and accessibility, ultimately personal and family preferences determine diet. Preferences are formed early and can persist throughout life. Mothers report that the preferences of their family are among the most important determinants in their food choices (Charles and Kerr, 1988). Preferences are rated higher than availability or access to large supermarkets (Dibsdall *et al.*, 2003; White *et al.*, 2004).

Family Environment

The family environment is the most fundamental context in which children learn food preferences and have exposure to different foods. The single most important determinant of a child's diet is the family diet, particularly the mother's (Oliveira *et al.*, 1992; Baird *et al.*, 2009). Parental consumption of fruit and vegetables is consistently positively correlated with the child's consumption (Rasmussen *et al.*, 2006; Pearson, Biddle and Gorely, 2009; Vanhala *et al.*, 2011; Wyse *et al.*, 2011; Zuercher, Wagstaff and Kranz, 2011), and is more significant the more meals that are eaten at home (Oliveira *et al.*, 1992). Research involving fruit and vegetable consumption in preschool children is limited, and most studies rely on school-aged children (Wyse *et al.*, 2011). A systematic review of studies of children aged 6-18 years identified the most important determinants of fruit and vegetable intake as parental intake, home availability, and socioeconomic position (Rasmussen *et al.*, 2006).

Other important factors are the frequency with which children are offered fruits and vegetables (Wyse *et al.*, 2011; Wyse, Wolfenden and Bisquera, 2015), what the child sees other family members consuming, parental styles, and food practices in the home (Hendy and Raudenbush, 2000; Hendy, 2002; Addessi *et al.*, 2005). Fruit and vegetable consumption tends to decline as children get older, with girls consistently eating more than boys (Rasmussen *et al.*, 2006). In the home environment, children who eat while watching television, those who do not eat with their parents, and those who eat more often takeaway more often suffer from a poorer quality diet (Baird *et al.*, 2014). As it relates to the parent's health, research on the presence of children in the home on the family diet has been mixed. Some studies show a positive impact (Yeh *et al.*, 2008), others argue that children cause parents to reduce the amount of fruit and vegetables eaten (Thomas *et al.*, 2003; Coveney, 2005).

Parenting Style

Parental beliefs, attitudes and behaviours affect children's health behaviours (Tinsley, 2003; Pearson *et al.*, 2009), not only through their example, but also through their parenting style. Restricting certain foods or pressure to eat are the most commonly studied parenting strategies for encouraging healthy eating (Birch and Fisher, 2000; Gubbels *et al.*, 2009). Not surprisingly, parents who encourage and facilitate fruit and vegetable consumption have children who eat more fruits and vegetables (Vanhala *et al.* 2011; Pearson *et al*. 2009; Wolnicka *et al*. 2015). Consumption of vegetables seems to be promoted by having clear expectations, modelling consumption, and encouraging consumption with praise and positive experiences, but not with pressure to eat, rewards or punishment (Fisher and Dwyer, 2016).

Parents who use food as a reward tend to have children with poorer diets, but children whose parents do not restrict access to certain foods also have a poorer diet (Jarman *et al.* 2015a). Mothers who use covert strategies to manage the child's food environment in order to control their child's diet have children with better quality diets, whereas those mothers who exert overt control are more likely to have children with an increased amount of neophobia (Pliner, 1994; Wardle, Carnell and Cooke, 2005; Jarman *et al.*, 2015a). Although research on the effect of different parenting techniques has been somewhat mixed, perhaps due to the subjectivity of measuring parental styles, encouraging talk about taste, colour and other attributes generally has a positive impact, but prompting statements like "eat your vegetables" or forceful and restrictive styles generally have a negative impact (Hurley *et al.*, 2015). Most longitudinal and laboratory based studies suggest that children exposed to high levels of food restriction and pressure to eat are more likely to consume sugar-sweetened beverages, snack foods, and calorie-dense food items than children exposed to lower levels, but there are contradictory cross-sectional studies (Loth *et al.*, 2013).

Taste preferences for a certain food are based upon exposure to it, and repetition is a critical factor for encouraging vegetable consumption in preschool children, with five exposures typically sufficient to increase intake (Caton *et al.*, 2013). But pairing food with a positive social context is also important (Rozin, 2014), so non-confrontational and stress-free mealtimes are more conducive to introducing new foods. Although taste preferences established in childhood can be long lasting, parents are generally more effective at transferring morals than preferences to their children, so a preference for a certain food may be changed in later life by price, availability and information (Rozin, 2015).

Power Dynamics

Families are political sites and power dynamics determine the control of resources (O'Connell and Brannen, 2014). These power dynamics are reflected in how parents, particularly mothers, negotiate food practices with their children. In low-income families, the children's preferences are one of the most often cited factors in determining food choices (Roux *et al.*, 2000; Attree, 2006; Khanom *et al.*, 2015). This reflects a desire to avoid waste (Khanom *et al.*, 2015), but also a desire to please the children and an acknowledgement that children are not just passive eaters but have their own strong preferences (O'Connell and Brannen, 2014; Khanom *et al.*, 2015). As parenting practices have become more child centred, there has been an increasing deference to children's choices (Tikkanen, 2007).

The food preferences of the father are also privileged (Khanom *et al.*, 2015). Pleasing an adult male in a household is a primary influence on food choices and often a barrier to healthy eating (Dibsdall *et al.*,

2003; Glanz and Yaroch, 2004). Public health interventions that hold mothers responsible for their children's diet do not take into account the wider structural issues or the children's agency and family power relationships (Warin *et al*., 2008; O'Connell and Brannen, 2014).

Neighbourhood

People make choices within the context formed not only by their family and friends, but also the communities in which they live. Living in a disadvantaged neighbourhood is associated with less fruit and vegetable intake (Dubowitz *et al*., 2008) and obesity (Kimbro and Denney, 2013). Low residential property values predict bodyweights of women better than either education or income (Drewnowski, 2012). This could be due to the presence of fast-food restaurants and lack of supermarkets which limit food choices in addition to the lack of income (Drewnowski, 2012; Khanom *et al.*, 2015). A lack of income is exacerbated in low-income neighbourhoods by the relatively higher cost of food and other services (Strelitz and Kober, 2007; Tait, 2015).

Structural factors such as the lack of shops with healthy and affordable food options have been well studied (Dowler, 2008). Although studies have shown that in the UK there are fewer shops selling healthy food and more fast-food shops in low-income areas (Morland *et al.*, 2002; Wrigley, Warm and Margetts, 2003), the evidence for the existence of 'food deserts' in the UK is debated (Beaulac, Kristjansson and Cummins, 2009). Yet, when people are questioned about the barriers to eating a more healthful diet, reasons cited are access to markets including transportation issues, the availability of high quality, culturally familiar food, and a food environment that makes unhealthy eating the easier choice (Yeh *et al*., 2008; Haynes-Maslow *et al.*, 2013; Fisher and Dwyer, 2016). Without a car or access to public transportation, it can be difficult to transport food home from the store. In some neighbourhoods, one solution to this problem includes a van selling fruit and vegetables that travels around the area (Khanom *et al.*, 2015).

Support Structures

Social capital is comprised of the social resources upon which people draw (Scoones, 1998). Extended family and friends as well as community organisations provide an important safety net for families and can enable healthier eating. As part of the Sure Start Initiative announced in 1998, children's centres were developed to provide early intervention services focused on child development. Over time services were expanded to provide childcare and other family support services (Hastings *et al*., 2015). Unfortunately, many services at children's centres such as after-school activities, holiday clubs and play centres have been cut as a result of local budget cuts, which have resulted in declines of £65 per head in the most deprived local authorities (Hastings *et al*., 2015).

Culture

"A culture is generally defined as a group of people with shared knowledge, beliefs, values and ways of living." (Grbich, 1999, p. 10). Culture and tradition comprise the sum of experiences and memories that have been accumulated from childhood. Cultural norms also vary by location and neighbourhood, affect parenting styles and food choices, and define what is a desirable bodyweight within a given group. The evidence from the UK by cultural group is lacking, but a study of low-income Latino mothers in the US

found that the mothers' perception of a healthy weight for their preschool children was consistently above the recommended norms, with 93% of the mothers identifying their overweight children as being "normal" weight (Valencia *et al*., 2016).

There is substantial research from North America that may be applicable to the UK. As immigrants become more incorporated into society and income rises, they tend to adopt the local eating habits out of convenience or desire to fit in, which may be less healthy than their native diet (Lesser, Gasevic and Lear, 2014), although this is somewhat moderated by level of parental education (Van Hook *et al.*, 2016). The duration of residence in the US, for example, is largely correlated with eating fewer vegetables, although the research is somewhat mixed (Van Hook *et al.*, 2016). Those who have been in the country longer are more likely to have adopted an "Americanized," less healthy diet (Wojcicki *et al*., 2012; MacGregor, Walker and Katz-Gerro, 2019).

1.4.2 Stigma

It is important to consider stigma under the "Social" umbrella, because shame and embarrassment may undermine policy effectiveness by discouraging participation. It may also decrease psychological resilience and lead to social divisiveness as people separate themselves from stigmatized groups.

The emotions related to stigma – shame, embarrassment, and guilt – require self-judgement for not meeting the expectations held by others or by oneself (Tangney, 1999). Stigma can be experienced as a positive or negative emotion. It reinforces group identity and builds solidarity among those who are not stigmatized, while causing low self-esteem and stress for those who are (Meisenbach, 2010). From a societal perspective, stigma undermines cohesion and provides legitimacy for inequalities. It is used as a device to justify punitive policies aimed at those at the bottom of the social class structure (Jones, 2012; Tyler, 2013; Scambler, 2018). Questioning the political function of stigma, and who benefits from perpetuating the stigma, is necessary in order to understand why the stigma persists and how it can be alleviated.

As a result of stereotyping and discrimination, stigma limits access to resources and power for those in stigmatized groups (Seeman and Goffman, 1964; Link and Phelan, 2014; Clair, Daniel and Lamont, 2016). Robert Pinker goes further, arguing that "The imposition of stigma is the commonest form of violence used in democratic societies . . . [It] can best be compared to those forms of psychological torture in which the victim is broken psychically and physically but left to all outward appearances unmarked" (Pinker, 1970, p. 175). As stigmatized individuals often lack power, the negative effects are magnified and can be persistent (Link and Phelan, 2001, 2014).

The threat to social identity resulting from stigma elicits a measurable neuroendocrine stress response (Dickerson and Kemeny, 2004; Kemeny, Gruenewald and Dickerson, 2004; Townsend *et al.*, 2011). This mental stress can lead to physical illness as well as decreased life satisfaction and self-esteem, and contributes to economic and social inequality. It can result in social isolation to avoid anticipated social comparison and discrimination (Tyler and Slater, 2018).

Stigma can be compounded when several stigmatizing attributes are present at the same time, such as poverty, obesity, race, single motherhood (which also carries assumptions about sexuality), and health

disparities (Hilmers, Hilmers and Dave, 2012). Each of these attributes alone can lead to discrimination affecting educational and career opportunities, but the effects are magnified when several are present (Powell, Amsbary and Xin, 2015).

Stigma of Poverty

The belief that people are responsible for their own economic circumstances has become the dominant view in Britain, espoused by politicians and perpetuated by the media. Poverty is more than the lack of economic means; it is a moral failing (Townsend, 1979; Lister, 2004; Spicker, 2007). This emphasis on personal responsibility has led to the myth that people fall to the bottom because they are undeserving (Dorling, 2017). Poverty is blamed on lifestyle choices rather than structural reasons (Seabrook, 2013, and Sutton 2016, cited in Caraher and Furey, 2018). This view has even been largely accepted by the poor themselves, even though they experience the structural challenges of their lives (Shildrick and MacDonald, 2013). When stigma is internalized and recipients perceive that they are undeserving and responsible for their own situation it may actually increase social inequalities rather than enhancing the status of the poor (Townsend, 1979; Baumberg, 2016). However, increasingly there is evidence of resistance to the narrative of personal responsibility and acknowledgement of the role of social, political and economic issues that have resulted in disparities in opportunity that limits an individual's ability to change circumstances (Tyler, 2013; Caraher and Furey, 2018).

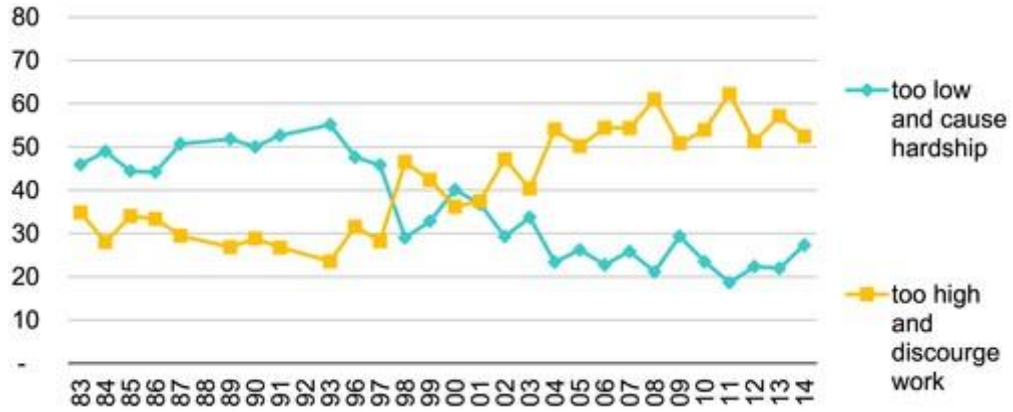
Stigma of Needs-Based Government Assistance

The most stigmatized of the poor are perhaps those who receive means-tested welfare benefits (Seccombe, James and Walters, 1998). The social stigma of means-tested benefit programmes has been well documented (Spicker, 1984; Rogers-Dillon, 1995; Stuber and Schlesinger, 2006; Baumberg, 2016). Benefits stigma is detrimental for several reasons. First, receiving needs-based benefits compounds the stigma of poverty because the selectivity acts as a form of labelling that announces that a person is poor (Spicker, 1984). The need for welfare can seem to represent a personal inadequacy (Seccombe, James and Walters, 1998). This stigma carries social and psychological costs (Rosier and Corsaro, 1993; Sykes *et al.*, 2015). It may also exacerbate inequality and contribute to low uptake of benefit schemes. Although counterintuitive, the more benefits are targeted to the poor, the less likely they may be to reduce poverty and inequality. Means tested benefits for those who need it most should reduce inequality, but countries with heavily means-tested systems such as the US have more inequality. Perhaps this is because the needs-based programmes have less political support and less is spent on them, and because the poor fall through the gaps due to the application process and stigma of claiming the benefits (Hills, 2017). Stigma is cited by nearly a quarter of recipients as a reason to not enrol in benefit schemes, undermining the success of the schemes and depriving needy families of additional funds (Stuber and Schlesinger, 2006; Baumberg, Bell and Gaffney, 2012; Baumberg, 2016).

Tracey Jensen and Imogen Tyler (2015) argue that the government reforms to social programmes after the 2009 financial crisis were made possible by the idea of the undeserving poor, which reflected stigma production from politicians and journalists. Rather than an engine of social cohesion, the view that "we are all in this together" espoused by Beveridge, or envisaged by Richard Titmuss as a contribution to the greater good, welfare has become a source of social division, "them and us" (Taylor-Gooby, 2016; Hills,

2017; Geiger, 2018). A core belief of Titmuss' was that everyone benefits from benefits (Hills, 2019). Although universal welfare programmes remain very popular, means based benefits became less sympathetic in the early 2000s and have remained so (Hills, 2017). This reflects a discursive shift in government and the media that increasingly stigmatizes the unemployed as unwilling to work (Okoroji, Gleibs and Jovchelovitch, 2020). The majority of Britons believe that benefits are enough to live on and that they discourage claimants from searching for work, which has justified benefit sanctions requiring claimants to demonstrate their efforts to find paid employment.

Exhibit 1: Perceptions of the Impact of Unemployment Benefits, 1983–2014



From Taylor-Gooby (2016).

Different benefits carry differing levels of stigma. The degree of stigma depends on how claimants are perceived, whether they are perceived as deserving, their level of need, and whether they can be blamed for their situation (Spicker, 1984). Policy design and delivery is important to the perception of stigma. In the US, research with recipients of the Earned Income Tax Credit illuminates how recipients of means tested government benefits view different types of benefits (Sykes *et al.*, 2015; Halpern-Meekin *et al.*, 2018). The Earned Income Tax Credit, which provides a tax credit to low-income workers based on income and the number of children, is not a stigmatizing benefit because it is viewed as earned through their work rather than a handout from government. Recipients consider themselves "real Americans", "not poor, but in the middle" and distance themselves from people on welfare (Sykes *et al.*, 2015). It is viewed differently because of three main differences to welfare programmes. First, it is delivered via a universal, non-stigmatized organization, the Internal Revenue Service, rather than the welfare office, which makes it invisible. Symbols such as food vouchers which require a public performance are more stigmatizing. Second, it is targeted at a group seen as valuable, working parents. And third it comes in a lump sum payment once a year when many Americans from all income levels are receiving a refund payment (Halpern-Meekin *et al.*, 2014). Even though the reality is that the Earned Income Tax Credit is most often used to repay debt, the lump sum payment allows people to dream, perhaps of saving for a home, investing in education, taking a vacation, or throwing a child a birthday party, because the rest of the year is spent with no discretionary income (Sykes *et al.*, 2015). Modest spending on treats and aspirations of upward mobility are key elements of social citizenship (Marshall, 1950).

Welfare stigma is also the result of a widespread misunderstanding of how the welfare system is used, by whom, and who pays for it (Hills, 2017). There are three main ways it is mischaracterized by politicians

and the public: the large disparity between the official estimate of fraud and the public perception (Wells and Caraher, 2014; Hills, 2017); the amount provided to those on benefits (Royston, 2018); and the relative size of welfare programmes.

The British Social Attitudes survey found that 81% of people feel "large numbers of people falsely claim benefits" (BSA 31, 2014). The official estimate is less than 1% (Baumberg, 2016). As John Hills notes, "Misconceptions about the welfare state and the way it is abused are not just a matter of harmless misunderstanding" (Hills, 2017, p. 264). This narrative of "benefit scrounging," which has been perpetuated by the press, has real consequences for millions of recipients (Patrick, 2016). As Hills argues, the popular misconception is that the government redistributes wealth to a permanent underclass that is unemployed and lives on benefits (Hills, 2017). Hills makes a compelling case that everyone benefits from the welfare state, and over a lifetime, those with higher incomes benefit more from public spending through education, pensions and the National Health Service (NHS). Rather than redistributing wealth between classes, the benefit system redistributes resources across different periods of life for individuals (Hills, 2017; Roantree and Shaw, 2018).

Stigma of Food Vouchers

Research indicates that people avoid using food banks except in the most extreme circumstances (Riches and Silvasti, 2014), yet less is known about the stigma associated with claiming food benefits. There is some research in the US showing that stigma is a barrier to using food voucher programmes, particularly among those with higher incomes (Powell, Amsbary and Xin, 2015). This was confirmed in earlier studies on Healthy Start, with some recipients claiming embarrassment or stigma as a barrier to using the vouchers, particularly when shop assistants are unfamiliar with them (McFadden *et al.*, 2013). The stigma was not universally felt, but was mentioned by many (McFadden *et al.*, 2013). Recipients noted strategies to avoid stigma when redeeming the vouchers, such as using self-service tills and choosing retailers they knew were familiar with the scheme (Jessiman *et al.*, 2013).

Response to Stigma

In order to expand on Irving Goffman's work on stigma, and to assist with the analysis of stigma management, Meisenbach (2010) developed a theoretical framework that classifies individual responses to stigma. The stigma management communication framework incorporates both the societal discourse and the individual's perceptions by categorizing responses to stigma as either acceptance of or a challenge to the appropriateness of the stigma (e.g., people who claim benefits should be stigmatized), and then either accepting or challenging that it applies to themselves (e.g., by distinguishing their situation from others). This framework is summarized as follows:

Exhibit 2: Stigma Management Communication Framework

Accept stigma applies to self		Challenge that stigma applies to self
Accept public understanding of stigma	**Accepting** • Passive acceptance • Disclose stigma • Blame stigma • Isolate self • Bond with stigmatized	**Avoiding** • Hide/deny attribute • Avoid stigma situations • Stop stigma behaviour • Distance from stigma • Make favourable social comparison
Challenge public understanding of stigma	**Evade responsibility for** • Provocation • Unintentional • Minimize • Transcend/reframe	**Denial** • Simply • Logically • Discredit the stigmatizers • Provide evidence

Adapted from Meisenbach (2010)

Stigma management theory would argue that individuals respond to the stigma of benefits in several ways. One is to avoid the stigmatizing behaviour by not participating in welfare programmes. The more generous and less stigmatizing the benefit, and the greater the need of the individual would determine whether the benefits outweighed the risk of enrolling (Powell, Amsbary and Xin, 2015). Only 14% of tax credit claimants give a shame-related reason for delaying or not claiming credits, compared to 23% of benefits claimants (Baumberg, 2016).

If the individual enrols in the scheme, there are three primary ways to respond to the experience of stigma (Goodban, 1985). The first is to psychologically distance themselves from others who receive benefits. They acknowledge that the stigma exists, but rationalize why the stigma does not apply to them. This includes when people describe themselves as "not poor," and use a "them not us" logic (Halpern-Meekin *et al.*, 2014; Garthwaite, 2016). As Karen Seccombe *et al* reported (1998) in a US study based upon mothers who were recipients of welfare, the mothers commonly invoked 'victim blaming' theories to explain other women who relied on welfare, describing them as lazy and unmotivated. However, they blamed their own situation on circumstances beyond their control. Tracy Shildrick and Robert MacDonald (2013) have argued that the discourse of the undeserving poor causes those in poverty to deny they are poor and disassociate from others to diminish their own sense of shame and stigma**.** This coincides with a decline in class solidarity which is both a result and a driver of the stigma.

The second strategy is to acknowledge that the stigma exists and accept that it belongs to them. This causes the stigma to be internalized leading to feelings of helplessness and low self-esteem. This is the most damaging to the individual and to society. It can result in people giving up trying to change their circumstances, and maintaining unhealthy eating habits (Larson, Story and Nelson, 2009). The shame is co-constructed as their internal judgement reflects the anticipated judgement of others (Chase and Walker, 2013).

A third strategy is to accept their status, but blame it on the structure of an unequal society, in this way challenging the basis for the stigma. This provides the possibility of solidarity with others in the stigmatized group. This is a more unlikely response in the UK, as the tradition of accountability for one's own circumstances has cultural acceptance, and poverty is less widely viewed as a structural problem. However, persistent, social constructions can shift and there are signs that this could be changing (Tyler, 2013).

Benefits stigma is inconsistently experienced by different groups, with the highest level of stigma reported by whites and females (Xu, Zhu and Bresnahan, 2016). Stigma also varies by location, as those living in neighbourhoods where a high number of people claim benefits report more personal stigma and are more likely to think that people should feel ashamed to claim benefits than those in neighbourhoods where fewer people receive benefits (Baumberg, 2016).

As this section has shown, it is not enough to consider the health aspects of food, as the social value of food is critical to understanding the role of food and food provisioning in the family and the construction of identity and self-worth. The sources of stigma can be the failure to provide a socially adequate diet and having to rely on assistance to do so. Stigma has been shown to reduce uptake for welfare programmes, decrease feelings of self-worth and decrease social cohesion.

1.5 Environment

This section considers the role that food has in the environment, and the potential for synergies with Healthy Start.

While there is no obvious link between the Healthy Start Scheme as currently configured and the environment, there are opportunities for synergistic policies that have been ignored. The threats to future food security from climate change need to be considered in all food policies. The production of food has many environmental consequences that should be mitigated to secure the UK's future food security. As Lang (2020, p. 209) argues "Good food produced by decently remunerated primary producers should be our goal and is essential to rebuilding UK food security".

The current food system is both susceptible to and a driver of the climate crisis (Lang, 2020). The 2017 UK Climate Change Risk Assessment identified risks from climate change to public health, flooding, the water supply, biodiversity and soil quality (DEFRA, 2017). It has been called the biggest challenge to the UK food supply (European Commission Food Strategy 2020).

Supporting local farms that are using environmentally sound methods has related benefits. Farming contributes £10.3 billion to the UK economy, as well as 55% of the food consumed here, but farming is more than economics or food production (Lang, 2020). It has historically been a culturally important use of land in the UK, a source of national pride, beauty and heritage. However, the amount of land dedicated to growing food has been declining, with implications for culture, food security, the environment and trade policies. There are significant future risks for farming from the potential loss of subsidies that may follow Brexit, because a significant portion of current profits are derived from EU subsidies (Lang, 2020).

As a multidisciplinary study, food policy design needs to consider all potential effects as well as opportunities for synergies with other government policies and objectives. Healthy Start vouchers could be envisioned differently to protect and support the environment by using locally and sustainably grown fruit and vegetables.

1.6 Summary

This chapter provides background on the political, health, economic, social, and environmental context that shaped the formation of Healthy Start and affect the potential for its success. The chapter began with the political context, describing the UK's historic commitment to reduce health inequalities and an overview of the current political environment. This was followed with an overview of the current government guidelines for nutrition, the importance of early nutrition, and the economic and social dimensions of family food practices. The next chapter provides a more detailed description of Healthy Start and critical analysis of prior research.

Chapter 2: What is Known About Healthy Start

2.0 Introduction

The purpose of this chapter is to describe the Healthy Start scheme, its history, operations, and what we know from prior research. History sheds light on how the policy was conceived – its intended aims and outcomes, and the political realities and limitations it faced, which may affect current operations and effectiveness. An analysis of the existing research provides the foundation for determining the research gaps and rationale for this research.

2.1 History

Healthy Start is the only UK government scheme that provides a direct benefit for families to purchase food. As discussed in Chapter 1, Healthy Start's foundations are in the WFS adopted during World War II to ensure a subsidized supply of milk and vitamins for all pregnant women and young children.

The British rationing system adopted during World War II allocated certain foods on a fixed basis per person based on the nutritive elements of different food to ensure a fair and healthy distribution of the available food. It also resulted in some overall improvements to the nutritional value of food, which benefitted the whole population, such as the fortification of margarine with vitamins A and D. Recognizing the special nutritional needs of young children and nursing and pregnant mothers, additional milk was provided to this group. As a consequence of rationing the overall nutritional value of the average diet was increased according to *State of the Public Health (1946)* (Burnett, 1967, p. 296). Infant mortality and the general health of children improved during this time. The WFS was available to all regardless of income until 1968, when some qualitative restrictions were instituted. It did not become a means tested benefit until the 1980s.

For reasons that will be discussed later in more detail, including the increasing recognition of the importance of fruit and vegetable consumption, in 2006 the WFS was expanded to include fruits and vegetables and renamed the Healthy Start Scheme. Unlike more traditional welfare programmes, which provide unspecified financial assistance, Healthy Start provides a voucher that can only be exchanged for certain items, a "labelled voucher," to ensure that healthy food reaches the targeted beneficiaries. At the time of research, Healthy Start vouchers could be exchanged for milk, infant formula, and fresh and frozen fruit and vegetables. This list was expanded in 2020 to include pulses and tinned fruit and vegetables. Separate vouchers for free vitamins are included for beneficiaries as well, although the focus of this research is the food vouchers.

Healthy Start is a relatively small scheme that provides vouchers to approximately 260,000 women and children. The average monthly benefit is £14.40 per beneficiary (Healthy Start Alliance, 2016) for an annual cost of approximately £45 million in 2018/19 (Churchill, 2020). By comparison, the child benefit is £89.70/month for the first child and £59.40/month for additional children with a total expenditure of £16.9 billion. (Office for Budget Responsibility, 2020). Sure Start maternity grants offer a one-time £500 payment for a total annual cost of £44 million (Department for Work and Pensions, 2020).

The Healthy Start objectives stated by the government are as follows:

> *The Healthy Start scheme helps low-income families by providing vouchers for free fresh milk, infant formula, fresh fruit and vegetables to young children and pregnant women, as well as free vitamin supplements. The scheme also encourages earlier and closer contact with health professionals who can give advice on pregnancy, breastfeeding and healthy eating* (NHS, 2015).
>
> *It aims to improve health and access to a healthy diet for families on a low-income across the UK* (Office for Budget Responsibility, 2020).
>
> *The Healthy Start Scheme aims to encourage healthy nutrition for pregnant women and new mothers, alongside breastfeeding, and the introduction of fruit and vegetables into babies' diets at weaning* (Department of Health, 2016).

In 1998, ex-Chief Medical Officer Sir Donald Acheson led an independent inquiry into health inequalities in the UK. Among his proposals, he suggested that improving the diet of low-income pregnant women and children was a targeted way to reduce inequities in health (Acheson, 1998). His theory was that nutritional inadequacies in low-income pregnant women would lead to poor health in their children making it more difficult for those children to achieve their full potential. This report was instrumental in the 2002 decision to commission COMA to review the WFS in light of then-current nutritional information. The report confirmed a need for the scheme but recommended expanding the benefit to include additional foods (Committee on Medical Aspects of Food and Nutrition Policy, 2002). This reflected the growing concern about the health consequences resulting from lack of fruit and vegetable consumption in the UK in general, but particularly among children of low-income parents. Healthy Start was conceived as a more ambitious intervention than the WFS that could address hunger as well as health inequalities (Committee on Medical Aspects of Food and Nutrition Policy, 2002). The report also raised the question of whether providing infant formula could be a disincentive to breastfeed, and suggested that vitamin deficiencies be treated with supplements. It specifically identified WIC as a successful policy in the US, making it likely that WIC served as a model for the revised Healthy Start scheme. The US WIC had been in operation since 1996 and was well studied and highly regarded.

Despite the loftier ambitions of Healthy Start to reduce health inequalities, rather than just ensure access to milk and infant formula, no additional funding was allocated for the scheme, which would continue to operate with the same budget as the WFS. The policy design of Healthy Start, including the restricted budget and broad objectives that are not clearly articulated or measurable has led to current operational issues such as lack of awareness of the scheme, lack of linkages with other government nutrition initiatives ((McFadden *et al.*, 2013), and lack of data and structures for on-going evaluations.

Until recently Healthy Start has been a small and largely overlooked part of UK assistance. The government has presented the scheme as a solution to childhood food insecurity and recommitted support to it in the Childhood Obesity Plan of 2016 (HM Government, 2016). The 2019 government response to the obesity plan included a commitment to consult on Healthy Start vouchers to "provide additional support to children from lower income families" (Department of Health and Social Care, 2019, p. 15).

With a grant from the Big Lottery Fund, two non-governmental organizations formed an initiative to tackle food poverty. Their annual theme for 2019–2020 was improving the uptake of Healthy Start and they funded small local initiatives to increase the visibility of the scheme. Despite this attention, uptake has continued to fall, with an average uptake in England and Wales of 51% for 2020 (NHS Business Authorities, 2021).

Just four years after the implementation of Healthy Start, it was conspicuously absent from the important 2010 review of health inequalities "Fair Society, Healthy Lives" (Marmot, 2010). Perhaps the reason for this was the tension between Healthy Start's role as welfare and as nutritional support. The starting point for that review was that "health inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice." The report describes the social gradient in health, or the correlation between earning a low-income and suffering from poor health. Stated in no uncertain terms, remedying this inequality was seen as a social justice imperative. The report also calls for the use of "proportionate universalism" or universal action, but in proportion to need. It is therefore surprising that this report did not specifically mention Healthy Start, given that it was established to operate not only as a nutritional safety net for children, but as a means to reduce health inequalities (McFadden *et al.*, 2014). When this report was revisited in 2020, Healthy Start was mentioned as an example of support programmes that had been cut, as the number of people eligible for the scheme decreased. Since 2011, the number of eligible beneficiaries has declined by a third as income eligibility requirements have not been adjusted for inflation.

2.1.1 Policy Formation

An analysis of the formation of the Healthy Start policy helps to illuminate its mission and the challenges to its implementation. Georgia Machell (2015) suggests that John Kingdon's theory "how does an idea's time come?" provides a useful framework for considering the policy formation of Healthy Start (Kingdon, 2003, p. 1). Kingdon proposed that a policy window was created when three different policy streams converged. These three streams are problem, policy and politics.

The problem was an out-of-date WFS that did not reflect more recent information on the importance of nutrition during pregnancy and infancy, particularly the importance of fruit and vegetable consumption. The Acheson inquiry into inequalities in health identified the issue of poor maternal health in low-income women, and hypothesized that nutritional inadequacy in pregnant women and young children would perpetuate health inequalities (Acheson, 1998).

The policy was the WFS which already had the goal of addressing nutritional inadequacy in low-income families. Enhancing the existing scheme provided the opportunity to incorporate the new information on the importance of diet in early years aligned with the priorities of the new government to invest in children.

The political climate, a newly elected Labour government with an agenda to reduce inequalities and the early years, opened the policy window (Machell, 2014). The new government commissioned the COMA report to guide policy. Its recommendations, which used WIC as an example, were for an expanded

scheme that would not only provide milk and infant formula, but incorporate fruit and vegetables, vitamin supplements and breastfeeding support for young and low-income mothers and their children.

Political factors that drove the change from the WFS to Healthy Start influenced more than the underlying public health messages and the operational considerations of implementation (Machell, 2015). The desire of the newly elected government to have an early policy success consistent with their agenda led to the modifications to the WFS and quick rollout of Healthy Start. This did not allow for a detailed evaluation of the social and operational aspects of the scheme. Perhaps as a result, there is a lack of clearly articulated policy objectives, no formal structure to ensure the policy is functioning as envisioned, and no framework for feedback to inform policy reviews and improvements.

The proposal document claimed that Healthy Start would have an impact on a broad range of issues from farming to child poverty while maintaining the same budget as the WFS. There was a focus on efficiency and maximizing the effectiveness of resources (Machell, 2015). The evidence suggests that there was indeed a problem, and the politics demanded a response, but there was little evidence that the Healthy Start scheme was a well-thought-out response to the problem. Potential beneficiaries and experts in welfare and poverty were not consulted in the policy formation, so the food practices of low-income women and the perceptions of welfare were not considered. An analysis of the responses in the consultation period reveals that 74% of the responses were from health professionals, health authorities and nutritional organizations; 17% of the responses came from the dairy industry and none from fruit and vegetable farmers (Machell, 2015, p. 170). This suggests that the policy design may have been influenced by the dairy industry at the expense of fruit and vegetable farmers and the needs of families. The swift rollout of the scheme could have contributed to the operational weaknesses of the scheme; however, an analysis of the policy design highlights other issues.

2.1.2 Policy Design

Kingdon's analysis considers how the problem was explicitly defined by policymakers. A traditional policy analysis would attempt to determine whether the policy was solving that problem. However, this approach does not encourage reflection on how the problem is conceptualized, whether or not it is made explicit. Post-structural policy analysis offers the chance to ask what the policy implies about how the problem is perceived. Carol Bacchi and Susan Goodwin suggest that "policies do not address problems that exist; rather they produce 'problems' as particular sorts of problems" (2016, p. 16). The framing of the problem shapes the policy intervention and can be inferred from the policy design.

The identified problem was nutritional inadequacy and health inequalities, but it is unclear what the policymakers thought was the underlying reason for this. Is the problem a lack of nutritional knowledge and cooking skills, inadequate parenting practices, or lack of funds to purchase healthy foods? As Healthy Start is a labelled voucher for a particular segment of the population, we can assume that the problem is that the targeted, pregnant women and children in low-income families, are not eating healthfully. The design offers clues to the problem, but many questions remain. If the problem were a lack of funds, there would be no need to limit the voucher use to a small list of food. The parents could be trusted to spend the voucher wisely. If the problem were a lack of nutritional knowledge in low-income pregnant women and

parents, nutritional support classes may be a better solution. Perhaps the vouchers were intended to offer an economic incentive. However, as the value of the vouchers is less than families typically spend on the labelled items, the funds provided could easily be substituted for funds that the recipients would have used to purchase the same items thereby freeing up cash but not changing purchasing behaviour. If the problem were a lack of fruit and vegetable consumption it is unclear why the vouchers include milk and infant formula.

It is important to consider the policy design not only because it provides insight into how the underlying problem is perceived by policymakers, but also because the design sends signals that can be internalized by the public, including the target population. This research is particularly focused on the social construction of the target population, that is how they are characterized and how their problem is defined. This is important because it shapes policy design and efficacy, and impacts social cohesion and political participation (Schneider and Ingram, 1993). The target group can be perceived to be deserving or undeserving, powerful or dependent, and this dictates how the policy is designed and how the problem is linked to the desired outcome of the policy. Policy makers could choose from a wide-ranging array of levers to address inadequate nutrition from education to limits on advertising, taxes for unhealthy food, price support for healthy food, or even criminalizing poor nutrition in pregnant women and children. The target could be companies, all individuals, or just a subset of the population. All of these could be justified depending on the definition of the problem, but they have very different ethical and practical consequences.

Policies are implemented in a certain time and place, and although Healthy Start inherited much from the WFS, it reflected then current ideas about nutrition and parenting. The importance of parenting style and parental behaviour in determining the development of children, and as a central cause of social problems, became increasingly popular in Britain from the late 1990s onward (Clarke, 2006). By the time Healthy Start was conceived, improving parenting had become an objective of social policy and was seen as a way to reduce health inequalities (Churchill and Clarke, 2010). The shift in social attitudes and the priorities of the New Labour government resulted in Healthy Start's focus on changing behaviour in pregnancy and parenting in the early years. In 2010, Frank Field MP produced a report entitled *The Foundation Years: Preventing Poor Children Becoming Poor Adults* in which he argued that the assumption that income was the problem was misplaced, and that in order to break the cycle of poverty, parents needed to be better able to nurture their children. "It is the aspirations and actions of parents which are critical to how well their children prosper" (Field, 2010, p. 11). The idea that large social problems like poverty and health inequalities could be solved by policies focused on the behaviour of individuals, maternal health behaviour and parenting styles, rather than structural issues is reflected in these comments.

2.2 Operation of Healthy Start

There are three aspects to the scheme: food vouchers, free vitamin supplements and nutritional information and support. The three platforms of the scheme are the health professionals who serve as gatekeepers as well as the link to nutritional education and social services, the recipients, and the approved retailers who exchange vouchers for food. The weekly voucher value is currently £3.10 per

week for pregnant women and children aged 1–4 years, and double that amount for infants under 1 year of age. This amount does not increase with inflation and was only increased once, in 2009, when it was increased from £2.90. The full value of the voucher must be redeemed at one time and recipients can spend the voucher on cow's milk, infant formula and fresh or frozen fruit and vegetables. Vouchers are mailed to recipients every four weeks. Nearly three-quarters of the vouchers are redeemed in supermarkets even though other retail outlets, including some corner shops and outside markets, are authorized to accept the vouchers (Sommerville, Henderson and Lennox, 2013; Public Health England, 2016). Several changes to the scheme have been announced and are due to be implemented in 2021. These are discussed below.

Healthy Start vitamins provide vitamins A, C and D for children, and folic acid, vitamin C and vitamin D for women (NHS, 2015b). In some areas recipients receive coupons redeemable for these supplements every other month that can be redeemed at approved pharmacies, and in other areas the vitamins are available to everyone, e.g., Birmingham and Camden. Healthy Start recipients are at particular risk of vitamin C and D vitamin deficiencies. Generally, families in lower income groups have less vitamin C in their diet, and vitamin D deficiency is common in young pregnant and breastfeeding women, as well as young children from ethnic minorities (Public Health England, 2008). Adequate vitamin C consumption has been shown to reduce heart disease, stroke and cancer (Naidu, 2003). Vitamin D deficiencies have been linked to rickets and even diabetes and multiple sclerosis (Power, 2014).

Although the scheme is available throughout England, Wales and Northern Ireland and delivered by NHS Primary Care Trusts, it is managed by the Department of Health in England. In this way it is more of a health intervention than a welfare benefit, as it is not managed by the DWP. At the local level, Healthy Start coordinators who are employees in the health system oversee programme implementation (NHS, 2015a). Recipients are usually identified when they seek prenatal care. The frontline professionals responsible for identifying eligible recipients and signing application forms are usually midwives (Lucas *et al*., 2013). There are several ways to determine eligibility for the scheme. Every woman at least 10 weeks pregnant who is under 18 is eligible. In addition, pregnant women over 18, and non-pregnant women with children under the age of 4, are eligible if they have income below a certain threshold. This can be proven by a candidate's eligibility for one of these three other UK government assistance programmes: Income Support, income-based Jobseeker's Allowance, or income-related Employment and Support Allowance. Women that receive a Child Tax Credit and have a family income of £16,190 or less also qualify (NHS, 2015a). This income threshold is not modified annually with a cost-of-living adjustment. Those eligible for Universal Credit are limited to a monthly household income of £408 or £4,896 per year. Until recently there has been a requirement for application forms to be signed by a health professional. The objective of the signature was to ensure the applicant was pregnant or had a young child and to establish a connection with healthcare services. Theoretically, this provides an opportunity for nutritional and wellness counselling.

There has been a significant decline in both eligibility and uptake in recent years, and the total amount spent on the programme is about a third of what it was planned to be. In October 2002 a Department of

Health press release announced that the budget for the scheme would be £142 million and the current scheme is estimated to cost about £48 million. It is unclear why fewer women are participating, and this warrants further research. The literature suggests a lack of awareness of the scheme by both recipients and gatekeepers (Lucas *et al*. 2013; McFadden *et al*. 2014).

Exhibit 3: Uptake of Healthy Start Vouchers, 2011-2020

Year	Percent Uptake
2011	80%
2012	79%
2013	77%
2014	76%
2015	73%
2016	71%
2017	67%
2018	66%
2019	57%
2020	51%

From Crawley and Dodds (2018) and NHS Business Services Authority (2021)

The National Institute for Health and Clinical Excellence (NICE) recommends that health providers advise Healthy Start beneficiaries on how to increase their consumption of fruits and fruit juices, vegetables, and legumes, as well as teach them about the importance of vitamin supplementation (National Institute for Health and Clinical Excellence, 2008). NICE also recommends providing practical information and ongoing support to encourage breastfeeding. In response to these suggestions, printed nutritional and wellness information appropriate to the age of the oldest child is mailed to recipients every other month with the vitamin vouchers (Lucas *et al*., 2013). The Change4Life website, which provides nutrition advice and support online mentions Healthy Start, and there is also nutrition information on the Healthy Start website, but it is unclear whether this is being utilized by recipients.

2.3 Recent Developments

2.3.1 Changes to Healthy Start in Scotland

In August 2019, Scotland implemented significant changes to the scheme and rebranded it the Best Start scheme (Ruskell, 2019). This included a 37% increase in the voucher amount (from £3.10 to £4.25) and a reduction in the duration of the scheme by one year, ending on the child's third birthday rather than the fourth. If consistently enrolled, this would result in an increase in the amount paid to each child over their eligibility life of £112: from £899 to £1,011. The paper vouchers were replaced with a smartcard that is topped up monthly, and eligible foods were expanded to include tinned as well as fresh and frozen vegetables, pulses and eggs. The eligibility criteria were also expanded, and the application was made easier to complete, with online, telephone and mail options. The application is linked to the Best Start grant (which replaced the Sure Start grants) and consists of three payments totalling £1,100 for a first child and £900 for subsequent children, paid over the first five years of life. The scheme is administered by the new Social Security agency.

2.3.2 Changes to Healthy Start in England, Wales, and Northern Ireland

In 2015, commissioning for Healthy Start was passed to local authorities, along with all of the public health services for 0–5-year-olds (Department of Health, 2015). In 2016, new eligibility requirements were introduced to adopt the eligibility criteria for beneficiaries of Universal Credit. Prior to this time, eligibility for Healthy Start was based upon receipt of the existing income-based benefits and tax credits. The goal was to achieve cost neutrality, with the same amount of claimants eligible after the change to Universal Credit. As shown above, the earnings threshold was reduced dramatically, from £16,190 for those eligible for Child Tax Credits to £4,896 per year for those eligible for Universal Credit. As a result of this change, 20,000 families with a child under 1 year of age became newly eligible and 2,000 lost eligibility (Department of Health, 2016). At the time it was recommended that these new thresholds be reviewed in the future (potentially in 2017) to determine the impact on eligibility. There have not been any formal reviews published since 2016. A public consultation on Healthy Start that was meant to begin in 2018 was promised in the 2018 Childhood Obesity Plan, but on 12 March 2019 it was announced that it would not occur until after Brexit (Doyle-Price, 2018). There has been no update.

Several changes to the scheme were implemented in 2020 and projected for 2021. From April 2020, owing to the difficulty of in person meetings with health professionals due to Covid-19, the need for a health provider to sign the application form was eliminated. An online application is planned for 2021. The paper vouchers are also due to be replaced by a prepaid card that can be used at any retailer with a chip and pin system, eliminating the need for retailers to apply to participate in the scheme. This will likely greatly increase the number of retailers that can accept the vouchers, but it is unknown whether the vouchers will be accepted at farmers' or street markets which primarily accept cash. Currently, vouchers are accepted at many farmers' markets, and the market organizer handles redemption of the vouchers for each stall. As a result of recent campaigning as well as the recommendation of the National Food Strategy, the value of the voucher is planned to increase in April 2021 from £3.10 to £4.25 per week (from £6.10 to £8.50 for infants under 1 year old) (National Food Strategy, 2020; Rashford, 2020).

In 2019, the Mayor of London, Sadiq Khan, established a Healthy Start working group of frontline professionals and campaigners to assess barriers to participation and contribute to the food advocacy alliance, Sustain. This was part of the Food Power initiative addressing food poverty throughout the UK. Their focus has been to increase uptake through webinars and toolkits for medical practitioners (Pattinson, 2018). So far, funding of £5000 has been given to five local authorities (Bexley; Camden; Croydon; Kensington and Chelsea; Newham and Southwark) to develop Good Food Retail plans. These plans include actions to improve Healthy Start uptake with the goal to increase uptake to 75% by 2024 in the participating local authorities. The plan is to incorporate more local authorities (Khan, 2019). This complements the work Sustain has done annually in the *Beyond the Food Bank* report. In this report local authorities in London are ranked based on their adoption of policies to increase uptake of Healthy Start. These measures include appointing a local champion for the scheme, providing information on local retailers that accept vouchers to recipients, setting a target of 80% for local uptake, and providing training for health professionals (Sustain, 2018). There is, however, no evidence that local authorities that have taken such steps have better uptake than local authorities without policies in place. The latest data from

December 2020 shows that uptake in London has continued to decline in 2020, from 52% to 48% (NHS, 2021).

Exhibit 4: Uptake in Healthy Start Local Authorities in London by Actions Taken to Improve Healthy Start Uptake

	5 Healthy Start actions	3 Healthy Start actions	1 Healthy Start action	No action/data	All
Number of Local Authorities	11	6	3	13	33
Average Uptake	66%	66%	64%	64%	65%
Range	56–76%	59–70%	57–74%	57–74%	56–76%

In a speech to the Fabian Society, Jonathan Ashworth, MP and Shadow Secretary of Health and Social Care, announced that the Labour Party would commit £26.8 million to the scheme as part of their Future Generations Wellbeing Act to focus on the improvement of well-being and reduction of health inequalities.

The latest London Food Plan set two goals for Healthy Start: to host a workshop and coordinate a working group (both of which have been instituted and in which I have regularly participated) to facilitate improved uptake and to encourage more retailer take up of Healthy Start vouchers (Greater London Authority, 2018).

The recommendations for the National Food Strategy (Part 1 released in August 2020) called on the government to increase the value and expand the eligibility for Healthy Start vouchers. It also recommended collaboration with supermarkets to provide free fruit and vegetables to recipients. Recent campaigning has supported this alliance with retailers, and in early 2021 several retailers have announced that they will enhance the value of the vouchers for fruit and vegetables.

2.4 Overview of Prior Research

The following table is a summary of the literature on Healthy Start. In addition, there are journal articles based on many of the evaluations listed below.

Exhibit 5: Summary of Prior Research

Title	Author	Year	Methods
Healthy Start Rapid Evaluation of Early Impact on Beneficiaries, Health Professionals, Retailers and Contractors (Tavistock Study)	Hills *et al.*	2006	Case study of pilot
Approaches to Evaluating Healthy Start – A Scoping Review	Dyson *et al.*	2007	Review
Are the Benefits of the "Healthy Start" Food Support Scheme Sustained at Three Months Postpartum? Results from the Sheffield "Before and After" Study	Mouratidou *et al.*	2010	Case study using food frequency questionnaires at baseline, 4, 8 and 12 weeks

Title	Author	Year	Methods
Diet and Nutrition Survey of Infants and Young Children. Annexe A. Healthy Start	Sommerville *et al.*	2011	Quantitative
Healthy Start: Retailer Research Summary	Department of Health	2012	Qualitative
Healthy Start: Understanding the Use of Vouchers and Vitamins	McFadden *et al*.	2013	Mixed method evaluation
Healthy Start Vouchers Study: The Views and Experiences of Parents, Professionals and Small Retailers in England	Lucas *et al.*	2013	Mixed method evaluation – interviews with parents, health professionals and neighbourhood retailers
Food Welfare for low-Income Women and Children in the UK: A policy Analysis of the Healthy Start Scheme	Machell	2014	PhD Dissertation, unpublished research
Considering Influences on the Policy Formation of Healthy Start: A Government-Funded Nutrition Scheme	Machell	2015	Journal article based on above research
The Healthy Start Scheme: An Evidence Review (Scotland)	Szpakowicz	2016	Evidence review
Increasing Healthy Start Food and Vitamin Voucher Uptake for Low-Income Pregnant Women	Mackenzie and Dougall	2016	Case study of intervention
Assessment of the Healthy Start Voucher Scheme: A Qualitative Study of the Perspectives of Low-Income Mothers	Browne, Dundas and Wight	2016	Qualitative study
A Realist Review to Explore How Low-Income Pregnant Women Use Food vouchers from the UK's Healthy Start Programme	Ohly *et al.*	2017	Realist review
Getting a Healthy Start: The Effectiveness of Targeted Benefits for Improving Dietary Choices	Griffith, von Hinke and Smith	2018	Empirical analysis
Has the UK Healthy Start Voucher Scheme been Associated with an Increased Fruit and Vegetable Intake among Target Families? Analysis of Health Survey for England Data, 2001–2014	Scantlebury *et al.*	2018	Statistical analysis
A Realist Investigation of the Impact of "Healthy Start" on the Diets of Low-Income Pregnant Women in the UK	Ohly	2018	PhD Dissertation, unpublished research
The UK Healthy Start Scheme – Evidence from Cardiff Shopping Observation and Research on Scheme Awareness	Food Cardiff	2018	Report
Apply for Healthy Start – Alpha	NHS	2018	Assessment

The first study was an evaluation of the pilot in Devon and Cornwall that focused on the mechanics of the scheme in order to provide recommendations for the national policy implementation (Hills *et al*., 2006). The evaluation was relatively small; 32 health professionals, 20 retailers and 18 beneficiaries were interviewed. Given these relative numbers, it appears that the viewpoints of the health professionals were privileged over those of the beneficiaries. The recommendations identified are consistent with this observation. The key recommendations were: adequate training for health professionals, links between Healthy Start and other health initiatives, links between Healthy Start and local social services, and the

establishment of national evaluation tools. As the focus was on the mechanics of the scheme, it does not provide insight into the use of the vouchers or the potential impact on nutrition.

Developing the evaluation tools was the goal of the 2007 study (Dyson *et al*.). It considered different options and provided recommendations for determining measurement criteria as well as a framework for ongoing monitoring of the scheme. The lack of existing routine data was highlighted, along with recommendations for adapting existing data sets to include information about Healthy Start. One of the problems identified was that due to the rapid implementation of the policy, which preceded the evaluation and monitoring recommendations, there was lack of comparison options for a comparative study. Two of the most robust forms of study, a planned before and after study, and a randomized controlled trial, were therefore not possible (Dyson *et al*., 2007). If a large baseline study had been conducted it would have provided a better sample group, or if the rollout had been done in stages a geographic comparison would have been possible.

The 2010 study, commissioned by the Department of Health, was based on a case study in Sheffield shortly after the roll-out of Healthy Start, and used food frequency questionnaires administered at baseline and then after 4, 8 and 12 weeks (Mouratidou *et al*., 2010). The goal of the study was to evaluate the operations of the scheme and determine its impact on diet through a comparison of recipients of Healthy Start and the WFS. In total 86 Healthy Start recipients and 64 WFS recipients were included at baseline, with 47 and 39 included at 12 weeks. Although the study provides promising comparative results, the limited population studied (Caucasian, English-speaking postpartum women from Sheffield) and the limited follow-up do not allow the results to be generalizable to the UK as a whole or provide an understanding of the scheme's impact on longer term nutrition.

The Diet and Nutrition Survey of children from 2010 found that 22% of children aged 4–18 months participated in the programme. Based on a survey of 580 women in receipt of vouchers, 47% of recipients spent all or most of their vouchers on infant formula, 25% mainly on fruit and vegetables and 9% mainly on cow's milk, 16% on a mixture of items, and 3% did not use them (Sommerville *et al.*, 2011). Although this remains the only information available on voucher use, because only a small percentage of recipients were surveyed it is difficult to assume that the results are generalizable to all recipients. Furthermore, the survey may privilege certain types of respondents, resulting in purchasing data that is not reflective of the broader population.

The 2013 evaluations, also commissioned by the Department of Health, were the first large-scale national evaluations. These both used literature reviews as well as interviews with participants, health professionals and retailers to determine their views on the effectiveness of the scheme and recommendations for improvements based on their experiences with it (Lucas *et al*., 2013; McFadden *et al.*, 2013). The Lucas *et al*. evaluation researched 13 primary trust areas and interviewed beneficiaries (n=107), retailers (n=20) and health professionals (n=65). The McFadden *et al.* evaluation was the larger study, and focused in the areas of London, Yorkshire and Humber. It interviewed beneficiaries (n=113) and health professionals (n=49) separately, as well as in workshops (n=56). A national questionnaire was also undertaken (n=620). Consideration was given to government and industry datasets. It is unclear why the Department of Health commissioned two evaluations in the same year, but it provides the potential for

confirmation of the results and conclusions. These primarily qualitative evaluations conclude that the schemes are effective despite the operational issues, but fail to provide robust evidence of programme effectiveness because of the lack of comparative data. The evaluations did not use objective measures of diet and health, but relied on the reports of those interviewed, further weakening the potential to provide evidence of a positive health impact. While these studies were large and offer the best research available on the scheme, the focus on the efficiency of the scheme preclude conclusions about the broader social impact of the scheme. There was no analysis of the economic impact on recipients or the government.

The 2015 empirical analysis used longitudinal data on food purchased and brought into the home from the two years prior to the introduction of Healthy Start and the two years after (Griffith, von Hinke and Smith, 2015). The goal of the analysis was to determine the impact of Healthy Start on the availability of fruit and vegetables in the homes of families in receipt of Healthy Start. Although the analysis used objective data for 266 UK households receiving benefits, it was not able to look specifically at families in receipt of Healthy Start vouchers as that data was not collected. The dataset was obtained from demographic data and purchasing information from families who were given a handheld scanner to record all food brought into their home. The analysis compared grocery purchase data of eligible to ineligible households before and after the Healthy Start scheme was implemented. Ineligible households were defined as those low-income households with a woman before she became pregnant or those with children aged 4–8 years. The study did not actually track purchases made with the vouchers, or even ascertain whether vouchers were used, but tracked the difference in purchasing behaviour between families before a woman became pregnant (using subsequent knowledge that she gave birth) or those with children slightly older than those who could have received benefits. Infant formula purchases were assumed to remain the same. A weakness of the scanner methodology was that it likely undercounted fruit and vegetable purchases because it only recorded those with a barcode, not those purchased loose or from a street market.

The study showed that those households with a pregnant woman or with children under 4 years old brought more fruits and vegetables with a barcode into the home, but it is difficult to reach the conclusion that Healthy Start was the reason for this. It could be that becoming pregnant or having a new child in the home provide motivation for healthier eating. There was a growing awareness of the importance of diet in the mid-2000s, which also could have influenced purchases. It is also impossible to know if the fruits and vegetables brought into the home were actually consumed. Since the number of Healthy Start beneficiaries in the UK population was so low – less than 1% of the population (480,000/65,110,000 = 0.7%) (Office of National Statistics, 2015) – even large population datasets will have a very small number of actual beneficiaries, and they may not be representative of the overall Healthy Start population. This is compounded by the fact that those most likely to be included in a long-range study have the most consistent housing and may not have a representative diet.

A 2016 quantitative study addressed some of the limitations of that paper (Scantlebury *et al.*, 2018). Using data from the Health Survey for England with 84,278 participants, 3.3% (2763) were deemed to meet the criteria for Healthy Start eligibility. The study grouped participants by eligibility for Healthy Start, rather than whether participants were actually Healthy Start recipients. In this way it tested the

"effectiveness of the Healthy Start programme in supporting fruit and vegetable consumption among target groups, rather than the narrower measure of efficacy of the vouchers for those receiving them" (Scantlebury *et al*., 2018, p. 627).

In the years tested, from 2001 to 2014, the eligible group consumed significantly less fruit and vegetables than the other groups, with consumption highest among girls, non-white groups, those living in less deprived areas and those with the highest incomes. While fruit and vegetable consumption for this group did increase between 2004 and 2006 compared to 2001–2003, the increase was consistent with the control groups, both for children and for adults. The overall increase could have been the result of the introduction of the 5 a day initiative in 2003. There was also a decline in consumption in 2010–2014 that could have been related to the recession, but the study does not show a causal link.

A limitation of the study was that it could only measure fruit and vegetable consumption in children aged 5 years and older because of the dataset used, and the scheme targets children under 4 years old. It is possible that the vouchers were specifically used for the young children and not shared in the household.

A strength of this study is that it did not look at Healthy Start recipients but at those deemed eligible for the scheme, which is the target demographic the scheme hopes to change. In this way it measures the impact on the target demographic. However, low uptake would affect the results and may explain the lack of a measurable impact on potential recipients. Other possible explanations would be that families used the vouchers to purchase items other than fruit and vegetables or that the vouchers enabled them to buy better quality or different fruit and vegetables that did not result in an increase in consumption. It is also possible that the vouchers allowed recipients to maintain fruit and vegetable consumption in line with the population rather than falling behind.

A qualitative 2015 Welsh study interviewed parents to determine what population-wide interventions they would recommend to improve their children's diet, with Healthy Start mentioned by some of the participants (Khanom *et al.*, 2015).

Several reviews were undertaken in Scotland in 2016. The Scottish government carried out an evidence review to determine the effectiveness of the scheme in Scotland and to determine if changes should be made to the Scottish scheme (Szpakowicz, 2016). This contributed to the significant changes made to the scheme in 2019. That same year, a study was published that tested measures for uptake improvement in a test site in Scotland. The intake improved in Lothian, but it declined for the rest of Scotland (Mackenzie and Dougall, 2016). A study funded by the National Institute of Health Research that interviewed 40 low-income mothers in Scotland found that the main barrier to lack of uptake was awareness, which was worse among employed, more educated women and those living in more affluent areas (Browne, Dundas and Wight, 2016).

In 2016, the digital technology group at the DHSC launched a project to assess the potential of technology to improve the scheme (private meeting with the DHSC). Their primary interest is the decline in uptake. Based on interviews with 19 mothers and 11 health professionals, they found an overreliance on health professionals to promote and support the scheme. This work was the foundation for the

proposed changes outlined above: eliminating the need for a health provider signature and digital cards. A rebranding of the scheme was also considered, with a new name and new graphics on the website.

A small qualitative 2017 study used a realist methodology to theorize and understand how vouchers are used, and uncover potential unintended consequences of the voucher scheme. The methodology develops programme theories to help explain how and why effects come about, and tests these using empirical evidence. In this way, the theoretical models that explain how the Healthy Start scheme could work are evaluated rather than the scheme itself. The value of this study was providing a theoretical framework for future evaluations of the scheme.

Two studies have looked at fraud in voucher use. A study commissioned by the Department of Health found that misuse of vouchers appeared to be rare, although the sample size (n=79) was small (Department of Health, 2012). A more recent study in Cardiff carried out by Food Cardiff on behalf of the Welsh government found that 58% of retailers (14 of 24) accepted vouchers for products not included in the scheme. This study did not use actual recipients, but sent people into a variety of retailers to use vouchers for ineligible items. The types of items purchased included other types of milk, baby food, other food products such as tinned fruit, frozen prepared vegetables and other drinks. They found that some staff were unfamiliar with the scheme and had to ask other staff how to use the vouchers. The recommendation of the research was to support retailers through increased technology and staff training so that the vouchers are not spent on ineligible items. This small study does not show that vouchers are being spent inappropriately, but does show that retailers in Cardiff may accept the vouchers for items not included in the scheme (Food Cardiff, 2018).

2.5 Findings from Prior Research

2.5.1 Effect on Nutrition

> *I think they [food vouchers] are a good thing because you can only buy milk and fruit and veg, so they're really encouraging* (participant quoted by Khanom et al., 2015, p. 9).

The small study done in Sheffield at the time of the introduction of Healthy Start, comparing 160 women receiving Healthy Start vouchers to 176 women who received WFS tokens, found that those receiving Healthy Start vouchers consumed significantly more fruits and vegetables (Ford *et al.*, 2009). This was confirmed by qualitative studies where recipients reported that vouchers increased the amount and variety of fruits and vegetables eaten (McFadden *et al.*, 2014). A further quantitative study of 266 UK households with children in receipt of benefits determined that those eligible for Healthy Start vouchers consumed 15% more than others (Griffith, von Hinke and Smith, 2015). This was refuted by the first large study of nationally represented data from the Health Survey for England, which found no difference between the changes in fruit and vegetable consumption in the group eligible for Healthy Start and other groups (Scantlebury *et al.*, 2018).

These studies agree that Healthy Start has the potential to improve the long-term nutrition of mothers and young children (McFadden *et al.*, 2014; Khanom *et al.*, 2015; Lucas, Jessiman and Cameron, 2015), with *potential* being the key phrase. Overall, health professionals believe it is beneficial, but this is based on

perception rather than objective evidence. The health workers in charge of implementing the scheme do not have data on its impact on families, and many describe it as having a limited impact on the nutrition of low-income families (Lucas *et al.*, 2013). Recipients report that the vouchers make a difference in their food budget, which is typically £30–50 per week, freeing up money to be spent elsewhere, but only a third report that the programme encouraged them to buy more fruits and vegetables (Lucas *et al*., 2013). This quote from a participant implies that the voucher does not change behaviour but rather is functioning like a cash benefit, as funds that would have otherwise been spent on milk, fruit and vegetables are diverted to other needs.

> *£3.10 a week when you are working doesn't feel like much but when you're not working and are on benefits it does make a difference, it's £3.10 a week you have of your money to spend on other things aside from milk, fruit and veg.* (participant quoted by Lucas et al., 2015, p. 462).

One encouraging but small study in Sheffield showed that consumption of fruits and vegetables were reported to be higher in Healthy Start recipients, averaging 3.4 portions per day versus 2.7 portions for the earlier group of WFS participants (Mouratidou *et al*. 2010). It also found that Healthy Start participants consumed more calories than WFS participants (Mouratidou *et al.* 2010). Some recipients reported that the vouchers enabled them to buy different fruits and vegetables, and after they stopped receiving the vouchers, they reduced their consumption (Lucas, Jessiman and Cameron, 2015).

Of the two large quantitative studies, one determined that fruit and vegetable consumption increased after the introduction of Healthy Start, and one found that there was an increase in consumption in line with the general population (Griffith, von Hinke and Smith, 2018; Scantlebury *et al.*, 2018). Griffith, von Hinke and Smith (2018) determined that the change from the WFS to Healthy Start led on average to a 15% increase in spending on fruit and vegetables in eligible households which is an average of 1.8 kg per household per month or two-thirds of a portion per household member per day. The increase was seen in households that generally spend less than the voucher value on fruits and vegetables (about 62% of those studied) and did not result in a significant increase in those that generally spent more than the voucher value. This is in line with the predictions of standard economic analysis, which predicts that people will spend a voucher like cash if the amount is less than they spend on covered items, but a voucher will have a larger effect on spending for those who normally spend less than the voucher value on milk, fruits and vegetables. For those who normally spent more than the voucher value, the voucher freed up cash to be spent on other things. Milk consumption was found to be relatively fixed and did not change with the introduction of Healthy Start vouchers. There was no effect found from any nutritional information provided by healthcare workers or the "prescriptive" nature of the vouchers.

Scantlebury *et al* (2018), using Health Survey for England data, determined that the introduction of the scheme did not increase fruit and vegetable consumption in the target population as their consumption rose consistently with the rest of the population. The authors concluded that the scheme did not contribute to better nutrition; however, it is difficult to make that assumption. While the vouchers did not lead to an increase in the consumption of fruit and vegetables, it is possible they may have allowed the target population to maintain consumption when it otherwise would have declined by contributing to the food budget.

2.5.2 Vitamin Usage

Health providers believe that vitamin supplements have great potential as a health intervention (McFadden *et al.*, 2015). But despite access to free vitamins, usage has been low in Healthy Start participants, below 10% in some area (Lucas *et al.*, 2013). Only 3% of mothers report taking vitamin supplements during pregnancy (McFadden *et al.*, 2013). Overall, only 30% of Healthy Start-registered breastfeeding mothers were taking vitamins when the infant was 4–10 weeks old, rising to 44% when the infant was 8–10 months. Only 13% of the infants were given vitamin drops at 4–6 months, rising to 19% at 8–10 months (Jessiman *et al.*, 2013). But despite these low numbers, vitamin usage in Healthy Start infants is higher than those not registered (13% compared to 8% at age 4–6 months). The reasons given by participants for the low vitamin use is poor access to pharmacies and other outlets that stock them, lack of awareness of their availability, as well as a lack of motivation (Jessiman *et al.*, 2013; McFadden *et al.*, 2015). Uptake of vitamins is particularly low in inner cities, with only 7% of babies being given vitamins at 6 weeks (Alderton, 2014).

2.5.3 Infant Feeding Practices

The last UK wide survey on infant feeding practices was in 2010. Prior to that there is good research as surveys had been conducted consistently since 1975. In England about 74% of mothers initiate breastfeeding and 45% are still breastfeeding at least part of the time at 6-8 weeks (NHS, 2015a). Rates have remained steady in recent years. The breastfeeding rates for Healthy Start participants are lower than those in the general population, and lower than those who are eligible but not registered (Lennox, Sommerville and Henderson, 2011; McAndrew *et al.*, 2012; McFadden *et al.*, 2014). Women report that their decision to initiate breastfeeding is influenced by their families, friends and beliefs about health as well as practical considerations, but not the availability of the Healthy Start vouchers (McFadden *et al.*, 2013). However, they do report that the duration of breastfeeding is influenced by the vouchers, as mothers report switching from breastfeeding to formula feeding sooner than they otherwise would have as a result of the Healthy Start support (McFadden *et al.*, 2013). Health practitioners are divided on whether they believe that the vouchers are a disincentive to breastfeed or an important nutritional intervention. Some fear that without the vouchers, mothers who did not want, or were not able, to breastfeed may resort to less expensive alternatives such as diluting infant formula or using cow's milk (McFadden *et al.*, 2013). The 2010 survey determined that nearly half of all vouchers were spent on infant formula. Not surprisingly, Healthy Start vouchers have a more significant impact on the diet of breastfeeding women, because those who use the vouchers for infant formula have none left over to purchase fruit and vegetables (McFadden *et al.*, 2013; Lucas *et al.*, 2013).

2.5.4 Engagement with Health Professionals

Healthy Start applications have historically required a signature from a healthcare professional in the hope that this leads to increased interaction with healthcare services and nutritional education. But there has been no evidence that Healthy Start has been associated with early or increased access to healthcare (McFadden *et al.*, 2014). NICE has recommended that health providers should provide nutritional, breastfeeding and healthy lifestyle support, but there is no clear evidence that this is effectively taking place, or that participants perceive it as a benefit (McFadden *et al.*, 2014).

2.5.5 Where are Vouchers Spent?

A 2010 Department of Health report showed that 73% of the vouchers were used in national supermarket chains, 15% in independent or franchised supermarkets, 5% with doorstep milk services, and the remainder with food cooperatives, box schemes or market traders (Department of Health, 2010). There is a recent campaign to register more community traders and markets, but it is unknown whether that has changed purchasing behaviour.

2.6 Limitations of Healthy Start

2.6.1 Declining Take-Up

As regards the application, application forms are only in English, making it difficult for those who are not fluent in English (Lucas *et al*. 2013; McFadden *et al*. 2013). The need to have a health professional sign the application may also impede access by creating an additional step, rather than providing the hoped-for contact with the healthcare system (McFadden *et al.*, 2013). The application form is attached as Appendix 1.

In terms of reluctance to discuss the scheme, a major focus of this dissertation is on the stigma that attaches to benefits. Some recipients were confused about where they could use the vouchers and embarrassed to ask shopkeepers. Some women report "shaming" at the check-out counter due to confusion about eligible foods (McFadden *et al.*, 2013). Prior research has suggested this embarrassment could be alleviated if recipients and markets were better trained to understand which foods are allowed (Lucas *et al.*, 2013; McFadden *et al.*, 2013).

Finally, participants and healthcare practitioners expressed the concern that many local shops and markets do not accept the vouchers, particularly in rural areas, and there may not be lists of authorized retailers provided to recipients. This question of designated stores and foods is a particular problem for women in migrant communities because they are often unable to use the vouchers at local shops and markets where they could find culturally familiar food (Lucas *et al*., 2013; McFadden *et al.* 2013). Women who are not fluent in English are at a significant disadvantage, both in enrolment and making use of the scheme, citing confusion about what the vouchers could be used to purchase. Many participants thought they were for milk only (Lucas *et al*. 2013; McFadden *et al.* 2013).

2.6.2 Budget

The voucher amount of £3.10 per week is "insufficient to outweigh the negative effects of poverty on nutrition" (Attree, 2006, p. 67). The impact has been further undermined as the voucher value has not changed since 2009, despite increases in food and living costs. Requiring mothers to choose between infant formula and fruits and vegetables, rather than allocating part of the vouchers for fruit and vegetables means that for those who do not breastfeed, the entire voucher is used on infant formula (Jessiman *et al.*, 2013; McFadden *et al.*, 2013). Another issue is that the voucher must be used all at once, and there is no way to save partial amounts. The proposed electronic card with stored value could offer more flexibility to participants to shop throughout the week.

Surveys of both recipients and health practitioners indicate that the household income threshold for families receiving tax credits is too low, with the consequence of discriminating against those in low paid work (McFadden *et al.*, 2013). An annual threshold was also viewed as difficult because it does not allow for fluctuations in income as people move in and out of work (McFadden *et al.*, 2013).

Operational weaknesses in the delivery of Healthy Start may be the result of a limited operational budget that does not include funds for health professional training or nutritional support for participants (Lucas *et al.*, 2013). Barriers to providing nutrition-related information to participants include lack of time in the health providers' schedules, language barriers, and a lack of training of health professionals (McFadden *et al.*, 2014).

2.6.3 Integration with Other Nutritional Programmes

The scheme is not linked to other public health policies, such as Start4Life and "5 a day", and an opportunity is being missed for better coordination between local healthcare providers and the NHS. As discussed in Chapter 4, most people, regardless of income, understand the importance of eating fruits and vegetables. However, the benefits of breastfeeding over formula, and the importance of vitamins, may be less well understood.

Some fear that inclusion of infant formula may provide a disincentive to breastfeed. In addition to the financial incentive, its inclusion in a healthy food scheme may lead some mothers to believe that it is a healthier alternative to breastfeeding. In the current scheme there is a lack of reinforcement provided to encourage and support women in breastfeeding.

Vitamin usage has remained very low. Wider availability in local shops may improve uptake as the current system of distribution is ineffective. One way to address this would be to provide free vitamins to all mothers and children, thus eliminating the need for eligibility. Sally Davies, the Chief Medical Officer of England, called for a feasibility study aimed at determining whether the benefit for free vitamin supplements should be extended to all pregnant women and children. In this study, NICE determined that universal availability of the supplements for all pregnant women and children would be cost effective, primarily because of the quantifiable benefits on reducing neural tube defects if folic acid is taken during pregnancy (National Institute for Health and Clinical Excellence, 2015). This universal approach would have the benefit of reducing the stigma associated with Healthy Start vitamins and would make access easier. It would also address the problem that certain ethnic groups are at particular risk of vitamin D deficiency yet do not meet the eligibility requirements for Healthy Start.

2.7 Research Gaps

The existing research is limited. It is useful in determining the perceptions of participants and providers on the operations of the scheme, and provides some information, which is contradictory, on whether the scheme has been effective at changing the diet of participants. While participants report appreciating the scheme, there is no evidence that it has improved health inequalities or provided a nutritional safety net. It does little to explain the underlying issues for the reduction in uptake, the broader social perceptions of the scheme, and its economic impact. The recent interest in uptake has resulted in more information about

operational obstacles to enrolment, but despite local authority and charitable efforts, uptake continues to decline and is at historically low levels. The possibility that recipients do not register for the scheme, or use it as a last resort, due to shame and stigma has not been adequately researched. More can be understood about how recipients of the scheme are perceived, both by recipients and non-recipients, in order to understand how the underlying problem is perceived.

When the scheme was conceived there was not a clear articulation of the problem that it was meant to address, or the mechanism for doing so. The design of the policy, which relies on a restrictive voucher for a targeted population, warrants further research. The policy design implies that there is lack of knowledge and or willpower that necessitates a restrictive voucher, yet there is no evidence that the lack of knowledge in the target population is keeping them from eating better. Future policy design could be guided by a better understanding of how the underlying problem of poor nutrition in low-income families is perceived by parents, both those eligible for the scheme and not, and how this compares to the way people describe their ideal diet and the reality of their diet. The social reality of how people construct themselves using their food preferences and practices also needs to be considered. Finally, an economic analysis that attempts to calculate the potential benefit to cost ratio of the scheme, as well as the economic impact on families, farmers, and the government, has not been undertaken.

2.8 Summary

This chapter has summarized what is currently known about the Healthy Start Scheme from existing research and publicly available information. Prior research has focused on the operations and effectiveness of the scheme in increasing fruit and vegetable consumption. Several gaps in the research have been identified that warrant further research: the reason for the low and declining uptake, the appropriateness of the policy design, the associated stigma and other social impacts, and the overall economic impact of the scheme. The next chapter details the research plan and justifies the methodology undertaken in this research to contribute to the knowledge base on the Healthy Start Scheme specifically and food policy more generally.

Chapter 3: Methodology and Research Design

3.0 Introduction

This aim of this research was to understand if the Healthy Start Scheme has the potential to improve early childhood nutrition and well-being. To achieve this aim, a primarily qualitative methodology was chosen to learn about the challenges a diverse group of parents in England have in providing their children with a healthy diet and their perceptions of the Healthy Start Scheme and its recipients in order to better understand the context of the scheme, how it is accessed, and how it is utilized. Following this qualitative research, it was determined that the economic consequences of the scheme as currently configured and with modifications should be calculated to provide a more complete evaluation of the scheme.

The chapter begins with an outline of the research stages, followed by the research questions and objectives. It then describes the process taken to recruit participants, provides demographic information about those interviewed, introduces the structure of the narrative interviews and questionnaire undertaken, and the methods of data analysis. This is followed by the ethical considerations and reflections on the challenges faced in data collection.

3.1 Stages of Research

The research followed several stages. However, this was not a linear process, as many of the stages looped back and forth as analysis and emerging themes were refined.

1. Literature review and development of research questions
2. Interviews with managers and health professionals in two urban areas who serve as gatekeepers for the voucher scheme (comparative case study)
3. Preliminary identification of themes and refinement of interview questions for parents
4. Narrative interviews with parents in two areas (comparative case study)
5. Transcription of interviews and development of a coding framework utilizing the NVivo software program
6. Analysis of data
7. Development of economic model to measure economic effectiveness and impact

3.2 Research Questions

The goal of this research was to go beyond prior research which had focused more narrowly on the operations of the scheme and potential impact on nutrition. It was not clear why the scheme was declining in popularity despite an increased focus from government and civil society, and an increase in need. While the research took a broad approach, the focus became the social context and consequences of the scheme that may affect its effectiveness. As experts on their own lives, interviews with parents were determined to be the best way to gain insight. With parents of young children, interviews explored knowledge of nutritional guidelines, food practices, obstacles to achieving their ideal diet, and the role of government and Healthy Start. Interviews with health professionals provided further context for the role of Healthy Start in the lives of families. During the course of the research, it was also considered

necessary to track the economics of the scheme to see who was benefiting from it, the impact on the family budget, and whether it was cost effective for the government.

The research questions were developed based on the perceived gaps in the prior research: the appropriateness of the policy design, the reasons for the low uptake, and the social and economic impacts of the scheme. Four broad questions were identified to invite a process of "exploration and discovery" (Agee, 2009, p. 433). This is consistent with the primarily qualitative methodology undertaken, intended to gain broader insight into the beliefs and perceptions of respondents. More specific questions were not proposed in order to avoid overly narrowing the research. The questions were modified slightly during the course of the research to reflect the inclusion of parents of all income levels, but not substantially changed.

> **RQ1**: How do the parents of young children describe their perception and practice of healthy eating and the obstacles they face?
>
> **RQ2:** How do parents and health professionals describe their perception of and experience with the Healthy Start scheme?
>
> **RQ3:** How are recipients of Healthy Start perceived?
>
> **RQ4**: What is the actual and potential economic impact of the Healthy Start scheme?

Based upon the research aim and questions, more detailed supporting research objectives were developed. These are outlined below with the data sources and methods used.

Exhibit 6: Research Objectives

Research Objective	Related Research Question	Literature Review	Interviews	Analysis	Observations and Site Visits
Identify the values and practical considerations that determine families' food practices	RQ1	X	X	X	X
Define the mission and operations of Healthy Start	RQ2	X	X		
Describe and analyse the historical and current social, economic and political context of the Healthy Start scheme	RQ2	X	X		X
Identify the obstacles to participation	RQ3	X	X	X	X

Research Objective	Related Research Question	Literature Review	Interviews	Analysis	Observations and Site Visits
Determine if there is stigma associated with claiming Healthy Start and compare to the stigma of other welfare benefits	RQ3	X	X	X	X
Calculate the economic impact of the scheme on those who benefit from it: the government, parents, retailers, and farmers	RQ4	X		X	
Evaluate the cost effectiveness of the scheme at different voucher amounts and eligibility levels	RQ4	X		X	

3.3 Literature Review

The first step was a broad literature search using key words. A list of the search words used is contained in Appendix 2. In addition, related resources with similar key words or sharing bibliographic information were identified with search engines such as Google Scholar, EBSCO, and Mendeley. Snowballing provided a rich source of related literature by using references in journal articles and relevant books. The UK government websites provided programme as well as empirical data. Parliament debates were searched for discussion of "Healthy Start" through the website www.theyworkforyou.com. "Grey" literature, such as twitter and news websites, was also reviewed for information on public perceptions and reactions as well as recent research. As knowledge grew, and based on the recommendations of other experts and academics, further literature was identified. Finally, through connections established with the director of the Healthy Start Alliance, the Department of Health and Social Care (DHSC), and the Greater London Authority, I participated in discussions and planning sessions with those who were trying to increase uptake and make improvements to the scheme. This allowed an insider's view of the process of policy advocacy as well as access to the health professionals tasked with promoting Healthy Start in the working groups.

The literature review provided a rich background from which to identify the research gaps and research questions, and to develop the methodology best aligned with the research aim. As this aim was to understand the perceptions of Healthy Start and its role in families' lives, a primarily qualitative approach was chosen to respond to the first three research questions. Interviews were undertaken with three key informant groups: 1) potential targets of the scheme, pregnant women and parents of children under 4

years of age; 2) health professionals who serve as gatekeepers for the scheme; and 3) regional public health leads with responsibility for the scheme.

3.4 Data Collection

3.4.1 Selection of Locations

Camden and Leicester were chosen as the interview sites for practical reasons, and because the two urban locations provided an interesting basis for comparison. Camden has a diverse population in the heart of London, whereas Leicester in the Midlands has a less diverse and more deprived population. Within Camden, three children's centres and two hospitals were visited, and in Leicester, a children's centre and a community centre. A champion was identified in each area to facilitate the research process. Both of the areas have higher than average uptake levels for Healthy Start; with Camden at 68% and Leicester at 74%. This was perceived as an advantage as it increased the likelihood of finding Healthy Start participants to participate in the research. The demographic characteristics of the two locations are summarized in Exhibit 7.

Exhibit 7: Characteristics of Case Study Areas

Location	Population	Index of Multiple Deprivation rank in England (1)	% Black, Asian and Minority Ethnic population (2)	% of Children in Poverty (3)	Healthy Start Uptake (4)
Camden	220,338	69/326	34%	40%	68%
Leicester	329,939	21/326	22%	41%	74%

(1) With 1 the most deprived area (Department for Communities and Local Government, 2015)
(2) (Office of National Statistics, 2011)
(3) Calculated after housing costs (Hirsch, 2018)
(4) (NHS Business Services Authority, 2021)

Camden is a borough with a population of 220,338. According to the 2011 Census, Camden is described in terms of "High-Density & High-Rise Flats" (32%), "Urban Elites" (29%), "City Vibe" (22%) or "London Life-cycle" (16%). Nearly a third of the residents were born outside of the UK and EU, with English as the second language for 23% of the population. Camden has areas of poverty next to areas of affluence. Camden is with the top quarter of most deprived districts in England and 28.5% of children in Camden live in low-income families (compared to a London average of 19.3%), which is the fourth highest in London (Storer, 2021). After housing costs, 40% of the children in Camden lived in poverty (Hirsch, 2018). At the time of the research, Healthy Start uptake in Camden was 68% compared to an average of 65% in London. Camden had the highest score given (at least five initiatives to increase uptake) from the *Beyond the Food Bank* report produced by Sustain (2018).

Leicester is a growing city, with a population in 2011 of 329,939. There is a significant Muslim population (19%) and the area where research was conducted was a majority Muslim neighbourhood. Leicester is ranked within the top 10% of the most deprived local authorities in England and has the 8th highest level of child poverty in the UK (Hirsch, 2018a). After housing costs, 41% of the children in Leicester live in poverty (Hirsch, 2018b).

3.4.2 Recruitment of Participants

Recruitment of participants worked differently in Camden and Leicester. Working with Helen Crawley, the director of the Healthy Start Alliance, a local champion was identified. The programme coordinator in Camden provided me with the names of midwives working in local children's centres that were willing to be interviewed, and willing to allow me access to the waiting room while they saw patients. I attended the children's centre on the days those midwives had antenatal or postnatal clinics, and sat in the waiting room. When the parents or prospective parents came in for appointments, I introduced myself, told them about my research, and asked if they wanted to participate. Usually they said no, but if they said yes, we went into a separate room after their appointment, and the interview was recorded. Interviews lasted from 15 to 45 minutes. The parent often had a new baby and siblings with them, so the interview was often interrupted and sometimes cut short. I spent nine months visiting clinics several days a week at three different children's centres. As I was present so often, I got to know the staff and observe the playgroups and other activities (such as infant feeding workshops) that took place at the same time. Sometimes, the leaders of those groups would announce to the group that I was doing research and ask if anyone wanted to participate.

In Leicester, I was introduced to the programme director who organized classes for expectant and new mothers and coordinated a large WhatsApp chat with many new mothers. I went to Leicester on Friday for four months and met with her at either a local children's centre or community centre. She used her WhatsApp chat group to ask if mothers wanted to participate in the research, and if so, they met me on Friday at the designated location. Additionally, she introduced me to the coordinators of the Healthy Start scheme in Leicester, and local midwives who were willing to participate in the research. Her help was invaluable in identifying those willing to be interviewed. But not all of the interviews were scheduled in advance. I also participated in classes and playgroups to identify potential respondents, many of whom agreed to participate after getting to know me.

The original intention was to target those experiencing poverty, whether or not they were recipients. Prior studies have only interviewed recipients of the scheme. However, due to the reasons cited above, income eligibility was not considered, and all pregnant women or parents with a child under 4 years of age were welcome to participate. While many of those interviewed were eligible for Healthy Start, the strength of the data is the diversity of respondents. Those eligible but not current recipients offered insight into why they may choose not to participate. Parents at different income levels offered insight into the differences in food practices and attitudes of those at different income levels, and their experiences with receiving benefits.

3.4.3 Observation

The months spent in the children's centres provided a wealth of information in addition to the interviews. Ethical approval for observation in the children's centres was obtained at the beginning of the study, but the data obtained from observation was not explicitly part of the data analysis. Rather, it provided a context for the analysis of the interview data which assisted in the initial coding, provided a check on the interview data as parents sometimes behaved in a way different to the way they described, and played a vital role in the recruitment of participants. Many days and weeks passed where no parent was willing to

participate, but as an observer in the waiting room as parents waited for their medical appointments there was an opportunity to see the intrafamily dynamics as well as the interactions with other families in the waiting area, how they presented themselves, and which snacks they gave their children.

Attending the classes in the children's centre, such as preparation for birth, infant feeding, cooking, sewing, and exercise allowed a view into the taught content and the questions asked by parents. However, the mothers often seemed less interested in the content of the class but rather to particularly appreciate the opportunity to meet other mothers. One of the most popular events was the playgroup which appeared to be more popular with the parents than the young children. Overall, the experience prompted a reflection and examination of personal assumptions which led to a more open-minded and open-ended interview approach. For example, I had naively assumed that I would be able to identify those on benefits, allowing me to target the interviews towards those eligible. But there were no external identifiers, and even accessories such as strollers, a high-cost purchase, did not indicate the financial situation.

3.4.4 Interviews

Data collection took place over nine months and was discontinued after 66 interviews. It is generally accepted good practice in qualitative research to conduct approximately 20–30 interviews with the goal of receiving theoretical saturation (Mason, 2010). However, due to the nature of qualitative research, this may vary widely depending on the nature of the research question. The number of interviews should be driven by saturation, but this may be difficult to identify. New data always adds something new and therefore the cut-off point may be arbitrary. In this study, saturation was defined as the point when new interviews largely repeated what had already been expressed.

The table below provides a brief summary of those interviewed. Detailed demographic data for parents from Leicester is contained in Appendix 3 and from Camden in Appendix 4.

Exhibit 8: Summary of Interviews

	Camden	Leicester	Total
Parents	24	26	50
Eligible for Healthy Start (1)	10	20	30
Receive Healthy Start (2)	4	8	12
Food Insecure (3)	3	9	12
Programme Directors	1	2	3
Health Professionals	7	6	13
Total Interviews	**32**	**34**	**66**

1) Eligibility was determined by the receipt of other qualifying government benefits; this may over or understate actual eligibility but was deemed a reasonable proxy without gathering extensive financial data, which was considered too invasive.
(2) This includes one parent in Camden and one in Leicester who had been prior recipients.
(3) Food insecurity was measured using the questionnaire developed for the US Census (USDA ERS, 2015) which describes food insecurity as changing the quality and quantity of food consumed due to a lack of funds.

The interviews had two components, a semi-structured interview and a structured questionnaire that was read aloud to the interviewee and completed by the interviewer. The guide served as a framework to direct the interviews, but the open-ended questions allowed the respondents some freedom to control the

pace, content and direction of the interview. This form of narrative interview is appropriate to the research questions that seek to understand people's perceptions and experiences (Weiss, Adler and Adler, 1994). Every effort was made to put the participants at ease so they felt comfortable expressing their thoughts and feelings, and I was surprised by the level of detail, openness, and emotion that was shared. The following questions were used as a guide to initiate and prompt conversation.

List of Interview Questions:

1) Tell me about your family
2) Tell me about your food practices. What do you typically eat? Who shops, who cooks, who decides what is eaten? If money were no object, how would you shop or eat differently?
3) Have you ever heard of the Healthy Start scheme? If so, what do you know about it? What are your impressions of the scheme?
4) If a recipient
    a. Describe the experience of applying for Healthy Start
    b. Describe the experience of using the voucher in a store
5) Do you think your children eat about the right amount of fruits and vegetables? If no, what are the barriers to getting your children to eat more?
    a. What would make it easier?
6) What do you think the government could be doing to make it easier for families to eat healthfully?

The questionnaire, included in Appendix 4, was used to collect demographic data about the household, to compare information among respondents and to ask questions in a more neutral way about more sensitive topics such as food insecurity and stigma. Food insecurity was assessed using a common measure based on the questions developed by the Economic Research Service at the United States Department of Agriculture (USDA) and used in the US census (USDA ERS, 2012). This short form measure of food insecurity has been shown to be effective (Blumberg *et al.*, 1999). It includes measures of the degree of food insecurity, from not being able to afford balanced meals to running out of food and skipping meals due to lack of funds.

The stigma of different types of benefits, including Healthy Start, was determined by asking respondents to rank the shame or embarrassment claimants should feel in claiming different benefits (questions 3–5). In the first set of interviews the third person was used because research has shown that people may be more open when speaking about stigma in the third person, and that statements about what other people think are in fact reflective of their own opinion's (Spicker, 1984; Powell, Amsbary and Xin, 2015). However, as respondents seemed very open, the question was also asked in the first person: "Do you think people should be ashamed to claim benefits?"

Income data was not collected, so a rigorous analysis of Healthy Start eligibility was not possible. For the purposes of this research, eligibility was determined based on receipt of other qualifying benefits, income support or jobseeker's allowance. This may over or understate actual eligibility, but provides a good proxy for the purposes of this study.

Additional Interviews

In addition to parents, interviews were conducted with health professionals (usually midwives) and the public health managers with responsibility for the scheme in each area. The following was the guide for the semi-structured interviews which encouraged discussion about the scheme.

1) What is your experience with the Healthy Start scheme?
2) Why do you think uptake has been declining?
3) Do you think the recipients experience shame or embarrassment to apply for or to redeem the vouchers?
4) If yes, what impact do you think that has on them and uptake of the scheme?
5) How do you think the vouchers are spent?
6) What do you think are the barriers to more fruit and vegetable consumption in young children?

Compensation

In recognition of their time, parents were given a cookbook containing healthy recipes for young children. Health professionals were not compensated.

Ethical Considerations

Ethical approval was obtained from City University of London and attached as Appendix 5. All participants were asked to provide informed consent before interviews, and every effort was taken to maintain the confidentiality of participants and interview data. Because the research required working around children (although not with them directly), I took the online course on child protection offered by the National Society for the Prevention of Cruelty to Children. It provided me with the tools to "recognise possible child abuse, respond appropriately, report concerns, and record what I've seen" (NSPCC, 2016). I did not see any potential cases of child abuse, although I was told of spousal abuse in two interviews and directed the mothers to the appropriate support services.

3.5 Data Analysis

All interviews were audio-recorded, and transcribed by me in order to retain control and familiarize myself with the data. This was challenging because many of the parents did not speak English well, and they often had a baby and other children with them. The children created a distraction and background noise that could make it difficult to understand the interviewees. This required that listening to the interviews repeatedly. The process of repeated listening and transcribing meant that I became very familiar with the data. The transcriptions were then analysed using content analysis.

3.5.1 Content Analysis

Content analysis is a well-established tool in social sciences that is used to identify themes and concepts to make inferences about meaning and relationships in qualitative data (Weber, 2011). It allows textual data to be broken down into manageable categories and relationships by identifying themes, subthemes and concepts.

The first stage of the analysis was identification of themes, which began in the interview process and continued through transcription and finally coding using the NVivo software package. NVivo is a tool for organizing and managing qualitative data that helps to store, sort and code it (Bazeley and Jackson, 2013). While the software was helpful as an organizing tool, it is important to note that software cannot analyse data, but rather supports the researcher during analysis (Zamawe, 2015). After the transcriptions were downloaded into NVivo, the data was coded into nodes eclectically using the process described by Bazeley and Jackson (2013) and Saldaña (2014). The initial coding framework was based on the research questions and preliminary themes that had emerged during the interview and transcription process. This framework was refined through several rounds of coding to identify common and recurring themes and relationships. The process of reviewing, refining and reorganizing the nodes in NVivo into higher level themes took place over 18 months. Themes and patterns were informed by the contextual knowledge gained in the literature search and through the ethnography – observations of behaviour and conversations that were not directly part of the interview. This process continued after writing began as the process of writing provided a further tool for analysis. Finally, key themes and concepts were described and interpreted using quotations from the data.

3.5.2 Economic Analysis

While the economic evaluation of health policies is widely accepted and recommended by NICE (NICE, 2014), this had not occurred for Healthy Start. To remedy this gap and provide a more comprehensive view of the actual and potential impact of Healthy Start, a three-part economic analysis was undertaken separately to answer RQ4: What is the actual and potential economic impact of the Healthy Start scheme? Microsoft Excel spreadsheet software was used to facilitate the financial analysis of the scheme.

First, the cost effectiveness of the scheme from the perspective of the government and the overall economy was calculated by modelling the present value of the cost of the vouchers compared to the healthcare cost savings achieved over the lifetime of a recipient using prior research for the assumptions of healthcare costs attributable to poor diet. This model calculates the cost of the scheme under four different assumptions for the value of the voucher, three for eligibility, and three for level of uptake. The benefits are calculated based upon three assumptions for the percentage of future healthcare costs averted, two assumptions for which healthcare costs are averted (fruit- and vegetable-related disease costs only and all poor diet-related disease costs) and two cases (direct benefits and direct and indirect benefits combined). These assumptions were based upon the interview findings which had suggested several remedies for programme improvements. This produced 144 scenarios, providing a rich source of data for evaluating the value of the scheme to the government and to the broader economy as the scheme is currently configured and with modifications to voucher amount and eligibility requirements.

Second, an evaluation of household food spending in the UK by income was undertaken. The interviews had shown the limitations of understanding individual food choices without considering the structural determinants, including the economic determinants, of the family's diet. This led to an analysis of food spending, both overall levels and what is purchased, at different income levels.

Finally, the money flows of the scheme were assessed. Little is known about the economic impact of the vouchers on those who benefit from the scheme – recipients, farmers, retailers, and infant formula

producers – and the effect on the family food budget and revenues of farmers and corporations. This provided a way to measure both the current and potential impact of the scheme to improve diets and further other policy objectives.

3.6 Challenges

As the most deprived members of a community use healthcare less, my sample may not have included the most deprived. It was particularly difficult to find recipients of Healthy Start, especially in Camden. In Leicester, a programme coordinator assisted in finding Healthy Start recipients who were willing to participate in the research. But in Camden, without a similar contact, it was left to chance.

At the time of research, Camden had about 930 households in receipt of Healthy Start. However, only about 25% of these involved pregnant women (2%) or a child under 1 year of age (23%), resulting in only about 230 (930 ´ 25%) households in Camden receiving Healthy Start and attending midwife appointments. The number is likely far lower because most antenatal appointments are in the first weeks after birth. It is therefore understandable that it was difficult to find beneficiaries. This did not impact the key findings of this research as the focus was not on the experiences of recipients with the scheme, but it did highlight the limited reach of the scheme due to the strict eligibility criteria (only about 15% of the relevant population is eligible) and low uptake (only half participate).

Aware of the power differential inherent in interviews, I began by sharing a few personal details about myself to establish a rapport and encourage participants to share more personal stories (Anyan, 2013). Even through my impression was that respondents were quite open, and that many were relieved to have an objective listener to their stories, interviewees to varying degrees probably experienced reluctance to share too much or too honestly, particularly given the personal nature of the research. Questions were designed with this in mind, and were as non-judgemental as possible. As discussed earlier, stigma was initially discussed only in the third person.

It is also possible that parents told me what they thought I wanted to hear in an effort to please me, which would cast them in the best light, particularly with respect to their children's diet (Emerson, Fretz and Shaw, 2013). Some of the mothers with older children with them may have felt inhibited from speaking freely about their situation. The observations did not always coincide with what people were telling me, as for example, I observed children being fed packaged snacks while the mother reported their children were only allowed fresh fruit for snacks. However, overall my impression was that respondents were quite open.

3.7 Summary

This chapter has described and defended the methods used in this research. Four research questions were identified based upon the gaps exposed by the literature review. The primarily qualitative approach chosen was appropriate to better understand the perceptions, experiences and challenges of parents. Iterative content analysis was used to make meaning from the data by demanding reflexivity to find concepts and themes from the data. The findings of this analysis are presented in Chapters 4 – 6 and

organized by research question. Chapter 4 responds to the first research question about the food practices of families with young children.

Chapter 4: Food Practices

4.0 Introduction

This chapter analyses the descriptions of the food practices of families with young children to attempt to answer RQ1: How do the parents of young children describe their perception and practice of healthy eating and the obstacles they face? The chapter begins with their descriptions of an ideal (which they all felt was a healthy) diet. They understood the benefits of a balanced diet, the importance of the quality of the food they were purchasing and eating, the benefits of cooking at home, the dangers of takeaway, and the benefits of breastfeeding children. This follows with the constraints that keep them from attaining the ideal diet to which they aspire, touching on affordability, family preferences, and convenience. The final part of the chapter looks at the described reality of the interviewees' diets, taking into account those constraints which includes experiences of skipping meals, eating little variety, avoiding new things, and generally making sacrifices themselves, or in other arenas, in order to protect their children's health.

As much as possible, the words of interviewees drive this section. All emphasis in the quotes is my own, which reflects the key themes and ideas identified during the process of analysis. Every effort was made, where the data was appropriate, to compare the aspirations, realities and perceptions of those eligible for benefits with those who were ineligible. However, there is very little difference between the groups. In order to maintain anonymity, all of the interviews received a code. The table at the end of this chapter sets out the key attributes of those interviewed; more detailed demographic information on all of the parents interviewed is contained in Appendix 3 and 4.

4.1 How do Interviewees Construct an Ideal Diet?

4.1.1 Prioritization of Food and Health

The overwhelming majority of those interviewed volunteered that providing food for their families was their first priority. They often add that sacrifices were made on discretionary items to ensure this:

> *No, we always **food is our priority**. We don't have to buy shoes or something which is not as needed at this time, but we have to provide food for our family first. That is the main thing.* (PL3)

> ***Food is our priority**, so even if we don't have money for anything else food is always there.* (PC6)

> *I wouldn't, but my husband goes **if you need it you need it** and that's what we're going to get. He shops differently from me, and he will pick it up and say we need it because his belief is if you don't have food than you're not going to be able to go about your day and you'll be dead, and you won't need food anyway. But to be able to go on and carry on doing what you're doing you need food.* (PL21)

> *We don't buy clothes and all, on that we buy less, but **food we buy everything**. We manage it.* (PL23)

In addition to the availability of food, most participants insisted on the importance of healthy food. As one mother from Camden puts it:

> ***Food is a complete priority***. *We don't have a car, we don't travel a lot, but healthy eating is something that I really care about because I think it relates so much to our health and wellbeing. So, to be honest it is a complete priority.* (PC5)

4.1.2 Understanding of Health

How do those interviewed describe a healthy diet? They demonstrated a broad awareness of dietary recommendations, and if they felt unable to meet them, they expressed their desire to do so. The following demonstrates the components that were perceived to constitute a healthy diet, and often, the difficulty in attaining it. Nearly everyone interviewed expressed a difference between their ideal diet and their actual diet, most often due to cost. There was little difference in the construction of the ideal healthy diet between those eligible for benefits and those not eligible; however, those not eligible were less likely to acknowledge that it may be more difficult for some to prioritize high quality healthy food because of economic constraints.

Fruit and Vegetables

Nearly all of the parents interviewed were aware of the importance of eating fruit and vegetables, with an emphasis on fruit. They were conscious of encouraging their children to consume the recommended amount, and to consume it themselves while pregnant.

> *Because it took so long to have him, I really looked at my diet while we were trying so I* ***cut out a lot of refined sugars****, made a lot of* ***food from scratch****, eat a* ***lot of vegetables****, we don't really eat a lot of meat in the week. If we eat meat, it will be at the weekend. (PC21)*

> *We've always had* ***lots of veg, and fruit*** *as well. With the baby she has plenty because I make sure she has it.* (PL4)

> *I try to take care of him.* ***I get a lot of vegetables and fruit especially for him****. So, we eat with him. When I was a little bit younger I didn't care, but now I take care of him.* (PC19)

> *Well, I know that* ***we are told 5 a day but it actually should be 10 a day*** *and that they said that they made it 5 a day because they didn't think people would be able to achieve 10 a day. I think probably I do, I'm a vegetarian so I probably eat quite a bit. My son does as well because he is a fruit bat. He is less so on the vegetables, but he gets there. At the moment he loves fruit, but he is changing slowly.* (PC5)

Often parents struggled to get their children to eat enough vegetables, although most enjoyed fruit, which was considered a healthy snack.

> ***Maybe more vegetables****, but with the fruit they are quite good. It's just maybe they could eat more vegetables.* (PL26)

When asked what they would buy if money were no object, many said they would buy more fruit. There was a shared perception that exotic fruit and berries are important for children. This mother of three from Leicester who is eligible for Healthy Start shared a typical response regarding fruit:

> *We give them a mix of fruit so they're always picking whatever they like. They like bananas because it is **swee**t, and they always have it in the morning or if they are asking for something before bed, we always give banana to keep them full and it's **healthy** as well.* (PL3)

When asked whether her sons eat a healthy diet, this married mother of three from Leicester who was eligible for Healthy Start mentioned fruits.

> *Yeah, I've just picked him up from school and he's already had three pieces of fruit. But we know that **fruits are healthy,** but we know that it doesn't always give you the energy that you need to go about your day. So, you've still got to eat your meat, and I've got cheese and pastry because I knew I was going to come out. But I've got meat cooked at home and chapatis ready to go, and my baby when he comes at three he will eat a wholesome meal. And if he needs a treat he will have his fruit on top of that. Even if it means opening up a tin of pineapple which he usually does.* (PL21)

This mother provides fruit and berries for her son because he likes them, using Healthy Start vouchers to supplement the food her parents purchase for them.

> *I just do fruit and veg mainly for him, things that he eats like berries and things like that he likes. So, I normally go to Aldi or somewhere that's a bit cheaper because then you can get a bit more stuff so I go to Aldi and **I will get him berries, strawberries and raspberries** mainly…My dad normally shops, mum and dad. I do once a week. Well, they get berries as well, they don't use my vouchers, they just buy stuff for him. Because no one else eats them but him. But they will still buy them, but he goes through quite a bit so once a week I will go as well and get some stuff for him because I've got the vouchers…I think he eats over the right amount of fruit and veg to be honest. He has like 6 different fruits a day because he loves all the berries and there's so many different types. He has things like mango, pawpaw. What else does he eat. He will have at least 2 satsumas a day and banana, so yeah, quite a bit.* (PL25)

Seasonality

One mother emphasized seasonality and the importance of nutritious food, although she confesses that she likes chocolate too.

> *I do like my chocolate, but I think it's important to eat **nutritious** food. **You are what you eat** so I do try and eat **in season** if I can because good tasting vegetable is better than when it is not in* season. (PC3)

Limiting Junk Food

Interviewees understood the dangers of "junk food" to health. A married couple of PhD students in the UK on student visas, and therefore not eligible for benefits despite a low-income, describe avoiding it:

> *It really depends on what we want and how much money we have. We try to make it as* ***healthy as possible*** *and* ***get rid of junk food****, I think that's the principle. We think food is very important and we like to save money in other places or in other things. We hope to use the right money on the right food. So, I think that's very important for us.* (PC17)

This mother notes the struggle to buy her son the expensive fruit that he had been accustomed to when they had two incomes. She prioritizes expensive fruit and healthy food for him over food for herself because she does not want to give him junk food which she perceives as cheaper:

> *I mean saying that, when I was in a full-time job buying food was you know like to feed my little son he loves the most expensive fruits, so it's the blueberries the raspberries, the watermelon, the mangoes. They are quite expensive fruits, but he is really into that because I think we gave him the option when both my husband and I had full time jobs. Now, neither of us are working full time so* ***it is a struggle, but I have to prioritize****. I have to make sure I buy that fruit for him because I know he needs to eat it and I don't want to stop him. So, you do sort of cut down on the things that we need. So, I just buy basic essentials and basically,* ***he has the right to have the fruit*** *and the food that he needs to eat* ***rather than just giving him some junk food*** *instead. I want to keep that up. So, you do prioritize don't you as you get older as well and to your situation I suppose.* (PL16)

Quality

Those interviewed sometimes depended on the ambiguous category of "quality" to describe the ideal diet. These two women who are eligible for Healthy Start describe prioritizing and purchasing good quality food. They live in extended family groups that share resources, and may provide protection against their own low-income.

> *I think with food we've always been... we* ***buy good quality food*** *and things. So, I don't really skimp on food.* (PL25)

> ***Cost is not that important for me****; I think* ***quality is important****. Like what I need for myself and for my baby is more important.* (PL13)

The most common answer to the question "what would you purchase if cost were not an object," was higher quality foods, often of the foods they already purchased.

> *We'd probably eat the same, but the* ***quality of things*** *would be different*. (PL9)

> *I would buy more* ***quality*** *meats and fish, it's expensive. That's what I would buy.* (PC4)

> [With more money I would buy] *less of the junk, and definitely try to get* ***better quality.*** (PC1)

Quality is related to where the food is purchased. Among those eligible, nearly all expressed the desire to purchase higher quality food from speciality shops, farmers' markets or higher end grocery stores. This father's ideal would be shopping at many local shops or a farmers' market:

We've got one up near Belsize, we love going there, but it's just, it's not, like you have to go, if there were more places next to the store. It's hard to go all the way up there just to get your fruit and veg, it's like, obviously it's more convenient to go to the supermarket because you can get this you can get that, but we do have days when we do try to go to these places and get all of our bits there because it's all ***freshly made and it tastes so much better****. It does taste so much better. But those are the things I'd probably do if I had more money as well [go to fishmonger and butcher]. I would be able to go to these separate places because you just would, because you could.* (PC2)

Another agreed:

I'd probably go a little bit ***up market*** *if I had enough money. I would buy different items.* (PC12)

Organic

Whether or not the interviewees were eligible for benefits, many thought the ideal was organic, local produce, food that was described as more "natural". Most did not buy organic presently, but said they would if given the funds.

I'd eat more organic; I would ***definitely do organic****. Anything that is* ***home grown*** *and not been synthetically made or anything that has been altered. I wouldn't go near anything like that. I'd be just top fussy boots.* (PC2)

I think everything would be organic, firstly. We always try to have an organic diet and we look at the prices and we're like it's just so vast. You have broccoli for 40 something p and then there's like £1 for broccoli that's even smaller but it's organic. Sometimes we do get the organic when I'm feeling positive and that we want change, but I guess we go back and forth. But definitely we would definitely shop for organic ***and*** *shop in better places.* (PC1)

If money weren't a concern I'd definitely go for the organic, but it's just so expensive and with a large family they eat more. We buy lots of fruit and lots of veg… If money wasn't an issue yeah, we'd definitely go ***organic and local produce*** *and things like that so yeah, definitely.* (PL9)

Yeah, I would probably buy a lot more ***organic and the healthier side*** *of food. When I've just been paid, I will tend to buy all the nuts buy* ***all of the organic fruit and vegetables****, and then come the end of the week when I go to shop it's a bit tighter with the budget. So, if I could I'd buy better ingredients,* ***more natural****, where you* ***know where they come****. Those tend to be more expensive.* (PC8)

I probably would go a bit more organic with a lot of the food. I'd quite like to get a ***veg box*** *like you can get Riverford to deliver a veg box and you don't know what's in it. Because sometimes I do find I am just drawn to certain vegetables that I'm used to eating and then I think hang on I need to go buy something else because he's just having courgette and kale and whatever. So that would be quite good if you're just given something and you have to cook with it*. (PC21)

> *Yeah, I think I would shop at an all **organic and whole foods** kind of place if I could. That would be my aim is to find as **locally sourced** and as **organic** and as **naturally produced**.* (PC5)

This mother acknowledged that she does not have to think about the cost of food, even though she receives benefits, and expressed the common answer that if she had more money, she would think about purchasing organic food:

> *I know we're fortunate that we don't have to think about it. **Maybe I would go for the organic** then because I know it costs more.* (PL5)

Another mother expressed this contradiction more directly: she thinks she should want to purchase organic, but does not seem convinced that it is more nutritious or worth the extra money:

> *I would say that I don't buy the organic range and everything, that's where I do [cut back]. I will buy, I don't mind buying the value items in fruit and veg because I don't know if there is any difference in the nutritional value to be honest. I know I've heard that. I know organic is better, but I don't know if like, the body is still getting what it needs from the fruit and veg, that's how I feel. Apart from eggs, I go for free range all the time. Sorry, what was the question? Would I shop differently, no, maybe I would go for more of the organic because I do find that it is expensive, but as I said... **People try to convince me to buy organic food, but I don't believe it**. So, it's still the same for me.* (PC19)

This sentiment was shared by a mother who started to eat only organic food in order to conceive, but then after her baby was born, she admits that she no longer eats an organic diet:

> *We had trouble conceiving and were advised to go on an **organic** food diet to remove some of the hormones out of my body which seems to have worked for us…But then conversely with all of that because of going to organic stuff, that has gone out the window and it's almost as though the roles are reversed because I'm slightly loathe to buy organic stuff and pay twice as much as a perfectly good non-organic thing but obviously there are benefits associated with the organic things so **it's worth the extra money but I really struggle with that**. There is a really good vegetable shop next to the house that has really good fresh vegetables but it's not organic and I really struggle not buying them.* (PC11)

<u>Home Cooking</u>

All the families interviewed believed that home cooking was healthier than dining in restaurants or having takeaway. Cooking at home from raw ingredients was the norm for all of the families interviewed.

> *We are cooking products, so we are **cooking ingredients**. We try and eat 10-20 times, but we do a rotation. She [daughter] is keen on everything so far but bananas. But she likes everything, but it depends on the time… We basically shop the same thing we used to shop before because we like to shop cooked ingredients for **healthy cooking at home**.* (PC6)

This mother expressed her belief that home cooked meals were healthier, and she has successfully convinced her husband to limit takeaway to once a week:

*Food wise**, he prefers to eat take-away all the time or anything that is unhealthy**. I prefer home cooked meals because that's what I was grown up eating, so I'm used to home-cooked meals. Once a week I don't mind a takeaway but most of the time now I've got him to eat home-cooked meals.* (PL11)

Eating in restaurants was viewed as a luxury. When families described eating in restaurants, they defended their choice by describing a healthier restaurant.

It is an event to go out to eat… Maybe once [a week] but we don't eat really bad, we'll go out to a restaurant and mainly order pizza or something. (PC1)

*Eating outside I would say we would do **maybe two meals over a weekend**. But eating out meaning like going to Pret rather than a restaurant. And then maybe once every couple of weekends we might go to a pizza express or something*. (PC14)

No, we have had like 2 meals out since my son was born. [16 months]. (PC5)

*It is **an event to go out to eat**.* (PC3)

*Once in half a year, **on holidays** [*we eat in a restaurant*]. We went on holiday for 5 days to Greece and we ate in a restaurant every day. It was a luxury.* (PC16)

Eating takeaway was more common than going out to eat, but was still described as rare.

*"**Very rarely**, once in a blue moon really. Usually, it is always **home cooked food**.* (PL6)

"I can't remember the last time" (PC5)

Typically, takeaway was limited to once a week and viewed as a treat that was unhealthy but convenient.

*We have one day a week where it is a **takeaway kind of treat day.*** (PL5)

*We usually eat at home, **occasionally we can have a takeaway which is pizza**. No other takeaways.* (PC10)

Only one low-income mother interviewed reported eating at McDonalds because their coupons offered good value. While she expressed the desire to eat more fruits and vegetables which she viewed as healthier food, because of cost she was unable to do so. She relied on fast food which she described as junk food:

*because **it's cheaper… It stretches the money longer**. All the food that's good for you is expensive… how is a cheeseburger £1 and strawberries are £2? It don't make no sense. I see more McDonald's adverts than anything. It's just there and it's cheap. And you get vouchers for it. Coupons, I've got some in my bag.* (PC15)

Those not eligible for benefits talked about takeaway in the same way, as an occasional treat.

*We have like **twice a week, Saturday and Sunday**, only weekends.* (PL2)

*I'd say maybe **3 times a month**, not very often.* (PL7)

***Once a month** maybe* (PC16)

***Take out is more of a treat**. I wouldn't say we do it on a regular basis. Maybe once a month or something like that we might have a takeaway* (PC21)

Breastfeeding

Nearly all of the mother's interviewed describe breastfeeding as desirable and healthier for their baby. Nearly all had breastfed their babies after they were born and continued for months at least part of the time. Midwives in Camden and Leicester agreed:

*A lot **of mums breastfeed, definitely.** And with the breastfeeding supporters and maternity support workers, **the uptake to start with is really high**.* (HWC1)

A programme director described a desire to breastfeed:

*The **vast majority of pregnant women aspire to breastfeed**, and the community as a whole values breastfeeding. So, they value breastfeeding, they see it as normal, women want to do it.* (HWL6)

One mother described breastfeeding her baby even though she preferred to bottle feed because it was best for her daughter.

***I put her before me**.* (PL18)

Only two of the new mothers interviewed were not breastfeeding. This mother defends her decision not to breastfeed and the mixed reaction of health professionals:

***I never wanted to breastfeed**. It's never been something that I've had interest in. I've never needed that. I have a history of depression and was quite aware that postnatal depression was in the cards, so I wanted to ensure that we made it as easy as possible, that transition. I felt like moving into parenthood was going to be difficult enough as it was that whatever we could do that [husband] could relieve some of the pressure, and if that was feeding, him being able to feed at night time or just me not feeling like I was giving up my body all the time. So, I'd made that decision before I even got pregnant. We discussed it. We had moments in the hospital where there was a lot of pressure behind it and then we've had moments of people who have just been like, do whatever you want. So, it's been really mixed as to the reaction we had in the hospital and the advice that we had.* (PC11)

4.1.3 Perceptions of Others' Nutritional Knowledge

Despite this evidence of wide awareness and prioritization of healthy eating, perceptions exist in government, among health professionals, and among the interviewees themselves – both those eligible and those not – that most people do not have nutritional knowledge and cooking skills.

The belief that food education and improving the local retail environment are the solution to the problem is very common, and often expressed by those in government. This comment from a Liberal Democrat in the Scottish Parliament does not address the affordability of food:

> *The areas ranked highest in the tables are often those that are furthest away from fresh produce and where* ***people lack independent living skills and a basic understanding of how to prepare healthy, home-made, cheap meals*** *on a daily basis* (Ruskell, 2019).

A programme director worried that people did not have the knowledge to change their behaviour and may misuse the vouchers:

> ***We don't know what they are spending it on****, and* ***we don't know if the messages around health and well-being during the pregnancy and for the children is actually coming through*** *and is it that they're buying these fruit and veg or things that you can buy with the vouchers and therefore feeding their families better and learning new skills or using new ingredients. Because if not, then when those stop when the child is four, if they collect them that long, what happens then? You know I mean, there is part of me that thinks there is too much* ***disconnect between the health messages and the skills to feed your family well*** *and the kind of giving out the vouchers, does that make sense?* (SC1)

A programme director from Leicester who organizes nutrition and cooking classes noted that information and education is needed, but it is not enough to compete with corporate advertising of brand name products for children:

> *I think it really needs much* ***more emphasis on helping parents to understand how to feed their children healthfully****. There is a big, big vested interest still in this community. Although they eat healthfully themselves, it's still completely the norm to use packets and pouches and boxes of stuff for your baby, so babies will be given box food really commonly, or Cerelac, that's the norm.* (HWL6)

Yet, she went on to describe healthy cooking and eating:

> *In this area people are actually pretty good on eating healthfully, they* ***cook from scratch****, eat* ***plenty of vegetables****, and* ***limit sweets…*** *At Lesley Hall we had a bazaar stall with cakes and these Asian ladies said no, these have got sugar in them I don't think I ought to buy them, but goodness, these were my homemade cakes. They seemed to be very aware of healthy eating, and I think maybe the whole promotion around that community about things like diabetes and heart disease has actually had an effect.* (HWL6)

A midwife in Camden thought early education on the importance of a healthy diet was important, and thought the early years in school was the time to start. While she acknowledged that cost is an issue, she cites Jamie Oliver's campaign as a great example of early nutritional education, despite having no direct knowledge of his work:

> *I think it has to be done from an early age and I think when you get to pregnancy it's okay, but really it ought to be done much earlier. I think all these things are embedded in you when you're at school and clearly if you have that sort of lifestyle where you have been given a healthy diet to begin with it's much easier to continue that and give that to your children. So, while women are motivated while they are pregnant, I'm not sure what happens to them after they've had the baby when they have a few other children, other pressures. Whether they continue to eat healthfully. And of course, the cost of it. I think cost is a big issue, as well as education. I think the* ***education has to start a lot earlier****. I suppose to some extent that is happening in schools. It is supposed to be. I thought Jamie Oliver's campaign was great. He got a lot of attention and it seemed to make a difference. I have no direct experience of that but certainly what you saw on the news, I know you can't always rely on that, but it did seem to educate people into a healthy diet and subsidized school meals is a very good idea*. (HWC4)

Yet, she then contradicted herself by explaining that a lack of nutritional knowledge is very rare in her patients – even if they do not always eat healthfully:

> *I think they know what they should be eating generally. I think* ***it's very rare that I find a woman who doesn't realize what she should be eating****. But she doesn't necessarily do it.* (HWC4)

A programme supervisor noted that education was important for everyone, not just those on a low income:

> *The informed choice. Everyone at every income level would probably benefit from that.* (SL1)

When it came to the perceptions of parents about other parents, there was no significant difference between the opinions of eligible and not eligible parents. Nearly all thought their knowledge of nutrition and cooking was unique, separating themselves from the majority that they assumed were ignorant. Only one parent, who was also a Healthy Start recipient, wished she had more nutritional knowledge and cooking skills. She is a 20-year-old pregnant woman who had never lived on her own, and her mother is responsible for all of their cooking.

> *What I would like for my family, as in me and my partner and my future child, because I don't have much experience in cooking and healthy eating, I would like to know more about how I can eat healthier. Because me and my partner we do generally go for like the easier option which is often not the healthier options. So, if there was a way that we could have sort of* ***cost effective and quick easy meals to cook*** *because* ***I don't have much experience in cooking*** *that would be good. Definitely, and ways to incorporate different vegetables in meals as well so that everyone's getting what they need. Because he generally doesn't eat as much vegetables because he doesn't like them as much. So, he'd rather have fruit than vegetables but obviously if you're doing your dinners you need to put vegetables rather than fruit.* (PL15)

This mother in Camden was more typical. She had done research into nutrition, but separated her family from others who she assumed lacked knowledge, blaming their ignorance on the profit motives of capitalism.

> *I definitely think that there is a* ***major lack of nutritional education in this country*** *and in the world. We've watched so many documentaries on things like the new cancer is sugar and against sugar and sugary foods.* ***We've actually been looking at nutrition quite a lot*** *and seeing that doctors are really not educated in nutrition at all. It's not difficult educating someone, it's very basic, but it's just getting the knowledge for it. You need to just go to so many different parties to get to someone who knows what to eat or the correct stuff. Especially at the GP, if you were to go and discuss it, because your weight can lead to depression. So, if you go to a GP and you're not getting any feedback or information relative to your issue, which would obviously be the lack of a healthy diet, it is really problematic. And I know it's definitely difficult and we have researched a lot into the lack of nutritional knowledge especially among people our age. I'm 26. So yeah, I think it's a huge, huge crisis. And I think it's happening on purpose. I don't want to sound like a conspiracy theorist, but it's all part of the agenda and it's all about pushing the wheel of capitalism onwards and forgetting the health risks that come with that as well.* (PC1)

A single pregnant mother described buying only fresh food for herself and her daughter and reported that her daughter eats more than enough fruit and vegetables:

> *[My daughter] eats more [fruit and vegetables] than she is supposed to [she is eating a plum during the interview] …I just buy fresh things.* ***I avoid processed things, so things not in a packet and more fresh is what I buy.*** (PC4)

Yet she believed her knowledge of healthy eating and how to feed children was not shared by most people:

> *I think* ***not many people know how to eat in general, they don't know what to feed their children.*** *So, it's that inexperience as parents about healthy eating… I think cooking classes and giving people ideas because I know a lot of people don't have the idea of what to feed their child. That's the problem for a lot of parents. And the kids are fussy eaters and I guess because of the way they have been eating,* ***once they get used to a certain way of eating it is harder to change them*** *if they don't start from the beginning.* (PC4)

This mother from Camden prioritized healthy eating, distinguishing herself from the perceived others who do not:

> ***So, for me it is always going to be a priority, but I can tell that there are some people it's not a priority to, but that's anathema to me. I can't operate on that.*** *I think there would be a whole lot of other things I would give up before I would give up healthy eating.* (PC5)

Another mother described cooking a healthy diet for her family:

> *I mainly cook, and I mainly do the shopping and I always have... I* ***cut out a lot of refined sugars****, made a* ***lot of food from scratch****, eat a* ***lot of vegetables****, don't really eat a lot of meat in the week. If we eat meat, it will be at the weekend. Before we had him, we would eat out on the weekends, like for Saturday night go out for dinner or something. We eat quite varied meals as*

well. There is nothing we don't eat, fish, meat, veg, lentils, neither of us are that fussy with food. (PC21)

But she assumed that other people do not eat well and would abuse vouchers or free healthy food. When asked what might improve this situation, she suggested education and cookery classes, and she was not alone:

> *I think **it's all about education** really. I think you can't force anyone to give their child certain food because if they don't eat it themselves it's going to be really difficult for them to start cooking a separate meal for their child. You need to educate them and make them enjoy eating vegetables because if they don't I think it's quite hard. I find it's a real difficult one because if you gave vouchers or it became free then people abuse that and then there's a lot of waste. I am not too sure; I don't know what the government could do. Education maybe, doing **cookery classes** that kind of thing rather than just here's go buy some veg and cook something up. I think it's actually enjoying the cooking and enjoying the food and then maybe from that cooking class give them the ingredients to go home and cook it themself or something like that.* (PC21)

This married mother of a 1½-year-old daughter enjoys cooking and shows much nutritional awareness:

> ***I do all the cooking**, all the purchasing of the foods. We don't really eat out that often, we've never... I enjoy cooking so I prepare all of our foods and his lunches when he goes to work… I try to have a **balanced meal, a lot of fruit and veg** and then healthy carbs, whole wheat pasta if we can, whole wheat bread always. And then protein is quite important, I try to do a varied throughout the week, some fish, chicken, and some non-meat proteins, lots of beans mixed in with things, lentils mixed in pasta sauces if I can*. (PC3)

Yet she shared the common view that nutrition is not well understood, and the answer is nutritional education in schools.

> *I think nutrition should be taught in school. I think it should be a part of the curriculum. At the moment, **if you ask anyone to read a food label nobody really knows what all of that means**. The thing with the fats and the sugar and the salt, I mean that's good but at the end of the day some basic understanding of what are sugars on the ingredient list, what are salts, what are fats, what makes a complete meal and why it's important to have a colourful plate and these different types of food throughout the week. So, I think it should be implemented more in school.* (PC3)

The complexity of messaging about healthy nutrition was mentioned by this mother, although she did not express confusion about nutrition.

> *I just think clarity of **messaging around healthy food**. Just very simple messages and guiding principles like target amounts of fruit and veg and practically zero sugar and salt til 1.* (PC14)

Reiterating the lack of knowledge, as well as financial constraints, in another community compared to her own, this mother credits the cultural heritage of her community with their healthier eating.

In the Highfields of Leicester where it is dominantly mostly Indian/Asian people our cultural food is curry and chapati and rice, you go to [names another area] where there is the white class, the white people who are not on really good high income and a lot of them are young mums and when I spoke to the people we work with, they have a lot of problem accessing healthy food not only because of their financial situation, ***just lack of knowledge***. (PL21)

4.2 Constraints on Attaining the Ideal Healthy Diet

As many of the accounts so far have touched upon, the ideal healthy diet is just that, an ideal. There are many constraints that make it difficult to attain part or most of the time. Those constraints include affordability, family preferences, and convenience.

4.2.1 Cost

The most common problem expressed was the high cost of healthy foods as opposed to "junk food," and the need to pay fixed expenses first.

I think when you look at junk food it's very cheap. It's cheaper than eating healthy, and I think that this country is going through a tough time when it comes to affording things, like shopping and everything. And it just becomes, it's ***very hard to buy healthy food****, so you just look at the cheaper alternative and go for junk food instead. Which I've done most of the time anyways. I've been running short of money, or if I was to buy my fruits and everything, I'd be spending over £100 and on a weekly basis that's a lot of money… Most of the money goes to rent and stuff.* (PL18)

I think ***nuts are really, really expensive now****, so that's like a healthier snack option. But they are so expensive, so you buy them, but you don't buy as many if they were a lot cheaper, I think. Because like* ***a big bag of chocolate is £1 and a bag of nuts is like £7****.* (PL4)

This is especially true for fruits and vegetables, which are sometimes perceived to be out of reach.

I just buy junk because it's cheaper. *I try to buy fruits but it's just expensive*. (PC15)

Another mother chose the less expensive fruit rather than the fruit she loved:

I would buy berries I love berries. But it's a small pot and it's a few of them for £1.50 so I think okay I can get a bag of apples or bananas which is more. I will be more filled up. The ***money is an issue always****.* (PL3)

This mother displays knowledge of the prices of different foods and describes eating fewer vegetables than she should because of the cost compared to chicken:

If I wanted passion fruit I'd have to think twice before I buy a packet with 3 pieces of passion fruit for £1.25. That's not even a very wholesome fruit, it's just for me to put in my smoothie just for the taste of it. Mangos, ***have you seen the mangos*** *out there? A box of mangos are selling for £9-10. It's mango season in Pakistan, India. That's the price you've got to be willing to pay for*

*mangos… **We don't eat veg as much as we should**. I buy one piece of veg for £1.65. I don't know what you call it, but for the green curry. But for £1.65 I can buy a whole chicken. I'd say what would you rather eat? I'd rather eat the chicken, but you need the veg. **You've got £2, you either buy the chicken or you buy the veg and only you're going to eat it**. That's just how we work. That's how we spend.* (PL21)

This mother was forced to eliminate fruit because of the loss of income when she stopped working in her pregnancy.

*Yes, because when I stopped working, we didn't get that much earning. Because when I came here our council tax got doubled and that was the reason, I just decided to work so that my job was helping him a lot. I was giving the council tax. We just decided that these things I have to do, and he was paying the rent and the other things, and I was paying the council tax and some of the bills as well. So, when I stopped working a gap £80 or £50 a week so sometimes, we have to cut down some things. I would say, sometimes **we have to cut like fruits** and juices and the other things we have to cut down because we have financial issues as well.* (PL8)

When asked how the government could help people achieve a healthy diet, those on some forms of benefits were more likely to say that they should make healthy food less expensive.

***Make the good things cheaper**. Because how is a cheeseburger £1 and strawberries are £2? It don't make no sense. And then they want to complain that people are overweight. Well, that's because the food is cheaper. So, if they swapped it around that would help*. (PC15)

*Yeah, just making, just the normal things like all vegetables they should be giving it to people. There should be places you can go and just pick up your vegetables. You shouldn't really be buying them. I don't get the whole process of buying vegetables anyway. If the government was to do anything they could **cut the price on vegetables ridiculously low**. It's something to sustain…Anything that's profit is just, it needs to make revenue so cut the prices of that and up the price of alcohol and cigarettes tremendously. I know it's a bad trait, I smoke, I have the odd drink, but I wouldn't do it as much if it were cleaning me out before I even got drunk. You're supposed to wake up pissed and be like, oh my god I spent a bit too much money on that, you want to be like oh I spent too much money on that before you even have a drink. Do you know what I mean? Fruit and vegetables should be cheap as chips, cheaper than chips. And then, yeah, that's the only way that they can help families eat better, cheaply, by just cutting the cost… No one wants to spend £3 on a cabbage, no one does, but there is places. If you go down to Chelsea you can find £3 cauliflower, it's not a joke.* (PC2)

Take away the junk food, or make it more expensive**… So, I think the price of fruits and veg, and **especially veg, is really expensive. (PL16)

4.2.2 Family Preferences and Responsibility

Household preferences and power dynamics exert a strong force on the eating habits of families. By way of introduction, this section looks at the primary role that women play in the family's food provisioning and nutrition. It goes on to examine the pressures imposed, mostly on women, by other members of the family, and the importance of convenience.

"Me, obviously": Women's Responsibility

For nearly all of the parents interviewed it was the responsibility of the mother to shop and cook, and this was taken as given. This did not differ between whether families were eligible for benefits or not. The child's nutrition was also seen as the mother's responsibility.

> ***I mainly cook, and I mainly do the shopping*** *and I always have…. **Only me, I do all the shopping as well**, I can say could you pick up a gallon of milk on the way back from work only because I'm here and I cannot go into town. I don't buy milk from local Indian shops because I hate the way they store it in the heat today. I find I get home and it's all clotty.* (PL21)

Most described enjoying cooking, or at least, believing it was their obligation to provide healthy food.

> ***I do all the cooking, all the purchasing of the foods.*** *We don't really eat out that often, we've never... I enjoy cooking so I prepare all of our foods and his lunches when he goes to work.* (PC3)

> *Yeah, because if I don't do the cooking, if my partner does the cooking, it's not as healthy.* (PC9)

In Leicester, many of those interviewed lived in extended family units where resources, shopping and cooking responsibilities are shared among the women. This was described by a programme director in Leicester.

> *They are eating together usually at least once a day and they cook, so they spent a lot of time. You're expected to cook, especially if you're the newest mum in the family, **you're expected to spend a lot of time cooking***. (HWL6)

Yet this often provided a challenge for mothers because despite the best intentions for feeding their baby, they may be thwarted by family desires and expectations.

> *You might want to give your child the very best foods and you might have all the knowledge in the world about how to start on solids well and what foods to give and everything that's in these books, but you're surrounded by family who are wanting to give your baby chocolate and crisps and Coca-Cola.* (HWL6)

These women explained sharing family responsibilities:

> ***Me and my sister-in-law help each other, we both cook****…Well to tell you the truth I don't do shopping. My sister-in-law does and she decides what to buy and then we just cook together so I don't buy things.* (PL2)

> ["Who is responsible for cooking in your family?"] ***Me, obviously***. *And my sister-in laws they all prepare their own food depending on what they want…my mother-in-law does the shopping for the whole house. The cooking we all sort ourselves out basically.* (PL4)

A pregnant woman who had recently moved to Leicester from Pakistan described her household responsibilities for the family, even though she has a full-time job in a local shop:

> *I had to start early in the morning at 6:00 and finished at 3:00 and I rushed home* ***and I cook food*** *and I have seen my husband and mother-in-law as well and* ***the housework cleaning and everything*** *because over here you have to do everything, but I managed*. (PL8)

While far less common, a few of the families described sharing the shopping and cooking responsibilities with their partner, and two reported that the father cooked occasionally.

> ***During the week I do, on Saturdays my boyfriend always does*** *and then on Sunday it's whoever planned the schedule, the meal.* (PC16)

> *We* ***share cooking and shopping***. *I do most of the shopping and he does most of the cooking and we decide what we fancy on the day when we are in the shops, we decide what to have. And then we do the shopping according, vegetables protein and then pasta or whatever.* (PC10)

> *It's a* ***collective thing***. *We do food shopping together. We both decide when we get takeaways and when we cook as well so it's pretty connected with me and my husband. My son is still pretty young [so he doesn't have a decision-making role].* (PC1)

This mother is particularly proud that her son has the example of his father sharing responsibilities.

> *My partner and myself… especially as a boy I love the fact that my husband is cooking because I really want my son to get the impression that this is totally part of his life, and* ***he doesn't have any idea that moms do this, and the dads do this***. (PC5)

Even if the father only cooks on special occasions or as a hobby, rather than on a day-to-day basis.

> *We have a recipe book that my husband is working his way through. Now that we have a child, he is doing a lot more cooking so* ***he quite often says I'd like to try and make this, and I will go and shop for it.*** (PC5)

Male Partner's Preferences

While the mothers are largely responsible for food provisioning, they are constrained by the preferences of their families. Only one mother told me that it was all her choice what the family ate; most of the mothers interviewed let the husband decide or shared the decision making. Sometimes, the husband and/or children had separate meals. There was not a difference between those who are eligible for benefits and those who are not.

These responses were typical:

> *I shop, and **I ask my husband every day what he wants to eat**, so I will do like prawn fried rice, I made that yesterday. It's more of what he wants to eat and that's what I'll cook.* (PL18)

> *Mainly it's Indian food because **my husband is Indian, so he prefers Indian cuisine**. For the **children I try to cook Polish meals** without the spices just salt and pepper. Not as full of flavours as Indian food… It's me who has to think of it every single day, what to make, because it's easier for me to make Indian meal. The kids can eat anything like a pasta, potatoes, beans. We like those kinds of food as well, he doesn't as much so I maybe cook Indian food**. If the kids want, we share with him the meal, but if not, I cook something else for us**.* (PL3)

This mother expressed two common themes beyond her husband's preferences – that she cooks what is familiar and that healthy eating is important:

> *It's either if we are out shopping, **he'll suggest we try this** or try that. Otherwise, if I can't think of what to serve then I **just stick to what I know**. But we do try and eat as **healthy** as possible.* (PL7)

For others, a husband's preferences could be obstacles to healthy eating or budgeting:

> *I do the cooking and my husband, and I both do the shopping together. We make a shopping list before we go shopping**, I stick to it, he doesn't**.* (PL11)

A mother of a young child who lives with her husband and parents-in-law described cooking at home every night with her mother-in-law. Although she knew that she should be eating more fruits and vegetables, it was the preferences of her family for meat-based meals that kept them from eating as much as she thought she should:

> *We try to keep our lifestyle healthy in terms of like I said less oil and spice, but in terms of eating fruit and veg we don't really eat as much as we should. We definitely **don't keep up with 5 fruits and vegetables a day**. I may have 2 or 3 fruits a day, something like that. So, no we don't eat as much, no… My house is definitely meat eaters**. My husband likes his meat**, so when it comes to vegetables even that needs a bit of meat in it. So, my mother-in-law always tries to cook more meat-based curries and stuff like that rather than more vegetables.* (PL6)

Only one mother, married with an infant son and not eligible for benefits, said that it was mostly her choice what to eat, but her son was not yet weaned.

> ***Mostly my choice**, it is my choice.* (PL12)

However, consistent with the women being responsible for the budget, one woman expressed overruling her husband's preferences in favour of efficient use of resources:

> *Me, he can tell me "Can we have" but I just go with what we've got. So, for if I know, for example, I've got loads of cheese at home I buy pizza bases and I'm going to make homemade pizza. **I'm just trying to utilize what we have so I decide**.* (PL21)

Children's Preferences

Many mothers described changing the menu to suit the children's desires. This response was the most common: it is the mother's responsibility, but the rest of the family have input into what she prepares.

> *Sometimes I say I am having this, and if you're not happy with that what would you like to eat? And then from there that's how we work around it. And if I know my kids may not eat this and I probably have certain other things that I rotate that way. But* ***we work together*** *something.* (PL26)

> *Who decides,* ***my children will tell me what they want to eat****…I do* ***like us to have a balance,*** *so we are having a vegetarian meal and meat, so we do get meat and veg in there I do try to balance it out.* (PL5)

This family changed their diet based on the preferences of a baby daughter who has recently been weaned.

> *We now decided that we like a little bit more sweet potatoes and carrots* ***because she likes them****.* (PC6)

Many mothers felt challenged by their children's food preferences, and tried to please everyone in a nutritious way.

> *It is a mix. It is mostly based on the diet that my husband and I follow and then we adapt slightly for the girls. But we do find ourselves in a tricky situation really with the toddler because we constantly go backwards and forwards about* ***producing the food, we know she should be eating and having it not eaten*** *versus giving her pasta with grated cheese on it which is what she tells me is the only thing that she is going to eat or her walking away with an empty tummy but of course* ***that's a challenge****. So, but I guess we do adapt and simplify certain meals. I know by the way things look and taste the chances of her eating them. So, we obviously don't add, if it were just my husband and me, we would add salt in cooking whereas we don't add it, but we add it at the table. The older one refuses to eat meat. We're not a vegetarian family we eat a lot of vegetarian meals, and I guess that's had an impact on her. I guess we eat less spicy food at this stage. We try to give them flavourful foods with a bit of spice sometimes, so that has impacted the way we eat.* (PC14)

> *I try to prepare healthy foods because I've got growing children and I know it's important for them to have their carbohydrates and protein. I try to limit their fats, but* ***you know what children are like****. So, I try to control the sugary things like soft drinks, and they do understand what a good meal is and what a not very good meal is, takeaway and things like that. I try to explain that to them. But I think we have a variety throughout the week, so I'll try to make sure we've got lamb, chicken, we've got some veggies, we've got some pulses, we've got salads if possible. Fruit is just available throughout the day.* (PL9)

There was one instance of preference given to the males in the family. This mother describes separate meals for her husband and her son, but not the girls in the family.

> *In my household I do the cooking. It varies, for now I've got five girls that can eat with us all the time, so he has the dinner, he has is what we eat. If he does eat with us, I do English dishes, lasagnes, roast chicken or pastas, rice dishes. My husband is more of a dry food eater so things like barbecued stuff, he prefers that. My older son he likes to eat everything, so he likes to eat Indian food, curries to chapatis to pasta to lasagne to pies, all sorts of stuff.* ***I have to make his separate as well.*** (PL16)

4.2.3 Convenience

Many interviewees cited convenience as an important limiting factor in their shopping and cooking practices. As this mother put it:

> *I think the fact is* ***for us that it's more around preparation time and shopping time and food issues with the two-year-old****. Those are the biggest drivers for us.* (PC14)

While this father would prefer to shop in small stores or a farmers' market, the reality is that he shops at one supermarket and chooses what is on offer that day. His reason is saving money and convenience.

> *We've got one up near Belsize, we love going there, but it's just, it's not, like you have to go, if there were more places next to the store. It's hard to go all the way up there just to get your fruit and veg, it's like, obviously* ***it's more convenient to go to the supermarket****…, you get your points, you get your £10 off if you spend £40 and all that. So, they are kind of drawing you in. It's convenient. That's why they're called convenience stores…It's because if you go there* ***on a particular day, you can get half off at the shop****. And some days you go in there, and at one point they were getting cabbages from America, and it was about 3 times the price. That's not the time you're going to be getting a cabbage, a lettuce. So, you avoid that time. Sometimes fruit and veg are not always in consistent with the amount, so it goes up and down. Apples are not always the same price and bananas aren't always the same price. So, giving us a set price that we can't work up and down with we're not always able to get the exact same thing as we got last week… it's more about walking around, seeing what's on offer, seeing, oh look there's two bits of cod there for £2 let's go get some baby potatoes and broccoli, so it's more like whatever takes our fancy on the day*. (PC2)

Supermarkets were consistently described as the most convenient.

> *It's just because it's all there,* ***it's time consuming to get everything differently*** (PC22)

This mother cited her choice of where to shop as a matter of convenience, yet she shops at large inexpensive supermarkets.

> *A*nywhere ***close by, Aldi, Asda****.* (PL11)

While this mother wanted to go to specialty shops for “wholesome meat, fruit and veg” she confessed to falling back on what was convenient.

> *I was at university, and I was working so I was always on the go, so I'm always used to just grabbing food outside and I was never much around the house to learn how to do proper big cooking. And then we got together and so it was like okay, so what do we do now? Do we still do what we used to do? And it was like no, we need to* ***go to the butchers and get good wholesome meat and get fruit and get veg****… But I always end* ***up falling back in the old, oh, let’s just get this or get that****.* (PC1)

4.3 Realities of Diet

As many of the responses have shown, most of those surveyed felt that they had an adequate and healthy diet. They displayed good knowledge of the need for fruit and vegetables, and most cooked from scratch most days. Those on a limited income also exhibited a sophisticated knowledge of prices of different food items and used creative budgeting techniques to stretch the money spent on food. However, they have also described the challenges that they face. This section looks at how those challenges can translate into reality for some parents. Finally, the questionnaire data on food insecurity is summarised with related demographic information.

4.3.1 Undereating/Poor Quality Eating Because of Cost and Maternal Sacrifice

Parents on a low-income described sacrificing food for themselves in order to provide healthy food for their children. They often felt, as explored in Section 4.1.2 that their children had an adequate diet, but this came at the cost of their own nutrition.

> *I passed my time being young, but* ***I obviously don't want my daughter to be eating unhealthy stuff*** *and being full of junk and* ***you don't really think about yourself****, but when it comes to the children you don't want them to be filling themselves up with junk food.* (PL18)

> *I've been giving her broccoli, carrots, different textures of vegetables to make her get used to it. But I don't know about the future. Getting more of these things, it is very expensive. Just for 5 apples it's about £1.59 and it's a lot when you're not earning that much****… I prioritize my daughter*** *and paying the bills and stuff. So as soon as I've got her stuff,* ***I put her before me****…I decide to buy what's important, obviously putting my baby first and getting her stuff first. And if I've got leftover money, I will buy the other things that I need. And the other things would probably be cheaper stuff like fish fingers, baked beans, these kinds of things. It's not really fruit and vegetables for myself.* (PL18)

> *He likes berries so if I buy them, I give it to him, I won't eat it. My daughter doesn't like it so it's okay, it's fair. But then I'm thinking if I buy a small box and I eat it as well he won't have as much as he wants.* ***Mothers are always last*** (PL3)

> *Because I just want him to be healthy and if he likes something I will fix it.* ***I don't want to deprive him of it, so I'd rather buy less of something else for me****. Especially if it's healthy and*

it's good for him. He doesn't eat sweets and junk and things so obviously I don't spend money on things like that. (PL25)

*It is probably what most mothers would do**, I forget about myself** and the things I know she likes to eat, she likes mangos and sometimes she loves strawberries, she loves grapes and apples, the ez peel, so the things that I know that she likes.* (PL19)

When asked if they have ever cut the size of their meals or eaten differently, this new mother's response was typical of those who are not physically hungry, but eat less frequently and have poorer quality meals. She did not think of herself as food insecure because she was not hungry, but she only eats one meal a day and snacks on junk food:

*Yes definitely, not having afternoon meals and breakfast. Just having tea instead of having a proper breakfast… **I've never gone hungry** because even if I have a glass of juice or milk or whatever it is. I tend to, whenever I get hungry, get a **packet of crisps, cheese and onion, put it in bread and I fill myself like that.** So, I do always find an alternative. It won't probably be like a heavy meal, but it's definitely a snack. Something very light, but I will eat it if I'm hungry… I sort of have **sugary stuff just because you need that energy**. Because at the moment I'm not really having 3 meals a day, so I kind of like skip breakfast, I only have tea. I skip the afternoon and just snack on chocolate and things and then have like, at dinner time that's when I eat my meal.* (PL18)

Another explained:

*No, we didn't really skip meals, but we did have to **rethink the type of foods** that we were making…And I think portions. I've started to **reduce portions**.* (PL4)

A single unemployed mother on benefits wanted to eat better food, but ate junk food because it was cheaper:

***I just buy junk because it's cheaper.** I try to buy fruits but it's just expensive. So, the only fruit I buy is strawberries and blueberries and occasionally a mango. Other than that, it's junk cause it's just cheaper. It stretches the money longer. For me, anyway… it's cheap. All the **food that's good for you is expensive**, I just don't get it. It don't make no sense to me,* (PC15)

This mother explains why it is logical for people to purchase crisps rather than fruit, although she describes the choice as something other people would do, not herself. This sort of response joins the overwhelming consensus explored in Section 4.1.3 – that others on a low-income lack the knowledge or ability to provide a healthy diet for their families but the person being interviewed did not consider him or herself part of that group.

For someone that's on a low-income £1.50 for 6 pints [of milk] which we get in Iceland would sound like a lot. Along with the apples and pears and bananas you've got to buy. You get a pack of 5 apples for £1. You've got 5 people in your family that's a pack a day. So, in 7 days I need 7 packs of apples just so everyone gets one apple a day. £7 and people who are not on really good

income they cannot put £7 aside just for a piece of fruit because for £7 you can buy 3 chickens. ***Because they make the healthy stuff so expensive people will just go for crisps****. You get 40 packets of crisps for £4. That will last you for 40 days, that's a month.* (PL21)

4.3.2 Undereating/Poor Quality Eating Because of Time Constraints

Some mothers expressed a high level of activity and competing demands on their time that limited their ability to eat healthfully, and sometimes, also their children. For this mother, it is not only cost but a lack of time that results in prioritizing her daughter's needs over her own food:

> *I think* ***it's time****. Sometimes I forget to eat lunch. I haven't eaten anything today [late afternoon]. It never used to happen before, but when you've got other things on your mind, I always think I'll do this and then I'll eat and then it never happens. And then usually I'll eat when my son gets home from school, so I'll have a snack with him, and I think gosh I haven't eaten all day. Or sometimes I can go a whole day. So, for me I think it's making a conscious awareness to actually eat rather than putting it away and thinking I'll eat later. Because you* ***prioritize the baby over food. And then you end up eating rubbish****.* (PL16)

For some, fatigue and work schedules made it more appealing to eat out or have takeaway. This mother defended eating out when she is tired, even though she believed that home cooking is better:

> *Brutal honesty* ***more often than we should, that's because I'm tired****, so you just give yourself this golden excuse like it's fine, it's just one day it doesn't matter, then it's next week and it's okay, today it's fine also. But yeah, we do eat it quite often,* ***maybe once [a week] but we don't eat really bad****, we'll go out to a restaurant and mainly order pizza or something. But* ***we make sure we're in a nice place****.* (PC1)

This mother described takeaway meals for convenience, although she acknowledged that it is not as healthy:

> *The nature of my work means I'm quite often working long hours, when I'm working long hours then I end up eating sort of Deliveroo type stuff to the office which invariably means you're* ***not necessarily going to be eating the same kind of balanced diet****.* (PC11)

This Leicester programme director's account suggests that perhaps families rely on takeaways and restaurants more than they reported:

> *But there's equally* ***quite a few families who eat a lot of fast foods, pizzas and things like that****. You'll have quite a few takeaways, you do go out to eat as a family as well, you go to restaurants, that's quite common*. (HWL6)

This mother who is responsible for the cooking classes at a children's centre cited convenience and economic reasons for why other parents eat takeaway food. She, however, separates herself from them – a theme that emerges consistently in this data:

When SureStart ran the course there, because that was the most deprived area, they could simply make rice or fish fingers or things like that. Not only the young mums, but just because it's just easy to pick up a box. We can buy a box of fries for £1. It's just easier to pick up chicken nuggets for £1. You've got 5 chicken nuggets and a box of chips. That is why they are eating fast food…How often does my family have takeaway, hardly, why, because we don't have the money for that. That I don't put money aside for. You know how ***people say I will treat my family to a takeaway on a Saturday, Sunday. In my house that is dangerous.*** *That's our understanding of it, that's because of our knowledge of takeaway.* ***Some people lack that knowledge****, isn't it?* (PL21)

Evidence that occasionally eating takeaway food may be important to the sense of cultural belonging is suggested by this recent immigrant. She describes cultural pressure to try takeaway food, even though she doubts that she will enjoy it:

*Yeah****, I need to try*** *[takeaway food], but I don't think I like it. I need someone to help me. But I will try.* (PL12)

4.3.3 Relying on Extended Family

As discussed, many of the families interviewed live in extended groups that provide a safety net. But even for families who lived independently, extended families often provided food and other support.

Sometimes then if I am out of milk or anything than I will probably have ***to ask mum what she's got*** *and if she's got any milk at home.* (PL19)

My mom and all bring so much because of my baby*, she is the first baby in our house, so she brings so much things to our house. She brings everything.* (PL23)

4.3.4 Eating Fewer Fruits and Vegetables than Desired

While many parents described eating plenty of fruit and vegetables with their families, the most common food that parents expressed the desire to purchase, if they had more funds, was more fruit and vegetables.

If money were no object I would definitely shop differently. I would ***buy a lot more fruit and veg****. It is* ***expensive to eat healthy****, but I just buy... I try to eat as much fruit and veg as possible. I have expensive taste, and I can't feed myself what I'd like to, but I still have a healthy diet, meats and fish and chicken and vegetables and rice and stuff like that.* (PC12)

I would be ***buying fruit til my heart was content****. I love fruit. I don't really like vegetables, but I love fruit. I would be eating a lot better. If money wasn't an issue, I'd be eating a lot better.* (PC15)

If money wasn't a concern, I would buy ***every sort of variety of fruit and vegetable*** *there is and try it out.* (PL18)

This mother's response was typical of many mothers who expressed anxiety that their children may not be eating enough fruit and vegetables. She accepted responsibility and blamed herself, as many mothers did:

> *He doesn't eat that bad, but I don't think he gets his 4-5 a day as he should. And **I always think about it, and I always beat myself up for it**. Because I'm like, why is he not getting it, what am I doing wrong? Am I just being lazy? Do I not have it in the fridge? Because we do have fruit, but it just ends up going off.* (PC1)

4.3.5 Buying Lower Quality

Although those eligible nearly all expressed the desire to purchase higher quality food from speciality shops, as explored in Section 4.1.2, most were more practical in their shopping, prioritizing price and the convenience of going to one large store.

This mother shopped at one supermarket because of cost.

> *So, I normally go to **Aldi or somewhere that's a bit cheaper** because then you can get a bit more stuff.* (PL25)

Another acknowledges that she would not shop at Aldi if money were not a concern.

> *I do shop differently; **I shop at Aldi on purpose because it's half the price**. So yeah, I definitely shop differently. I definitely think about what I'm picking up.* (HWL3)

While Asda and Aldi were the most common supermarkets mentioned by those eligible for benefits, those not eligible for benefits tended to shop at higher quality, more expensive shops. Tellingly, the only interviewees to mention shopping in Waitrose, Marks and Spencer, or Sainsbury were not eligible for benefits.

A married mother of one in Camden who was not eligible shopped mostly at Sainsbury's, but would like to shop at smaller shops and Waitrose:

> *I think I'd try and do a little bit more of **green grocers, more organic** if I could, more maybe at **Waitrose** because the produce is better. I think **quality** does make a difference to the meal. But I already try as best as I can within our means now.* (PC3)

Another mother also shops at Waitrose as evidence of her commitment to high quality fruit and vegetables.

> *We do an online shop and one of the decisions the pair of us has made and we spend more money on **good fruit and vegetables, so we buy Waitrose**. We don't buy anything if it doesn't taste of anything. I don't see the point of buying a packet of cheap tomatoes that don't taste like tomatoes. I'd rather spend the money. So that is our decision. Our spend on food is probably a bit more than average, and maybe that will change once we've had a baby, but we tend to buy **high quality food** and I don't eat meat anyway.* (PC9)

4.3.6 Eating Little Variety/Avoiding New Foods

The need to eliminate food waste was mentioned by parents who are eligible for benefits and also by those who are not. This means that parents were hesitant to try new food or recipes, for fear their families would reject them; that they purchased fewer fresh vegetables, which do not last long; and that they tried not to purchase anything extra that might not get eaten.

> *Yesterday I was watching [a celebrity chef cooking show on tv] and she was cooking a lot of healthy summer salads and stuff. Half of the things that she put in there I literally thought okay fine, I'm going to make that. So, I went into Tesco and put the things in the basket, and it came up to like about £20 and I thought I can't do this for one meal. You're* ***better off just buying a little tub of frozen stuff or whatever it is***. (PL18)

> *For me, I'm going to be really honest here and this is a horrible thing to say but I think that* ***it's frustrating to see fruit and vegetables go off*** *and that's a disincentive because there are other foods that give you longer.* (PC14)

> *I think* ***I'd probably buy a lot of stuff that I wouldn't eat because I want to try it****. I want to make this I want to make that, but I probably would never make it.* (PL7)

> *Sometimes I think, I know we used to before say we'd buy a steak for the whole family whether we were going to eat it or not just in case and then the next day it might be left over. Now we are more aware of doing that now. Our fridge used to be full of leftovers, so now we're a bit* ***more conscious of just making enough for us*** *and maybe a little bit extra.* (PL16)

> *I don't buy snacks and stuff like that really. I literally* ***buy what I'm gonna cook and what we're going to eat and that's it***. (HWL3)

4.3.7 Purchasing Brand Names

This is not a behaviour that the interviewees discussed, but based on my observation of parents feeding their children during interviews, and confirmed by a teacher of the infant feeding classes at the community centre, parents did feed their children brand name packaged snacks.

> *They are perceiving anything you can buy to be the best thing. So that could be pouches for example. They are so heavily advertised now, and everybody will use them. And there was a crazy thing on the WhatsApp group [of everyone in the class] recently about oh, do you know, have you seen you can buy this special spoon that now you can just screw onto the top of your pouch. But only on Ella's Kitchen ones, and where can I buy them? And I said look, just use a teaspoon if you want to use pouches, just use a teaspoon. How is it different, how have you got to buy something that screws on? So, it's a very, very big thing and I know that's the same with formula milk as well that* ***they will buy the most expensive one even if they have no money.*** (HWL6)

She also described a mother who, despite teaching the healthy cooking class, insists on buying brand name food for her children but not for herself.

> *She said I still insist on buying brand name foods for my children. I won't mind if I don't have brand name foods for me,* ***but I insist on buying the best brands for my children***. (HWL6)

4.3.8 Looking for Bargains

Many of the parents interviewed described searching online and in-store for sales, even if this was stressful and time-consuming.

> *We have a menu and when we go shopping, we make a* ***shopping list*** *according to the menu…when we go shopping if there are any* ***offers on anything cheap*** *and I think I'm going to use it then I'll buy it and then I'll change my menu accordingly to fit that in*. (PL11)

> ***I shop around****, so if I'm in Aldi what I'll normally do is I'll check out the prices in there. If they seem decent to me then I'll buy it. Because I shop like Asda and everywhere I'll probably search around on the internet and look for decent prices and then I'll go there and buy it.* (PL22)

> ***I'm always looking for some sale or something****, good quality of course, but some price reduction. Because it's lots of money, we never can save the money.* (PL24)

4.3.9 Infant Feeding

While many women reported breastfeeding, midwives explained the expectation that formula milk would be used as a supplement, and that this often replaces breastfeeding.

> *So, they* ***value breastfeeding,*** *they see it as normal, women want to do it, but there is also a very strong expectation that you will* ***use bottles as well*** *either because your milk is not enough or because you haven't got time because you've got to share the responsibility for feeding amongst the whole family and make sure that the mother can contribute to doing the food and the housework… So yeah, breastfeeding is normal, but mixed feeding is also normal. And that means that lots and lots and lots of mothers end up just formula feeding because they start feeding and they use top ups and then they stop breastfeeding…. I'd like to see a lot more about encouraging and understanding breastfeeding*. (HWL6)

Two other midwives, one in Camden and one in Leicester, expressed the same sentiment, that by 6 months, or even 6 weeks, rates of breastfeeding decrease significantly:

> *Obviously here after sort of 6 months or even 6 weeks is when it starts to go down, but to start with most mums will definitely give it a try.* (HWC1)

But for some mothers, breastfeeding, even if not enjoyable, was a sacrifice they were willing to make for the health of their children, and because it helped to save money on formula.

> ***I put her before me****. I chose to breastfeed because of that [the cost of formula] as well. I looked at the price of the formula milk and it was about £11-12 and you're spending that on a weekly*

basis? With the benefits of breastmilk for a child as well I said I'm fine and it's really ***good for me because I save a lot of money*** *rather than buying formula milk every time.* (PL18)

4.3.10 Food Insecurity

For those experiencing food insecurity, skipping meals or eating a reduced quality diet with little variety is common. This research, as discussed in Chapter 2, measures food security using the US Household Food Security Survey Measure which relies on the perceptions and experiences of respondents. Those who described sacrificing the quantity and quality of the food they eat due to financial constraints are deemed to be food insecure. The food insecurity of family members was not directly evaluated, but is likely to also be affected. As discussed in section 4.3.1, children are somewhat protected by their mother's sacrifice. While the focus of this research is the diet of young children, it is nevertheless a relevant and important finding that so many of the mothers interviewed experience food insecurity.

In total, about a quarter of the respondents experienced some level of food insecurity. Very low food security, defined as those that reduced the amount of their food intake by skipping meals and eating less than they would like due to financial constraints, was described by six of the respondents or about 12% of respondents. Another six respondents reduce the quality and variety of their diet, which is classified here as low food insecurity. Since this was a qualitative study, no conclusions can be drawn from a statistical analysis of the respondents, but it is interesting to identify common attributes among those reporting food insecurity. These are discussed below and the basic demographic characteristics of the food insecure respondents are summarized in Exhibits 9 and 10.

Recipients of government benefits, including Healthy Start, were more likely to experience food insecurity. In total, 62% of the total respondents and 83% of those who experienced food insecurity received benefits. Of the twelve recipients of Healthy Start, a quarter of them reported food insecurity. Of the six that had very low food insecurity, all received some form of needs-based benefits, but only one received Healthy Start. Four of the six with low food security received benefits, and two of those received Healthy Start.

Households with fewer adults have a higher risk of food insecurity. Of all of those interviewed, there is an average of 2.3 adults in the household, but on average only 2.0 adults in those households who reported food insecurity. Of the nine single mothers in the study nearly half (four) were food insecure.

Younger respondents were also somewhat more likely to experience food insecurity, as were those who were pregnant (three of ten respondents). The average age of respondents in the study was 32.4 years of age while those classified with very low food insecurity average 27.7 years of age and those classified with low food insecurity average 30 years of age

Less than one quarter of all of the parents interviewed identify as White British, yet they disproportionately experience food insecurity. Of those with very low food insecurity half described themselves as White British, and of all of those who experience some level of food insecurity, one third were White British.

Exhibit 9: Demographic Information for Parents with Very Low Food Security

	Age	Adults in household	Education	No. of children	Ethnicity	Age of Oldest Child	Eligible for Healthy Start	Receive Healthy Start
PL1	28	2	BA +	1	Indian	7 months	Yes	No
PL8	35	3	A level	0	Pakistani	Pregnant	Yes	No
PL14	32	1	University	2	White British	7 years	Yes	Yes
PC15	20	1	Below A Levels	1	Black Caribbean	6-18 months	Yes	No
PL18	22	3	A Levels	6	White British	11+ years	Yes	No
PC24	29	2	A Levels	0	White British	Pregnant	Yes	No

Exhibit 10: Demographic Information for Parents with Low Food Security

	Age	Adults in household	Education	No. of children	Ethnicity	Age of Oldest Child	Eligible for Healthy Start	Receive Healthy Start
PL2	27	4	Below A Levels	4	White British	13 years	No	No
PC12	32	1	A Levels	0	Black Caribbean	Pregnant	No	No
PL19	32	1	BA +	1	British Pakistani	4 years	Yes	Yes
PL21	30	2	A Levels	3	Muslim/Asian	6 years	Yes	No
PL22	NA	2	Below A Levels	1	Asian	3 months	Yes	Yes
PL26	29	2	BA +	2	British Indian	4 years	Yes	No

4.4 Summary

This chapter has explained how the parents of young children interviewed describe their perceptions and practice of healthy eating and the obstacles they face. Parents' descriptions of ideal diet reflect a priority for healthy and socially valued foods and food practices. There was no evidence that parents lacked nutritional knowledge or skills, despite a widely shared belief among health professionals and parents that other parents lack the nutritional knowledge and cooking skills to provide a healthy diet for their families. The constraints that parents describe that keep them from attaining their ideal diet are primarily the affordability of healthier foods and the preferences of other family members. As a result of these constraints the reality of the diets fell short of their ideal, often requiring mothers to make sacrifices in their own food or in other areas to provide the food they believe is best for their children. Those on the lowest incomes describe skipping meals, lower quality food with less fruit and vegetables than they would like, little variety, and limited opportunities to try new foods and recipes. The following chapter reviews interviewee perceptions of the Healthy Start Scheme and how its recipients are perceived. Preceding the chapter, Exhibits 11, 12 and 13 provide a summary of the codes given to those interviewed to maintain their anonymity.

Exhibit 11: Key to Codes for Parents in Camden

Code	Received benefits (1)	Receive HS	Food Insecure
PC1	Yes	No	No
PC2	Yes	Yes	No
PC3	No	No	No
PC4	Yes	Yes (past)	NA
PC5	No	No	No
PC6	Yes	No	No
PC7	Yes	Yes	No
PC8	No	No	No
PC9	No	No	No
PC10	Yes	No	No
PC11	No	No	No
PC12	No	No	Yes
PC13	No	No	No
PC14	No	No	No
PC15	Yes	No (applied)	Yes
PC16	No	No	No
PC17	No	No	No
PC18	Yes	No	NA
PC19	Yes (daughter)	No	No
PC20	No	No	No
PC21	No	No	No
PC22	Yes	Yes	No
PC23	No	No	No
PC24	Yes	No	Yes

(1) Does anyone in your household receive needs-based benefits (not including child benefit). This was used to determine eligibility for Healthy Starts for the purposes of this research

Exhibit 12: Key to Codes for Parents in Leicester

Code Name	Received benefits (1)	Receive HS	Food Insecure
PL1	Yes	No	Yes
PL2	No	No	Yes
PL3	Yes	No	No
PL4	Yes (sister)	No	No
PL5	Yes	No	No
PL6	No	No	No
PL7	No	No	No
PL8	Yes	No	Yes
PL9	Yes (past)	Yes (past)	No
PL10	Yes	No (applied)	No
PL11	No	No	No
PL12	No	No	No
PL13	Yes (father in law)	No	No
PL14	Yes	Yes	Yes
PL15	Yes	Yes	No
PL16	Yes	No	No
PL17	Yes	Yes	No
PL18	Yes (mother)	No	Yes
PL19	Yes	Yes	Yes
PL20	No	No	No
PL21	Yes	No	Yes
PL22	Yes	Yes	Yes
PL23	Yes	No	No
PL24	Yes	Yes	No
PL25	Yes	Yes	No
PL26	Yes	No	Yes

(1) Does anyone in your household receive needs-based benefits (not including child benefit). This was used to determine eligibility for Healthy Starts for the purposes of this research

Exhibit 13: Key to Codes for Health Professionals

Health Professionals in Camden
HWC1
HWC2
HWC3
HWC4
HWC5
HWC6
HWC7
Health Professionals/Programme Directors in Leicester
HWL1
HWL2
HWL3
HWL4
HWL5
HWL6
Supervisor in Camden
SC1
Supervisors in Leicester
SL1
SL2

Chapter 5: Perceptions of the Healthy Start Scheme

This chapter addresses two research questions RQ2: How do parents and health professionals describe their perception of and experience with the Healthy Start Scheme? and RQ3: How are recipients of Healthy Start perceived? It sets out how health professionals and parents perceive the goals of the scheme; how aware people are of the scheme, how they find the application process and eligibility requirements, how effective they find the scheme and, finally, how stigma about benefits is expressed and experienced. The testimony followed here suggests certain shortcomings of Healthy Start. The economic impact of these will be discussed, and potential remedies suggested and quantified, in the next chapter.

5.0 Introduction

As discussed in Chapter 2, the Healthy Start policy does not have clearly articulated or measurable objectives. It straddles a public health and welfare scheme with dual aims to improve nutrition and to provide the funds to do so. The aims of the scheme have been described by the DHSC, NHS and NICE.

> *enable low-income and disadvantaged families to purchase fruit and vegetables* (Bethell, 2020).

> *improve health and access to a healthy diet for families on a low income across the UK* (National Institute for Health and Care Excellence, 2015).

> *help low-income families by providing vouchers for free fresh milk, infant formula, fresh fruit and vegetables to young children and pregnant women, as well as free vitamin supplements* (NHS, 2015b).

> *encourage relationships with health professionals, thus improving the nutrition of lower income pregnant women and children. It aims to improve health and access to a healthy diet for families on a low income across the UK* (NHS, 2015b).

Healthy Start is often cited by the government and mentioned in Parliament as a "nutritional safety net" that promotes "healthy food provision".

> *There are existing schemes that* ***support the consumption of healthy food****. For example, the Healthy Start scheme provides vouchers for lower income families which can be used to buy, or be put towards the cost of, fruit, vegetables, milk and infant formula* (Rutley, 2019).

> *Government policies are addressing* ***healthy food provision****; the tackling obesity strategy, Healthy Start vouchers and free school meals* (Eustice, 2020).

In response to a question about the childhood obesity strategy, Lord Bethel cited Healthy Start not only as a nutritional safety net but as having a social role to bring families together.

> *I also emphasize the Healthy Start vouchers, a scheme to provide a **nutritional safety net** to hundreds of thousands of pregnant women and families with children aged under four, which is one way of **bringing families together around healthy food*** (Bethell, 2020).[1]

The scheme is described as part of a "significant investment" in child nutrition in the Agriculture Bill.

> *The Government are also making **significant investments** in schools to promote physical activity and healthy eating, through our Healthy Start, school fruit and vegetable and nursery milk schemes* (House of Lords, 2020).

As uptake has declined, civil society organizations have become increasingly involved in promoting the scheme. One of the most active has been Sustain, the Alliance for Better Food and Farming. They echo the government and perceive the role of Healthy Start vouchers both as a nutritional safety net and as a way to encourage healthy food choices.

> *The vouchers are a means-tested scheme that act as a basic **nutritional safety net** and encourages families to **make healthy food choices*** (Sustain, 2019).

In November 2020, more than 50 representatives from civil society organizations, professional nutrition bodies, directors of public health, and academia and local government signed a letter to Rishi Sunak (MP, Chancellor of the Exchequer and Matt Hancock (MP, Secretary of State for Health and Social Care) emphasizing the importance of Healthy Start and requesting an increase of funding to provide an expansion of the scheme. In their words:

> *The devastating impact that Covid-19 continues to have on food insecurity means that the Healthy Start Scheme has never been so important in safeguarding the health and nutrition of young families… The scheme is a targeted and efficient way to reach those who are most vulnerable and in need of support*. (See full letter in Appendix 7)

The legislators describe Healthy Start in very broad sweeping terms. It represents a "significant investment" that "enables low-income families to purchase fruit and vegetables", "improves health and access to food", is a "nutritional safety net" and "brings families together around healthy food". Civil society organizations have become active in promoting the scheme as a "nutritional safety net" and "important in safeguarding the health and nutrition of young families".

[1] As of September 2020, there were 271,498 beneficiaries of Healthy Start in England and Wales, the number of families receiving vouchers is unavailable. (NHS Business Services Authority, 2021)

5.1 Public Perceptions of Goals

It is interesting to compare the publicly stated goals of the scheme to the perceptions of the health professionals and parents. As might be expected, this research showed no clear consensus among them about what the scheme was intended to do.

As the gatekeepers of the scheme, the health professionals generally had a positive impression of the scheme; there was a general sense that anything that supports nutrition and babies is a good thing. But they had little specific understanding of its goals, and many had no knowledge of the scheme before it was described to them. The response of a midwife in Camden was typical of most.

> *Well, I'm a **great believer in Healthy Start** and all these schemes that we do for the women that help with a healthy start for mothers and babies.* (HWC4)

One midwife in Leicester suggested that its goal was to "prevent poverty maybe" (HWL2), while another midwife, who had previously been a recipient, was more negative, expressing that it was a fairly empty gesture:

> *I don't think it does prevent poverty, it's not enough. It's just a little **gesture of good will**… I think it is to **make the government look like they are trying** to do something* (HWL3)

Despite the lack of understanding of the scheme, and expressed concerns that at best the scheme was not up to the task of preventing poverty, and at worst an empty gesture intended to benefit the government above all, the midwives and supervisors universally supported the scheme. The reason for their support was cited as support for mothers and babies.

Parents also generally had a positive impression of the scheme when it was explained to them, whether or not they had any experience with it. Most responded that they did not know what the goals were, whereas some who were familiar with Healthy Start were divided on whether the goal was to promote healthy eating habits or to combat poverty.

A single mother with a young daughter who is a recipient thought that the goal was to improve nutrition, and that it was good to encourage mothers to buy healthy food.

> *It **helps you buy like fresh fruits and vegetables**, that's what the voucher is for, so yeah, it's good. I think it encourages you to buy it because I don't think you could buy other things.* (PC4)

However, a mother who struggles with food insecurity and has recently applied for Healthy Start was more cynical about the government's motivation and thought the scheme was not enough to help families purchase fruit and vegetables.

> *To make them **seem like they're helping, but they're not really helping**. Cause like I said, fruits and veg are really expensive! It's expensive!* (PC15)

A married mother of a 1½-year-old daughter who had heard of the scheme but was not eligible believed the goal was to improve nutrition, teach parents how to prepare healthier meals, and ultimately benefit the NHS, consistent with the economic argument for Healthy Start.

> *I think it's to try and **get people to eat healthy** because in the long-term it's **less of a strain on the NHS** and everything else and it's important to start especially with children to get them eating the right things in the beginning. It's important for their growth and development and to encourage, you can make these meals at home that are tasty, it's cost-effective as well.* (PC3)

A married mother who was food insecure and eligible for Healthy Start, but not a current recipient, believed the goal was to improve the health of future generations, and that it was good to encourage parents to buy healthy food:

> *So, in a way it is good to **encourage people to eat healthy** and do these things for them like giving them vouchers to buy stuff because it's more of like **the future generation.*** (PL18)

The parents also supported the scheme because it was for healthy food for children, and generally believed it would encourage people to eat more healthfully, whether or not they had any knowledge of the scheme.

5.2 Perception of Scheme's Visibility

There is a general lack of awareness about Healthy Start, although there was a significant difference between Camden and Leicester. There were no posters or leaflets on display in any of the children's centres visited in Camden. There was one poster in one centre in Leicester.

<u>Camden</u>

Midwives in Camden often thought uptake was declining because of lack of awareness.

> *I think probably the main factor is **ignorance**. **People don't know about them.*** (HWC7)

Two midwives blamed this on a lack of promotion.

> *There is **no promotion of it**. I only know about it when people bring it to me*. (HWC6)

> *Maybe there's **not enough advertising** around it. Obviously, there is here the leaflets, [she had leaflets in her desk] but maybe there's not enough on the walls.* (HWC1)

Another had never been asked by a patient to sign an application.

> *No, so far, no. **Probably because they have not been informed.** There was I think some family on benefits.* (HWC7)

In Camden, when asked how parents who knew of the scheme had heard about it, it was from sources other than their health providers.

*I'm sure **through my other friends** having children… You have to sign up to them, but I knew from when Sophie and them were having their children years ago.* (PC22)

*I've only literally heard of the vouchers **from where I worked at Sainsbury's**, I had people coming in with the Healthy Start vouchers and things like that. And they had leaflets and stuff about them. That's the only reason I know about it.* (PC24)

Two mothers had a vague memory of seeing something about the scheme.

*I guess after I gave birth when the midwife or health visitor came round, I think it was in **amongst all the flyers** and paperwork that you get.* (PC3)

*I **think I saw a poster up in the hospital once**, but then I read the bit about means-tested or whatever they call that, and I didn't pay attention to it.* (PC11)

<u>Leicester</u>

In Leicester, by contrast, parents who knew of the scheme had mostly been informed by their health professionals.

*So, I found out about it **through my midwife**, and then I sent in the application, and that's when I started getting the vouchers through the post, which is really good. But I haven't used them as much, to be honest, as I probably could have done. Generally, my mum does the weekly shopping, so I'd give them to her and then she'd use it to get things*. (PL15)

*Healthy Start scheme, yeah, I have heard when I gave birth, so the **health visitor she came to my house, and she introduce about this thing.** Maybe it's like you get some few money and then for you and for your baby to have some milk or bread or something like that.* (PL1)

Yet, even in Leicester, most of the parents interviewed were not aware of the scheme, even though the midwives reported routinely discussing it with their patients. A health professional thought promotion of the scheme had declined since 2010:

***I don't think it is promoted really**…But I used to work in Birmingham for a year in 2010 and there was a big push on it and lots of visuals that were being used then in all the children's centres and clinics. Big visuals about Healthy Start, not just the vitamins but about fruits and vegetables, big posters about them. I've not seen anything like that here in Leicester. There's also, there was, I've got in the cupboard over there, I think there were some badges that health visitors or midwives could wear saying ask me about Healthy Start. You know that's all gone round. So, there was a push once but not really now.* (HWL6)

This mother describes being preoccupied with pregnancy and having a new baby and being unable to "pay attention" until now that her baby is six months old.

*Must have, but I can't really remember. She must have, but I think at that time I was a bit with her, and **I was just expecting and everything, so I wasn't really paying attention** so at that time*

*it was a bit difficult. So, at the moment **I will pay attention now** because of her, because she is growing up*. (PL2)

With little public promotion of the scheme, whether potential recipients are aware it is largely dependent on the individual health professional they interact with and that person's sense of responsibility for the scheme.

Though conversations with health professionals, five themes were identified that contribute to the lack of promotion, and therefore lack of visibility, of the scheme.

5.2.1 Inconsistent Training of Health Professionals

Camden

In Camden, none of the midwives in this study had been trained in Healthy Start. This midwife had worked in the centre for 18 months and, in her induction and training, Healthy Start was not mentioned:

> *Because I'm quite new I really didn't know what it was, **so I had to ask my colleagues to explain me**… I know that I have to fill it, sign, date and then they apply for it… I would like to know more about it. Because when I started here nobody told me anything. I just learned by my way, or I have it in my folder so when I have a chance, I look at it. But no, **nobody trained me**.* (HWC2)

A midwife's assistant who had recently completed her training had not received any training in Healthy Start:

> *Absolutely not, I don't remember, **nobody mentioned it**.* (HWC7)

Due to a lack of staff and time this midwife had not heard of Healthy Start when she began working in the children's centre. Consistent with the other midwives, her first exposure to the scheme was when a patient asked her to sign an application.

> *There **isn't enough staff or enough time** for someone to orient you that well to all the different things that are available, so I didn't even know they existed until I started working in a clinic here and somebody asked me to sign one, and I didn't know what it was. So, I think what I know is that it is for people from low-incomes or if they have a young child and it's for milk vouchers and vegetable vouchers. And I have to sign it and they send it away in the post. That's all I know.* (HWC3)

This midwife also confirmed her first exposure to the scheme through a patient.

> *Yes, that was probably it. And I looked at it* [the application] *and said okay, I will sign it, it's for you. Because I certify that the woman is pregnant and her due date.* (HWC6)

Leicester

According to the public health leads responsible for the scheme in Leicester, when the system is working according to their policies, Healthy Start is promoted by the midwives, the health visitors, and reinforced by the children's centre classes and programmes. There is training for the health visitors and midwives as part of the Healthy Child programme called Healthy Together. The supervisors of the Healthy Start scheme for the city of Leicester and Leicestershire County were interviewed together, and when asked if the training of the health visitors, midwives and children's centre staff was occurring properly one responded:

> *Yes, I think they are actually because the infant feeding coordinator who works for Leicestershire Partnership NHS Trust is part of the 0-19 Healthy Child programme team Healthy Together. She actually developed a guidance and a pathway which we are just in the process of updating and in her training around baby friendly initiative* ***they always mention Healthy Start in the training****. So that training is for children's centre staff, health visiting teams, and also of course her counterpart, the infant feeding coordinator, also do training around BFI including information about Healthy Start as well. So that means that midwives and people working in the acute hospital trust are also aware of the Healthy Start scheme.* (SL1)

Her counterpart said she did not know if training was happening as it was planned, but she did know that health visitors promoted the scheme.

> *I seriously don't know, would be the really honest answer.* ***I'm not sure****. When I talk to clinical team leaders or see health visitors shadowing them, they* ***all talk about Healthy Start as part of their day-to-day discussions*** *so I know they are aware of it and I know they are promoting it, but what sits behind that I couldn't comment on it… My role with Healthy Start is quite distant, I think it is fair to say. I specified in our service* ***specification that health visitors needed to promote it*** *and use it and be part of it, part of that scheme but I don't have day to day work with it, and actually I think* ***don't know as much as I should about it****. That's what I reflected coming over here.* (SL2)

This is consistent with the responses of the midwives interviewed in Leicester who routinely discuss the scheme with their patients. The scheme is also presented in the antenatal classes offered at the centre:

> *No,* ***I suggest it. When I book a lady then I will ask them if to see if they are entitled to it.*** *And we will go through the checklist and if they're not then, if they don't know, because some of my ladies are immigration control. So, their husbands are working but they're not working. Because the immigration control, they're not entitled to it. Or they think they're not entitled to it, but I will give it to them still and tell them they can find out on the government website…I may have given out about ten since I've been in the community and that's a year.* (HWL2)

Promotion of the scheme in the classes seems to be dependent on the individual teachers. The programme coordinator responsible for the initiative that was specifically aimed at low-income families was unaware of the scheme. She described her responsibilities:

> *I work with parents around volunteering, employment, pathways out of poverty. I work with the community in terms of community groups and supporting community groups and developing that. I also do consultations with parents and look at parent participation. I manage the adult and family learning programmes as well.* (HWL4)

When asked what she knew about the Healthy Start scheme, she said:

> *nothing… I don't work with children;* ***I work with the parents, so I don't get involved*** *in any of the sessions or anything.* (HWL4)

5.2.2 Midwife Time Constraints

All of the midwives interviewed reported a lack of time to cover all of the routine health related items they needed to discuss with the patients. There is a long list of things they need to cover in antenatal appointments, but since Healthy Start is not on their checklist it is often overlooked.

One of the midwives in Camden said that this research had reminded her to learn more about the scheme, but she acknowledged that a lack of time and more pressing priorities had kept her from doing it in the past.

> *It is also going to make me read the leaflet properly, because as usual I see it, I get it from the women, and I go, oh I have to read that. I always forget to read it. But* ***I don't have time to read it, so I just sign it and I think that's the thing****. I'm focusing on the pregnancy midwifery stuff, but it really has prompted me to think maybe I should think about this a more, how I'm not using it* (HWC3)

Others agreed:

> *I have usually, people who need it,* ***I have 10,000 other things that I need to worry about****. So that's the barrier, and also if midwives don't know where to get those forms, and children's centres don't promote them, then how will they find that? One colleague told me that I could print it from online, and that's what I did. But sometimes they don't have those resources to print them. So that's the main obstacle.* (HWC6)

> ***Time is always a factor*** *with everyone. So it might be that it's one of the things unless women come to us with it, we don't firstly think in our heads that we need it.* (HWC1)

Several midwives talked about helping applicants fill out the form, which was easier for the applicants, particularly those who were not comfortable with English, but also that it was difficult with the time constraints they faced:

> *Some people don't speak English, they don't have access to other services, and* ***it's not the first thing that pops into my head on a busy day***. (HWC6)

The public health lead from Leicester blamed low uptake on a lack of awareness because health visitors had limited time.

> *I would say it is about **lack of awareness**. **Health visitors having the time** to sit with somebody to help them fill in the forms, health visitors understanding benefit systems enough to know the person is eligible for it, that person knowing their benefit system, all of those kind of processy things, probably, or not knowing about it. I suppose if you have somebody who didn't tell you about it.* (SL2)

Healthy Start aside, midwives described a lack of time to discuss nutrition at all. As discussed in Chapter 2, the requirement to have the application form signed by a health professional was thought to be a way to facilitate a link with the healthcare system, which would ensure that children received healthcare and parents could receive nutritional education. But conversations about nutrition may not be happening at all because of time pressure.

> *That **definitely doesn't happen**…I have 20 minutes for my appointment, and I have to do a urinalysis, a blood pressure, a chat about whatever point it is in gestation, answer any of their questions, do a palpation and listening to the baby, and then document it all. And sometimes take bloods. So, it's a **very limited amount of contact** and chat time that you would get that I don't think, you just can't fit in a fully nutritional talk I don't think. Are you eating a healthy varied diet? Your iron is low, have green leafy vegetables. It's not, like I wouldn't get into details at all. I **don't think you have time**.* (HWC3)

While this midwife echoes the concern that she does not have enough time to support nutrition, she reinforces the widely held belief that education is the answer and cites a parenting course for those needing extra support, defined as single parents, those on a low-income, or young parents:

> *I think there is always more time we could spend, **there's never enough time**. But they are starting in Camden and Islington the 5-week course about bonding and they are for people that might need extra support. So, if you're a single parent, if you are low-income or you are young, they are just trying to get you to be involved, and they do a lot about well-being for yourself and babies.* (HWC1)

5.2.3 Cuts to Services

This public health lead from Camden describes the cuts to funding that have meant less time for the health professionals to develop relationships with their patients beyond their immediate medical needs, as well as fewer services offered in a declining number of children's centres.

> *People who actually coordinate the scheme in public health departments or wherever are, those teams are being restructured, they are getting **more and more things on their plate**, they are being spread thinner and thinner so the amount of focus they can put on something like Healthy Start is probably less and less. I think that probably has something to do with it. Also, a lot of services get tendered out to different providers so then there is different ways of working and less collaborative working possibly. And also, **less time to build that kind of working relationship with people** and promote things and all of that. So I'm not surprised that [uptake has] gone down to be honest. I think it does take quite a bit of focus to keep it on everyone's*

radar when there is ***so much else going on****. And if you haven't got the time to do that because you're also* ***dealing with another ten topics*** *or agendas or projects then I guess it is going to be harder and harder.* (SC1)

A midwife in Camden attributed the lack of application forms to budget cuts.

There used to be a box of [applications] *here ready, but obviously* ***we don't have that anymore****. So, it* ***probably is down to the cuts and getting it available****. I think if you have them here and they are ready and you know, but will people do it? Some people obviously will.* (HWC1)

5.2.4 Confusion About Responsibility for Healthy Start

Often health visitors assumed it was someone else's responsibility to inform parents about the scheme, either the antenatal clinic, the healthcare assistant, or the jobs centre in the children's centre.

This midwife refers patients to the job centre, even though the responsibility for Healthy Start lies with the DHSC and not the DWP.

And when women ask me, ***I usually direct them to the job centre****. I know that there is a form online I did print out once for one of my clients. But again, it was just something to sign, and we have so much work.* (HWC6)

While no representatives from the jobs centre were formally interviewed as part of this

research, casual conversations with the DWP employee in the children's centre indicated that they had little knowledge of the scheme and did not believe it was their responsibility.

These midwives in Camden assumed that the healthcare assistants were promoting the scheme:

I do know that the healthcare assistants always talk about it *to the women when they first come, or at some stage throughout their pregnancy, but quite early on in pregnancy generally. So, it's certainly something that we're conscious of, and make sure that women have that information.* (HWC4)

Not a lot I have to say. I usually ***leave it to our healthcare assistants*** *who participate with us, and they explain the Healthy Start scheme to the ladies. Because I only work bank now and again, they usually deal with all that.* (HWC4)

However, the healthcare assistant interviewed who worked with those midwives had little knowledge of the scheme:

Well, ***I don't have experience with it****. I didn't use it when I had my baby and then I forget. When you mentioned it, something clicked, but it's been going on for quite a while I think because my son is nine. And they were already here ten years ago. Now, I didn't use them, and actually nobody told me about them. Probably I read something in a children's centre, but I never enquired.* (HWC7)

As cited above, when asked if she had received any training in the scheme, she said, “absolutely not” (HCW7).

The lack of training in the scheme noted in Camden resulted in the lack of awareness of the scheme by the midwives who could promote it. Professionals were left to educate themselves and promote the scheme or not at their own discretion. As there is no publicity for the scheme, the promotion varies widely in different areas and is largely personality driven. As shown above, the supervisors in Leicester ensured that there was training for incoming midwives and health visitors. As a result, contact with the health system was the common way for parents to be informed of the scheme.

5.2.5 Focus on Vitamins

As an observer at many meetings over the past several years with public health leads responsible for the scheme as well as interested midwives, the focus of the discussion has been on vitamins. Debates around the formulation and distribution of the vitamins, until quite recently, eclipsed the attention given to the vouchers. The health professionals viewed the vitamins as being related to health and thus their responsibility, but not the vouchers. As the children’s public health lead in Leicester put it:

> *Let's just be honest, on the vouchers, in terms of* ***Healthy Start our focus has always been on the Healthy Start vitamins****.* (SL1)

This was echoed by the infant feeding director in Leicester.

> ***When people do talk about Healthy Start, health professional wise they are talking about the vitamins not the voucher scheme****… I know that the commissioners and the infant feeding leads and so on still think that* ***Healthy Start is just the vitamins****. That's all they really know, and they think about. So, the Healthy Start task force [in Leicester, 2-3 years ago]* ***only looked at vitamins****, nothing was talked about the vouchers at all, or the foods or how to promote that or how to encourage it.* (HWL6)

The public health lead in Camden’s focus is also on the vitamins.

> *I don't know, there are lots of issues going on. I mean I work more with the vitamin side of it and the* ***food voucher side of it we kind of just hope takes care of itself****… I think the* ***vouchers sort of took a back seat a little bit****.* (SC1)

When asked about how the scheme was promoted in Camden, she reinforced this by only referring to the problems of promoting vitamins.

> *I think one of the problems with the Healthy Start Scheme is that like for example in Camden it's only available in I think about five children's centres and three health centres. So, if you're a mum that doesn't live near any of those sites, to go and pick that up is difficult.* (SC1)

She found the scheme difficult to promote because, until recently, the vitamins were only offered to those on a low-income. But after Camden offered Healthy Start to all pregnant women and young children, she promoted them as a public health message.

> *I think what I found really difficult was the fact that **it is a hard scheme to promote because only certain people were eligible**. You couldn't say everyone was at risk of these deficiencies but only the people who are Healthy Start beneficiaries have access to the vitamins. So, you **couldn't promote it as a public health message**.* (SC1)

When asked if people are more aware of vitamins than vouchers a midwife in Camden confirmed that it was easier for her to discuss vitamins than vouchers, and easier because vitamins are universal.

> *Yeah, I think so. Because it is so automatic. It is a **much easier prompt about the vitamins** because everybody, it seems to be such a given that pregnant women take vitamins that I always get asked about what vitamins or tablets should I take. So even if I haven't already told them about it, it prompts me to tell them about that. If you register in your local children's centre, you get free vitamins. Whereas I don't think I would have the same kind of immediate thought of the Healthy Start vouchers.* (HWC3)

> *For us it is **more about the vitamins**, especially obviously in pregnancy and then afterwards we can talk about it, but I think there is always more time we could spend, there's never enough time.* (HWC1)

When asked about the barriers to accessing the scheme this midwife in Camden talked about challenges to accessing free vitamins, then describes the problem as a lack of information that could be solved with nutritional education.

> *The barriers I guess it's that only certain people can have them. I think the problem is they can't always just get them here if they run out. It might be that they're just not available there and then so people won't... If you have to go and collect them from somewhere, you have to fill out a form, it's not directly accessible. So, people forget. People don't collect them. Lucky enough it's all free, so it's not about the money, but it's easier for people with money. But I think if they're not just there directly at that time, would people still... if they've got kids, if they've got other responsibilities going it won't be the first thought in their mind as to why they are taking it. And maybe the **information needs to be there** why need these things and why it's important. Like why the **education of a well-balanced diet**, about fruit and veg, about milk, what's the importance of it.* (HWC1)

5.3 Perceptions of the Application Process and Eligibility

Many of those interviewed described difficulties with the application process, which could be related to language, changes in circumstances, the need for a health professional's signature (now suspended because of Covid-19), or the stringency of eligibility requirements.

The application process was described by two supervisors as "torturous" and "long-winded".

> *The process of application is torturous I think, in a way. Not very helpful, it just puts up barriers. (SL1)*

> *I think the application **process is a little bit long-winded**. Maybe the application form isn't in all the obvious places. I don't know, like is it in job centres or places where people pick up welfare that kind of thing. (SC1)*

The applications are available only in English, and at the time of this research they needed to be printed and signed by a health professional (midwife, health visitor or doctor) and mailed. Since 6 April 2020, the health professional signature has been waived, but the application form available on the Healthy Start website still indicates the necessity of a signature (attached in Appendix 1). It takes about four weeks for a reply, and about 25-30% (27% on average) of all applications received are denied. The most common reason is because the application is incomplete or not signed (8%). The number rejected because they do not qualify is less than 5% (Department of Health: Healthy Start Issuing Unit, 2017).

Among those interviewed in this research there was confusion about where to find the applications, and as discussed, who was responsible for providing them. The Camden health professionals relied on the applicants to find the application, print it, and bring it in to be signed. In Leicester they were more proactive about helping the applicants find the application online and also helping them to fill it out.

A midwife interviewed in Leicester confirmed she was proactive in offering to complete the application for her patients in order to facilitate their application:

> *I think **the application is easy because I do it for my ladies**. I do it in a 10–15-minute timeframe for my ladies because I've given one to a dad and I didn't realize, he speaks English, but he doesn't write it, so I fill it out for them in 15 minutes, so the application is so easy. It just asks how many kids is in the house, it asks for your husband's National Insurance number*. (HWL2)

Among those interviewed who were recipients, most did not have a problem with the application form. However, as recipients, they are not representative of the people who did not apply or were unsuccessful in their attempts. Furthermore, all those who described the process as straightforward were native English speakers.

This new mother knew about the scheme from friends and applied early in pregnancy. She found the application to be straightforward. However, she had recently given birth, and was unaware that she needed to reapply for the vouchers. This provision for change of circumstances will be discussed in a later section.

> *You have to sign up to them, but… I knew about them from friends having children. It was **pretty straightforward***. (PC22)

> *It was **quite easy really.*** (PC2)

Another mother who had recently applied, but not yet received the vouchers, also thought the application was easy, although she describes a tedious process:

> *It wasn't so bad once I reached the right person. When I found out about it when she was first born, I tried to do it online and I had to print it, instead of sending it to my email, but it was just*

long. When the health visitor came, she gave me a form and I just filled it out and got it stamped and sent it off and I'm just waiting to hear back now... I had to go to the midwife and get her to do it because the health visitor forgot the stamp. (PC15)

Below are the main impediments to the application process.

5.3.1 Language

Parents who spoke English and had access to the Internet and a printer did not have problems with the application, although it was sometimes a painstaking process. But for those who did not read English or have access to technology, the assistance of a health professional with the application was critical. For many of the parents interviewed, English was not their first language and they struggled with the application. Some were recent immigrants and others, although they had been in the UK for years, lived in communities where it was common to speak their native language. Even those who spoke English may have not learned to read and write in English. The interviews for this project were all conducted in English, so it is likely that potential recipients who did not speak English were overlooked. As the Healthy Start application is only available in English, both health professionals and recipients were asked if this was a barrier. A midwife from Camden explained:

> *A lot of women around here is Bengali, and a lot of women **don't speak English**. And they are probably the people that need it more. They need the support so especially around here.* (HWC1)

This was confirmed by another midwife:

> *And then I think **as well a lot of the women who do apply for it, English might not be their first language**, or they have limited English. And I think it's really difficult for them to fill in the form because it is complicated and then sometimes, I have time to go through it with them and sometimes I don't. So, I think that would probably miss out a lot of vulnerable people in that way.* (HWC3)

The response of a pregnant woman from Leicester who had recently applied for Healthy Start was typical for many who did not write English.

> *What I understood, my name, I filled out myself, the other bits I asked the midwife to help, and she filled it out for me.* (PL10)

A programme director in Leicester noted that due to budget cuts there is not a translating service, even in the hospital:

> *There are no translators at all, like the interpreting service here, the hospital doesn't have one. They got rid of their in-house interpreter and used their commissioned service which has now gone bankrupt. At the moment they haven't really got anything, so no, they don't have anyone there and it's really, that's one of the things that has been cut.* (HWL6)

5.3.2 Change of Circumstances

Rather than the stereotype of welfare recipients consistently on benefits, research shows that people rely on benefits intermittently. This means that they become eligible and ineligible frequently, and going through the long process of applying for, and being granted, Healthy Start may not make sense for them. Furthermore, those who have applied and been rejected are unlikely to reapply even though their circumstances have changed.

Nearly all of the recipients interviewed received Healthy Start for just a short time:

> *I had it for just a couple of months **maybe just 6 months** or something.* (PC4)

This recipient from Leicester with one young daughter received vouchers briefly when she was pregnant, but then stopped them when her husband found a job. When she was divorced and became a single parent, at the urging of her midwife, she reapplied:

> *Yes, I **used to get them when I was pregnant and then it stopped** for a bit when my ex was working, and we were getting the working tax credit. So, after **we separated** then obviously with me not working, I was **back on Healthy Start vouchers** and yes, I've been using it.* (PL19)

Often the loss of a job is the reason for financial hardship. This former recipient had relied on vouchers for a short time following her husband's job loss.

> *My husband was working abroad and then **he was made redundant,** so it was a very difficult time, and I knew someone, a family member, had gotten these, so I remember thinking that **every little bit helps**.* (PL9)

Health professionals noted that changes in circumstances complicated access to Healthy Start. As one Healthy Start supervisor in Camden noted:

> *I think there are a lot of people who have no recourse to public funds that are really struggling and would benefit from the scheme. People come **on and off the scheme because their circumstances change** during that period.* (SC1)

A programme director in Leicester remembered talking to a woman who missed out on Healthy Start because her circumstances changed.

> *And she told me when we were talking that when she got pregnant, she wasn't eligible for Healthy Start because she was working too many hours but during pregnancy her employer, which they often do, cut her hours, because then they wouldn't have to pay maternity benefit so much so then she was eligible. But then she didn't have the time then, or nobody mentioned it until after she had her baby and she had so much going on that she said it was too much of a headache with everything else I can't even think about bothering to do that application. So that's always sort of stuck in my head that there's a lot of people whose situations, particularly in this area, **change all the time.** Especially with employment and **insecure employment**. So most people, you don't get perhaps such a huge number of people here who have benefits for some*

> *time, but you get a lot of people on low wages or transient employment who may well be eligible at some time but you need to know what your rights are and you need to know how to do it and* ***you need to have access to the forms at the right time****.* (HWL6)

Not only is reapplication a disincentive for parents, but often a rejection means the family never applies again unless prompted by someone. This mother remembers hearing about Healthy Start when her child was born, and she applied and was not eligible. However, her husband had recently had a large cut in his pay, and she had become eligible for benefits, but has not reapplied.

> *She was born in October 2017 but we applied the child tax credit now in this month. And housing benefit, we applied for housing benefit as well because of some, my husband don't have enough working hours so that's why we applied… the council they are telling me like maybe they will start from this month.* (PL1)

When asked if she had experience with the Healthy Start scheme this mother of three children replied:

> *Yeah, I applied for those but wasn't eligible to get them*. (PL3)

Although her circumstances had changed since she had applied and she was now receiving qualifying benefits, she had not reapplied because she assumed she was still ineligible.

This was confirmed by another mother who had been denied benefits and she thought this was a reason for low uptake:

> *Unless the people like me that have been told they can't do it and they never went back to it again after that.* (PL22)

Not only do applicants need to make a new application each time their circumstances change, but they also need to reapply after a baby is born. This was not well known, and neither the health professionals nor the parents interviewed were unaware of this rule. As a result, none of the recipients interviewed had received vouchers both in pregnancy and after birth.

5.3.3. Health Professional Signature

The need for a health professional (registered midwife, nurse or medical practitioner) to sign the application form creates an extra step. The form asks the health provider to certify "I confirm that I have given him/her health-related advice" and "I certify that the information (s)he has given in Part A question 5 about his/her children is, to the best of my knowledge, correct." (Application is attached as Appendix 1). Although the signature can be helpful if it means that the midwife mentions the scheme and helps with the application, particularly for those who do not speak English, it often serves as just another hurdle to overcome. Because the application requires the health professional to certify that the applicant is under his/her care and that the applicant has been given health related advice, some midwives are reluctant to sign the forms without a medical relationship with the applicant. If an applicant comes to the children's centre with the form and asks for it to be signed without a medical appointment, they would likely be unsuccessful in Camden. Among the midwives encountered in this study there was a wide variation in

their willingness to sign the application form for those not under their care, with most in Camden assuming that they needed to know the applicant, whereas the children's centre in Leicester would allow parents to drop off the application for a midwife to sign when she had time.

One midwife in Camden explained that she would not sign forms for people not directly under her care.

> *Because it says, when I sign it, there is a little box that says I have given health advice or something like they are known to me or something like that. So that's why, any of the other things that I sign they have to be under my care, and I have to have seen them for an appointment within that time. So, I suppose I'm also a bit like if there is,* ***I don't think anybody is going to commit fraud for £3 but at the same time I would be a little bit nervous without knowing who the person was just in case.*** (HWC3)

This midwife also confirms that the requirement of the signature is not just a formality, but requires the midwife to know the patient, which takes time.

> *They need to get them signed and it's not just there you go; you can have it here and it is done.* (HWC1)

The signature is described as a stumbling block by this programme director.

> *It was also a very difficult scheme to administrate in the sense that you needed sign off from a health professional. So, you needed the application signed and I think the idea behind that was so that you would have access to that professional for families that wouldn't normally access them. But it sometimes became a* ***stumbling block,*** *and it became something that probably prevented people from applying and wasn't straight forward, so I think that was a block.* (HWL6)

The requirement of the signature was eliminated in April 2020, not because it was widely seen as an obstacle, but because of the difficulties of in person care during Covid-19. It is unclear whether the requirement will be reinstated.

5.3.4. Stringent Eligibility Requirements

The eligibility requirements are very stringent, with only those on a very low income qualifying. You are entitled to vouchers if you receive Income Support, income-based Jobseekers Allowance, Child Tax Credit and an annual family income of £16,190 or less, or if you receive Universal Credit and earn a family take-home pay of £408 or less per month. The income threshold under Universal Credit appears very low (£4,896 annually vs £16,190 with Child Tax Credit) but was chosen based upon modelling that shows that this level would result in the same number of beneficiaries under Universal Credit as there were previously (Healthy Start working group meeting, London City Hall, 21 November 2018).

Midwives described the tight eligibility of the scheme as a weakness, and expressed some confusion about their role in assessing eligibility (they have none).

For example, this midwife in Leicester explained:

> *It's a **very tight criteria** of who you can give it to and who you can't. So, I think that's what the problem is…Well we can only give it to pregnant ladies, so I suppose if, I think it's the criteria, definitely*. (HWL2)

She went on to point out that it is difficult for immigrants to receive the benefit because they have to make a certain amount of money to meet the immigration criteria.

> *In this area is a lot of British men marrying women from abroad, so because the woman is pregnant, she won't get it. And a lot of the husbands will have to work **two jobs to make enough to meet the immigration criteria***. (HWL2)

A single parent from Leicester who had applied when she was pregnant also found she was excluded by the criteria even though she was struggling and would have appreciated the financial help:

> *It was just at the time when I was expecting with her I was not annoyed and upset but it was like there are **people like me who kind of like do work hard** and just because I mean I was literally, I wasn't even on full time work or anything, it was part time hours but because I was not getting any benefits it literally made me unable to get these which I think is **unfair** that just because you're not on the benefit you can't get these either.* (PL22)

And although she says she was not annoyed and upset, she goes on to describe feeling annoyed and frustrated:

> *It's just like a couple of years back I think I was just earning about **£1 more than the threshold** and because of that £1 I was unable to get any help at all which I think is quite **unfair**. Because if I'm coming to you, I'm coming because **I need support and help**…. I did find it quite annoying, and frustrating, like how couldn't they [provide her benefits], but it was like because, the **benefits I'm getting are because of her**. At that time, I was basically getting nothing so my money that I was earning on the part time wage going toward my bills, full council tax, my own shopping, bills on top and then I'm supposed to be looking after myself to keep myself healthy for her as well. It was **quite sad***. (PL22)

Some of the parents who were not eligible for benefits but still finding it difficult to manage thought that they were squeezed between those who were wealthy enough to afford what they needed and those who were assisted by the government, leaving them in a difficult situation. One mother who was employed part time and not eligible for benefits thought that increasing the threshold for receiving benefits would help, as would looking at each family's circumstances individually to determine their worthiness:

> ***My family really ends up in the middle***. *We're not the high end and we're not the low end, so really, we get nothing. So maybe the threshold should be put up enough to help us or there should be a way of judging everybody's circumstances individually so they're not looking at everybody together, but they're looking at each family separately. That's more work for them, that's why they don't do that.* (PL11)

A supervisor in Leicester recommended eliminating income eligibility requirements:

> ***Make it universal**... If it was a universal programme everyone would benefit, and I think it would have much more of an impact.* (SL1)

This parent also thought income eligibility requirements should be eliminated, although she approved of the vouchers being restricted to only fruit and vegetables:

> ***Vouchers for children. If you've got children, full stop**. You really can't say oh I've got £3 I'll just put it toward my meat or something, it should be **specifically going to fruit and veg**. That would be a good way of doing it.* (PL21)

Despite the many positive reviews that have been reported throughout this chapter, actual enrolment in the scheme has declined every year. The findings show a general lack of awareness and promotion of the scheme, which has been explored in this section. Although the DHSC sends letters to those they believe to be eligible with prepopulated applications (Attached as Appendix 8), no one in this research remembered receiving such a letter. Additionally, the DHSC does not have information on pregnancy until it is reported by the woman, so women in early pregnancy or those not in the healthcare system would be overlooked by this notification. Recipients often knew about the scheme because they had heard about it from friends or in classes at the children's centre. Some mentioned a vague awareness, but it may require more than one mention or pamphlet because this is a time when families are particularly busy and focused on other things.

5.4 Perceptions of its Effectiveness

5.4.1 According to the Government

As shown above, Healthy Start is usually given as an example of a response to child malnutrition and hunger. More recently, there have been those in government who have questioned the efficiency of Healthy Start, suggesting modifications to the scheme. As the scheme has received more visibility, the decline in uptake has been questioned, as well as its operations. This comment from Robert Halfon, Chair of the Education Committee, and Conservative Member of Parliament for Harlow, is typical of those with a concern about uptake.

> *To the Government's credit, there are a number of schemes to relieve food hunger, but what is being done to ensure that they are working? In September, for example, just 47.3% of eligible mothers were receiving healthy start vouchers, and those uptake figures are in decline. Much more could be done to boost awareness of those schemes, digitise healthy start vouchers and ensure that all those eligible for free school meals are registered quickly* (Halfon, 2020).

And some have called for an increase in the amount of Healthy Start vouchers, consistent with an increased visibility for childhood food insecurity as a result of the Covid-19 pandemic.

> *More needs to be done to ensure that no child in my constituency or the country at large goes to school hungry…. Healthy Start vouchers also need to be increased* (Ali, 2020).

5.4.2 According to Health Professionals

When health professionals were asked whether they felt the scheme had a positive effect on nutrition, nearly all who responded thought it was a good idea and helped people, even if they had no or very little knowledge of the scheme. Most, however, felt that the voucher amount needed to be increased.

The benefit of the vitamins was mentioned first by this midwife, and then the financial benefit:

> *Of course, **it helps**, definitely. I think especially with the pregnancy vitamins because what we always talk about as midwives is the vitamin D and the importance for the baby, for the mum, so I think that's massive. With the formula milk obviously if people need help with **financial benefits** than that is going to help them. And **because healthy foods can be more expensive**. Absolutely, I think it is only a benefit, definitely.* (HWC5)

A midwife in Camden was a wholehearted supporter:

> *I'm fairly confident that **whatever scheme there is will be useful** to the women and the women are always very receptive to those schemes I have to say. I can only know from past experience that any of those, like SureStart when that was here, that definitely had an impact on women and the health of them and their babies. So, I can only imagine that this would do a similar thing.* (HWC4)

She did admit, however, when asked to describe the scheme, that she knew very little about it:

> *Not a lot I have to say. I usually leave it to our healthcare assistants who participate with us, and they explain the Healthy Start scheme to the ladies.* (HWC4)

One supervisor in Leicester thought the food restrictions may support nutrition, but did not address the underlying issue of food accessibility due to poverty:

> *Because it is **ring-fenced for certain foods then it means that you buy those foods.** I think that's important, because otherwise what you need is a scheme or something that tackles poverty in general. And **I don't think Healthy Start does that**. I think you need a plan to tackle poverty if you're going to deal with the rising food banks and all that kind of stuff. I think you need some other means of dealing with that, because yes people who go to food banks, they might be given a whole load of stuff they're never going to use because it's a package if you like, a pre-made package. So, in some cases, those families, they probably do **need money more than anything**, but actually they shouldn't be in that situation in the first place. So, I don't know that Healthy Start is the answer to that.* (SC1)

There was very little knowledge about how the vouchers are actually spent, or whether they have an impact on the consumption of fruit and vegetables. When asked how the vouchers are spent, a supervisor in Leicester guessed “formula milk probably” and said she had “no idea” if the vouchers had an impact on consumption of fruit and vegetables. (SL1)

Although believing that something was better than nothing, most health professionals thought the voucher amount should be increased from the current amount of £3.10 per week (twice that for infants under 1 year of age) to reflect cost increases since 2009, when the value was last adjusted.

A midwife in Leicester summed up what most said. The voucher is not enough, but it is a help:

> *Well, fruits and veg are on the increase**. I don't think £3.10 per week is enough**. My fruits and veg are a lot more than that per week. No, I don't think it's enough... Because even though it is only £3 it does help.* (HWL2)

A midwife who had been a recipient agreed:

> *And I **don't think they're enough money** £3.10 a week …I used to save mine up, and I would shop weekly, but I would save them up and spend them all in one week, so for three weeks I didn't have any help… But £3.10 is £3.10 is not nothing.* (HWL3)

A midwife and programme supervisor noted that if parents are using the vouchers for infant formula, it does not cover the expense.

> *I think they need to raise the £3.10 though, it's been £3.10 for a couple of years now. Because when I used to go shopping with my friend when she got them, and her daughter is 6 now, and it's still £3.10 and milk, the price of baby formula has gone up. You cannot find baby formula for less than £10 now, so if a baby is drinking one formula a week or a fortnight that doesn't cover it. So, they **need to increase it**.* (HWL2)

> *It's tiny…It **wouldn't pay for formula milk**, that's really expensive.* (SL2)

Some midwives were concerned that the effectiveness of the scheme was limited because it was not part of a comprehensive nutrition education programme. As we have seen in Chapter 4, health professionals and interviewees tended to frame the problem of malnutrition in lower income populations as a lack of education.

> *The idea is good, but the delivery options have not been effective. Because it **should be part of a more informative programme about healthy eating**… food is really important. So, I always wanted to educate women what is good food but also what is good food for you.* (HWC7)

But when asked if she had time to do that with her patients, she said

> *Not anymore.* (HWC7)

This view was also shared by a supervisor in Camden.

> *And I think generally there is **very little information given during pregnancy by midwives about nutrition** anyway so the importance of it, do health visitors and midwives know how to explain the importance of nutrition and health in pregnancy to those mothers and relate it to the Healthy Start scheme, is there a training for that. So, there were a lot of things that weren't in place I think it was quite difficult.* (SC1)

A supervisor in Leicester expressed a common concern that the vouchers were not spent appropriately, despite acknowledging that she did not know how they were spent.

> *They are **probably not spending it on what the government would like**. There are a lot of competing demands for parents, aren't there. So, I think they probably spend it on what feels most appropriate to them at that point that they are in the shop which isn't necessarily what the government means…It might be nice to talk to the shopkeepers and find out if they ever accept them just as part of the shopping, I doubt if there's any way of tracing it to what you buy.* (SL2)

This led her to conclude that the outcome of the scheme was the cash benefit.

> *I think it probably just eases that general burden of making your finances last. Some of these people, it's a fundamental top-up*. (SL2)

5.4.3. According to Parents

Recipients

Many recipients were thankful and reported appreciating the financial help.

> *Well, I remember I got some for my six-year-old as well and I find it **really helpful** to be honest. Like even for this one I get the vouchers. It helps a lot with the cost, it really does, with the grocery bill. So, I find it **very beneficial**.* (PL17)

> *Yeah, and that **helps** because you know it's expensive* [to buy fresh fruits and vegetables]. (PC4*)*

> *It is like, when I go for shopping £20 is nothing. One bag of shopping is £20-25. It is difficult. So, the voucher **a little bit helps** me.* (PL24)

> *£3.10 is £3.10 **is not nothing.*** (HWL3)

> ***Every little bit helps**, especially when you have kids, and you need that extra cash.* (PL19)

However, they often went on to comment that the voucher amount was insufficient.

> *The **vouchers run out really quickly**.* (PL19)

> *But again, it just **doesn't cover the price***. (HWL3)

A new mother in Camden with a high degree of food insecurity had recently applied for Healthy Start vouchers, but had not yet received them. She was desperate for assistance, but did not think the amount was enough because of the expense of buying healthy food and formula:

> *Healthy Start vouchers are not enough. £**3 a week I don't think it's enough**. I don't understand, you know what it is because fruit and veg, they are expensive, they are actually really expensive. I don't understand how something that is supposed to be good for you is more expensive than junk food. Junk food is cheap. So, for me I don't feel like it's enough, they don't give enough a*

week…I just think they need to make it more a week. I don't really care about more in the benefit, it's just they need to make the vouchers more. Cause £3.10 a week is not enough for nobody. It just doesn't make any sense, because I think they give you the whole thing for a month, so if it works out to about £12 something a month that's gone in 5 minutes. Because formula is £10 something and after you buy that how much you got left after that? (PC15)

One former recipient noted that she used her vouchers for milk and had nothing left to buy fruits and vegetables:

If you pay for milk, you've got nothing left. (HWL3)

Although recipients reported some confusion about where they could be redeemed, nearly everyone shopped at the large supermarket chains and did not find it inconvenient to use the vouchers there:

*It is **quite easy** because I think it's the, what do you call it, shopping stores like **Aldi and Tesco are the ones that accept them.** My local stores it is very rare, I don't think I've found one Asian shop so far that has said to me that they accept them. So, it's like a matter of going to the shopping stores, and because I go regularly to shop it's ok for me to use them up, otherwise it's just like, where my mom's house is there's an Asian shop, but I can't just walk down the road and use it I have to make sure I'm doing a shopping to be able to utilise it.* (PL22)

However, this mother's local shops did accept the vouchers:

*It was **really convenient** because a lot of Asian stores took them as well. So, Iceland and all the local grocery stores, so it was quite easy, there were quite a few shops that would take them, so that was okay. But they had a date as well, so you had to make sure that you used them before they expire.* (PL9)

Only one parent mentioned that it would be more convenient if she could use the vouchers at more shops or online. Her mobility was reduced as she used a wheelchair, and it was difficult for her to get to large supermarkets. Her mother did her shopping for her at the larger supermarkets and used her vouchers:

*Sometimes, because **locally you can only use them in the bigger supermarkets**. I had tried asking at the news agent if I need a bit of milk or fruit or anything, but they didn't do it. They never did that. So, then whenever mum or dad, whenever they do their shopping, they can get the stuff for me like fruits and the vegetables that she likes. So, they use it only on the foods. I do my shopping online and I'm not really sure, can they be used online? Because that would help if it could have been done. But it's okay as long as my dad whenever they go out and do their shopping, they can use it… it's easier for mum and dad they can just go there and get the stuff and they can use it on whatever I need.* (PL19)

Most of the cashiers at the larger supermarkets knew about the vouchers, although sometimes there was a new employee who had to learn how to process the vouchers.

> *The **bigger supermarkets knew about them**. It would happen that if there was a new worker there then they wouldn't have heard of it and then they just go in and double check and come back. But I think more often than not they did know about it.* (PL9)

> *Yeah. I give it at the end, and **they just take it and scan it and it is easy**.* (PL17)

Non-Recipients

Parents who were not recipients but had friends who had received the vouchers thought that it helped people to afford certain foods, it encouraged their consumption in those who might not otherwise eat them, and, overall, they had a generally positive view of the scheme.

> *I know a few of my friends have the vouchers and find it **quite helpful**. But I think it's the eligibility of it, that's the thing. Because I'm not on any benefits apart from maternity and so I think a lot of people are not eligible for it.* (PL4)

> *I think, I don't know, they don't have any negative perceptions. Maybe, I think **it just helps** toward the shopping. The people that I know have gone on it with one child, so it's quite useful for them especially with milk and fruit and stuff like that for packed lunches… I think they probably would have bought the stuff because of the vouchers. Because I think it **requires you to eat healthy** if you get it for free.* (PL7)

> *From what I've heard, they really **enjoyed it** and they find it very **helpful**. Especially the vouchers that they get that makes them buy healthy food since you have to spend it on fruit and vegetables, so that's what they have to buy.* (PL11)

This mother of four children said she had heard it spoken of positively:

> *I guess if there are **people out there that maybe you have to compensate because they can't afford**, then I guess, yes, it is a good idea… It was just the mention of it really, but yeah, I've heard of it being spoken about in a positive way because as I said if people are unable to afford certain foods and if it's helping their children then why not. If it's helping the family, so yeah, I guess it's a positive thing in that way.* (PL5)

But she later contradicted herself by saying that people complain about the benefit:

> *I've heard **a lot of people complaining** about it.* (PL5)

5.5 Perceptions of Those Receiving Benefits

When talking to people about their experience or perception of claiming benefits it becomes clear that, for most, benefits have a level of stigma attached to them. That stigma is experienced differently, and to varying degrees, in different groups. The section begins by considering a common perception that has emerged in the previous chapter and in this one so far: that low-income people would make bad health choices without intervention. Many people believe that voucher restrictions are necessary because a lack of knowledge or desire to eat healthfully will result in the vouchers being spent on unhealthy foods. The

second perception explores the concept that benefits are stigmatizing more generally, looking at the responses of health professionals, recipients, and non-recipients. We cannot separate the perceptions of low-income people's behaviour from the stigma associated with having a low income in the first place.

5.5.1 Perception 1: Low-Income People Make Bad Choices, so Restrictions are Important

It was common for health professionals to suggest that recipients would not be making healthy choices if not for the scheme. The restrictions are seen as a way to keep parents from spending on less healthy foods.

> *I would say generally speaking I would think that was quite a good idea. Because where there are pressures of income, they are going to spend it on, they may not spend it on what is entirely healthy. It might be treats for the children or they may feel like they have to supplement their usual shopping list or something like that. So, I would think it is worthwhile being specific about it.* (HWC4)

This midwife assumed that people do not eat well, and that the vouchers serve a dual role of providing funds, which takes away the excuse to eat poorly, and provides guidance by telling recipients how they should eat.

> *I think it's a very good idea. I have to say that I'm not from this country, and I see that* ***people here don't eat very well****. That's what I think, so that's a thing so it will tell that it's not an excuse not to eat well, if they have that help. And also, they will* ***give them ideas*** *of a better way to eat.* (HWC2*)*

This midwife's assistant who had no direct experience with the scheme agreed that it was a good idea because of the educational component. She assumes that recipients do not eat healthfully because they do not know how:

> *Because it is really great. I mean it is really also* ***educational because it makes you think that you should change your way of eating, or improve your way of eating,*** *including some healthy food. Sometimes I don't really realize as much because I am Italian, and we are a food culture. So,* ***for me it is natural****, that's why sometimes I don't really think****. I take for granted that everybody knows it but it's not true****.* (HWC7)

A supervisor in Camden cited poor nutritional habits which are difficult to change without nutritional education and support. She also raises another issue which is that low-income families may prioritize their children's happiness over health, and choose unhealthy snacks they believe will please their children:

> *Although maybe their priorities are a bit different, I don't know. There was some social research done some time ago around social marketing and they were saying that families in low socioeconomic groups* ***don't care if their food is healthy,*** *they* ***want their children to be happy****. So, they equate giving them a bag of crisps is going to make them happy, and that's more important than healthy. And healthy is not something that is, you know if you could market*

something as healthy it's not going to attach to that group of people. That was the research at the time which I found quite interesting. So, I guess it's all about what you're saying the impact that change in diet is and how much they believe you. And how much they see it as something important enough to make the change. Because making any change is quite tricky, so in one ***sense I don't know what the impact of the food voucher scheme is****. If it gets people eating more fruit and veg great. If it gets them to change some habits long-term and introduce more foods into their children's diet, great. And I suppose it does where they have things like the Rose voucher scheme working and nutritionists on board and all that investment. But across the board I don't know.* (SC1)

The inclusion of infant formula in the allowed voucher items was questioned by several health professionals:

> *If it's a Healthy Start voucher, why is it able to be used on something like formula unless it is medically indicated that they need formula. I would have thought it would be for fruit and veg or milk if they are of age to be drinking milk… I don't like that*. (HWC3)

While the health professionals interviewed expressed concern that the vouchers may encourage formula feeding, none of the recipients in this research used the vouchers for infant formula. This contradicts the finding from the 2010 infant feeding survey, which suggested that the majority of the vouchers were exchanged for infant formula. Yet, that research only included children aged 4–18 months, a time when breastfeeding is likely to decline. The amount of the voucher would cover such a small portion of the cost of formula feeding that it does not appear to work as an inducement. In fact, the relative cost of formula feeding was cited as a reason to breastfeed. In addition, there was a widespread awareness that breastfeeding is better for the baby. The only mother interviewed in this dissertation who did not initiate breastfeeding was relatively affluent and the cost of the infant formula was not a factor for her.

One programme director did not see the need for restrictions because recipients would normally purchase items that would qualify for the vouchers, resulting in a cash benefit for the recipient but not a change in behaviour:

> *I think that most people would use it in their weekly shop and have things of that value in their weekly shop whether it's the milk or vegetables, fruit*. (HWL6)

Most parents expressed the concern that while they made healthy choices themselves, others could not be trusted to do the same. A recipient from Camden knew the importance of eating vegetables, yet worried that other recipients would not make healthful choices.

> *We're always eating fruit and vegetables. I make a big, massive pot of vegetable soup to eat whenever we're hungry… We love our meat, I love meat, but we do more vegetables than anything…*
>
> *They should take money out of your benefits and then put it into the vouchers as well. So, they should minimize your benefit a tiny bit and increase your spending vouchers for fruit and veg.*

> *Because that money is not always going on fruit and veg**. If you have to spend it on fruit and veg then you'll spend it on fruit and veg**, it's the same as the housing benefit. They're giving all these people their money to do what they want with it now, it's not a good idea**. People don't act correct** when they've got money in certain lifestyles. So, I think they should decrease a little tiny bit of the benefit and add it to that [the vouchers] because you do spend it on fruit and veg and you realize how much fruit and veg you can actually get. With £3.10 on a voucher, you leave with a big bag. You don't know it until you actually spend it. so no, I would say that you would need to take some of the benefit and increase the voucher*. (PC2)

A prior recipient supported the voucher limitations because other recipients might make poor choices, but cited an example where she would have preferred more flexibility to purchase other foods:

> *I think actually it is good that it is specific to milk and fruits and veg because otherwise **people would just spend it on anything, chocolate and crisps and drinks**. I think if the government is funding it, they want people to be healthy, so I think it's **nice that it's limited** to certain things. We used to say that **it would be nice if it was generalized**, if the dairy was more like eggs and cheese as well because that's healthy too. Rather than just milk because sometimes it happened, I had forgotten to take it and we had already bought our fruit and veg and then we'd have to think should I just buy extra milk.* (PL9)

She described teaching her children about healthy eating and limiting sweets and takeaways.

> *I try to prepare healthy foods because I've got growing children and I know it's important for them to have their carbohydrates and protein. I try to limit their fats, but you know what children are like. So, I try to **control the sugary things** like soft drinks, and they do understand what a good meal is and what a not very good meal is, takeaway and things like that. I try to explain that to them. But I think we have a variety throughout the week, so I'll try to make sure we've got lamb, chicken, we've got some veggies, we've got some pulses, we've got salads if possible. **Fruit is just available** throughout the day.* (PL9)

A prior recipient repeated a news story about the misuse of vouchers:

> *There was a bit six or seven months ago that they were **using it to buy cigarettes** in this local area. I don't know how true it is, but it was in the news*. (HWL3)

She separated herself from others who did not shop for healthy foods:

> *It **didn't make me shop differently**, but I could see how it could make **other people** shop differently, and you're aiming to get them eating healthier foods, definitely. But again, it just doesn't cover the price*. (HWL3)

Consistent with the findings of the rest of this section, a mother eligible for benefits but not a Healthy Start recipient thought that the relative price of food was the issue, and found fruit and vegetables too expensive. Yet, while she acknowledges that she finds fruit and vegetables expensive, she thinks

restrictive vouchers are a good idea because you cannot necessarily trust people to buy fruits and vegetables:

> *Here if you want to eat healthy you need to spend more money in the supermarket because the* ***not nice things are always cheaper*** *and easy to buy for someone. I do find fruits and vegetables a little bit more expensive than they should be, so that's... lower the price wouldn't be possible, but maybe give help just to buy those things for people that cannot do that. I don't know if people could go to workshops and give vouchers especially for vegetables and fruit and instead of giving money that you can spend on anything else.* (PC10)

5.5.2 Perception 2: Benefits are Stigmatizing

Health Professionals

Health professionals tended to acknowledge a stigma associated with welfare. A programme director in Leicester describes the pride of not having to claim benefits as a deterrent to applying for the scheme.

> *Some people do.* ***Some people certainly feel they shouldn't have to use welfare****, so then maybe for some parts of the community and for some communities as well. I think particularly for example maybe the Somali community. I know that they tend not to really, their families will get together really. Families do joint things, so they will do their shopping as a family rather than an individual mum. And that can happen in this area too. So, it may be* ***sort of a little bit stigma****, a little* ***bit just not what we do****, just a little bit well* ***we don't want to have hand-outs****. So,* ***pride rather than stigma****. So, it can be a combination. But I think there are also quite a few mums who would be pleased who would very much welcome if they find that they can get them.* (HWL6)

A supervisor in Leicester acknowledges that Healthy Start is stigmatizing, and it is difficult to ask for help, but she speculated that vouchers may be less stigmatizing than being given food, and for those in a very difficult situation, people put pride aside.

> *I don't know, to be honest, I don't know. I think it would depend on the parent. I think* ***for some there probably would be a stigma****. The only thing I can relate it to is I've done some work in a food bank and I've met people who are beneficiaries of Healthy Start and I've met people who are on welfare and who need food and it is a really difficult thing to ask for, I guess. I guess it's slightly different if you're just using them as the payment system because people use vouchers in supermarkets anyway normally, so I don't know if it would feel as bad in a supermarket handing it over in exchange for milk or whatever, so I guess it's* ***not quite the same as being given food*** *if you like. So, I don't know, I don't know what people's perception or stigma around it is. I think when you're in a difficult situation and you've* ***crossed that first hurdle to ask for help****, I think that anything that will help is seen as useful*. (SC1)

A midwife in Camden acknowledged that stigma may be keeping people from using Healthy Start:

> *Whether they use the vouchers, possibly there is stigma attached****. I'm not sure everybody would use the vouchers****.* (HWC4)

She also speculated that Healthy Start may be less stigmatizing than other types of benefits:

> *But possibly because when you're pregnant or* ***feeding your children*** *there is probably a motive to whatever helps or* ***whatever might help, that's a good thing****. I don't know. Because when I'm applying for this does it feel like I'm applying for welfare? The way the application form looks there is this, obviously it asks about your income, but it is also have got fruit and veg things all over it, so it is slightly different, it* ***links it to health and healthcare****, so maybe it has a slightly different feel than just a straightforward welfare application, but obviously I'm not in that situation so I don't know.* (SC1)

A programme director in Leicester felt that Healthy Start was not as stigmatizing as food banks because those are seen as being for poor people, despite the fact that as a means-tested benefit, Healthy Start is, by definition, for those with a low income:

> *With Healthy Start I don't think so, because I think parents see it as* ***an entitlement for their children*** *and if you haven't got any money to buy milk then* ***it's a starting point****. But with regards to food banks, I'd say yes there is stigma attached in terms of people see that it's for poor people or people that don't have money.* (HWL6)

One midwife in Leicester thought it was less stigmatizing than welfare in America because it is used in a shop:

> *Yeah… I think it is a bit different from the welfare system in America where you get like a welfare card and things like that. No, you can* ***use it any shop, so I don't think there is a stigma****. I've seen women use it in Tesco when I was at the till, and I don't think anything of it.* (HWL2)

But a supervisor in Leicester doubted this:

> *Presumably there might be a* ***stigma when you actually come to exchange your vouchers*** *in the shop, but I don't know actually.* (SL1)

Some argued that the stigma might be based on location, and that the more people on benefits in a community, the less stigma would be attached to the benefit.

> *Not necessarily, Again, because* ***probably in the communities where you are using it, loads of people are using it****.* (SL2)

Presumably because of the potential stigma of being labelled as poor or in need of benefits, all of the midwives in Camden interviewed said they would not mention the Healthy Start vouchers to every patient because they did not want to imply that someone may be on benefits. They typically waited for the parents to ask them to sign the form unless they know that a patient was eligible. One midwife said:

> ***I wouldn't automatically, no.*** *I wouldn't [offer the forms to parents]. It's only if I got into discussion or* ***I kind of knew from their history that they were maybe a bit more vulnerable or something****. Then I would say do you know about these vouchers. But usually, they are the ones who will come to me.* ***I wouldn't ask every woman****.* (HWC3)

Although when asked if she thought there was a stigma associated with enrolling in the scheme, she said.

> *I wouldn't, no I don't think so.* (HWC3)

Others echoed this:

> ***I wait for them to ask it from me**. We offer the vitamin D normally but not the Healthy Start.* (HWC2)

> *They usually bring it up. Although **if I have a client who is vulnerable, I might bring it up** and advise them and **even print it out for them** if necessary.* (HWC6)

This Camden midwife thought it obvious that she would not offer it to everyone.

> *Maybe we don't talk to the women as much, maybe until we get to know them. **Obviously, we don't offer it to everyone anyway**.* (HWC1)

She believes people would not be embarrassed to discuss Healthy Start with her, but they may be in a big group:

> *I don't think people are ever worried about coming in with the form. I don't think people will ever be embarrassed about that from what I understand. **People are quite happy to sort of say I want to do the Healthy Start, or me chatting about it**. I don't know in a big group, because **obviously I've never discussed it in a big group** whether you ask for a show of hands on who is eligible. I don't feel like people would sort of feel embarrassed about being offered them at all. And a lot of people know through families and friends especially in certain areas, so I think a lot of people know about it already.* (HWC1)

In a casual conversation a week later she said that as a result of the interview she mentions Healthy Start in all of her appointments with pregnant women. She explained that of the people she had spoken to who were eligible, many declined to apply because they said they could still afford to buy food and other people needed it more; they did not want to take NHS money. When asked how she felt about that she thought that their response was "sensible", and she applauded their decision not to accept the benefit.

A midwife who had worked in Camden for six years said that she would only mention it to women she had known for a long enough time to get to know their circumstances:

> *Sometimes we ask, **obviously only certain people are on benefits**, that can apply or if they are single or not working. A lot of the time they bring it in to us to the children's centre, generally. But if I know someone through the pregnancy, not at the start, but later on when I get to know the women, I find out about them and I can head them in the right direction…*

> *Maybe we don't talk to the women as much, maybe until we get to know them, we don't really, like you say, offer it to everyone anyway. So, **unless we know certain people that need it.*** (HWC5)

In Leicester, on the other hand, the midwives interviewed did routinely offer it to their patients. This response was typical:

> *I may have given out about ten since I've been in the community and that's a year… I suggest it. When I book a lady then* ***I will ask them to see if they are entitled to it****. And we will go through the checklist.* (HWL2)

Parents Eligible for Healthy Start

Using the vouchers was described as a stigmatizing event by recipients, although some parents assume the stigma is greater in more affluent areas or in supermarkets perceived as more upscale. A recipient expresses this as she acknowledged the stigma, but attributes it to the area where she lives:

> ***I live in a different area and there was definitely a stigma*** *attached to handing them over… It's just the* ***feeling of having to lay voucher the in front of people****… They are looking at you like "Oh, you must be poor." But again, that was because of where I lived, I don't think that would happen here in this area*. (HWL3)

This recipient from Leicester was embarrassed to use the vouchers in Waitrose:

> *When I first used it, it was awkward. When you use it in certain places, once I went to Waitrose, normally I go to Aldi. Once I went to* ***Waitrose*** *and they'd never seen them before. So, they were like, we can only use one at a time and then they had to call someone to ask, and it wasn't the best experience. You know what, it's quite embarrassing in a way because…* [she became quite uncomfortable and stumbles and reaches for her glass of water] ***It was awkward for me***. (PL25)

Prior research has suggested that self-check-out counters may be a way to avoid embarrassment, but this mother stated the opposite, because it required someone to come and process the voucher for her:

> *Well, you've got the* ***self-check-out counters,*** *so if you go to one of them you can't use the voucher you* ***need someone to come and do it for you***. (PC2)

Those who received benefits often felt the need to defend themselves against a stigma, by distinguishing themselves from other recipients, just as they stressed their own healthy eating while doubting that of others. A benefits recipient summarizes this well when she is asked if people should be ashamed to claim benefits:

> *I think so. That these people who always spend their own money on their own, so I think* ***they should feel ashamed*** *if you are begging... like benefits are sort of like getting money for your expenses from somebody. I really feel very ashamed that I'm not doing anything, and I don't want to struggle and I'm just taking money from the others and spending on me****, I don't feel good personally***. (PL8)

To avoid the shame, she admits she should feel, she separates herself from others, citing her pregnancy and expectation that she would be on benefits a short time:

*This is something good but if it is **for a short time like if I am pregnant** and I am struggling and if I can get help from somewhere, so if I can take it, it is good for me. But right after when I have a baby and things are normal, I have to go back to my work and why don't I give the tax to the government and why won't I work instead of taking that stuff from the government.* (PL8)

This mother suggests that because she had worked and it was a short-term need, she should not be stigmatized:

*Yeah, **people look down on people on benefits**. A lot of people do. They tend to think, I don't know, I can't really explain it, that **they don't really matter** in a way. Yeah, it's not very nice. I've had an experience where I went to the drugstore for something, I can't remember what it was for and the **way the woman was looking at me as if... I used to work you know, you don't have to look at me like that.*** (PC15)

Another mother distinguished herself because she needed a kick-start, but described others who abuse the system:

*I think if people generally, because we've been through a time when we had to claim, so I know what it's like, so **when you really do need to claim** and claim then for them it's fine, they shouldn't be ashamed because they need that help just to give them a **kick-start**. But then there are **people who abuse the system** and maybe have not been truthful and honest and I think they should be really ashamed. And there's nobody out there to go and check each statement that you make a lot of the time and that's when the system gets abused, and I think that's really unfair.* (PL9)

A pregnant woman from Camden believed that the stigma of benefits was necessary to encourage young people to work, even though claiming benefits had made her feel "quite crap". She separates herself from others because she believed she was entitled to benefits for her prior work and taxes paid:

Well, I've worked since I was 15 and I have paid tax and national insurance since I was 15, so for me it was never a, well I'm not entitled to that. I've paid into it since I was 15 years old, and I was made redundant after 3 1/2 years of being in full time employment and it just so happened that I was made redundant while I was pregnant, so it wasn't like I went out to work. But a lot of my friends, even my friends, would look at me like oh my god you're claiming jobseekers. Like do you not feel embarrassed walking into the job centre. And I'm like, no, I don't feel embarrassed because... don't get me wrong I do feel like if people haven't paid into it and they just think of it as a career, l do know some people like that. That from 16 years old I'll just go sign on. And I don't agree with that, don't get me wrong, I think that younger people should be pushed more to get into work and not make it so easy for them to claim jobseekers, but I have had that stigma, and I've worked since I was 15 and I'm coming up to 29 now. So, I've paid into that, so I feel while I'm struggling at the moment, I feel like I'm entitled to that, and I shouldn't be made to feel bad about that. So, I do feel like yes, I need to claim jobseekers. It's helping me out at the moment. But there is a massive stigma which I never knew... Like I said, I've never had to experience it. so, it's like when people used to talk about it, I never used to think much of it. But I

think since obviously I've had no choice but to [claim] it has shocked me. It really has shocked me. And it does make you feel quite crap. It does. It's not a nice feeling. Certain people just have a very weird view… You do get looks from people walking in [the job centre] which I never thought. People look at me and I'm pregnant and it's like ugh, another one… So, it's not a nice feeling. It's stupid. But that's the society we live in. (PC24)

A mother from Leicester who is food insecure and receives benefits separated herself from those who claim Healthy Start when they can afford to eat healthfully but choose not to:

With Healthy Start I think people who are in a lot of problems, like going through a lot and they can't afford it, then these people should be given the vouchers, but ***not people who can afford things and choose not to eat healthy****, but they can afford it. Then no, they shouldn't be given anything.* (PL18)

This mother similarly separates herself from those who, she believes, claim benefits they do not need:

It depends on the circumstances of the family. I can't say yes or no but it's okay for some people, for other people it's not. ***They want to claim, not that they need it****. I say 4 [on a scale of 1-5 of how embarrassed people should be to claim benefits].* (PC19)

This parent believes some people exploit the system to receive more benefits:

Tax Credits it depends because some people have a lot of children, and they seem to get a lot of money for it. ***For the sole purpose of getting tax credit, they have more kids****.* (PL18)

When one mother of four, who receives benefits, but not Healthy Start, was asked if people should be ashamed or embarrassed to claim Healthy Start on a scale of 1–5, she said: 'I'd say a 3'. (PL5)

A mother who receives Healthy Start believed that people should be ashamed to claim benefits (3 on a scale of 1–5). Her ambivalence was apparent when she acknowledged that the scheme may be viewed as charity, which she views negatively, at the same time she admitted that it helped her:

Maybe ***some people they might feel like it's a bit of a charity or something****. Maybe but in my case if it helps even if it's just £3.10* ***it's better than nothing. It helps****. Sometimes you tend to go over the limits.* (PL19)

This mother from Leicester receives benefits and is food insecure, but does not receive Healthy Start. She did not think people should be ashamed to claim benefits, but describes immigrants coming to the UK for benefits and expressed pride in not claiming them herself:

If you're receiving Healthy Start, they automatically know you're on some kind of benefit, but if you're ***rightly eligible for a benefit then I don't think I would be ashamed****, or could be ashamed, if I received it lawfully, then I'm not ashamed of it. When Labour was in power why was there so much foreigners trying to get into the UK? It was just to claim them, we all knew why they were coming, because* ***they thought money grew on trees here****. It's the Labour party that's giving out money. And the people would justify it by saying we have low-income, or we*

can't get a job. ***People justify it to themselves; people only came to the UK for it really****. So, they're not bloody ashamed to claim it, but* ***in my household we don't claim it*** *because we don't need it.* (PL21)

Another mother distinguished herself from others of certain backgrounds and class who are not educated and who she believes are happy to receive benefits:

I'm not being horrible, but I think it depends on the ***cultural backgrounds and the class****. Maybe because a lot of, I don't want to sound mean, but by Asian I mean* ***Muslim, Pakistani, Indians, because they would probably be happy receiving the extra benefits*** *especially for those who aren't educated or don't have, who aren't financially well off. So, you understand what I'm trying to say, it's just hard to find the words because I don't want to sound horrible.* (PL19)

She continued with a common theme – recipients prefer to earn their own money and do not want to accept welfare:

I hate getting government benefits *I would be happy doing something, but the only time I have actually worked, because it's* ***so hard to get a job****, so I did a few internships after I completed my degree, so they were through a big uni. So, I applied for everything and for a few months as long as the company needs you, but you still get paid for the internship. It was good and it* ***makes you feel good knowing you've earned it****. It's just hard to answer that question [should people be ashamed to claim benefits] but it just depends on people's backgrounds because everyone has their own beliefs. So, some might be happy with it [receiving benefits], some probably wouldn't feel, they wouldn't want to openly discuss with their friends that they are receiving benefits because maybe they will be looked down on. Again, if you've got kids then you understand it is hard and things like this, the Healthy Start vouchers they do help a lot whereas those who have not got responsibilities of children, yet they might not realize. So, it just depends on everyone's situations and needs.* (PL19)

Nearly all of the recipients expressed a preference for paid employment and pride when they have earned money. This mother received other needs-based benefits, but not Healthy Start:

I should prefer that I should go to work, and I can earn by my own self. (PL8)

This mother justified her use of government programmes because her parents have paid into them:

Knowing that my parents have been here since the 50s and until my mom had her accident a few years back my parents had worked every day whether they were sick or not sick, come rain come shine. *And you think that a lot of the national health stuff that I personally am receiving now,* ***my parents have paid into that****. And whether they are getting pension and so on, my parents helped to build that* ***so that I can benefit,*** *so she can benefit* [daughter] *so that her children can benefit.* (PC13)

But she acknowledged that different classes of people may perceive benefits differently. Perhaps the poor and the wealthy do not stigmatize benefits, but those who are in the middle, working hard and not

receiving benefits, are resentful of those they perceive as not working hard enough and relying on government benefits:

> *You're talking about different classes of people now and those that need it with the children, you're still broke at the end of the week, you needed it, all right. Whereas you have those where two parents, both working and actually don't need child benefit, those are the ones that are going to be looking at these people and thinking, well really* ***if they got up their backside and got a job, they wouldn't need to be getting child benefit****. Then you've got the super-rich that are quite happy to probably donate their child benefit, which I've heard of that happening. But I think it's* ***only really the middle class*** *that think that their earning capacity, and they've got their house and their car and so on,* ***would look down on those that... Glenfield, you've got the block of flats that are claiming all the benefits you could possibly claim****, and outside you've got millionaires. It's a stark reality*. (PC13)

This mother described being treated with respect because she is a professional who is temporarily out of work in contrast to her husband, who was not treated with respect at the job centre because he was not a professional:

> *Well, I've got a bit of a mixed opinion because* ***I do take benefit now because I've already got a profession, I had a career****. I stopped work at the moment. So, I've never had an experience where it's been a bad experience going to the job centre or someone helping me because I think it's quite nice. But then on the other hand* ***my husband is not professional****, he's not really got a career, he lost his job, and he went to the job centre and had a* ***completely different experience****. Now we feel that it's probably because I've got a profession and they know that well,* ***she studied, she's got a career behind her****, she can get into a job straightaway, whereas he felt that he is seen as not got anything so therefore would be on benefits for a lot more longer because he probably couldn't find a job. But really, it's the other way around at the moment because he has found a job before I have. so, that's the feeling he got, but I have personally never had anything... I was always treated with respect.* (PL16)

<u>Parents Not Eligible for Healthy Start</u>

Those who did not receive benefits were eager to set themselves apart from recipients, some emphasizing pride in not being eligible.

> *Yeah, it's a good idea for* ***other people****. But it's not something that we would qualify for. so, that's why it's never been mentioned, because we are both self-employed and we are not on benefits.* (PC9)

Another mother who is food insecure but does not receive benefits believed that many people would look down on those receiving benefits, but not those who had fallen on hard times themselves:

> *I think* ***if you know people that have been in that situation or you've come from that situation yourself you are a little bit more relaxed about it****, where I think people that have never come*

> *from that wouldn't agree they would be number 5s on that. They think that people should be earning and making their way.* (PC12)

Interviewees were also asked about the stigma associated with different types of welfare in the UK. Nearly everyone interviewed believed that there is a stigma to claiming benefits in the UK, with some types of benefits more stigmatizing than others. This response was typical:

> *It **depends on the benefit**, and I think it depends on who you are talking about like the job centre is different I think going in there I think it is impartial, but I think the general public there are stigmas associated with certain benefits.* (PC11)

Another, who lives with her sister who receives benefits, seemed to bemoan the lack of stigma that had made it acceptable not to work – in terms that reveal a strong stigma:

> *I think the taboo over benefits is... I think **it is so common now for everybody to be on benefits that it's just the norm**. Before there was just a handful of people on benefits whereas now **there's a handful of people that are working**.* (PL4)

One parent thought Healthy Start was not stigmatizing "because it's for children" (PC17).

But most parents did think Healthy Start was stigmatizing, although perhaps less than other forms of benefits.

> *Yes, I would say so. I think with **the jobseekers allowance it's easy to put a stigma and say you can get up and go and work,** whereas other situations like child benefit or housing benefit, if **you've got a child and you can't work then it's a little bit more acceptable,** I think, maybe.* (PC13)

A mother from Leicester who was not eligible did not think people should be ashamed to claim benefits if they really need it, but shame should discourage those who do not really need benefits:

> *I think if they are needy, and the government is giving the opportunity then they must not be [ashamed or embarrassed]. If they are needy. For me I know I don't get this. If you husband is earning enough so you are not eligible for child benefit. So, the other four kids of my husbands they used to have it. I never had it. **If they are needy then it is okay. It depends how much you need it.*** (PL20)

5.6 Summary

This chapter addresses research questions RQ2 and RQ3, describing the perceptions of Healthy Start and its recipients. Health professionals and parents were queried about their awareness of the scheme, its goals, operations, and effectiveness. Finally, they responded to the question of whether recipients should be ashamed or embarrassed and their own experience with benefits stigma. The testimony followed here suggests that the goals of the scheme are not well articulated, identifying areas of weakness in the scheme: the low visibility, the complicated application process, the restrictive eligibility and the inadequacy of the voucher amount. Finally, how recipients are perceived by others is consistent with the

general belief in the UK that beneficiaries of welfare should be embarrassed to claim benefits, and that recipients need restrictive vouchers because they would not otherwise have the knowledge or self-control to purchase healthy foods.

The next chapter attempts to calculate the economic consequences of the scheme, both as currently configured and with changes that are suggested from the findings above.

Chapter 6: Economic Analysis of Healthy Start Scheme

6.0 Introduction

This chapter is an attempt to calculate the economic costs and benefits of the scheme. The purpose is to answer RQ4: What is the economic impact of the Healthy Start scheme? Although this chapter was not planned at the onset of the research, upon analysis of the findings from the interviews with parents it was determined necessary. This chapter is separated broadly into two sections.

Chapter 5 identified issues with the scheme that may be addressed with policy modifications; the economic costs of which are modelled in the first section of this chapter. The model quantifies the benefits and costs of the scheme to the government and to the overall economy over the lifetime of the recipients. This is calculated as the scheme is currently configured and with the modifications suggested by the findings.

The findings set out in Chapters 4 showed the importance of the economic drivers of food consumption in the home, which drove the need for the second half of this analysis. The second section begins with an analysis of household food purchases by income decile to attempt to identify differences in consumption due to income. This is followed by an analysis of cash flows to measure the impact of the scheme on those who benefit from it – families, farmers and corporations – as the scheme is currently configured and with the same modifications.

6.1 Economic Benefit/Cost Analysis

This section models the cost and benefit of the scheme using different assumptions and scenarios by comparing the expense for the scheme over the life of a recipient with the quantifiable economic benefits resulting from improved nutrition. The assumption is that nutrition improvements from the scheme are maintained at a minimum level over the recipient's lifetime, resulting in avoidance of diet-related disease and the associated healthcare savings and increased workforce productivity due to a decrease in disability and early death. The methodology is consistent with the human capital approach that has been widely applied in evaluation of public health policies (Robinson, 1993; Briggs, Scarborough and Wolstenholme, 2018). The net present value of the cost savings that are realized over the recipients' lifetime is then compared to the net present value of the projected costs of the scheme for the first four years of the recipients' lives, to result in a benefit/cost ratio. A ratio above 1 is a cost-effective programme. It is important to note that in order to ensure success over a lifetime, Healthy Start should be situated within a web of other policies that support nutrition and provide consistent support throughout the recipients lives (Lang, Barling and Caraher, 2009; Hawkes and Haddad, 2016). These other policies are not accounted for here.

The cost of the scheme is developed using different assumptions for voucher amount, eligibility, and uptake. The benefit analysis models the tangible lifetime health savings for the current Healthy Start cohort if better nutrition is achieved and maintained. Potential benefits fall into three categories: 1) the averted healthcare costs of treating people with diet-related diseases; 2) the indirect economic benefits that result from increased productivity due to better health; and 3) the intangible benefit of increased

wellbeing. The benefit/cost analysis only incorporates the first two categories of costs which can be more easily quantified and ignores the intangible benefits. This is a weakness of nearly all benefit/cost analysis which draws attention to the importance of other types of policy evaluation and is the reason why the economic analysis is only a supplement to the qualitative research detailed in Chapters 4 and 5.

The model has been developed, as will be described in detail in the section below, to first determine costs, then benefits, and lastly to test the benefit/cost of the scheme at different voucher and eligibility levels. The purpose of this analysis, and its contribution to existing literature, is to quantify the cost of modifications to the scheme and to reframe the thinking about the scheme as an investment rather than as an expense. This offers a starting point for discussion about the assumptions that are required for a cost-effective scheme. While calculating the cost of the scheme under different benefit levels and eligibility criteria is relatively straightforward, it is much more difficult to quantify the benefits. The costs are realized in the short term, but benefits would be realized over the longer term as future disease is avoided and lifetime productivity is increased. There may be immediate health benefits, such as a reduction in preterm births (the basis for a benefit/cost analysis of WIC in the US; see Devaney, Bilheimer and Schore, 1990, 1992; Nianogo *et al.*, 2019), and boosted infant and childhood immunity, but there is no available data to quantify these benefits in the UK. The methodology employed in the analysis is detailed below.

6.1.1. Calculation of Costs

This section reviews the assumptions used to calculate the cost of the scheme as it currently operates and if adjustments were made to address weaknesses. First the current costs are evaluated and then a summary of identified weaknesses and potential remedies is outlined with potential costs. Other potential improvements to the scheme were not considered because they were not identified in the findings of this research. For example, increasing the age eligibility beyond the first years of life is not quantified here, but this is an important consideration for future research. The economic impact of vouchers is likely to be the greatest when targeted at the very young because of the importance of nutrition in the early years, but of course it is important, and likely constrained by financial means, at every age. Each of the weaknesses and the potential remedies are then discussed in detail. The last section determines the cost of the scheme over the recipients' lifetime using a range of assumptions.

The steps in the calculation of the direct costs are as follows:

1) Calculate voucher cost in each of the programme years (pregnancy through to 4 years old)
2) Multiply costs by number of recipients
3) Add administrative costs
4) Calculate the net present value of annual scheme costs over the lifetime of the cohort

The base year annual cost of the current scheme as currently configured (Steps 1–3) is calculated as follows:

Exhibit 14: Annual Cost of the Healthy Start Scheme

	Eligible Recipients (000s)	Voucher Amt (£/week)	Total Annual Voucher Cost (£ millions)	Admin Costs (£ millions)	Total Annual Costs (£ millions)
Pregnant women (1)	35.8	3.10	3.6	0.3	3.9
0-1	58.2	6.20	18.8	0.5	19.3
1-4	174.7	3.10	28.2	1.6	29.8
Total	**268.7**	**3.77**	**50.6**	**2.4**	**53.0**

(1) Pregnant women are assumed to receive vouchers for 32 weeks

The modelled changes to the scheme are to eligibility, voucher amount, restrictions on purchases or a combination of these. These recommendations are discussed in detail in relation to the programme weaknesses identified in Chapter 5, and then summarized in Exhibit 15.

1. <u>The goal of the scheme is unclear and does not align with the programme design</u>

As introduced in Chapter 2, and discussed in detail in Chapter 7, the stated goal of Healthy Start is to support better nutrition, but it is unclear whether the scheme is primarily a public health or welfare scheme. As a result, it currently falls somewhere between the two. It is unclear if the underlying problem is viewed by policymakers as a lack of funds or a lack of knowledge. While the scheme encourages fruit and vegetable consumption, it does not do this specifically as the vouchers can also be spent on cow's milk and infant formula. This confuses the nutritional message. If the goal is to improve overall nutrition, then the scheme should include other healthy foods.

The scheme is perhaps better thought of as a welfare programme. Since the voucher amount is lower than a typical family currently spends on the eligible items, the voucher frees up cash that would have been spent on those items. As discussed in Chapter 1, rational economic theory would suggest that if the voucher amount is less than or equivalent to the household's normal food expenditure on the allowed items, then a voucher will not change purchasing behaviour. However, there is some evidence that a labelled benefit such as Healthy Start may affect diet through the nudge effect by reminding parents of the importance of nutrition (see Benhassine *et al.*, 2015). Yet, the nudge effect is muddled in the design of Healthy Start because if the objective is to increase fruit and vegetable consumption the vouchers should be limited to those items. If the problem is identified as inadequate fruit and vegetable consumption in the population, the vouchers should be offered to all young children. If, on the other hand, the underlying problem is inadequate funds, Healthy Start could be described as a welfare scheme and targeted at children from low-income families. In this case there is no supporting evidence to justify the restrictions on which foods can be purchased, and these should be eliminated.

2. <u>Eligibility for the scheme is based on low income</u>

Although low-income children are at a particular risk for malnutrition, it does not follow that the impact on national public health will be maximized by targeting policies at low-income families.

> *Interventions that can shift the distribution of a risk factor in the whole population are generally more effective for improving population health than interventions targeting high-risk individuals* (Rose, 1985*).*

The problems of poor nutrition and inadequate fruit and vegetable consumption are not limited to those on a low income, even if those on a low-income are at a heightened risk. There is a need and opportunity to improve the nutrition of the entire population.

There are three major negative consequences of the limited eligibility. As discussed in Chapter 1, and analysed in relation to this research in Chapter 7, the UK culture values self-sufficiency, resulting in participants experiencing the stigma of being marked as poor and dependent on applying for and using the vouchers.

The second consequence is that the application process itself creates an obstacle that results in vulnerable families not receiving the help they need. As demonstrated in Chapters 2 and 5, there are many currently eligible people who would benefit from the scheme but are not receiving benefits. Additionally, there are many families who would benefit but are not currently eligible and are struggling to afford a healthy diet.

Finally, the third consequence is the additional administrative burden and cost required to check eligibility. This is likely the largest component of the associated administrative costs that could be eliminated if the vouchers were universally available. There are also costs associated with the requirement of a health provider signature, but this is difficult to quantify as it is an opportunity cost of using the health providers time to assist with the forms rather than a direct expense. There are also administrative costs associated with promoting the scheme and ensuring retailer adherence to the restrictions on purchases.

The remedy for all these obstacles is to expand the eligibility for the vouchers. A universal scheme would eliminate stigma, promote better nutrition for all children and align with a universal public health message that could be supported by other healthy nutrition programmes. Administrative costs would be reduced to minimum levels because vouchers could be distributed to everyone with no requirement for health providers to be trained to promote the scheme to a segment of their patients or applications to be completed to check for eligibility. This analysis calculates the cost of universal benefits as well as increasing the eligibility criteria, so that more low-income families make the cut. This analysis utilises the minimum income standard (MIS). The MIS was developed in 2006 based on research with consumers and experts and has been updated annually by the Joseph Rowntree Foundation (Hirsch, 2019). It calculates the level of income necessary to achieve a minimally socially acceptable standard of living. Widely used as a research tool in many countries, it is the basis for the calculation of the Living Wage. If the eligibility criteria were changed, the number of eligible recipients in the UK would increase from approximately 15% of the population currently to 45% under the MIS. As a point of reference approximately 50% of the babies born in the US are entitled to WIC benefits (Oliveira and Frazão, 2015).

3. <u>The vouchers restrict purchases</u>

Changing the restrictions on purchasing, but not the voucher amount, would not affect the cost of the scheme, but it could provide other benefits. As discussed, the current restrictions are confusing, do not

have a clear public health message and are not supported by evidence that low-income families should be singled out by the government. If the goal is to increase fruit and vegetable consumption, the vouchers should be limited to those items in order to maximize the "nudge" effect. Another alternative would be to increase the range of healthy foods that could be purchased to more accurately reflect the Eatwell Guide. This would necessitate an increase in the voucher amount consistent with the cost of purchasing the Eatwell Guide. Since it would exceed what families are currently spending, an increase in the voucher amount would increase the likelihood of healthier eating. This is more consistent with a welfare scheme to ensure that families have a safety net that provides the means to purchase food. This type of scheme is similar to SNAP in the US, which has been shown to have a positive impact on nutrition and poverty and to reduce healthcare costs for recipients (Hoynes, Schanzenbach and Almond, 2016). The history of calculation of the current voucher amount and the potential basis for alternative amounts are outlined below.

4. The amount of the voucher is not sufficient to purchase healthy food

As discussed, the voucher amount was originally calculated so that it would approximate to the benefit received under the WFS. The amount has never been calculated as the amount necessary to meet the nutritional needs of pregnant or lactating women, infants or young children, or even related to what is required to be spent on fruit and vegetables to meet government guidelines. It should be noted that meeting the expense of nutritional guidelines does not consider what is socially and culturally acceptable. As this chapter will show, there are several ways the voucher could be calculated to more accurately reflect nutritional needs. Three different methods of calculating costs have been considered in this analysis:

a. Cost of purchasing infant formula
b. Cost of purchasing the recommended amount of fruit and vegetables
c. Cost of purchasing the Eatwell diet

Current Voucher Amount

The current voucher amount is £3.10 per week for pregnant women and children aged 1–4 years and £6.20 for children under one year. If used exclusively for fruit and vegetables it provides for the purchase of less than the recommended amount. If used for infant formula it falls far short of the cost. The value of the voucher is further diluted because of normal food sharing that may occur in the household, which likely results in less than the value of the voucher reaching the intended recipient. While the voucher value is planned to increase in April 2021 to £4.25, this is still not related to the price of food nor subject to review and recalculation as prices change. *Voucher Based on Cost of Infant Formula*

The current UK guidance is for exclusive breastfeeding for the first six months of an infant's life, yet for many personal, professional and health reasons this is rarely the case in the UK. While most mothers begin breastfeeding, they soon supplement with infant formula and increase the proportion of infant formula as the child grows. The 2010 Infant Feeding Survey found that 31% of mothers gave milk other than breastmilk at birth, increasing to 77% by the time the baby is 6 weeks old. (McAndrew *et al.*, 2012). The latest data shows that the exclusive breastfeeding rate for England at 6–8 weeks of age is only 48%,

meaning that 52% of babies at 6–8 weeks are formula fed at least part of the time (Public Health England, 2021). Families who cannot afford infant formula may resort to unsafe practices (saving it after use or diluting it) or sacrifice other food items (First Steps Nutrition Trust, 2018). Since mothers often sacrifice their own diet to ensure their children have enough to eat, it is not surprising that some women skip meals in order to afford infant formula (Karpf, Smith and Spinks, 2017).

Based upon March 2020 prices at Tesco for two popular brands of powdered infant formula at different price points (Aptamil and Hipps), the average weekly cost of infant formula was calculated to be £12.13 for the first year of the child's life. This is likely to be a low estimate as the cost of powdered formula is much less than the cost of premixed (First Steps Nutrition Trust, 2017) and it assumes no formula is wasted. The actual expense will vary over the infant's first year, increasing in the first half of the year and declining in the second half after weaning. A more detailed analysis of infant formula prices should be undertaken, but for the purposes of this analysis a weekly amount of £12 was used to recommend a voucher amount for the infant's first year. The £12 cost was assumed for the entire first year of the infant's life primarily because as less is spent on infant formula, more will be spent on complementary food. If the infant is exclusively breastfed for the first six months, the mother will need to increase her calorie consumption of healthy foods and £12 per week would allow her to have approximately 5.7 portions of fruit and vegetables per day.

Voucher Based on Cost of Fruit and Vegetables

As reviewed in Chapter 1, the recommendations for fruit and vegetable consumption when Healthy Start was launched was 5 a day, which has subsequently been increased to 7 a day with the introduction of the Eatwell Guide. However, the optimal level of consumption is likely to be much more than the recommended amount (Lalji, Pakrashi and Smyth, 2018). For the purposes of this analysis, the cost of one adult serving of fruit and vegetables is assumed to be £0.30, based on the mean price as determined by Scarborough *et al.* (2016). A child's portion is estimated to be half the size of the adult portion, based on the recommendations of First Steps Nutrition Trust (2017) for a price of £0.15 per serving. The recommended voucher amounts for five portions per day are £10.50 for pregnant women and £5.25 for children aged 1–4 years; for seven portions, the voucher amounts are £14.50 and £7.25, respectively.

Voucher Based on Cost of the Eatwell Guide

The Eatwell Guide provides nutritional guidance for a balanced diet, but it was not designed to consider the affordability of the recommended diet. This is an important omission, as price is critical to determining purchasing behaviour. In 2016, an analysis commissioned by Public Health England and carried out at Oxford University compared the cost of the Eatwell guide with the Eatwell Plate and the actual British diet based on average purchasing data. It found that the cost of the Guide was similar to the cost of the current mean diet per day (£5.99 vs £6.02) with only a modest 3% increase over the old recommendations of £5.81 (Scarborough *et al.*, 2016). A weakness of the analysis was that the cost was calculated on a per portion basis, even though people do not purchase by portions, and therefore likely underestimates how much a person would need to spend to purchase the diet. Alison Tedstone, the chief nutritionist at Public Health England, was quoted at the time saying that cost was not the reason why people were not achieving a healthy diet.

> *This report suggests £6 per day for an adult; we are currently spending about the same amount eating poorly. Our food choices are affected by other factors such as the volume of fast-food outlets on our streets and promotions of unhealthy food in our shops, highlighting why our work to improve the nation's diet is so important* (Butler, 2018).

However, this masks the fact that half of families are not spending sufficiently to afford the recommended diet. Averages mask the differences in food expenditures by households, and the cost of a healthy diet is out of reach for many Britons.

An analysis of UK food expenditure by the Food Foundation found that only 53% of households spent enough on food to purchase an Eatwell diet (Scott, Sutherland and Taylor, 2018). On average the poorest half of UK households would need to spend nearly 30% of their disposable income to meet the recommended dietary recommendations and the richest half would need to spend only 12% (Scott, Sutherland and Taylor, 2018). This disproportionately affects children. Of the households that need to spend more than 25% of their disposable income on the Eatwell Guide, more than half, or 4.2 million households have at least one child. The result is that only 52% of households with children are able to afford a "socially acceptable diet" (O'Connell *et al.*, 2019). Households with only one adult are even less likely to be able to afford it. There is also a substantial difference between families who are just below the level of deprivation and those significantly below. Not surprisingly, those falling below 75% of the food budget standard are likely to have a much more difficult time affording food. (O'Connell *et al.*, 2019). The problem has been worsening, as the proportion of households that are not meeting the food budget standard has been increasing, reflecting the elasticity of food budgets in times of economic stress. As has been well documented, this results in families skipping meals and eating poorer quality foods (Dowler, Turner and Dobson, 2001; Griffith, O'Connell and Smith, 2013). This was confirmed by this research, as discussed in Chapter 4. Many parents cited cost, particularly for fruit and vegetables, as a major reason why they were unable to eat a healthy diet.

Despite this evidence, DEFRA maintains that food is affordable, citing that families in the lowest income quintile spend only 16% of their gross income on food. However, this does not consider the quality or healthfulness of the food or the relative cost of other fixed expenses.

Using the cost of the Eatwell diet calculated in 2016 by the Oxford University team as £5.99 per adult per day (Scarborough *et al.*, 2016), the cost for children was calculated based on the methodology of the Food Foundation report (Scott, Sutherland and Taylor, 2018) to capture differences in consumption at different ages. This estimates the cost of the Eatwell diet for a child aged 2–4 years to be £12.37 per week, or £1.77 per day, which is 30% of the cost of an adult diet (Scott, Sutherland and Taylor, 2018). This reflects both the efficiencies of people living together in the household and the smaller portions eaten by children. Yet, the reality is that children are not efficient eaters, as they often waste food when learning to feed themselves or when they acquire new tastes. Based on this calculation, my model uses a recommended voucher amount for children aged 1–4 years of £12.37 per week in order to afford the Eatwell recommended diet.

This analysis has chosen the government's recommended nutritional guidelines as a conservative measure of food cost. But, of course, food is more than just its nutritional quality. This Eatwell diet may not be socially or culturally acceptable and ignores the role that food plays in our social world and identity. A consensual food basket that is informed by cultural norms would likely cost more because it would include food to meet cultural requirements, such as biscuits with tea or a birthday cake. Significant work has been done to attempt to cost a healthy, socially acceptable shopping basket that takes into account food preferences. For a summary of these, see Caraher and Furey (2018). Although there are many ways to determine the cost of a healthy, socially and culturally acceptable food basket, it is clear that it is out of reach of those on the lowest incomes.

The following chart summarizes the proposed voucher amounts, based on the current scheme, the value necessary to purchase five and seven fruits and vegetables per day (5 F&V and 7 F&V) and the recommended Eatwell diet. The cost of the scheme was calculated under the four recommended voucher scenarios. The cost for infants under 1 year of age is calculated as the cost of infant formula. The other component of cost is administrative expenses, which is discussed in the following section. The increase in voucher costs for all of the proposed scenarios range from £46 to £146 million annually and are summarized in Exhibit 15.

Exhibit 15: Summary of Proposed Voucher Amounts

	Current	5 Fruit & Vegetables	7 Fruit & Vegetables	Eatwell Guide
Pregnant Women	£3.10	£10.50	£14.50	£41.93
Children 0-1 (1)	£6.20	£12.00	£12.00	£12.00
Children 1-4	£3.10	£5.25	£7.25	£12.37
Weighted Average	£3.77	£7.41	£9.25	£16.23

(1) The voucher value for children under 1 year of age is recommended at the level to purchase infant formula

Administrative Expenses

Currently the government has contracted with an outside company to manage the administrative aspects of the scheme such as processing applications to check eligibility, mailing the vouchers to recipients and reimbursing the retail outlets for the vouchers redeemed. The value of the contract with Serco for the Healthy Start Scheme was £14,576,200 for a period of 6 years, terminating on 31 March 2020 (Dinenage, 2019). Therefore, the annual value of the contract is £2,429,367, which is currently approximately 6.5% of the total amount spent on vouchers. This is a high administrative expense margin that reflects the fixed budget for administrative expenses despite a declining amount spent on vouchers. As discussed in Chapter 2, the budget for the scheme was planned to be £142 million, but is currently less than £50 million due to declining eligibility and declining uptake. When the Serco contract began in 2014 the annual spend in England was £82 million, representing approximately a 3% administrative expense margin (£2.4 million/ £82 million). There were 520,777 beneficiaries in 2014, making the administrative cost per recipient £4.66 compared to 263,529 in 2020 for a £9.22 cost per recipient. It appears that there is a significant opportunity for administrative expense savings.

It is difficult to precisely estimate the reduction to administrative expenses that would result from a universal scheme, but it is likely to be substantial. Processing applications is the most time-consuming part of the administrative process, and eligibility checks would no longer be required. The balance of the administrative expense is for mailing the vouchers and reimbursing the retailers. A digital card, when introduced, will eliminate the need for retailer reimbursement, and the Healthy Start card, if universal, would be inexpensive to distribute.

For the purposes of this analysis, administrative expenses are estimated to reduce by 90% if the scheme is universal, which is based on a nominal charge of approximately £250,000 for voucher printing. In the case of expanded eligibility, the administrative expenses are assumed to rise by an amount proportional to the increase in recipients.

The following table summarizes the potential weaknesses and remedies that are quantified in this analysis. The potential remedies may expand eligibility, increase the voucher amount, or change voucher restrictions. The increase in annual cost of each of the potential remedies is then calculated. To facilitate the evaluation of each change, they were calculated as if they were added individually without changes to other aspects of the scheme.

Exhibit 16: Summary of Identified Weaknesses and Potential Remedies

Weakness Identified	Potential Remedy	Expand Eligibility	Increase Voucher	Change Voucher Restrictions	Increase in Annual Cost (Millions)
1. Goals of scheme not identified in programme design	If welfare, eliminate restrictions	No	No	Yes	£0
	If public health, eliminate means-testing	Yes	No	Yes	£623
2, Eligibility for the scheme is based on low-income	Increase eligibility to:				
	Those below MIS (1)	Yes	No	No	£101
	All income levels	Yes	No	No	£623
3. Voucher amount is not sufficient	Increase voucher to cost of:				
	5 F&V/day	No	Yes	Yes	£46
	7 F&V/day	No	Yes	Yes	£68
	Infant formula	No	Yes	No	£18
	Eatwell Guide	No	Yes	No	£146
4. Vouchers are restricted to a small list of foods	Change restrictions to:				
	F&V only	No	No	Yes	£0
	Expand healthy food	No	No	Yes	£0

(1) Minimum Income Standard (MIS) as defined by the Joseph Rowntree Foundation (Hirsch, 2019).

The increase in annual costs modelled range from £0 to £623 million. A change in voucher restrictions does not increase the cost if the eligibility and voucher amount remain at the current level of £3.10 in

2020. Increasing the eligibility from the current level to include all pregnant women and children under 4 years old living in households below the MIS increases the annual cost by £101 million, and a universal scheme for all pregnant women and children under 4 years old increases the annual cost by £623 million at the current voucher level. If the eligibility remains the same but the value of the voucher increases, the additional annual cost is £46 million for a voucher that can purchase 5 portions of fruit and vegetables daily to £146 million for a voucher that can purchase the government's recommended diet.

6.1.2 Calculation of Benefits

The calculation of benefits assumes that the vouchers improve nutrition which in turn improves health and productivity. There is substantial evidence, as discussed in Chapter 1, that fruit and vegetable consumption is associated with a lower risk of disease, including coronary heart disease, stroke and certain types of cancer (Ekwaru *et al.*, 2017). It may also reduce type 2 diabetes and the chance of osteoporosis (Lalji, Pakrashi and Smyth, 2018). Poor diet has been estimated to account for 15.3% of the UK's overall disease burden (Greenshields, 2014). The following is a summary of the potential mechanisms, outcomes and related economic costs that result from improved nutrition.

Exhibit 17: Potential Mechanisms, Outcomes and Economic Effects of Improved Nutrition

Potential mechanisms	Regulate blood sugar (Coyne *et al.*, 2005) Lower blood pressure (Steffen *et al.*, 2005) Prevent cancer (Glade, 1999; World Cancer Research Fund, 2016)
Final outcome	Reduced NCDs (Oyebode *et al.*, 2014) Reduced pre-term birth Improved cognitive ability Increased years of education Higher earnings Better job quality Increased sense of well-being (Ocean, Howley and Ensor, 2019)
Economic effect	Lower health costs Increased productivity Increased lifespan GDP effect of benefit Increased productivity in household labour Increased leisure time Increased wages Increased well-being

Adapted from Nugent *et al.* (2020). GDP, gross domestic product; NCDs, non-communicable diseases.

The analysis presented here calculates the economic costs of poor nutrition in two parts:

1) Direct benefits from actual healthcare costs averted
2) Indirect benefits from increased productivity

Direct Benefits from Actual Healthcare Costs Averted

These are the actual healthcare costs that would be saved if a change in diet reduced the lifetime disease burden. This is not an immediately realized cash savings. In order to determine the annual NHS costs that are diet related, this analysis relies on the disease burden of poor nutrition developed by Scarborough *et al*. (2011, 2016) and developed by others (Greenshields, 2014; Briggs, Scarborough and Wolstenholme, 2018).

The annual amount spent by the NHS in the UK for medical costs related to poor nutrition was estimated to be £5.8 billion of the £81.3 billion budget in 2006–2007 (Scarborough *et al.*, 2011), or 7.1%. This number was updated in 2011–2012 and the amount was found to be £7.5 billion, a 26% increase from 2006–2007 but a smaller share of the overall costs of 6.2% (£7.483/£121,279 = 6.2%) (Greenshields, 2014). Although a significant rise in real terms, the percentage declined because of an increasing budget for the NHS overall. The percentage of costs related to inadequate fruit and vegetable consumption is assumed to be 25% of total poor diet-related health spending based on prior research (Rayner and Scarborough, 2005; Ekwaru *et al.*, 2017). The steps taken to calculate the NHS costs saved are:

1) Identify disease where poor diet or inadequate fruit and vegetable consumption is a risk factor.
2) Identify the total cost to the NHS for these diseases
3) Based on the WHO global burden of disease study, identify the population attributable risk fractions (PAFs) related to the risk factors for each disease (World Health Organization, 2014)
4) Apply the PAF to NHS expenses by disease category to determine the annual NHS spending attributed to poor diet or inadequate fruit and vegetable consumption
5) Calculate these costs on a per-person basis
6) Forecast these costs over the lifespan of the Healthy Start population (81 years)
7) Calculate annual savings as a percentage reduction in relevant healthcare costs from year 45 through life expectancy for the Healthy Start recipient population.
8) Calculate the net present value of the savings due to avoidance of NHS poor-diet related disease treatment expenses using a discount rate of 3%.

The NHS costs saved were modelled based on a percentage of the healthcare costs related to poor nutrition. These percentages varied by the voucher amount, assuming that a larger voucher resulted in a greater improvement in nutrition: 10–30% for the current voucher amount, 30–50% for the 5 F&V case, 50 –70% for the 7 F&V case and 70–90% for the Eatwell case. The midpoint range efficacy has been used in this analysis. It is reasonable to assume that a larger voucher would have an increased benefit on health but, as discussed in Chapter 2, the evidence that the current scheme increases fruit and vegetable consumption is weak and mixed. The analysis here assumes that the voucher will have improved the recipients' diet for the rest of their lives. None of the cases assume no diet-related disease because it is unlikely that a voucher in early life would eliminate all diet-related diseases. Costs saved are calculated in two ways: on the basis of an overall improvement in diet and the resultant reduction in healthcare costs; and on the basis of an increase in fruit and vegetable consumption that reduces related healthcare costs.

This is based on prior research, which identified the healthcare costs directly related to diseases that result from inadequate fruit and vegetable consumption compared to an overall improvement in all aspects of diet related disease except obesity (Rayner and Scarborough, 2005; Ekwaru *et al.*, 2017).

While we know that diet is impacted by financial resources, there are many other factors, as even those with the highest income do not meet the recommended dietary guidelines. Therefore, it cannot be assumed that a food voucher will solve all of the problems of nutrition. But it may be one policy lever that can eliminate one barrier and show the government's commitment, providing a nudge towards better nutrition. The following tables present the net present value of the healthcare costs averted in two ways: 1) if only the diseases related to inadequate fruit and vegetable consumption are averted; and 2) if all poor diet-related disease costs are averted. The assumption for the percentage of healthcare costs saved increases from 20% to 80% as the voucher amount increases. These two healthcare cost assumptions are then calculated based upon four voucher amounts and three eligibility levels.

Exhibit 18: Net Present Value of Direct Benefit of NHS Costs Avoided (£ Millions) – Fruit- and Vegetable-Related Medical Costs Avoided

% of NHS costs saved	Voucher Amount	Current Eligibility (15%)	Below MIS Eligible (45%)	Universal Eligibility (100%)
20%	Current	31	92	408
40%	5 F&V	61	184	816
60%	7 F&V	92	276	1,225
80%	Eatwell	122	367	1,633

Exhibit 19: Net Present Value of Direct Benefit of NHS Costs Avoided (£ Millions) -- All Poor-Diet Related Medical Costs Avoided

% of NHS costs saved	Voucher Amount	Current Eligibility (15%)	Below MIS Eligible (45%)	Universal Eligibility (100%)
20%	Current	116	347	1,544
40%	5 F&V	232	695	3,088
60%	7 F&V	347	1,042	4,632
80%	Eatwell	463	1,390	6,176

Indirect Benefits of Better Nutrition

The indirect benefits are more difficult to quantify, as they are not actual costs incurred by the NHS, but are the costs to society of lack of productivity in paid employment due to diet-related illness measured in increased gross national product which translates into increased tax receipts. Workers who miss work through illness and premature death are a significant cost to the economy that far exceeds the annual healthcare costs. In addition to the reduction in absences from employment, another potential indirect benefit is more years spent in education resulting in a higher earnings potential. There is evidence that better early nutrition leads to more years in education, which likely results in improved employment opportunities (Nugent *et al.*, 2020).

When the economic impact of lost productivity is included, the economic impacts increase dramatically. A study in the US estimated that of the total economic costs attributed to poor diet 47% are direct medical costs, and 63% are indirect, with 39% due to premature deaths and 13% related to lost productivity (Frazao, 1999). A Canadian study calculated the indirect benefits as 67% of the direct benefits related to disease due to inadequate fruit and vegetable consumption and 63% for all poor diet-related disease (Lieffers *et al.*, 2018). The global cost of obesity has been estimated to be about 30% attributable to the direct cost of disease, and 70% to productivity losses (Nugent *et al.*, 2020). Therefore, the indirect costs have been estimated to be 64%, 67% and 70%. For simplicity, this analysis assumes that the indirect costs averted are 65% of the total direct costs averted.

It should be noted, however, that this method overlooks the benefits of unpaid labour, which is a significant portion of the economy, especially for those who work in the home providing childcare, food provisioning, and other household tasks. An alternative method is the human capital approach, which quantifies the benefit to society of unpaid household labour and leisure time (Cadilhac *et al.*, 2011, 2015).

Unpaid labour can be calculated by applying the same methodology above (risk of absenteeism due to illness from diet-related disease) to hours spent on unpaid tasks using time-use studies that show the average time spent on different tasks. The value of the household work can be valued with the replacement cost method using government pay scale summaries. An Australian study estimated that the unpaid work and leisure annual savings that would result from adequate fruit and vegetable consumption was more than seven times more valuable than paid labour (AUS$161 million vs. AUS$21 million, or £89 million vs. £12 million; Cadilhac *et al.*, 2015). These benefits were not included in this study, but would increase the benefit/cost ratios by approximately seven times if they were included at the same rate as the prior study.

Intangible Benefits of Fruit and Vegetable Consumption

There are intangible benefits from better nutrition, even if they are the most difficult to cost and excluded from traditional benefit/cost analysis. The importance of food to social inclusion, as discussed in Chapter 1, has been well documented. This research confirms that the value of a healthy and socially appropriate diet has social as well as nutritional benefits. Fruit and vegetable consumption in particular has also been linked to an increased sense of well-being, in addition to protecting from physical disease (Ocean, Howley and Ensor, 2019). More fruit and vegetable consumption (both quantity and frequency) was found to be directly correlated to a higher self-reported feeling of well-being. The effect was quite profound. The positive increase in reported well-being was equal in magnitude to the negative effect experienced when losing a spouse (Ocean, Howley and Ensor, 2019). The amount of fruit and vegetables consumed can positively and significantly predict life satisfaction and the benefits do not appear to decline even with consumption in excess of recommended amounts (Mujcic and Oswald, 2016). Although it is difficult (but not impossible) to quantify in economic terms, this increased sense of wellbeing undoubtedly has an impact beyond mental health to physical health, productivity and longevity. Increasingly there is recognition of these benefits, and studies such as The World Happiness Report published by the UN Sustainable Development Solution Network ranks countries by general life

satisfaction. This is a welcome recognition of benefits beyond those easily measured by gross domestic product. One of the drawbacks of this analysis or any economic analysis is that it typically ignores these.

6.1.3 Benefit/Cost Results

The benefit/cost ratio was calculated first with the direct benefit only (healthcare costs saved) and then with direct and indirect benefits (of increased productivity). The direct benefits were calculated for two cases: 1) if diseases related to inadequate fruit and vegetable consumption were avoided and therefore the related NHS treatment costs were reduced (1.6% of NHS costs); and 2) if diseases related to all forms of poor diet and therefore the related NHS treatment costs were avoided (6.2% of NHS costs). To be conservative, these amounts exclude costs related to overweight and obesity. Obviously when all poor-diet related costs are included, the benefit/cost ratios improve significantly.

A benefit/cost ratio greater than 1 indicates that the net present value of the benefit exceeds the cost. Considering the direct benefits resulting from improved fruit and vegetable consumption, there is not a positive benefit/cost ratio for any of the eligibility or participation cases at the current voucher level.

However, when the voucher amounts are increased, the ratio is positive. When the direct costs of all poor diet-related illnesses are included, all of the voucher amount and eligibility levels are positive, ranging from 2.5 times the benefits/costs for the current case and 6.2 times for the universal case at the voucher level required to purchase seven fruits and vegetables.

When indirect benefits are included, the scheme is positive in all cases for the fruit- and vegetable-related healthcare cost cases, ranging from 1.1 times for the current 5 F&V case to 2.7 times for the universal 7 F&V voucher level. For the poor diet scenario, the range is 4.1 times for the current 5 F&V scheme to 10.2 times for the universal 7 F&V voucher scheme. The optimal voucher level appears to be adequate to purchase seven fruits and vegetables in all of the eligibility scenarios. In all of the cases, the benefit/cost ratio increases with greater participation and is highest for the universal case. The worst is the current case, with the lowest eligibility. The highest benefit/cost ratio is 10.2 times the benefits/costs for a voucher at the level necessary to purchase seven fruits and vegetables (£9.25 weighted average) and universal eligibility for all pregnant women and children under 4 years of age with direct and indirect benefits from all poor diet-related expenses. This would result in an annual budget for Healthy Start of approximately £1.6 billion and a lifetime saving of £16 billion. While this is a large increase in the budget, when compared to the potential healthcare savings and productivity improvement there is a strong economic argument for expanding the scheme and increasing the voucher amount. If the current voucher were maintained and the scheme became universal for all pregnant women and children under 4 years of age, the annual cost would rise to £676 million but the potential savings would be £3.8 billion.

The analysis here shows that the improvement in nutrition resulting from an increase in voucher amount justifies an increase to the £9.25 level, but not to the level necessary to support the Eatwell diet at an average of £16.23. The current voucher does result in enough of an impact on nutrition and therefore on NHS costs saved to justify the scheme, although it about breaks even when the indirect benefits are considered.

Costs were calculated based on four voucher amounts, three participation levels (based on three eligibility levels and three participation levels), three assumptions for the percentage of healthcare costs averted, two assumptions for which healthcare costs were averted (fruit- and vegetable-related disease costs only and all poor diet-related disease costs) and two cases (direct benefits and direct and indirect benefits combined). This results in a total of 144 scenarios that show the impact of increased participation, voucher amount and healthcare cost savings. Presented below are 48 of these scenarios.

Exhibit 20: Benefit/Cost Analysis with 15% Eligibility and 50% Take-Up (Current Case) – Fruit- and Vegetable-Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	0.7x	1.1x
5 F&V	1.0x	1.7x
7 F&V	1.3x	2.2x
Eatwell	1.2x	1.9x

Exhibit 21: Benefit/Cost Analysis with 15% Eligibility and 50% Take-Up (Current Case) – All Poor Diet-Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	2.5x	4.1x
5 F%V	3.9x	6.5x
7 F&V	5.1x	8.4x
Eatwell	4.5x	7.4x

Exhibit 22: Benefit/Cost Analysis with 45% Eligibility and 50% Take-Up – Fruit and Vegetable-Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	0.8x	1.3x
5 F%V	1.2x	2.0x
7 F&V	1.5x	2.5x
Eatwell	1.3x	2.1x

Exhibit 23: Benefit/Cost Analysis with 45% Eligibility and 50% Take-Up – All Poor Diet-Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	3.0x	5.0x
5 F%V	4.5x	7.5x
7 F&V	5.8x	9.6x
Eatwell	4.8x	8.0x

Exhibit 24: Benefit/Cost Analysis with 100% Eligibility and 100% Take-Up – Fruit- and Vegetable Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	0.9x	1.5x
5 F%V	1.3x	2.1x
7 F&V	1.6x	2.7x
Eatwell	1.3x	2.2x

Exhibit 25: Benefit/Cost Analysis with 100% Eligibility and 100% Take-Up – All Poor Diet-Related Costs Avoided

Voucher Amount	Direct Benefit/Cost	Direct & Indirect Benefits with Paid Labour/Cost
Current	3.4x	5.6x
5 F%V	4.9x	8.1x
7 F&V	6.2x	10.2x
Eatwell	5.0x	8.3x

Economic Stimulus Provided by Vouchers

An additional way to measure the economic impact of food vouchers would be to think of the voucher as a fiscal stimulus for the overall economy. Vouchers have been shown to have a more immediate and greater impact than cuts in taxes which are more likely to be saved and do not increase immediate spending (Zandi, 2008). Food vouchers are a particularly effective stimulus because they are spent quickly. A US study estimated that a $1 billion increase in SNAP benefits increased overall economic activity by $1.79 billion due to increased farm production as well as production to meet increased demand for other items such as housing and clothing (Alderman, Gentilini and Yemtsov, 2017). The increased demand is not limited to food because although the benefit is tied to food spending, it frees up resources that would have been spent on food for other household needs. (Hanson, 2010).

Means-tested benefits play an important role in stabilizing the economy during economic downturns. More people become eligible for means-tested benefits as incomes decline, resulting in an income smoothing effect for families and providing a stabilizing effect for the overall economy.

If Healthy Start had a similar stimulus effect to SNAP in the US, the current scheme would have an economic stimulus effect of £98 million and if the scheme were expanded to a universal scheme at the 5 F&V per day level it would produce a stimulus value of £2.5 billion at a cost of £1.4 billion (1.8 stimulus on SNAP benefits see Alderman *et al.*, 2017). As a comparison, in 2020 the UK announced a £30 billion stimulus package to support the economy during the Covid-19 crisis (Payne and Colson, 2020).

6.2 Who Benefits from the Healthy Start Scheme?

The last section of this chapter addresses the impact of Healthy Start by measuring the money flows to those who directly benefit from the scheme. The chapter begins with an analysis of current food spending in the UK and then determines the impact on the family budget from the current Healthy Start scheme and the scheme with modifications. This continues with an analysis of the impact of the revenues from

the scheme (as currently configured and with modifications) that are or would be received by farmers, retailers and infant formula producers. If the scheme were modified to increase the overall voucher spend or the eligible food items, the revenue stream would change substantially. The scheme is currently immaterial to the large retailers and infant formula producers, unlike the food voucher schemes in the US that provide a significant source of revenue for both (Oliveira, Frazão and Smallwood, 2011; Fisher, 2017).

6.2.1 Families

Household Food Spending

While the cost of the Eatwell Plate to the average UK household is affordable, this masks the fact that only 53% of households in the UK spend enough to meet the cost of the Eatwell diet (Scott, Sutherland and Taylor, 2018). Therefore, it is necessary to look at food spending by income decile in order to unmask the average expenditures.

An analysis of household food spending showed that spending by the wealthiest decile and the lowest decile were very different in monetary terms, but that the categories of spending were surprisingly consistent for food eaten at home. The biggest difference is the spending on food and alcohol outside of the home, which was over seven times higher in the highest decile. Takeaway food is a luxury for those at the lowest income levels, with the lowest decile spending only £3.20 per week compared to £22.30 for the highest decile. This is consistent with the findings in this research, as families, particularly those on the lowest income, describe takeaway as an occasional treat. Alcohol outside the home is also much more prevalent at higher income levels, as the lowest decile spend £2.30 per week and the highest decile £44.30 per week. While it is impossible to know how much of the food budget spent outside of the home was spent on different food categories, it can be determined that the lowest decile spends a significantly greater portion of their food budget on food eaten at home and that is likely to translate into a larger portion of their budget spent on fresh fruit and vegetables, bread, rice and pasta. This is consistent with prior research (Leather and Caroline Walker Trust, 1996, p. 25).

Exhibit 26: Weekly Household Spending by Category

	Lowest Decile	Highest Decile	Average for All
All Food at Home (£/week)	£32.80	£99.20	£61.90
Percentage of Total Spending on:			
Meat	20%	21%	20%
Bread, Rice, Cereal	9%	9%	9%
Fish	5%	5%	5%
Milk	4%	3%	4%
Fresh Fruit	6%	7%	7%
Fresh Vegetables	7%	8%	7%
Soft Drinks	3%	3%	4%
All Catering – Restaurant, Takeaway and Alcoholic Drinks Away from Home) (£/week)	£12.20	£90.30	£40.70
All Takeaway	£3.20	£22.30	£11.00
Alcoholic Drinks Away from Home (£/week)	£2.30	£44.30	£19.40
Alcoholic drinks at home (£/week)	£4.40	£17.90	£9.10
Total Food Spending (£/week)	**$45.00**	**£117.10**	**£102.60**

(Office for National Statistics, 2020): calculations are my own.

However, a more detailed analysis of food expenditures found that the categories in the household food expenditure data may mask some of the differences in caloric density of food purchased. This data is not directly comparable because it is not per household but per person; however, it shows that total expenditures on food in the lowest quintile are about half what they are in the highest quintile, whereas the calories purchased are about 12% higher. This confirms that while less money is spent on food, what is purchased is more calorie dense (Pechey and Monsivais, 2016). To purchase 1000 calories, those in the lowest quintile spend 43% as much as those in the highest quintile (£1.10 compared to £1.69). Those in the lowest quintile derive fewer of their calories from fruit and vegetables (5.7% vs. 7%). This does not include food purchased for consumption outside of the home, which may exacerbate these differences due to the financial constraints as well as the quality of takeaway shops and restaurants available in more deprived neighbourhoods. Those with lower incomes are also more likely to shop in low to medium cost supermarkets (59% vs. 16% of those in the highest quintile), suggesting that quality may also be sacrificed.

Exhibit 27: Food Purchasing Behaviour Mean) by Quintile

	Quintile 1	Quintile 2	Quintile 3	Quintile 4	Quintile 5	Total
Total Expenditure (£/person/day)	1.54	1.87	2.10	2.43	3.14	2.22
Total Calories Purchased (Per person/day)	1,396	1,332	1,295	1,288	1,245	1,311
Expenditure (Per 1000 calories)	£1.10	£1.40	£1.62	£1.89	£2.52	£1.69
Energy from Fruit & Veg	5.7%	6.4%	6.9%	7.5%	8.4%	7.0%

Kantar data from 2010, adapted from Pechey and Monsivais (2016).

It is important to note that data on food purchasing may not accurately reflect the food consumed, particularly for those with a higher income. Those with a lower income are more likely to consume the food purchased because they do not have the luxury of food waste.

As shown above, the average UK household spent £61.90 per week on food eaten at home in 2019, while those in the lowest income decile spent only £32.80. This is far below the £120 per week that is estimated for a consensual diet that is healthy and socially and culturally appropriate (MacMahon, Thornton and McEvoy, 2019). Of the amount actually spent by households, on average £10.70 (17%) is spent on milk and fresh fruit and vegetables, with £5.71 by those in the lowest income decile. This compares to the estimate of £27.29 necessary for the consensual food basket. This highlights both the difficulty experienced by those on a low income in purchasing adequate fruit and vegetables as well as the low overall consumption of fruit and vegetables in the UK[2] (Office for National Statistics, 2020).

The average Healthy Start household receives £4.42 per week (Crawley and Dodds, 2018), a significant portion of the current spending in the lowest decile for milk and fruit and vegetables, nearly bridging the gap between the spend for the lowest decile and the average spend. However, these numbers do not include infant formula, and it is likely that 47% of vouchers are spent on this (Sommerville *et al.* 2013), on average only 25% of the vouchers are spent on fruit and vegetables (Sommerville *et al.* 2013). For the average family receiving Healthy Start vouchers, the voucher would cover 13% of their weekly food budget at current levels. If the current voucher were limited to fruit and vegetables purchases, it would allow families to purchase an extra 2½ portions per week in addition to their current purchases of 14.3 portions. However, this assumes no displacement of funds, and families on a limited budget may choose to replace at least some of their own funds for voucher funds resulting in a limited increase in fruit and vegetable consumption.

[2] Households are not directly comparable because a household is defined in the Office for National Statistics data as an individual or group living together, and the consensual food basket is a family of four with one preschool-aged child and one primary school-aged child.

Exhibit 28: Household Food Spending in the UK

Household Spending on Food per Week	All	Milk	Fruit	Veg	F&V	F&V portions/ day	Milk, Fruit and Veg
Average for all	£61.90	£2.20	£4.10	$4.40	£8.50	4.0	£10.70
Lowest Income Decile	£32.80	£1.40	£2.10	£2.20	$4.30	2.0	$5.71

From Office for National Statistics (2020).

Exhibit 29: Voucher Amount as a Percentage of Household Food Spending

Current Voucher		F&V	Milk+ F&V	Total
£4.42	**Total Population Spend**	52%	41%	7%
£4.42	**Lowest Decile Spend**	103%	78%	13%
5 F&V		**F&V**	**Milk+ F&V**	**Total**
£8.69	**Total Population Spend**	102%	81%	14%
£8.69	**Lowest Decile Spend**	202%	152%	26%
7 F&V		**F&V**	**Milk+ F&V**	**Total**
£10.84	**Total Population Spend**	128%	101%	18%
£10.84	**Lowest Decile Spend**	252%	190%	33%
Eatwell		**F&V**	**Milk+ F&V**	**Total**
£19.03	**Total Population Spend**	224%	178%	31%
£19.03	**Lowest Decile Spend**	443%	334%	58%

6.2.2 Farmers

The current value of the vouchers to farmers is very limited due to the small size of the scheme and the small amount that farmers receive from retail sales.

Exhibit 30: Revenue Currently Received by Farmers from Healthy Start Vouchers (000s)

		Fruit & Vegetables	Milk	Total Farmers
Healthy Start Annual Spend on Fruit and Vegetables		£11,725	£13,132	£24,857
% to Farmers		21%	48%	
Farmers--Fruit and vegetables		£2,479		
UK	53%	£1,314		
Other	47%	£1,165		
Farmers--Milk UK			£6,240	£6,240

(Sommerville, 2013; Wunsch, 2020).

Fruit and Vegetable Producers

If 25% of the value of the vouchers is spent on fruit and vegetables, that would be an annual spend of £11,725 (Sommerville, 2013). Of this, farmers receive about 21% of the retail value (£2.2 billion farmgate value vs £10.4 billion retail value) (Wunsch, 2020).

An opportunity exists to support UK farming with incentives to purchase local produce. If the vouchers were limited to fruit and vegetables the increased demand would likely be met with increased production in the UK as well as increased imports, unless the vouchers were limited to farmers markets, local box schemes, or other local initiatives. If the vouchers were limited to local farmers, the benefit to UK farmers would be five times higher since they would receive all of the revenue.

There is a precedent for government food vouchers being used to support local agriculture. The US government has supported farmers through the Farmers Market Nutrition Program which issues vouchers to WIC recipients. The increased demand leads to a need for additional farmland as well as labour. A US study showed that a 10% increase in demand for fruits and vegetables led to a 2% increase in demand for land and a 4% increase in demand for labour (Jetter, Chalfant and Sumner, 2006). This increase in demand would also have a multiplier effect on the economy. A study in Iowa showed that for every $1 increase in demand for fruit and vegetables, $0.50 in additional revenue was created for supporting industries (Swenson, 2006).

Exhibit 31: Potential Annual Value to UK Farmers if Vouchers were Limited to Fruit and Vegetables (millions)

Voucher amount	Current Eligibility	Universal Eligibility	Universal Eligibility Limited to Farmers Markets
Current amount	£11.5	£153.5	£730.8
5 a day	£22.5	£300.2	£1,429.8
7 a day	£28.1	£375.1	£1,786.2

The scheme has the potential to offer a significant source of income for UK horticulture farmers if the vouchers were limited to fruit and vegetables and could only be used with local producers through farmers' markets or box schemes. Even at current voucher levels with universal coverage this would provide £731 million of revenue to farmers each year. This is not only good for the farmers but also better for recipients. Fruit and vegetable vouchers that can only be redeemed at farmers' markets have been shown to be more than twice as effective at increasing consumption than those that could be redeemed at the supermarket (Lieffers *et al.*, 2018).

Milk Producers

The farmgate price of milk is approximately 48% of the retail price (Shahbandeh, 2020; DEFRA, 2021) Dairy farmers receive about £6,240 annually from Healthy Start vouchers and about £6,900 from supermarkets. As the UK is a net exporter of milk, it can be assumed that the sales benefit UK farmers.

6.2.3 Retailers

The last available data on voucher redemption showed that 73% of vouchers were spent in supermarkets, 15% in independent or franchised multiple retailers, 5% with doorstop milk services, 5% with chemists, and only 2% spent with local food cooperatives, box schemes and markets.

Exhibit 32: Healthy Start Spending by Retail Outlet (000s)

Category	Percentage	Amount
Supermarkets	73%	£34,237
Independent multiple retailers	15%	£7,035
Doorstop milk delivery	5%	£2,345
Chemists	5%	£2,345
Other	2%	£938
Total	**100%**	**£46,900**

The retail food business is a £193.6 billion industry (Statista, 2020). If the top food retailers share in the Healthy Start business in proportion to their market share, they currently receive an immaterial amount of revenue. Assuming a universal scheme with the current voucher value would result in supermarket revenue of £533 million. If the voucher value were increased to the 7 F&V case the annual revenue would be £1.3 billion.

Exhibit 33: Revenue from Healthy Start Vouchers for Largest Supermarkets (000s)

Supermarket	Percentage	Amount
Tesco	27%	£9,347
Sainsburys	16%	£5,409
Asda	15%	£5,101
Morrisons	10%	£3,526
Total	**68%**	**£23,384**

(Coppola, 2020)

6.2.4 Infant Formula Producers

The most recent data available on the amount of the vouchers spent on infant formula is 47% (Sommerville, 2013). The two largest producers of infant formula in the UK accounted for 96% of the market in 2015–2016: Danone with 82% market share and Nestle with 14% (Bedford, 2016). The amount received by the producers from the retail outlets is not readily available but, owing to the small size of the scheme, the amount is small. If the scheme were expanded, it could be a meaningful revenue source for producers. In the US, the USDA has negotiated a contract with one infant formula supplier to secure low prices for WIC recipients. This results in cost savings for the WIC but may also create brand loyalty and a large dedicated market share.

6.2.5 Serco

In 2014 Serco was awarded a 4-year contract worth £12.1 million for administrative support for Healthy Start. This was extended for two years for a total of £14.6 million for six years. Serco is a large multinational corporation, and this contract represents less than 1% of their annual revenues (Serco, 2019).

6.3 Summary

The analysis here measures the actual and potential economic impact of the Healthy Start scheme. A simple model was used to measure the benefit/cost ratio of the scheme as it is currently configured and with modifications suggested by the research. Its actual and potential financial impact on recipients, farmers and retailers was also measured. The model has shown that the scheme can have a positive economic impact and that the highest return on investment would result from an increase in the voucher amount and an expansion of eligibility to all children under 4 years of age. The next chapter discusses all of the findings presented in Chapters 4 – 6.

Chapter 7: Discussion

7.0 Introduction

This dissertation began with the fact that despite increasing levels of food insecurity and increased attention, half of those eligible for Healthy Start do not participate in the scheme. Prior research had focused on the operations and nutritional impact of the scheme, resulting in a gap in the knowledge about the social and economic consequences. The research aim was to gain greater insight into the potential for Healthy Start to improve health and social and economic welfare. This has required a broad understanding of the origins of the policy, the nature of the problem that the scheme is tasked with addressing, the social and economic context, and the impacts of the scheme. Four research questions were developed to pursue, learning about the challenges faced by parents in providing their children with a healthy diet, what they and their health professionals thought of the Healthy Start Scheme, how recipients are perceived, and what economics underlie the scheme. Interviews with health professionals, managers and parents highlight the operational issues of the scheme, as well as the social stigma associated with needs-based benefits and failing to meet societal expectations for mothering and food provision.

This chapter brings together the findings from Chapters 4 – 6 in light of the background literature analysed in Chapters 1 and 2. The major themes and tensions that have arisen are described in detail here using the categories identified in Chapter 1: health, social, economic, and political. While the organization of this chapter uses those categories as a tool, it is important to again emphasize that they overlap and are not exclusive. The health and social sections have been combined, as it was deemed impossible to separate them. This dissertation demonstrates that the policy design and implementation have led to operational inefficiencies and social consequences that have reduced the scheme's uptake and effectiveness. Yet, the economic analysis shows that the scheme has the potential to be cost-effective, with benefits of as much as £10.20 for every £1 invested.

7.1 Health/Social

Healthy eating is the result of a complex interplay of systemic and personal factors: structure and agency (Cockerham, 2005). This section examines the nutritional knowledge and ideal diet described by those interviewed and the constraints, both structural and personal, that affect their nutrition. It also considers the strategies that parents employ to ensure that their children's nutritional needs are met. This section combines health and social concerns because, as the literature suggests, and the findings support, these are impossible to separate (Coveney, 2005).

Dietary guidelines purport to deliver the "facts" of a healthy diet, but they have often been revised and have been shown to be fallible. In addition to changing evidence on nutrition, guidelines are not objective but are written by individuals and groups from a distinct historical and cultural position, which is reflected in the guidelines written. Patricia Crotty and others describe the current nutritional discourse as a form of control which is "moralistic, sexist and class prejudiced" (Crotty, 1995 in Coveney, 2006). For these authors, food choice is necessarily a moralized choice, reflecting an individual's ability to make good choices (Murcott, 1998). The duty for following nutritional guidelines falls to each individual, or for children, typically to their mother.

Although there were exceptions, the findings were largely consistent with a large body of research by Murcott (1998) and others that conclude that providing food for the family most often falls to the women in the family. Overwhelmingly, women reported that meal planning, shopping and cooking was their responsibility. When it was a shared responsibility, it was most often with other women in the household. Most women did not question this responsibility, assuming it was their role. When fathers participated it was often to assist in the shopping, and more rarely the cooking. In the few instances where the father participated, the women expressed gratitude, particularly that the father was providing a good role model for the children, rather than an expectation that it was a shared responsibility. Mothers in this research at all income levels largely expressed pride in their prioritization of healthy high-quality food, their understanding of nutritional guidelines, the importance of fruit and vegetables, and the importance of eating family meals at home. But more than nutrition is at stake, as the respectability of the family depends on healthy, home-cooked meals.

A narrative of personal responsibility for food choices holds individuals responsible for choosing health through their eating practices. As a culture, our emphasis on individual choice and personal responsibility asks people to make good nutritional choices for themselves, their children, and the planet. Take, for example, the idea that one chooses the type of world one wants to live in by "choosing with your fork", which has been popularized by mainstream food writers such as Michael Pollan (2007). Food shopping practices are increasingly linked to broader ethical concerns for the environment and unfair labour practices (Adams and Raisborough, 2010). This research confirms that this message has been received. The desire to eat organic, locally sourced food was cited by a majority of the parents interviewed, with organic food the most likely answer given when asked how they would shop if money were no object. This is consistent with prior research that has identified eating organic food as a signifier of good taste (Adams and Raisborough, 2010; Cairns, Johnston and Mackendrick, 2013) and ideal motherhood (Cairns, Johnston and Mackendrick, 2013).

In the social sciences, this moralized view of enlightened, ethical consumption has been problematized. It has been recognized that consumer choice is governed by a complex set of variables, many of which are out of the control of the consumer (Lang, Barling and Caraher, 2009). When it comes to making good choices for the planet, it seems more straightforwardly true that this may be a luxury that not all can afford. Such a position would likely be met with widespread understanding. And yet, when it comes to making good choices for one's children, no such understanding exists. Unlike buying organic, this is not considered an optional activity. Existing research does not always consider the economic, social, and cultural realities that govern the more basic choices, not organic or standard broccoli, but broccoli or pasta. Rather than considering the structural constraints that make pasta the more attractive option, and holding the food system accountable, the reigning narrative of "personal responsibility" tasks parents alone with selecting the broccoli (Guthman, 2011). When they do not, it suggests that the government needs to get involved.

This is the position of Healthy Start, the government programme designed to ensure that parents reach for the broccoli. When poor nutrition is viewed foremost as the result of poor choices, regulating that bad behaviour seems justified. This is what happens with Healthy Start and its paternalistic administration of restrictive vouchers. The key assumption here is that parents lack not just, or not even primarily, the

funds to make healthy choices but also the knowledge, willpower, and control to do so. This message has also been received. It is perpetuated by the government, the media, health professionals, and as this research has shown, parents and Healthy Start recipients themselves. As a member of the House of Lords said, "The poor are going hungry because they can't cook", identifying porridge as a filling and inexpensive meal within everyone's budget if they are taught to cook (Holehouse, 2014). When asked how the government could address the problem of poor nutrition, the most common answer given by the health professionals and parents in this research was nutritional education. The perception that parents lack knowledge is widely shared and was not questioned by any of the parents or health professionals interviewed. Health professionals consistently expressed the concern that vouchers may be misspent and highlighted the need for the scheme to be supported with nutritional advice. In other words, the voucher limits, and contact with health professionals who can impart knowledge, are necessary to nudge parents in the right direction and ensure that they follow through.

The restricted nature of Healthy Start's vouchers has not been questioned, despite a lack of evidence that it is necessary or efficient. This research suggests that the restrictions should be reassessed because their underlying assumption – that parents lack the knowledge and willpower to buy healthy food – is incorrect and the wider social context in which people make their nutritional choices is not adequately taken into account. Discourses around the ignorance and untrustworthiness of the poor – discourses that Healthy Start responds to as well as constructs – distract us from asking questions that may be more central to the problem of malnutrition.

In fact, consistent with prior research, there is no evidence that those on a low income lack knowledge of nutritional guidelines, cooking skills, or motivation to provide a healthy diet for their families. The parents interviewed in this research were familiar with government guidelines for healthy eating and the importance of fruit and vegetable consumption. Food is described as a priority in their homes, first the availability but also the quality and healthfulness of the food available. They describe healthy home cooked meals, little takeaway and junk food, and a desire to eat more high-quality organic food and fruit and vegetables. On the whole they were passionately invested in providing healthy food for their children. The government message has reached them – and more. For many of those interviewed, providing healthy food was synonymous with being a good mother.

In this research, the way that mothers described their children's diet reflected their understanding of what it means to be a good mother, a responsible citizen, and a hard worker. There is perhaps nothing more critical or visible when caring for children than providing healthy, wholesome meals. It is a core part of being a good mother, a social imperative that determines a woman's social acceptability and status. As Beverley Skeggs (1997, 2004) argues, the desire to be a "good mother" is a marker of class and social acceptability, and mothers are tasked with the responsibility for maintaining the family's respectability. For the mothers interviewed, to be a good mother is to give your children the best start by breastfeeding, then to provide fruit and vegetables every day, to care about nutrition, to enforce healthy eating, to develop children's taste for wholesome food, to budget carefully, and to be thoughtful and discerning. Nearly all of the mothers held themselves to these high standards, despite living very different lives (Dowler, Turner and Dobson, 2001). Often, they expressed guilt and frustration when they fell short of their expectations for themselves.

It is important to stress the gendered dimension of this. Not only the burden of the family's food shopping and preparation that typically falls on the mother, but also the social repercussions and health implications. This research upheld what many have documented: women dominate in menu planning, preparing, and serving food to their families (Murcott, 1983; DeVault, 1991; Dowler, Turner and Dobson, 2001). Mothers are expected to privilege the needs of their families over their own, reflecting a gendered and judgemental distribution of caring responsibilities and household resources (DeVault, 1991). With the responsibility for food provisioning, they also accept responsibility for the entire family's nutrition.

This suggests not that women lack the knowledge or desire to make healthy choices but, in fact the opposite, that pressure on them may be overwhelming in this respect. This research shows mothers who accept the primary responsibility for the family's food provisioning, yet often feel frustrated and worried that their children's diets are not as healthy as they should be. Partially this is the result of the rhetoric of choice and personal responsibility that often leads to despair for those with limited choices. With the responsibility to be a "good mother" by providing healthy meals comes the moral and social cost when the goal is not met, which can lead to the internalization of blame, feelings of guilt and inadequacy, and the tendency to separate oneself from others to avoid judgement, a gesture that ensures judgement never dissipates. Not only do the mothers in this research bear the physiological consequences of prioritizing their children's health – the sacrifice of their time and their meals or food preferences to provide their children with their desired food, even costly berries or organic vegetables—but they also bear the social consequences of falling short, including guilt, shame, anxiety, and stigmatization. The findings show mothers at all income levels, those that receive benefits and those that do not, "beat themselves up" when their children are not eating as healthfully as they believe they should.

Previous studies have not considered these consequences, reflecting the priority placed on young children as a social investment. As Tony Blair put it in 2004:

> *One thing that we know is that the more we invest in young people at the earliest possible age, the better chance we have of making sure that they become responsible adults—hence the importance of programmes such as Sure Start. That is why it is important that, as well as clamping down on antisocial behaviour, we should continue to invest in the education of our young people* (Blair cited in Lewis, 2006, p. 53)

The recognition of the importance of early childhood nutrition for a productive future generation provides the fundamental justification for the Healthy Start scheme[3]. And indeed, research on the first 100 days, and the willingness of new parents to change their habits, makes this an ideal time to establish healthy eating preferences that may carry through the child's life. However, no researcher has yet studied the impacts of the Healthy Start scheme on the nutrition and wellbeing of the mother, on whom the success of

[3] The scientific evidence on the importance of nutrition on the developing brain has been used to target the health behaviour of parents, especially mothers, as a solution to larger issues often beyond their control such as low wages, insecure work arrangements, and systemic poverty. In this way health behaviours become moralized and markers of good parenting, and policymakers come to believe that parenting education is the solution to social problems (Churchill and Clarke, 2010).

the scheme rests. As Ruth Lister (2006) argues, the government's construction of children as an investment in fact justifies the regulation of mothers who are held responsible for the health behaviour of their children. The limited nature of the Healthy Start voucher is an example of this, and its implication, that poor mothers cannot be trusted to make healthy choices on their own, was expressed by many of those interviewed, both health professionals and parents.

This message, that poor mothers cannot be trusted to make healthy choices on their own, is both constructed and reinforced by Healthy Start. It is hindering the effectiveness of the policy and obscuring the wider social circumstances in which choices about nutrition are made. In what follows, I argue first that the findings show that the message is wrong and betrays a misunderstanding of the nature of the problem. The findings show that finances and social pressures are to blame. Second, I argue that the message makes Healthy Start less successful by promoting stigma, which hinders uptake and damages the wellbeing and confidence of mothers, without whom the scheme cannot exist.

7.1.1 The Message is Wrong

Evidence suggests not that poor people fall short of an ideal diet, but that everyone falls short of an ideal diet. This is consistent with this research, as even those on a relatively high income faced challenges to achieving their goals, citing the high price of certain desirable food, particularly organic, and the time and energy required to pay attention to changing food guidelines and prepare healthful, interesting food that their families would enjoy.

Consumption of fast food and takeaway was not prevalent among those interviewed, especially for those with the lowest income. This is consistent with research in the US showing that fast food consumption is not as prevalent at lower income levels, but increases as income rises to middle levels (Zagorsky and Smith, 2017). Only one mother interviewed reported eating at McDonald's, which she did because the coupons offered good value. This is consistent with prior research that has identified the social pressure for families to have home-cooked family meals together (Bowen, Brenton and Elliott, 2019).

The parents interviewed, at all income levels, want to shop at the "right" store, defined as a local specialty shop or Waitrose, because of the perceived high quality. Many expressed the desire to try new recipes from well-known chefs, and experiment with new ways of cooking that incorporate new foods. Several described watching cooking programmes on television and reading magazines for new ideas. Yet it was often not possible for them to try the recipes because the cost of the ingredients was prohibitive, and they could not risk the possibility of waste if their families did not enjoy the new dishes. They prioritize cooking family meals at home, rejecting junk food and takeaway. It was not a lack of knowledge or desire that kept the families in this study from eating their ideal diet. When describing their families diet they prioritized fruit and vegetables, with some suggesting that the guidelines of 5 a day are not adequate, and that it should be far more. Yet those interviewed consistently believed that they were unique, and others did not share their food values and knowledge.

This concern, that nutritional education was needed to ensure that parents made good food choices, was shared not only by most of the parents, but also by the health professionals interviewed. Yet, when asked about the food practices of their patients, the health professionals generally agreed that parents had a good understanding of nutritional guidelines and a mostly healthy diet. A programme director shared an

anecdote that parents had rejected her home baked cakes at a parenting class because of their desire to limit sugar in their diets.

Although research going back to the early twentieth century consistently shows that mothers are generally responsible and knowledgeable, and also exposes the unaffordability of a healthy diet, the prevailing discourse continues to blame individuals for their own inability to make better choices (Bosanquet and Reeves, 1914). There remains no evidence that the problem of malnutrition is lack of nutritional knowledge, cooking skills, desire, or willpower. There findings in this research contribute to the evidence that healthy choices are restrained by finances, time, and the preferences of family members, partners and children.

Finances

Despite the expressed desire of many parents interviewed to purchase high quality, local, organic food, none regularly shopped in that way. The reason given was lack of time and money. Those whose finances were not constrained were not more likely to eat organic food or shop locally. The high cost of organic food and the uncertainty that it was worth the additional cost were cited by parents at all income levels.

Often parents needed to prioritize fixed bills, leaving little left to purchase food and discretionary items. Many of the parents interviewed describe skipping meals and eating low quality and monotonous food due to a lack of funds, filling up on crisps and bread sandwiches, and bowls of rice. Many of those on a low income were nutritionally protected by their reliance on social and familial ties, which is consistent with research showing that many families receive direct support and share resources with other family members (Halpern-Meekin *et al.*, 2014; Edin and Shaefer, 2015; Anand and Mantovani, 2018). Particularly for those living in extended family groups, shared housing and food resulted in the ability to eat adequately on a lower income. But others in this research without the buffer of family described food insecurity. Worrying about having enough food, skipping meals, and eating poor quality food was an everyday reality that carries health and social implications.

These concerns may not be easily measurable when it is only the nutrition of children that is examined; research has shown that children are often shielded by their mother's sacrifice. This research confirmed this, as the mother was most likely the one to skip meals and eat poor quality, monotonous food so that the children's diet – even allowing for special treats such as exotic fruit – was protected. Rather than resent this sacrifice, they saw it as their duty and described it as "what any mother would do." The pride that they were able to provide high quality, brand name food for their children that their children enjoyed outweighed any sacrifice they had to make. Several mothers said their time had passed, and the child was their priority. The sacrifices described by the mothers in this study is consistent with the "mother's sacrifice" that has been well documented in the literature (Dowler, Turner and Dobson, 2001; Bowen, Brenton and Elliott, 2019).

While mothers describe their own poor nutrition, they do not report deficiencies in their children's nutrition due to financial constraints. Although the child's nutrition is the focus of this research, the food insecurity described by their mothers is still an important finding that warrants consideration. Beyond the moral argument, there are health and economic reasons to value the mother's nutrition. Her health is also important for the next generation as she is not only an example to her children, but she provides the

nutritional foundation for her children through breastfeeding and preparing her body to bear more children.

Social Pressure

Existing research, and the Healthy Start scheme, do not sufficiently take into account the social significance of food. Parents must balance their desire to adhere to the advice given in guidelines not just with financial constraints, but with pressures put on them by family members (impacted by the gender and power dynamics in the home) and by society at large. These can conflict with the goal of healthy eating as defined by the government. This is because, as we know, food signifies far more than nutrition. It is constructive of social identity. It fosters a sense of belonging or alienation, care or neglect. A carrot may sometimes be a sign of love, but so can a takeaway, a birthday cake, or Haribo.

While the mothers interviewed usually accepted responsibility for food provisioning in their family, they worked within the preferences of other family members who often determined the family's diet. Even with the best of intentions, mothers describe children who will not eat as many vegetables as they would like and partners who want to eat more meat or takeaway without regard for the family's food budget or nutrition. Navigating the preferences of all family members significantly reduces the mother's ability to control the family's nutrition, and often results in additional work and cost preparing separate meals. While the family power dynamics were different in all families, they often created a challenge for mothers, who blamed themselves when unable to achieve their ideal. In extended family groups, mothers were particularly subject to the desires of others, even for the feeding of their own infant.

7.1.2 The Message Promotes Stigma

This section is concerned with the stigma associated with welfare and poverty in general, and the Healthy Start scheme specifically. The existence of stigma related to poverty and welfare has been well documented (Spicker, 1984; Goodban, 1985; Rogers-Dillon, 1995; Colton *et al.*, 1997; Stuber and Schlesinger, 2006; Hansen, Bourgois and Drucker, 2014). The findings here confirm prior research on the existence of welfare stigma in the UK. Because of the power of the personal responsibility narrative, poverty is seen as a personal failing, which is then judged. The shame of claiming benefits is therefore both internal and external. The external shame arises from the judgement of others and the internal shame from one's own judgement.

Many in this research believed that the stigma of food banks, or other kinds of welfare such as jobseeker's benefit, is higher than Healthy Start. The reasons given by those interviewed were because Healthy Start is for children and is linked to health, and is a more subtle form of welfare than going to a job centre or food bank. The stigma of using food banks has been well documented (Purdam, Garratt and Esmail, 2016; Middleton *et al.*, 2018). Health professionals in this research assumed that food bank use would be more stigmatizing than Healthy Start because visiting them explicitly labels users as poor, even though by definition Healthy Start recipients are poor. But the difference may be less significant than is often assumed. The findings here also show that while parents ranked the stigma from jobseekers benefit higher than Healthy Start, regardless of the question of relatively, Healthy Start definitively carries a stigma.

According to Irving Goffman, stigma has several components: a personal flaw, the feelings of the stigmatized person, and the attitudes of others towards the stigmatized person (Goffman, 1963). Many others have expanded on Goffman's foundational theory, interrogating the way power structures and inequalities are perpetuated by stigma (Parker and Aggleton, 2003; Tyler and Slater, 2018) and analysing the coping mechanisms used by the stigmatized individuals (Meisenbach, 2010). The findings of this research shed light on the experience of stigma, and the way it is perpetuated by parents and healthcare professionals.

The "personal flaw" at work in welfare stigma is poverty and the reliance on government benefits. Healthy Start makes this "personal flaw" very visible. As cited in the findings, one mother described people around her looking at her like "you must be poor" (HWL3). The vouchers need to be used in public space, distinguishing them from some types of benefits that are less visible, and singling out recipients in a way that some found embarrassing.[4] Here, the "personal flaws" include not just poverty and dependence on government, but also the presumed failure to meet the expectations for food provision.

However, it is not just the "people around you" who may have and express judgement. The findings are consistent with prior research showing that even those with direct experience of poverty and welfare share and reproduce views reflecting the "personal responsibility" mentality (Shildrick and MacDonald, 2013). As cited in the findings, health professionals and parents alike share the concern that people are overly eager to claim and rely on benefits that they do not really need.

Many respondents, even recipients, believe that social judgement around benefits is justified, since it motivates people to work hard and not take advantage of the benefit system. They feel that shame helps to enforce societal norms of self-sufficiency. As a response to this shame, recipients disassociate themselves from others who claim benefits, citing qualities that make them different from the "other" benefit recipients.

<u>"Othering"</u>

In order to manage the stigma of poverty and needs-based welfare, low-income parents employ coping strategies to protect their social identity. The first, and perhaps the most common coping mechanism, is "othering". Lister describes othering as a response to the stigma of poverty: "Othering can be understood as a discursive practice which shapes how the "non-poor- think and talk about and act towards 'the poor'" (2004, p. 103). The findings in this research confirm what many others have described: those who experience poverty and welfare feel looked down upon and distance themselves from the stigma by distinguishing themselves from others to maintain their respectability. Shildrick and MacDonald have identified potential explanations for why people living in poverty disassociate themselves from others in a similar situation:

> *First, that socially and geographically close points of comparison diminish a sense of relative poverty and deprivation; secondly, that this is an outcome of the long-standing stigma and*

[4] A policy design that provides invisible benefits, through a bank transfer, for example, would eliminate this element of stigma.

> *shame of poverty but in a time of heightened 'scroungerphobia'; thirdly, that the pressure to dissociate from 'the poor' and the 'welfare dependent' articulates with wider processes of class disidentification and the more general demonization of the working class; fourthly, that 'ruling ideas' and political orthodoxies about 'the undeserving poor' more easily take hold, even amongst 'the poor', in contexts of a diminishing politicized, working-class consciousness. Through these processes 'the poor' deny their poverty and castigate 'the poor'* (Shildrick and MacDonald, 2013, p. 301).

By distinguishing themselves from other recipients, those who receive welfare deflect blame for their own situation. As most recipients were on benefits for a short time and had paid taxes in the past, these were the most common reasons cited for the difference between recipients and others.

The findings show that parents look down on those who they believed did not share their food values and skills by distinguishing their own prioritization of healthy and socially desirable food. When they struggle to eat healthfully, they described constraints largely out of their control, but did not extend those same circumstances as easily to others. There is a crucial disconnect between people's own values, knowledge and experiences and their perceptions of other people's. Even the recipients interviewed believed that the restrictive vouchers were necessary to ensure parents did not misuse them, yet the restrictions largely did not change their own purchasing behaviour. The contradiction in the way they perceived themselves and others shows an acceptance of common societal narratives.

Acquisition of More Expensive Goods

Another technique identified in research to avoid the stigma of poverty is the acquisition of expensive branded goods (Hamilton, 2012). Observations of mothers in this research show that expensive brand name strollers, brand name food and more expensive types of fruit for their children are a particular priority for those on lower income. Some mothers described significant sacrifices to their own needs in order to provide these items. Observation revealed that the mothers within a geographic area tended to have the same high-end brand of stroller and it was a particularly prized possession. This was also seen in the way parents described their ideal diet. The desire to shop at premium shops such as Waitrose, and to buy premium brand names for children such as Ella's Kitchen, shows that parents adopt the perspectives and attitudes of the elite. While Elizabeth Dowler (2008) has argued that societal values such as health and sustainability are shared by those on a low income, the socially desirable foods and brands were particularly important to the lower income parents in this research. Perhaps this is because it allows them to show their "good taste" and protect the risk to their social acceptability (Bourdieu, 1984). They are able to show that they are managing by owning the best stroller and feeding their children expensive berries. More affluent parents may not feel the need to show their respectability because they do not feel it is at risk.

There is some evidence in this dissertation, consistent with previous research, that vouchers are spent on exotic fruit as a treat for children (McFadden *et al.*, 2013). Several mothers described their children's preferences for berries and mangos rather than apples and bananas. While this is a legitimate and healthy use of the vouchers, it may also prove to be problematic. As highlighted by a health professional, children may develop a linking for a particular food that is subsidized by the vouchers, such as out of season

berries. When the child turns 4 years old and the vouchers end, parents will sacrifice to continue to provide berries for them, even if it requires the mother going without food. This concept was confirmed by a mother in this research who had introduced her children to berries when she, and her husband, were working. After the birth of her child, she lost her job and her husband's hours were cut to part time. Yet, she reported going without food herself to continue to purchase her son the berries that he had come to love. She explained that she does not want to deprive her child of a treat he enjoyed, and she believed was healthy for him. On balance, this does not support public health because the mother's nutrition is sacrificed, and the child's nutrition is not necessarily improved, as a local fruit may provide the nutritional benefit and be sustainable over the longer term. Therefore, while it may seem appealing that vouchers enable parents to introduce new and more expensive fruits, in practice this is likely not consistent with public health goals.

7.1.3 Consequences of Stigma

Stigma is likely a major barrier to Healthy Start's success. Besides "othering" and the acquisition of socially valued goods, another method of protecting oneself from stigma, according to stigma management theory, is avoidance (Meisenbach, 2010). Parents can avoid the stigma of benefits by not acknowledging they are eligible for Healthy Start and not enrolling.

While rational economic theory would suggest that people would always maximize their income, the rejection of welfare due to its stigma has been previously documented in the research (Moffitt, 1983; Stuber and Schlesinger, 2006). The findings here confirm that parents are proud and do not want to accept benefits except as a last resort.

Since everyone who is eligible for Healthy Start is sent a letter inviting them to apply, it is surprising that so many mothers report never having heard of the scheme. They are certainly distracted with a new infant in their home, yet perhaps they also choose not to know about it. In this way they avoid the stigma of acknowledging themselves to be needy enough to qualify for the benefit. Paul Spicker (1984) argues that the admission of stigma itself may be stigmatizing, which results in the denial of stigma. By claiming unawareness of the benefit, they may be avoiding the stigma of qualifying for it, whether or not they choose to apply.

Reduced uptake means that the scheme is less effective because it is not reaching those who need it. For this reason, it is important to evaluate a policy by considering the target recipients rather than only recipients. A scheme that is only reaching half of those eligible has eliminated the possibility of a positive benefit for half of the target population. The reduced enrolment therefore compromises programme efficacy even if the scheme were otherwise operating perfectly.

Equally importantly, this research shows that stigma makes individuals less likely to be aware of the scheme because of the reluctance of health professionals to discuss it. Many of the health professionals interviewed do not discuss the scheme with patients because they do not want to insult or embarrass them by assuming they are on benefits. Thus, even though some health professionals report that they do not believe the scheme is stigmatizing, their hesitancy to raise it tells a different story. Some described it as "obvious" that they would not offer it to everyone. The result is reduced visibility for the scheme and, consequently, uptake.

This view was reinforced by a midwife who expressed approval of an eligible mother who declined to apply for the scheme because she was "managing" as "sensible". This illustrates that the benefit may be viewed not as an entitlement, but as a gift that recipients should be grateful to receive and only accept if they really need it. Many recipients did express gratitude for the vouchers, reinforcing their belief that it was not a right. Many parents and health professionals described Healthy Start as inadequate, but better than nothing. The idea that "every little bit helps" is consistent with the view that recipients should be grateful for any assistance from the government.

Other, more general, consequences arise from stigma. For Lister, "othering" is more than a coping mechanism for those experiencing stigma; it is fundamental to perpetuating the stigmatization of the poor and helps to explain how the discourse of the lazy, unworthy welfare recipient persists. In managing their own internalized stigma, people maintain a culture of shaming, the same shaming that they do not appreciate when it is directed at them. This leads to social division, a fracturing of a group that has much in common. People who "other" deny themselves the ability to identify and create bonds of solidarity with those in a similar situation. While the recipients interviewed tend to think their situation is unique, in fact, in general, those interviewed described benefits as a last resort. Rather than a long-term dependency, recipients typically claim benefits for a short time as a result of a financial shock such as a job loss, pregnancy, or divorce. The findings show that recipients of benefits describe a preference for the money they have earned, pride of past employment, and accepting benefits as a last resort. This is consistent with the work of Sarah Halpern-Meekin and others who have researched the importance of the origin of funds (2018).

The social division that results makes coalition building for political change more difficult. By reinforcing the narrative of personal responsibility over the structural reasons for poverty, and creating barriers rather than alliances with those in similar situations, the existing power structures are maintained, and government is not pressed to consider structural inequalities. Furthermore, the deflection of stigma by "othering" or avoidance never completely works. Stigma is always internalized to some degree, leading to feelings of personal inadequacy that can affect the individual's confidence and resilience in difficult circumstances. The impact of the "lethal effects of social divisions" has been described by Wilkinson (2009) as resulting in psychological consequences, notably stress and damage to self-esteem and social relations, as well as reduced life expectancy (Wilkinson, 1992; Wilkinson and Pickett, 2009).

The government guidelines are clear; the call to do the "right" thing for children (and for the planet, if we add the well-intentioned food activists who encourage more sustainable and ethical consumption) is being heard. Mothers interviewed understood what was socially expected of them and they took this responsibility seriously and personally. None seemed confused about what they "should" be feeding their families and how. They face pressure to be good mothers, guardians of the family's nutrition and health while operating on a budget that, as studies have shown and parents confirm, is not enough to purchase a socially acceptable healthy diet. Mothers measure their own worth against an ideal they cannot meet, and it is a recipe for anxiety, depression, and anger, all of which have consequences for their children as well. Either they do not accept benefits and are unable to feed their families the way they are told to do, or they claim benefits and still fall short of their hopes. Many of the mothers in this research described anxiety and guilt that their children were not eating as well as they believe they should, although they

acknowledged the limitations and challenges that they face. However, when discussing other families, they held them to an ideal that often failed to consider the everyday challenges faced by everyone, but particularly those with limited resources. The inability to access highly valued foods can result in feelings of deprivation even when good nutrition is not compromised (Lang and Caraher, 2001; Stead *et al.*, 2004).

Under these pressures, women respond with frustration and by rationalizing and describing themselves as different from others, which blocks social solidarity, engenders more stigma, and worsens the problem of malnutrition (if we are to believe, as argued here, that stigma hinders Healthy Start's efficacy). They assume that others do not share their food values and knowledge and they often justify their use of benefits as a short-term solution to a problem, highlighting their paid work in the past and commitment to earn their own money when possible. But this is tiring and isolating mental work. Recipients report feeling looked down upon, which exacts an emotional toll. Even the language used by parents and health professionals to describe those on benefits – "deprived" and "vulnerable" – can be demoralizing (Lang and Heasman, 2004). The consequences of stigma on the well-being of mothers, which this dissertation argues is perpetuated by the Healthy Start scheme, which essentially tells women they are not trustworthy or motivated to be "good mothers", demands our attention. The consequences of maternal anxiety, isolation and frustration are no less impactful for their children's health.

7.2 Economic

This section discusses findings from the economic analysis of Healthy Start in two phases; first, the overall lifetime economic benefits and costs of the scheme to the government and the overall economy, followed by the direct impact of the scheme to those who benefit from it.

7.2.1 Economic Benefit/Cost Analysis

Overview

As the scheme has been justified as an economic investment in children, economic evaluations are warranted to monitor if the scheme is cost effective. Evaluating the cost effectiveness of government policies and public health programmes is a widely accepted practice (Liljas, 2010; Traill, 2012). Yet, to date there are no studies that evaluate the economic feasibility of Healthy Start. The purpose of the analysis provided in the findings was to attempt to fill this gap by assessing the potential investment return from participation in Healthy Start as the scheme is currently configured and with modifications to voucher levels and levels of participation. This analysis was done from the perspective of first the government, and then all of society. The benefits were modelled by following one cohort of beneficiaries throughout their lifetime. Building on the foundation developed by other researchers, a model was developed that compares the cost of providing vouchers for pregnancy and the child's first three years with the savings that would result from the reduction in healthcare costs related to poor nutrition. This was first calculated as the savings related to avoiding diseases directly linked to inadequate fruit and vegetable consumption, and then to all diseases linked to poor nutrition. Finally, the indirect benefits resulting from increased productivity in the workforce were quantified and included in the benefit to cost calculation.

The analysis provides a starting point that may assist policymakers in determining the best policy interventions and policy design as well as to facilitate ongoing evaluation. The foundation of this analysis is the assumption that a nutritional investment in children will improve the child's long-term health. The cost of poor nutrition is high, and consistent with prior research, a public health initiative that prevents poor-diet related disease is likely to be more cost effective than treating disease later.

Mechanism for Nutritional Improvement

The mechanism for nutritional improvement could be the increased availability of funds to access healthy foods, or the prescriptive value of the labelled vouchers. The strong association between family income and the child's health, behaviour and educational outcomes have been well documented (Lucas *et al.*, 2008). As discussed above, the findings show that parents are knowledgeable and prioritize a healthy diet for their children, but sometimes fell short of their own expectations because of a lack of funds to purchase healthy food. Therefore, an increase in family income would be expected to have a positive impact on nutrition.

However, as Healthy Start vouchers are a relatively small amount received for a short period of the child's life it is difficult to predict the long-term impact on nutrition. The prior research reviewed in Chapter 2 has not shown the vouchers to have a significant nutritional impact. Unless the vouchers exceed the amount currently spent by the family for the allowed food purchasing behaviour may not be affected. For this reason, this analysis also calculates the economic impact at higher voucher levels, assuming that the impact on nutrition is greater at higher levels. But, as discussed in Chapter 1, even at the current voucher level there is the potential for nutritional improvement. Even if the voucher is below what the family is currently spending, there is limited evidence that the prescriptive nature of a labelled voucher can have an impact beyond what would be predicted by rational economic theory.

Another key question is whether the vouchers would have a positive impact on nutrition that would persist throughout the recipient's life. When the vouchers end on the child's fourth birthday, the family may be forced to revert to poor eating habits. As there is little evidence on effective policy interventions that have been shown to increase fruit and vegetable consumption in children under the age of 5 years (Hodder *et al.*, 2018), the model's assumption that vouchers will have a long-term impact on consumption may be erroneous. Yet the assumption is reasonable because this is the justification for the scheme. Further research is necessary to refine the underlying assumptions, but the value of this analysis is to provide a starting point for discussion of the economic viability of the scheme overall and a method for comparing the relative economic value of different voucher amounts and eligibility criteria.

For the purposes of this analysis the voucher value was increased to that required to purchase infant formula for infants under one, and for pregnant women and children from one to four, either that required to purchase five portions or seven portions of fruit and vegetables per day, or the cost of the government recommended diet. This would ensure that the cost of providing healthy food was not an obstacle. As shown, affordability of diet studies have shown that more than half of families do not have a sufficient food budget to purchase the recommended diet (Scott, Sutherland and Taylor, 2018). However, this method likely understates what a family would need to spend, as it ignores the social and cultural

acceptability of the recommended diet and assumes food can be purchased in single portions with no waste.

Currently, the average Healthy Start benefit of £4.42 per week per household (Crawley and Dodds, 2018) is below the £5.71 spent by families in the lowest income decile for fruit, vegetables and milk. Although there is widespread concern, seen in the media and expressed by those interviewed in this research, that the vouchers may be spent on items not explicitly allowed, with the amount currently spent by families likely in excess of the voucher amount, there would be no incentive for families to misspend the voucher. The voucher serves as a replacement for funds that can now be used for any purpose. The findings indicate that a voucher increase to £8.50 per household per week that is limited to only fruit and vegetables would increase the budget of those in the lowest decile to meet the average amount currently spent in the UK. This is a potential solution to the problem of the fungibility of money, as the voucher would exceed current spending for those with income below the median, ensuring that they would have to increase spending on those items specified by the voucher. Eligibility was calculated at three different levels, the current level, all families below the minimum income standard, and universal.

Findings

The most compelling finding is that increasing the voucher amount and expanding the eligibility to a universal scheme increases economic return. Although the increase in the upfront costs is substantial, the improvement in nutrition results in even greater future healthcare cost savings, justifying an expanded scheme. The current design of the scheme is based on the assumption that vouchers will improve the nutrition of those on the lowest income but not for all children. If nutrition for children at all income levels were improved, expanding the scheme would be an economic imperative. The evidence on children's current fruit and vegetable consumption supports the conclusion that a broad policy response is required, as childhood fruit and vegetable consumption is below the recommended levels at all income levels.

The findings present the cost of the scheme under four voucher amounts and three eligibility scenarios. The healthcare costs saved were calculated assuming savings in lifetime healthcare costs due to disease related to inadequate fruit and vegetable consumption, and due to all poor diet-related disease, resulting in 20 - 80% reductions in healthcare costs. Finally, the indirect benefit arising from increased productivity in paid employment was also included in the model. Perhaps the most important finding was that under all scenarios increasing the eligibility to universal coverage increased the cost effectiveness of the scheme. A universal scheme required a lower assumption of cost savings than a targeted scheme in order to be economically viable.

At present, the full potential economic benefits of Healthy Start are not realized because of the restrictions on eligibility, which then drive the low uptake. Increasing uptake would increase the economic return. However, increasing the eligibility criteria has a far greater impact. An increase in eligibility that includes more families, but is still based on income, would increase the reach of the scheme to other families who struggle with the affordability of healthy food, but still, the scheme would likely suffer from low uptake due to the stigma of needs-based welfare. Furthermore, efforts to increase uptake are likely to be unsuccessful, as recent efforts in some areas have shown that despite the increased funding for promotion to increase Healthy Start's visibility uptake has not increased.

A remedy for this problem would be a universal scheme, which would eliminate the issue of stigmatization of needs-based benefits. A universal scheme would have greatly reduced administrative costs as well, as there would be no need to determine eligibility. Of course, the overall cost of the scheme would increase substantially as the total voucher costs would increase. The cost savings of improved nutrition could more than outweigh this cost if nutrition were improved. It is unknown whether nutrition would be improved for children at all income levels to the same degree. However, this analysis suggests that the economic benefit gained in a universal scenario warrants further investigation. The associated public health message – that fruit and vegetables are important enough to children's development that the government is investing in the scheme – may provide a nudge to encourage families to purchase more fruit and vegetables, even though the amount by which this would increase fruit and vegetable consumption is unknown.

The returns are greatest for a universal scheme with a voucher that is more than doubled from the current £3.10 to £7.60 per week. If all poor-diet related disease healthcare costs are considered, the returns on such a scheme would be 6.2 times the investment. When the indirect benefit of increased productivity is included, the returns exceed the investment by more than 10 times. The least economically viable scheme is the current scheme with restrictive eligibility, low enrolment and a low voucher amount. The current scheme does not have a positive return if only the low fruit and vegetable related diseases are averted, but becomes cost effective when all poor-diet related treatment costs are included. The economic return ranges from 2.5 to 4.1 in this case.

While the methodology is different, the conclusion of the findings is supported by a comparison with studies of the cost effectiveness of WIC in the US. There are many differences between the two programmes as well. WIC is a much larger programme with more valuable vouchers, an expanded list of allowed foods, and less restrictive eligibility criteria, but it still provides a useful comparison as they are both food voucher schemes for very young children. WIC has been called one of the "most successful and cost-effective nutrition intervention programs" (Oliveira and Frazão, 2015), even though existing economic evaluations of the program are limited (Traill, 2012). The existing economic evaluations of WIC are based upon the cost savings due to reductions in preterm births rather than improved nutrition. Yet on this measure alone, WIC has a benefit/cost ratio of as much as 6.8 times the investment (Devaney, Billheimer and Schore, 1992; Nianogo *et al.*, 2019). Consistent with the findings here, research argues that benefits would be even greater if the scheme were universal (Nianogo *et al.*, 2019).

Strength of the Analysis

The strength of this analysis is that it evaluates the costs and benefits of Healthy Start for the first time. This facilitates a cost effectiveness analysis on the overall economic viability of the scheme, but also calculates the current and potential economic impact on families, retailers and farmers under multiple scenarios. This provides the evidence to support an expansion of the scheme and an increase in the voucher amount. Perhaps just as importantly, it calculates the amount that the economy, particularly UK farmers, could benefit from modifications to the scheme. To my knowledge there has never been an evaluation of the potential for Healthy Start to support local farmers, but the potential, as discussed below, is significant.

Limitations of the Analysis

The precision of the analysis masks the imprecise nature of the assumptions that drive the model. Although the assumptions are derived from prior research, they are estimates, and small changes in assumptions will yield dramatic changes to the results. This analysis does not compare the cost effectiveness of different interventions. Low-cost interventions such as information campaigns and restricting advertising may have a more limited impact on nutrition, but it is possible that they are more cost effective because of the low cost of implementing them.

The analysis is dependent on prior research, and it should be refined as more Healthy Start specific data is available to support the underlying assumptions. This analysis does not consider the possibility that the impact on different socio-economic or racial groups may vary because the data for this is lacking.

Productivity gains that result from the better health of those not in the workforce are ignored in this evaluation. This fails to account for the value of caregiving, household tasks and leisure activities. Given the gendered nature of caregiving and household tasks, this particularly undervalues the contribution of women. More broadly, the analysis is, by its nature, one dimensional. It does not consider or value any elements of the scheme that cannot be quantified. The drivers of food choice behaviour, family dynamics, and food sharing are not considered. Rather, it is assumed that additional family resources will be spent on healthy food for the designated recipient.

Undertaking an economic analysis raises a series of questions that are unanswered. What is the mechanism by which the voucher changes behaviour? Is it a nudge and reminder to parents? Is it primarily an income supplement? Does the voucher displace funds already allocated for food and support families in other ways? Do different segments of the population respond differently? What is the difference between long and short-term effects? Further research is necessary to understand the underlying behavioural reasons for changes in consumption that may be driven by vouchers. This highlights the importance of multi-disciplinary research, as economic research only sheds light on one aspect of the scheme's impact. The questions it has raised may be better understood, for example, by a better understanding of social politics.

Finally, the cost effectiveness of a policy is only one aspect to consider. The human capital approach taken in this analysis is widely accepted (Robinson, 1993; Rayner and Scarborough, 2005), but as discussed above, is problematic from a social perspective. The dark side of the approach is that mothers are tasked with maximizing the economic value of their children by producing healthy, contributing members of society. This justifies controlling their behaviour and ignores the costs to mothers of bearing this responsibility.

7.2.2 Other Economic Impacts

Families

Analysis of the population food spending data by income level supports the conclusions of the qualitative research. Families at the lowest income levels spend about the same proportion of their budget on the basic food groups. The biggest difference is that those on a low income spend less on alcohol and food eaten outside the home. The concern that families with low incomes misspend their budget on alcohol and

takeaway appears unfounded. Families at every income level are not purchasing, on average, enough fruit and vegetables to meet the government recommendations. But those in the lowest quintile allocate a relatively higher portion of the food budget to fruit and vegetable purchases (13% compared to an overall average of 8%). Overall, those at the lowest income level spend much less on food per person, about half of the average for all families, yet they purchase more calories. This supports the conclusion that those with a low income value fruit and vegetables, but due to the relatively high cost, the food budget must be maximized with food with higher caloric density.

As the current voucher level is well below the £5.71 currently spent by families in the lowest income decile for fruit, vegetables and milk, rational economic theory would suggest that the vouchers do not change purchasing behaviour, except as a reminder or nudge. The voucher rather contributes to the overall household budget, which can be used for any purpose, effectively working as a cash benefit. But it is a needlessly expensive and inefficient cash benefit because of the administrative burden of enforcing the restrictions and reimbursing supermarkets. It is also inconvenient for recipients because vouchers can be lost, must be presented when shopping, the value must be used in one trip, and they have an expiration date. A cash transfer would efficiently avoid all of the friction involved in a voucher system.

As shown above, if the government wanted to increase the budget of those in the lowest decile in order to impact their consumption of more fruits and vegetables, the findings indicate that a voucher increase to £8.50 per week per household would be necessary.

Supermarkets

The vouchers provide more than a benefit for families, as they also provide a revenue stream for the merchant or farmer which could be significant with certain modifications to the scheme. The findings show that currently the vouchers are typically redeemed in large supermarkets, and the current amount of the redemptions is not significant to their income. However, if the voucher were substantially increased or became universal, it would become more important to the retailers. Even at current levels, supermarkets are using the vouchers as a public relations and marketing tool. Some supermarkets have announced additional incentives to Healthy Start recipients through voucher matching or free additional goods when the vouchers are redeemed (Calman, 2021). While this appears altruistic, it is smart business and an inexpensive marketing tool that encourages shoppers to do their weekly shopping in their stores.

Farmers

The Healthy Start scheme does not incorporate other government priorities or policies. Currently the UK is missing the opportunity for synergies to support local agriculture. Presently the impact of the Healthy Start scheme on the farmers who grow the food is small, with farmers receiving a fraction of the amount of revenue the supermarkets receive. Since the UK imports about half of the fruit and vegetables consumed, the impact on UK farmers is even less.

Currently, Healthy Start provides revenue to UK farmers of about £7.5 million, £6.1 for dairy farmers and £1.3 for fruit and vegetable farmers but, as shown, it is not likely to be an additional revenue source because families are probably not spending more than they otherwise would. Yet, there is a significant potential to support local farmers. If the vouchers were increased to £7.60 and there were universal

eligibility for all children under four, combined with a more restrictive voucher that could only be spent on fruit and vegetables from local farmers, the revenue for those farmers would be £1.8 billion. At the current voucher level, the impact would be £731 million. This amount would provide a significant boost to farmers as well as to the local economy through the expansion of farming to meet the increased demand. The expansion would help related businesses such as farm inputs and transportation, as well as increase the farmland in the UK, adding to the aesthetic beauty of the countryside and, potentially, tourism.

7.3 Political

This section begins with a discussion of the operational issues associated with the implementation of the policy, and then follows with an examination of the origins of the operational and social issues described, the policy design.

7.3.1 Policy Operations

The findings of this research have identified two operational reasons for lack of visibility and uptake for Healthy Start: lack of support from health professionals and impediments in the application process.

Lack of Support from Health Professionals

Midwives and health visitors are the first point of contact with pregnant women, and offer an opportunity to promote the scheme. However, several reasons were identified in this research for this not occurring: a lack of awareness of the scheme due to inconsistent training, time constraints, confusion about responsibility, a focus on vitamins, and the fear of offending patients.

Lack of Training

The findings showed inconsistency in the training in Healthy Start offered to health professionals. None of the midwives or health visitors interviewed in Camden had been offered information on Healthy Start as part of their initiation whereas there was a training system in place in Leicester: this locational difference highlights the need for consistent national guidelines. Without a policy or system in place to ensure that Healthy Start vouchers are discussed with the health professionals tasked with being the gatekeepers for the scheme, and a system for ensuring that they discuss the scheme with clients, there is little promotion of the scheme.

Time Constraints

All of the midwives expressed frustration at the lack of time in the appointments allotted to each patient to cover any topics beyond the list of required health checks at each point in the pregnancy. The time constraints are not surprising given the reduction in children's centres and staff.[5] As the national government delegated responsibility to local authorities without increasing local funding, it was inevitable that services would need to be cut. While these cuts have reduced costs in the short term, the longer-term impact of the rushed delivery of medical services is difficult to quantify.

[5] The number of children's centres declined by 33% from 2009 to 2017 (Smith *et al.*, 2018)

Confusion about Responsibility

The findings show confusion among healthcare professionals about responsibility for the scheme. Some midwives thought it was the welfare support staff who were responsible for promoting the scheme. Unless individuals took responsibility for promoting the scheme among their patients, it did not occur. While this confusion is partially the result of the scheme straddling welfare and public health policy, it is also due to the implementation of the policy with its lack of clearly defined advocates for the scheme (Machell, 2014).

Focus on Vitamins

The health professionals interviewed as well as those observed in working group meetings consistently focused on vitamins, not vouchers, when discussing Healthy Start. Those interviewed suggested that the reason for this is that vitamins are more closely aligned with the traditional health recommendations for their patients, as nutrition was not something they routinely discussed. They also found vitamins easier to promote because they are recommended for all pregnant and lactating women and infants. As vitamins have become universal in some areas, including Camden, one of the research sites, the reminder to discuss Healthy Start with patients has been eliminated and promotion of the vouchers likely suffers as a result.

Fear of Offending Patients

Many of the midwives did not promote the scheme because they thought it would be offensive to those ineligible to suggest they may receive needs-based benefits. This was discussed further in Section 7.2.3 in the context of the relationship between stigma and low uptake.

Application Process

As cited in the findings, the application process was described by a supervisor as "long-winded" and "torturous" (SL1). The issues identified were the language of the application, the need to reapply as circumstances change, and the requirement of a health professional's signature.

Language

As the application is only available in English, it is difficult for those with limited fluency. Many of the mothers interviewed could not read or write in English, and would need to rely on assistance from a health professional to complete the application.

Change of Circumstance

None of those interviewed were aware of the requirement for the application to be resubmitted after the birth of a child. This creates an additional obstacle for families to continue receiving the benefit at a time that is especially busy and stressful. Additionally, many of the families described living very close to poverty – where job loss, cut in working hours, divorce, or birth of a child could change a family's eligibility for benefits. Mothers described applying once for Healthy Start and not reapplying even though their family's financial circumstances had changed.

Health Professional Signature

At the time of this research, the application required signing by a health professional. The signature could encourage a better connection between the healthcare system and pregnant women, infants and new

parents, but there is no evidence that the requirement works in a way that facilitates that connection. In practice this was another barrier for applicants and an extra responsibility for already overworked health professionals. The Covid-19 pandemic resulted in elimination requirement for a health professional signature because many health appointments became virtual. However, the Healthy Start website still requires the application to be printed and signed by the applicant before sending, requiring that applicants have access to a computer and printer. The application still has a place for a health professional signature, which is likely confusing to potential applicants. While there has been discussion of a switch to an online application, it has not yet occurred, although it would be particularly welcome with many applicants housebound due to the Covid-19 restrictions.

The implementation of Healthy Start has been flawed, but the policy design has also resulted in many unintended consequences.

7.3.2 Policy Design

Many of the operational problems and social issues identified in the findings have their origins in the policy design. The following issues have been identified:

1) the scheme straddles welfare and public health policy
2) the framing of the policy problem is underdeveloped
3) the objectives are not clearly articulated or measurable and there is no system in place for monitoring or evaluation
4) the inherited policy mechanism may not be appropriate
5) the budget is inadequate
6) there is a lack of coherence with related policies and goals

The section closes with a discussion of current events and the role of the state in food provisioning.

The Scheme Straddles Welfare and Public Health Policy

The origins of the issues with the Healthy Start scheme lie in the WFS. Both were rapidly implemented without proper definition of the problem, administrative support structures, or clearly defined accountability for the scheme's operations. Public health was not the primary impetus for the creation of the WFS. With the best of intentions, and an assumption that the problem was the supply of milk, the Ministry of Health introduced a designated supply for mothers and babies in July 1940. This was expanded to include cod liver oil, concentrated orange juice, and vitamins in 1941.

In order to incorporate the growing awareness of the importance of fruit and vegetable consumption while maintaining the existing budget, the WFS was rebranded as the Healthy Start scheme. It straddles health, economic, and social policy. The scheme is often cited as a government policy that combats childhood hunger, poverty, and obesity. However, it appears that supporting public health was secondary to political expediency when the policy was formed (Machell, 2014), and this has persisted. New Labour had been elected on a platform to create a more equal society, including support for children (Acheson, 1998; Hills and Stewart, 2005; Dowler and Spencer, 2007). Healthy Start was consistent with that agenda, and appears that then as well as now, it is more of a political statement than a well thought out response to an

identified problem. Rather than a large-scale programme to address structural inequalities or no response at all, Healthy Start appears to be a politically palatable compromise.

Because the vouchers are limited to healthy food and available for children, a group seen as especially worthy because they are perceived as blameless and also viewed as an economic investment, there has been political support. An increase in welfare for low-income families likely would have been more difficult, given the UK's government's rhetoric of personal responsibility and reducing dependence on welfare. There is a tension in policy design between policies that target upstream structural inequalities and those at the other end of the spectrum that target downstream issues with behavioural nudges. The Healthy Start scheme can be seen to be in the middle of this policy continuum because, as the vouchers are limited, it provides a financial as well as behavioural intervention.

Perhaps because of the unclear focus of the scheme, as described in Section 5.1, the responsibility for promotion of the scheme is not well understood or documented. There are no formal national guidelines on training for health professionals, thus the training of midwives and health visitors is driven by the local supervisor and the priorities of each local authority. In Camden, none of the health professionals interviewed had received training and their first introduction to the scheme was usually when a parent requested a signature on the application form. In Leicester the midwives had received training and they routinely offered the vouchers to their patients but the impact on uptake does not appear to be significant as uptake in Leicester is only marginally better than Camden. At the time of research, the uptakes were 68% in Camden and 74% in Leicester. Despite recent efforts, uptake has continued to decline. The most recent uptake data for January 2021 shows uptake in Camden has declined to 57% and in Leicester to 60% (NHS Business Services Authority, 2021).

The confusion over responsibility may stem from the lack of a clearly defined problem and misunderstanding of the problem that the scheme is meant to address. A substantial body of research on social and economic contributors to malnutrition could have informed the policy when it was developed. These contributors are outlined in Chapter 1, and confirmed by the findings of this research discussed above. Nutrition is a result of economic realities as well as complex societal and family dynamics. There is little evidence that knowledge of the social and economic realities of the target recipients, which could have resulted in a more clearly defined definition of the problem, was incorporated into the policy, or that its social and economic implications were studied. Similarly, the needs and preferences of beneficiaries and existing evidence of the effectiveness of the WFS were not considered (Machell, 2014).

The Framing of the Policy Problem is Underdeveloped

Traditional policy analysis considers the goal of a policy and attempts to determine whether it is meeting those goals. But as posited by Carol Bacchi and Susan Goodwin (2016), it is necessary to look behind the stated goals of the policy and critically analyse the knowledge that supports the policy, asking what the policy design can tell us about how the problem is conceived by policymakers. "Policies do not address problems that exist; rather they produce 'problems' as particular sorts of problems" (Bacchi and Goodwin, 2016, p. 16). As Paul Cairney posits, the definition of the problem relates to power and politics

(Cairney, 2020).[6] Policies are based on a set of assumptions that are often not explicitly stated but reflect cultural values that are widely taken for granted. The way the problem is framed not only determines the policy solution but also sends a message to society about the nature of the problem.

In these ways, the knowledge, lifestyle, budgeting and, indeed, parenting skills of low-income parents are called into question. Much has been written about the social construction of the poor, with their perceived inability to budget, make healthy choices, and control their impulses (Shildrick and MacDonald, 2013; Jensen, 2014). The media-constructed welfare mother spends her government benefits on cigarettes and alcohol (Seccombe, James and Walters, 1998). Rather than being the victims of forces outside of their control, individuals are blamed for their children's malnutrition, the result of a believed lack of knowledge, skills, or good parenting. The idea that the poor are in need of rehabilitation is not new. Margaret Thatcher stated in 1978,

> *Nowadays there really is no primary poverty left in this country . . . In Western countries we are left with problems that aren't poverty. All right, there may be poverty because they don't know how to budget, don't know how to spend their earnings, but now you are left with the really hard fundamental character-personality defect* (Thatcher quoted in Shildrick, 2018, p. 11).

Yet, as discussed above, the findings from this research show that parents did not resemble this description. They displayed knowledge of nutritional guidelines, good cooking skills, creative shopping and budgeting techniques, and above all a desire to provide high quality healthy food for their children. Their inability to achieve their ideal diet was due not to a lack of will, but primarily a lack of funds.

A food voucher is a solution to this problem. However, if the problem were assumed to be solely a lack of funds, there would be no reason to limit the vouchers to a limited number of food items. A limited voucher assumes that restrictions are required to convince low-income people to buy "healthy" foods. The limited nature of the vouchers implicitly assumes that the problem is knowledge (these populations do not know how to eat healthfully), budgeting (they do not have the money, or manage their money effectively enough, to spend what is required to obtain healthy foods), and/or willpower (they are unable to prioritize healthy foods). If the vouchers were provided to all parents they would be seen as a public health message, namely, that it is crucial for pregnant women and children to eat in a certain way. But because the vouchers are only available to those on a low income, it is assumed not only that those groups lack the funds to properly feed their families, (there would be no need to provide a limited voucher otherwise) but that this population cannot be trusted to do so without boundaries. Low-income people, the scheme implies, need to be required to make healthy eating a priority or else it will not occur. Vouchers may be called paternalistic because they impose a control on recipients that is not imposed on the rest of society.

The issue is not just one of childhood nutrition, but of the causes of poverty, the remedies for poverty, and the way those experiencing poverty are viewed, both by themselves and others. When poverty is thought of as a single issue, such as food, fuel, or digital poverty, it makes the problem seem manageable

[6] The tension between structure and agency remains the central sociological question (Archer, 1995)

(Chakrabortty, 2021). A food voucher appears to be a solution to food poverty, but does not address the underlying reason for poverty, and therefore will never be more than a temporary band-aid.

As the findings show, health professionals and parents hold individuals responsible for their own nutrition, assuming a lack of knowledge is the problem. In this way behaviour and parenting style is largely held responsible for the broader social issues beyond an individual's control, such as low wages, insecure work arrangements, and systemic poverty which result in the inability to access healthy food.

This is particularly important for the health behaviour of parents, but particularly mothers, due to the importance of nutrition on the developing brain. Research on the importance of nutrition in the first 1000 days has been widely accepted, and the parents in this research all went to great lengths to ensure that their young children were well-nourished. They expressed worry about the sufficiency of their breastmilk and defended their decision to formula feed as a supplement or exclusively, even though they understood that breastfeeding was the best for their child. Weaning provided a new set of concerns, what foods to start with and how much their children should eat. The child's own preferences, and those of other family members, often interfered with the parents' ability to provide an ideal diet, yet, parents describe "beating themselves up" when children were not perceived to be eating enough vegetables.

As shown in the findings presented here, parents and health professionals alike cited education as a solution to poor nutrition. This is consistent with the belief that if mothers can be encouraged to provide better nutrition for their children in the early years, those children will grow up healthier, smarter, stronger, and more resilient– in other words, endowed with the skills to contribute to the labour force and escape poverty. Health behaviours become increasingly moralized in this context. If good nutrition is the key to escaping poverty, any parent who does not give their children that tool is not a decent parent, and it appears justifiable for the government to interfere in family life, which UK policy has traditionally not done. In this way health behaviours become moralized and markers of good parenting, and policymakers come to believe that parenting education or redirection is the solution to social problems (Churchill and Clarke, 2010).

With the problem framed in this way, as a result of a lack of knowledge and skills, and therefore inadequate parenting, the rational policy intervention appears to be limited vouchers and nutrition education. But such an understanding of the problem is not supported by the existing literature or by this research. Research has consistently shown that the poor do not lack nutritional knowledge and use sophisticated budgeting and purchasing techniques to provide the best food for their families (Dowler, Turner and Dobson, 2001). As shown in Chapter 4, and discussed in more detail in Section 7.2, this research has shown no perceptible difference in awareness of the dietary guidelines and desire to feed children healthy food between those eligible for Healthy Start and those who are not. However, the perception of the problem as a lack of knowledge has taken hold despite a lack of evidence. Parents and health professionals in this research cited a lack of knowledge as the problem leading to poor nutrition, consistently separating themselves from others because of their nutritional knowledge and cooking skills. While education is widely seen as the solution to the problem, there is a lack of evidence that education is effective at improving children's nutrition (Williams *et al.*, 2012). The Overton window names politically acceptable policies based upon mainstream discourse (Lynch, 2020) and its theorization may explain why Healthy Start relies less on research than on public opinion.

A policy that reflects a misunderstanding of a problem will not only be ineffective at solving the problem (as Healthy Start has been), but will also perpetuate the misunderstanding, in this case a message that is damaging to the self-esteem of recipients and the social cohesiveness of vulnerable groups. This is reflected in the findings, as parents protected themselves from the stigma associated with the policy by separating themselves from other parents on the basis of not only their nutritional knowledge and values, but also their reluctance to accept welfare. When they were recipients of welfare they distinguished themselves from other recipients by their past work histories, their desire to work, and their unusual circumstances. Furthermore, the existence of the Healthy Start scheme may allow the government to escape with a small tokenistic policy rather than one that addresses the root problems of poverty, hunger and obesity.

The Objectives are not Clearly Articulated and Measurable and there is No System in Place for Evaluation

It is difficult to conclude whether the scheme is meeting objectives, or even what those objectives are. Among the managers, health professionals, and parents interviewed, some think it is a financial benefit to address poverty, others see it as an encouragement for healthy eating, and others imagine it as a gesture of good will. Without set goals, evaluation of the scheme has been difficult, often relying on favourable impressions expressed by health professionals and recipients. But of course, recipients are likely to express appreciation for something they receive for free, as social obligations dictate when receiving a gift (Caplan, 2016, 2017). As discussed above, recipients were thankful for the vouchers, but the language of gratitude some recipients used to describe the vouchers is more reminiscent of a gift than an entitlement. This does not provide evidence that the scheme is working to improve nutrition and reduce health inequalities. As cited in the findings, two respondents in fact perceived the scheme as a public relations tool "to make the government look like they are trying to do something" (HWL3) and "to make it seem like they are helping, but they're not really helping" (PC15).

If we assume the scheme's goal as stated by the Department of Health (2005) is to "improve diets in pregnancy and early years, particularly by encouraging fruit and vegetable consumption" and ensure "mothers and young children in low-income families will have greater access to and encouragement from health professionals and others to eat a healthy diet," interviews with health professionals reveal that this is not occurring. They express doubt that there is enough nutritional education in the scheme to improve nutrition, and do not have the time or initiatives in place to provide that education. But, as discussed above, lack of knowledge is not the primary constraint that kept families from eating as many fruits and vegetables as they believed they should.

Ambiguity about the intentions of the policy reduce uptake. A manager found it difficult to promote Healthy Start vouchers because she did not view it as a public health policy owing to it being limited to those on a low income. She believed that public health messages should be universally delivered to all patients, such as the need for certain vitamins in pregnancy. Since the scheme was more likely to be described and understood as a welfare policy by health professionals, there was confusion over who was responsible for publicizing the scheme, believing it was the responsibility of the DWP.

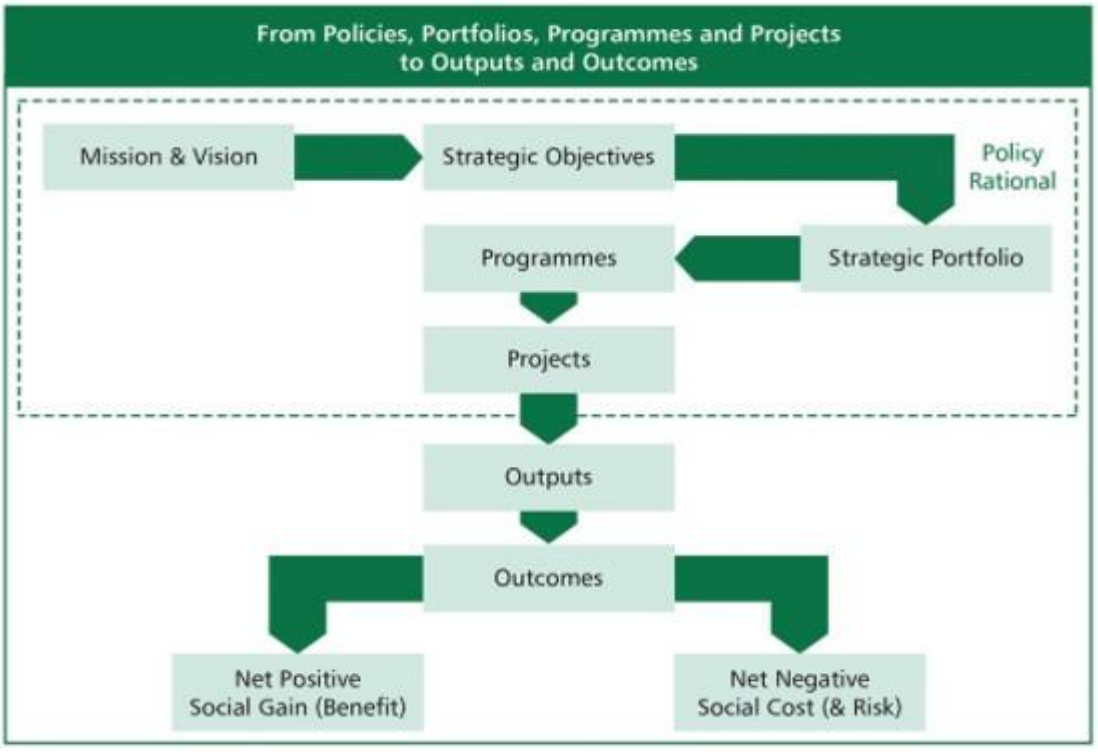
While it is difficult to claim that the scheme is failing without clear measurable objectives, there is weak or no evidence in prior research or in this study that the vouchers have an impact on nutrition or health

inequalities. The low and declining uptake of the scheme, despite renewed interest and support, is further evidence that the scheme has not been designed or implemented effectively.

The recipients interviewed report spending their vouchers on milk, fruit, and vegetables, but they may not be representative of recipients in general. The government does not track how the vouchers are spent, but even if voucher spending were tracked and the vouchers were all spent on fruit and vegetables, it does not necessarily mean that consumption of fruit and vegetables increased as a result of the vouchers. Without a detailed analysis of spending and consumption patterns before and after the vouchers were received, it is impossible to determine if the purchases changed purchasing behaviour and increased consumption, since the vouchers could merely replace funds that would have otherwise been spent on the allowed items, freeing up cash for other uses. This is not necessarily a bad outcome, but it is an inefficient one. If the value of the voucher is to increase available funds, a cash payment would be a more efficient, easier-to-use method with fewer administrative costs and less stigma, because the benefit would be invisible at the point of redemption (the retail outlet). The only advantage in this case of a labelled voucher is its political acceptability, as taxpayers are assured that their money is only spent on healthy food.

Many of these issues can be traced to Healthy Start's policy development as a modification of a wartime scheme meant to shield a vulnerable population from the nutritional effects of rationing. The government guidelines for policy development were not followed in its development. These guidelines state that the following steps from identifying a mission to evaluating outputs and outcomes, should be followed.

Exhibit 34: Policy Development from Mission to Outcomes



From HM Treasury (2020)

This is consistent with a framework for policymaking that identifies the following steps as necessary for effective policymaking and evaluation (Cairney, 2020). Defining the problem the policy is meant to address determines the rationale for the policy; clearly defined, measurable objectives facilitate appraisal; and monitoring, evaluation and feedback provide the mechanism for improvement after implementation.

Exhibit 35: Effective Policymaking and Evaluation

The following chart is proposed as a potential framework for evaluating the scheme with clearly articulated objectives, mechanisms to achieve the objectives, and measurable outcomes. It reflects the accepted belief that effective policy requires objectives that are clearly articulated, measurable, consistent with other government policies and aims, and economically viable (Waters and Hood, 2017).

Exhibit 36: Potential Policy Framework for Evaluation of Healthy Start Scheme

Objective	Mechanism	Outcome/Measurement	Evidence
Improve nutrition in children	Reach those who cannot access healthy food	Consistently high uptake of at least 80%	50% and declining uptake despite efforts to increase visibility
	Reduce food insecurity	Food insecurity measures in population decline	Food insecurity has increased
	Increase fruit and vegetable consumption	Fruit and vegetable consumption in children increases	No change
Positive economic Impact	Reduce healthcare costs	NHS costs related to dietary illness	NHS costs due to non-communicable diseases are increasing
	Support UK economy	Revenue of UK farmers increase	Impact on UK farm revenue is negligible
Promote social cohesion	Eliminate or minimize stigma of scheme	Assess stigma associated with scheme	Parents report scheme is stigmatizing
Environmental sustainability	Ensure products purchased with vouchers are environmentally sustainable	Vouchers support local sustainable farmers	Vouchers are primarily spent in supermarkets; data for how they are spent is lacking
Consistency with other priorities/policies	Align with other nutrition initiatives	Policy is part of larger web of nutrition policies	No connection with other initiatives

The Inherited Policy Mechanism May not be Appropriate

Healthy Start inherited the use of restricted vouchers targeted at low-income recipients from the WFS without evaluating if this was warranted or had unintended consequences. The issue of whether social benefits should be universal or targeted based on need has been much debated. David Ellwood (1988) describes the allocation of benefits based on income as the "targeting-isolation conundrum" and convincingly argues that society's desire to use its resources wisely by targeting benefits has the effect of isolating the poor and reducing the chances that they will join mainstream society. The Earned Income Tax Credit policy in the US has been very successful because it provides welfare to low-income people through a mechanism, a tax return that every citizen files, that allows the recipients to maintain dignity and does not identify them as poor (Sykes *et al.*, 2015).

A prominent social theorist, Richard Titmuss, argues that "There can be no answer in Britain to the problems of poverty, ethnic integration, and social and educational inequalities without an infrastructure of universalist services" (1968, p. 123). Fundamental to his argument is that confidence in the political system and a viable democracy requires a sense of shared social responsibility for ensuring that citizens' basic needs are met with humanity and dignity. While it may be tempting to concentrate benefits where the need is greatest, this results in a sense of inferiority for those who use the benefit, undermining its effectiveness and stratifying society into those who receive social welfare and those who pay for it. As outlined in Chapter 1, there is a widespread misunderstanding about the components of social welfare and how it is used over a lifespan. Rather than the takers and the givers, the reality is that welfare benefits have the effect of smoothing income over a person's life (Hills, 2017).

Targeted economic benefits can be structured as a cash transfer or labelled vouchers. As discussed, "labelled" vouchers come with the risk of stigma. They send the message that the government must restrict the beneficiary's choices, and in this case, as the vouchers are only given to low-income parents, it implies that the poor cannot be trusted to make wise choices. There is an obvious hypocrisy in attributing "indulgence" to the lower classes, a group of people incapable of satisfying their whims, while the upper class maintains its discipline. The findings presented here corroborate prior research that questions whether the paternalistic restriction of benefits is necessary and that recipients will make bad choices without government oversight.

On the other hand, limited vouchers can be viewed as a nudge to remind recipients to purchase healthy food. As the problem of inadequate fruit and vegetable consumption is present at all income levels, a universal voucher for fruit and vegetables may be justified. But the large body of knowledge that shows that low-income mothers are particularly resourceful at budgeting and unlikely to abuse the system does not support the necessity of income restrictions (Dowler, 1998; Dowler, Turner and Dobson, 2001; Sykes *et al.*, 2015). As discussed, the findings of this research show that food choice is the result of a complex set of factors affected by available resources and family dynamics, but not a lack of knowledge or good intentions.

The concern that vouchers are misspent is a topic that causes public and government concern. The research project commissioned by the government to determine if vouchers were being spent on

disallowed items sent government employees into retail outlets with vouchers to test the retailers by attempting to purchase disallowed items. The findings from that small study show that some retailers were not strict and allowed those purchases, but this does not shed light on whether recipients actually misuse vouchers, leading to confusion about what question the government wanted answered. Some recipients expressed frustration that the vouchers are limited and dated, but no one questioned whether the limits were necessary for others to ensure that the benefit would not be misspent. Health professionals also expressed concern that vouchers were misused, citing examples they had heard or read about of people using them to buy unhealthy items, perhaps as treats for their children. This is in line with media reports that describe Healthy Start recipients using the vouchers to purchase cigarettes and alcohol (Donnelly, 2011), and consistent with recent press that parents use school meal vouchers, intended to replace free school meals while children are at home due to Covid-19 restrictions, to purchase alcohol (Brown, 2020; Standley, 2020).

The Budget is Inadequate

At the time the policy was formed the voucher amount was calculated based on maintaining the costs of the WFS rather than contributing the amount necessary to purchase healthy food (Machell, 2015). There was no mechanism in the policy to ensure that the voucher value was regularly appraised, and as a result the amount has not kept pace with inflation. The high cost of infant formula and fruit and vegetables was cited as a barrier to their purchase and the voucher amount was described as low by many parents, both recipients and non-recipients. Although recipients as well as health professionals often said "every little bit helps", this is troubling. If the objective of the scheme is to improve nutrition, the amount should relate to the cost of purchasing healthy, socially acceptable food. Providing a small amount contributes to the sense that the scheme is a small goodwill gesture or gift rather than a well-designed and supported policy to improve nutrition.

Lack of Policy Coherence

There is a recognition among researchers that policies that are coordinated with other goals and policies are likely to be the most successful (Lang, Barling and Caraher, 2009; Hawkes *et al.*, 2020). Yet, there appears to have been no coordination of the scheme with other government objectives or public health initiatives when it was designed and implemented. The opportunity to coordinate with the DWP to identify potential recipients exists, but there is no evidence that this occurs. The opportunity to reinforce the public health message of fruit and vegetable consumption for young children could be coordinated with other nutritional initiatives and promotional campaigns, but this does not appear to occur either. Casual observation of breastfeeding and other infant feeding classes in the children's centres revealed only one of instance of a teacher with knowledge of Healthy Start that included information in the class about the scheme.

Current Events

As has been shown, the policy design may be responsible for the difficulties the scheme has experienced in uptake and effectiveness. The policy formation and design appear to have been rushed and consequently important research has been overlooked. And without a system of monitoring and evaluation, policy design has not been reconsidered. The significant and steady decline in uptake has

focused civil society and the government on increasing uptake and making minor modifications to delivery rather than questioning whether the policy is the best tool to address poor nutrition in young children.

One of the reasons why the scheme has not been fundamentally re-examined may be the inability to question a scheme on healthy food for children. All of the health professionals and parents interviewed in this research support the scheme and perceived it as a good idea, even though many had no knowledge or experience of the scheme before it was described to them. As cited in the findings, one health professional summed it up by claiming she was a "great believer in Healthy Start" despite having no knowledge of the scheme.

The Covid-19 pandemic has had a profound impact on dietary inequalities, and brought new attention to the problem of food insecurity, particularly in children (Loopstra, 2020; Power *et al.*, 2020). Campaigners such as Marcus Rashford have brought attention to the scheme which has resulted in an expansion of the foods that can be purchased with the vouchers and an increase in the voucher amount from £3.10 to £4.25 per week, to begin in April 2021 (Churchill, 2021). The uncertainties surrounding Brexit and future trade agreements and changing political structures will provide challenges to the UK food supply and to UK farmers and businesses (Lang, 2020). Yet there are also opportunities to rethink trade agreements, support for farmers and social policies in a way that could revitalize the UK farm industry and support nutrition. Determining the role of the state, charity and industry to solve problems of food access is critical to determining how policy will be developed.

Role of State

The founder of the UK welfare state, William Beveridge, imagined a social safety net that would protect all citizens 'from the cradle to the grave.' Fundamental to his belief was the idea that the collective interest of citizens was best served when all were supported throughout their lives, taking care of each other in times of need (Beveridge, 1942). As seen above, Titmuss, who helped to define the post-World War II welfare state, believed in the importance of universal services available to all on the basis of needs rather than income (Titmuss, 1968, 2019). He posited that social justice was best served by robust universal state welfare and that solidarity and social relationships relied on the reciprocity that arose from taking care of each other (Titmuss, 1970).

In the 1980s, politics reflected a shift in the view that it was the role of the state to solve social problems and increasingly individuals were believed to be responsible for their own situation. By 2010, the country was more consistently anti-welfare (Deeming and Johnston, 2018; Albertson and Stepney, 2019). The welfare mother, in particular, was socially constructed as responsible for her own fate, lazy, unmotivated, and reliant on government benefits that other hardworking citizens provided (Seccombe, James and Walters, 1998). The rhetoric of personal responsibility has become ascendent and as a result the state has withdrawn from welfare provision leaving a gap that has been increasingly addressed by private charities. This has in turn diminished the responsibility of the government to solve social problems. An example of this is the proliferation of food banks, which are often a hybrid between charity and private industry, to address the increasing food insecurity caused by the reduction in government support (Lambie-Mumford

and Green, 2017). Food banks have become increasingly accepted as a permanent feature of food welfare and the food system (Cummins *et al.*, 2020).

The tension between the responsibility for welfare provision by government, civil society and industry has been blurred in the Healthy Start scheme. In 2013, The Alexandra Rose Charity began offering vouchers to Healthy Start recipients to purchase fruit and vegetables from street markets in three London Boroughs (Lloyd, 2014). Through active fundraising from individuals and corporate partners the scheme has expanded into many more areas and nearly £600,000 vouchers have been redeemed since 2014 (Alexandra Rose, 2020). Recently, Healthy Start also relies on corporate partners to increase the value of the vouchers to recipients as several supermarkets have announced plans to increase the value of Healthy Start vouchers redeemed in their stores (Calnan, 2021). These developments highlight the tension between civil society, government and industry for welfare provision.

As has been shown, the design of the Healthy Start scheme has contributed to its weaknesses. As a modification of a prior policy, it inherited much of its design and budget from the WFS. As a result, the policy solution was based on an inaccurate perception of the problem, the objectives were not clearly articulated, measurable, or routinely monitored, and targeted, restrictive vouchers contribute to the stigmatization of recipients. Further, opportunities were missed to align the policy with other government departments, policies and objectives.

7.4 Summary

Many of the problems with Healthy Start reflect the policy design which is based on an inaccurate diagnosis of the underlying problem. The restrictive vouchers are inefficient economically and damaging socially. Vouchers reproduce the message that low-income parents cannot be trusted to make the healthy decision for their children, despite a long history of research, reaffirmed here, to the contrary. Identifying the child as an economic investment justifies sanctioning the behaviour of mothers, yet the consequences to them have not been considered. While there are many reasons for the low uptake of the scheme, the stigma of needs-based assistance is likely a major contributor which also serves to undermine the confidence of recipients. The economic analysis of the scheme supports an increase in the voucher amount and universal eligibility.

Chapter 8: Conclusion

8.0 Introduction

On the surface, Healthy Start's vouchers aimed at young children from low-income families appear to be a cost-effective, targeted intervention to reduce health inequalities. Healthy Start's public image suggests that it is a solution to childhood food insecurity, hunger, and obesity. The scheme is well regarded and even those with no knowledge of the scheme believe it is a good idea. Recipients are thankful for the vouchers, and they unanimously support the scheme. Nobody really wants to question the validity of a scheme for healthy food for children.

However, this dissertation argues that the policy was not well designed. The policy ignored existing research on the social and economic drivers of nutrition, resulting in misunderstanding of the underlying problem. This misreading, combined with poorly executed implementation, has resulted in a policy that is underutilized, stigmatizing, and much less effective than it could otherwise be (if, indeed, it is effective at all). As the findings have shown, the scheme may be understood as a successful failure. It remains well regarded and its foundation unquestioned, despite the lack of effectiveness and uptake.

This chapter begins with the key findings of the dissertation, followed by their application to the Healthy Start scheme and to food policy more broadly, suggestions for further research and, finally, the dissertation closes with reflections on the PhD journey and my development as a researcher.

8.1 Key Findings

Four research questions guided the research:

> **RQ1**: How do the parents of young children describe their perception and practice of healthy eating and the obstacles they face?
>
> **RQ2:** How do parents and health professionals describe their perception of and experience with the Healthy Start scheme?
>
> **RQ3:** How are recipients of Healthy Start perceived?
>
> **RQ4**: What is the actual and potential economic impact of the Healthy Start scheme?

The answers to these questions largely confirmed the findings from prior research. Parents have a good knowledge of nutritional guidelines. They are well intentioned and prioritize their children's nutrition. But their actual diet differs from their ideal diet because of financial and social constraints. Recipients are perceived in a way that is consistent with research on the stigmatization of needs-based welfare and food banks. The economic impact of Healthy Start had not been calculated before but, as the architects of the scheme predicted, the poor-diet related healthcare and lost productivity costs result in positive economic returns for interventions that improve diet. In short, although the interview questions got respondents talking and provided insight into the scheme, they did not go far enough because they largely confirmed prior research.

However, the broad scope of the questions and the open-ended nature of the interviews meant that interviewees shared much more than simple answers to four questions. They talked about their life experiences, their perceptions, their goals, their ideas about what it meant to be a good parent and provide healthy food for their children, and what role the government might play in facilitating it. Along the way they spoke to social dynamics relating to class, gender, and culture. They demonstrated some of the very judgements that they resented in others. The interviews were well suited to iterative thematic analysis that revealed deeper meaning in the data, and it is on that basis that this dissertation has been written, from the "unintended" knowledge gained during the research.

The key findings follow:

The policy design reflects and reinforces an inaccurate understanding of the problem the scheme is tasked with addressing.

Poor nutrition at all income levels is exacerbated at lower income levels because of the relative expense of more nutritious food. Yet the assumption implied by the restrictive voucher is that the underlying problem is lack of nutritional knowledge, desire or willpower.

As those primarily responsible for the health of their families, mothers bear the adverse cost of the misperception of the problem.

The unequal distribution of labour in the home persists, with most mothers responsible for the family's food provisioning and therefore nutrition. The focus on children as a social investment legitimizes regulating the mother's behaviour. This reinforces the message that mothers are unable or unwilling to make the best choices on their own, with emotional and social consequences to the mother that have not been previously considered with respect to the Healthy Start scheme.

The vouchers are an inefficient mechanism for transferring funds to families

As parents at the lowest income levels are currently spending more on the allowed items than the value of the voucher, the restrictions are essentially meaningless. They act more as a very inefficient cash transfer, entailing administrative costs. A bank transfer would eliminate these costs and have the same result for the recipient.

Stigma is likely a major factor in the low uptake, reducing the scheme's potential to be effective.

Stigma reduces participation in Healthy Start in two ways; it reduces visibility because health professionals are less likely to offer the scheme to patients for fear of offending them, and it reduces the willingness of parents to claim the benefit. Parents believe that those who receive needs-based benefits, including Healthy Start, are stigmatized in society. They largely agree that people should be ashamed to claim benefits.

Dissonance between the perceptions of self and others in food values and use of benefits is evidence of the stigma associated with malnutrition and accepting government aid.

Parents describe their ideal diet, which prioritizes healthy, organic, high-quality food prepared and eaten at home, distinguishing themselves as unique in their food values that they believe others do not share. This same dissonance applies to the use of benefits, as recipients separate themselves from others by their past employment and short-term hardship. They often assume that others are too quick to claim benefits

they do not need rather than seeking employment, while describing their own desire to work and the pleasure of earned income.

The scheme's popularity, which is surprising given the low uptake and a lack of evidence that it contributes to nutrition, is a barrier to its analysis.

While awareness of the details of the scheme is low, its approval rating by recipients, parents, and health professionals alike is high. Those who had never heard of the scheme nevertheless approve of it. It is difficult to challenge a benefit for healthy food for children, as no one wants to be perceived as opposing helping children. Perhaps this explains the positive attention the scheme has received. Although there are planned operational tweaks and a commitment to increased visibility and improved uptake, no one in this research, in civil society or in government, has questioned the basic tenets of the scheme. This highlights the political difficulty of interrogating the evidence behind a scheme that is held in such high regard. Despite the government's stated intention to base policies on evidence, it appears that this policy was based on ideas that were unsupported by the research (Smith, 2013). There is no mechanism in place for policy evaluation and feedback to challenge these ideas.

The economic impact of Healthy Start could be substantial if there is long term improvement in nutrition as a result of participation.

The economic cost of malnutrition is high. Children are more likely to succeed in school and become productive adults if they have been well nourished. Disease related to poor diet is a substantial and growing proportion of the NHS budget. The economic modelling shows that with modifications to the scheme, an improvement in population nutrition over the long term could result in benefits that exceed the programme costs by more than ten times.

8.2 Contribution to Food Policy

The lessons from this research are relevant for future policy development. The findings have shown the importance of incorporating academic experts and policy targets to ensure that the policy design is aligned with the underlying problem rather than with generally held assumptions about it. The formation of Healthy Start did not incorporate existing evidence and subsequent evaluations have not questioned the basis for the policy: that the food purchasing decisions of poor parents need to be circumscribed to ensure that they purchase healthy food. It appears that the politically palatable policy intervention was chosen rather than the best public health solution. The scheme's enduring popularity despite evidence that it is effective makes it an inexpensive policy "win" for politicians – giving the impression that policy makers are supporting childhood nutrition and absolving them of responsibility for addressing the underlying reasons for poor nutrition.

This research confirms the importance of using the interdisciplinary lens for policy analysis dictated by the interconnected nature of food policy. Prior research on Healthy Start has not incorporated the historical, political, health, social, and economic dimensions of people's lives, which is the foundation of this project. This has facilitated findings that go beyond the operational issues of the scheme, leading to new insights on stigma, gender, and economics in Healthy Start. While social stigma has been studied in relation to welfare in general and food banks in particular, it has been largely overlooked with respect to Healthy Start.

There are many opportunities for improvement. The public health goal of the scheme should be clearly stated, measurable, and monitored. Responsibility for the scheme should be clarified and included in employee performance objectives. Steps should be taken to reduce stigma. The policy should be integrated with other policies.

A universal scheme would have many advantages. Means testing is administratively expensive and leads to stigma, which reduces participation and has negative social and emotional costs for those who participate. A universal child allowance, which is supported by many researchers, would likely improve child health and development, reduce future healthcare costs, further educational attainment, and increase labour market productivity (Holzer *et al.*, 2008; Edin and Shaefer, 2015; Hoynes, Schanzenbach and Almond, 2016; Muennig *et al.*, 2016; Shaefer *et al.*, 2018). A voucher limited to fruit and vegetables has the potential to support nutrition as part of a universal public health message coordinated with other policies to encourage fruit and vegetable consumption. This does not necessarily need be more costly for the government than the current scheme, as a small increase in tax receipts from wealthier families could offset their benefit, yielding a revenue neutral scheme for those above a certain income level.

Healthy Start has the opportunity to be more than a public health policy. It could better align with other policy objectives to support local business, local farmers, and the environment. The need for policy coherence has long been an objective of food policy (Barling, Lang and Caraher, 2002; Lang, Barling and Caraher, 2009).

The challenge of Covid-19, combined with Brexit, has created a prime opportunity for change. The national crisis has exacerbated and highlighted health inequalities more broadly and food insecurity and childhood nutrition in particular, and brought renewed interest in Healthy Start. Cross border supply lines have been challenged. A government once committed to austerity has increased public spending dramatically. Perhaps this has created a policy window that allows for reconsideration of the objectives and evaluation of Healthy Start. But unless Healthy Start is grown dramatically, it alone will not solve the health inequalities, poverty, and food insecurity. It must not be allowed to distract policymakers from addressing the underlying reasons for poor nutrition, nor lead to complacency because a policy is in place.

8.3 Future Research

The economic analysis confirmed prior research that has demonstrated that interventions that improve nutrition are cost effective. But the mechanism and potential for limited food vouchers to change behaviour are unknown. More research is needed on the potential for food vouchers to act as a nudge to change behaviour and whether the inclusion of infant formula and milk confuses the message to consume more fruit and vegetables. A better understanding of the mechanism of the vouchers (economic assistance or nudge) and the impact of different voucher amounts on different population groups is necessary to design the most effective intervention. Evidence from research on the impact of food vouchers compared to cash on different population groups could guide future policymaking. The US study (Lieffers *et al.*, 2018) that showed greater impact on fruit and vegetable consumption for vouchers redeemable in farmers' markets rather than in supermarkets warrants further study in the UK.

A more in-depth analysis of the lives of parents of young children would help to identify potential policy interventions to address nutritional challenges. The interventions could then be evaluated based on trials to determine the relative cost effectiveness of the different interventions, resulting in the most cost-effective solutions. As a multi-faceted approach may be the most effective, it would be advantageous to assess combinations of interventions.

This dissertation has argued that the narrative that low-income parents need to be educated and restricted to make the right nutritional decisions for their children has distracted policymakers, advocates, and the public from asking more fundamental questions. This research largely confirmed what prior research has demonstrated Why does this discourse persist? Why do researchers and advocates support Healthy Start, which reinforces this discourse, and has not been shown to be effective (signed letter to government attached as Appendix 7). More research is needed to understand how best to disseminate findings that may not align with widely held beliefs and values.

A better understanding of the long history of research and ideas on food practices, food poverty, and food welfare would help to illuminate the current policy climate. From a study in the early nineteenth century on food practices in low-income homes (Pember Reeves, 1913), to the echoes of social researchers like Titmuss, I was consistently struck with the idea that we have been here before.

8.4 Reflections on the Research Journey

I chose to study Healthy Start because it is the only food voucher scheme in the UK and despite its crucial remit – improving early childhood nutrition – it seemed to be failing. I was interested in the effectiveness of using targeted food vouchers to improve childhood nutrition and suspected that Healthy Start was underutilized and underpromoted. Impressed with the WIC in the US, which has been very well researched and received many accolades, I was intrigued by the decline of Healthy Start. I believed that with better promotion and funding, perhaps through private matching funds, Healthy Start could be a much more successful scheme. I set out to prove that. I admired programmes in the US that enhanced the value of food stamps or WIC vouchers at farmers' markets, and I respected the Rose Voucher scheme. I wondered how programmes that partnered with the private sector could be expanded in the UK. While I decided to focus on Healthy Start, I followed the progress of the Rose Voucher scheme and hoped the lessons from Healthy Start could be applied to private schemes as well.

At the start I did not question the concept of the vouchers, and as I have learned, most people do not. The logic of fruit and vegetable vouchers seemed clear to me, yet over the course of the past five years I no longer believe this to be the case.

When I began this project, I was interested in learning more about how families spent their vouchers, and hoped to be able to access supermarket databases with that information. Yet I quickly realized that such information would be useless because the vouchers were more likely replacing funds they would have otherwise spent. It is impossible to make a conclusion about the impact on purchases without tracking all food purchased before and after vouchers were received. I turned my focus to listening and trying to understand the challenges that interviewees faced, as well as the role they saw for the government in their lives and in the lives of others.

Over the course of the research, I learned to pay attention to emotions – parents' frustration and feeling that they should do more to ensure their children were eating well. A mother described "beating herself up" because her children would not eat more vegetables; another thought she was "lazy" because she was not doing a better job. Many mothers described anxiety that they could not find a job and remember fondly those times when they had earned their own money.

Sometimes I heard anger at their lack of control of their lives and limited choices. The price of healthy food also made some parents angry. One mother repeated over and over: "it is just so expensive"; she ate most of her meals at McDonald's.

One of the most common emotions expressed was pride: pride in their children and husband, in their ability to manage their household, in their cooking and the fact that they did not use government benefits. Holding a paying job was worth more than just money. One woman spoke with tears about how much she had loved a paid internship she held after university and her frustration that, despite years of trying to find a job, she had not found work since. Another cried when describing being forced by family to leave a job she had for a short time that provided her with a sense of independence.

I learned to pay attention to what they did not say. Did their behaviour differ from what they were telling me? The mother who fed her children packaged snacks while telling me that they were only allowed fresh fruit between meals confirmed that parents may be communicating what they believe they should say rather than reality.

Sometimes I had to read between the lines to glean the unsaid. Gender was more of an issue than I expected, and it was so ingrained it was often invisible. One mother praised a husband who loved to cook, and she was very happy that her son got to see him cook; however, he only cooked once a week, after she bought the ingredients. Another mother was glad that her husband was an equal partner in raising their child, yet he was finishing his paternity leave to go back to work, and she was going to care for the child and try to work from home while the baby slept.

Many women did not choose to participate in the research, and some began interviews that they did not want to complete: one said the room was too hot; another had to go after a few minutes because her baby needed a nap. Another mother had been relocated to London by the police and was in hiding from her ex-husband, unable to see her daughter or friends. She was visibly uncomfortable and unable to stay in the interview for more than a few minutes. It made me wonder about the stories I missed. Were there differences between those who volunteered and those who did not? Was there something I could have done to make people feel more comfortable? One technique I discovered was knitting. It seemed to put parents at ease and gave them something to ask me about, rather than me asking all the questions. I often just sat in the waiting room knitting, with piles of cookbooks and information about the research project on a nearby table. Sometimes talking about knitting gave people the impetus to ask me about what I was doing there and then to participate. If I sat in the room with nothing to do, people seemed to avoid me.

I initially, and naively, assumed that benefit recipients may be identifiable in some way, and I hoped to be able to target recipients. This proved impossible. But I did, after some time, begin to sense a greater ease and confidence among many of those who did not worry about money. The mothers most likely to describe self-sacrifice as a matter of course were those with limited resources. One mother said that her

time was up, and it was her child's turn now. I was surprised at how many mothers had given up on their own needs.

If I were starting this project again, I would focus on fewer parents and spend more time with them. I would spend less time asking questions and more time observing and letting them tell me what is important to them. It would have been very useful to spend time with them in their houses or while shopping or cooking. I would ask what they think makes a good parent or mother, and when they are proud of themselves.

I faced several challenges over the course of the research that have proven to be what I now consider the project's strengths. It was a challenge to find Healthy Start recipients to interview. The relatively small number of recipients, and the possibility that they may be less likely to participate in the activities of the children's centre due to social withdrawal or chaotic lives, was the likely cause. This conclusion was supported by health professionals who confirmed that they saw recipients of the scheme infrequently, with some reporting that they had not been asked to sign an application in months. As a result, many more hours than anticipated were spent in the children's centres hoping to find recipients. This brought the unforeseen benefit of providing further context for the interview data as I observed mothers' behaviour with their children and with other mothers. The inability to identify those on a low income encouraged me to interview more parents over a range of income levels. Those who were eligible but not recipients helped to shed light on the reasons why parents do not participate. A comparison of those at different income levels also allowed me to ask questions about income-related differences in food knowledge, practices and constraints.

The biggest challenge I faced was identifying, and altering, my own assumptions and biases – such as the belief that benefit recipients would be identifiable by sight. I was repeatedly forced to question myself, my role as a researcher and the beliefs I held that informed this project, even questioning the foundation of the scheme itself. My own self-reflection facilitated the questioning of assumptions held by those I interviewed. It raised the issue of stigma and encouraged me to look deeper into the data for the underlying reasons why the scheme may be undersubscribed. It made me pay attention to the contradictions in people's view of themselves and others.

The topic has become more relevant as the research has progressed. The attention paid to the scheme has increased considerably over the five years of study, with growing support for expanding the scheme and improving delivery. Healthy Start is a topic of conversation in Parliament and in the news. My interest in the policy has grown with my conviction that fundamental changes are necessary, not just a simple tweaking of the existing policy.

8.5 Summary

Healthy Start promises to change the world. It appears to address health inequality, poverty and food insecurity, but a mere glimpse at the workings of the scheme makes it clear that this is overblown rhetoric. And so, we have to ask: Why is it so popular and why do misunderstandings persist? This research has pointed to stigma. Stigma allows existing hierarchies of power to be sustained. Government seems well meaning and the scheme appears to empower people on a low income to buy food that is

highly priced. However, the voucher limits are part of an ideology that comes through in ministers' comments that the poor do not know how to feed themselves, in health professionals believing that the poor require restrictions and in recipients arguing that while *they* make healthy choices others cannot be trusted to do the same. In constructing and perpetuating this narrative, Healthy Start can be seen as part of the problem, not part of the solution. It maintains ungrounded beliefs in the ignorance and irresponsibility of the lower class, beliefs that serve to justify, in the minds of rich and poor alike, the unfortunate situation of those at the lowest income level. If parents cannot afford fruit and vegetables for their children, it must be their fault. Healthy Start gives the government cover to appear concerned about the poor health of poor children, but without the funding for meaningful change or the operations to limit the amount of stigma experienced by recipients.

Of course, recipients are grateful for it. But their gratitude demonstrates that they perceive this benefit as a type of gift, not as a measure intended to offset the way in which the food system systematically deprives poor people of access. And that lack of access, represented foremost by the unattainable price of fruits and vegetables, is the real problem that needs to be addressed. The real message that needs reinforcing is that Healthy Start's financial contribution is inadequate, its restrictions on income and on food are condescending and unnecessary, and a government that accepts praise for it while failing to write specific goals and measure its success actually demonstrates the ignorance and irresponsibility that it attributes to the poor.

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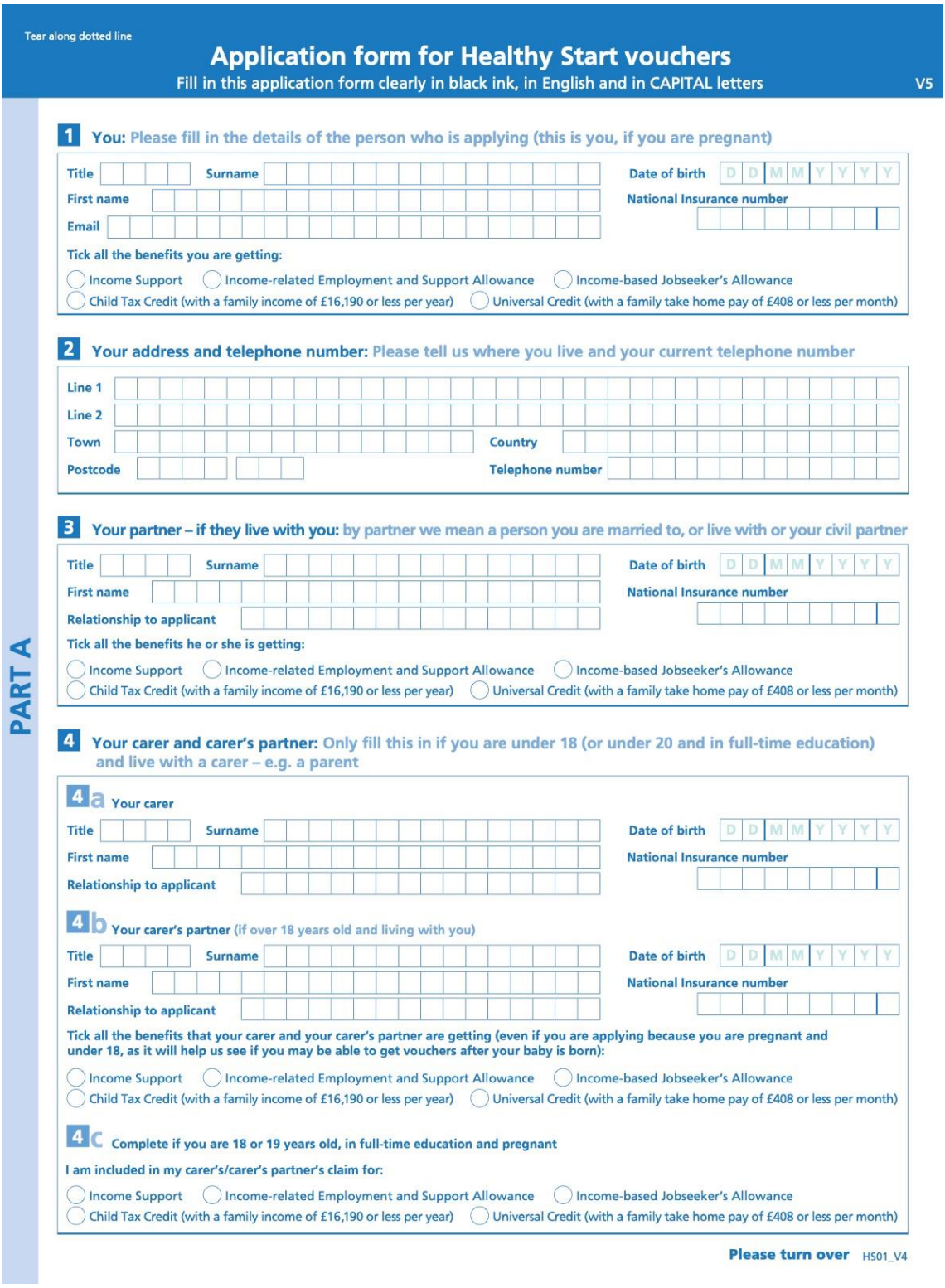
Appendices

Appendix 1: Application for Healthy Start



Tear along dotted line

Application form for Healthy Start vouchers

Fill in this application form clearly in black ink, in English and in CAPITAL letters V5

PART A

1 You: Please fill in the details of the person who is applying (this is you, if you are pregnant)

Title | Surname | Date of birth D D M M Y Y Y Y

First name | National Insurance number

Email

Tick all the benefits you are getting:

◯ Income Support ◯ Income-related Employment and Support Allowance ◯ Income-based Jobseeker's Allowance

◯ Child Tax Credit (with a family income of £16,190 or less per year) ◯ Universal Credit (with a family take home pay of £408 or less per month)

2 Your address and telephone number: Please tell us where you live and your current telephone number

Line 1

Line 2

Town | Country

Postcode | Telephone number

3 Your partner – if they live with you: by partner we mean a person you are married to, or live with or your civil partner

Title | Surname | Date of birth D D M M Y Y Y Y

First name | National Insurance number

Relationship to applicant

Tick all the benefits he or she is getting:

◯ Income Support ◯ Income-related Employment and Support Allowance ◯ Income-based Jobseeker's Allowance

◯ Child Tax Credit (with a family income of £16,190 or less per year) ◯ Universal Credit (with a family take home pay of £408 or less per month)

4 Your carer and carer's partner: Only fill this in if you are under 18 (or under 20 and in full-time education) and live with a carer – e.g. a parent

4a Your carer

Title | Surname | Date of birth D D M M Y Y Y Y

First name | National Insurance number

Relationship to applicant

4b Your carer's partner (if over 18 years old and living with you)

Title | Surname | Date of birth D D M M Y Y Y Y

First name | National Insurance number

Relationship to applicant

Tick all the benefits that your carer and your carer's partner are getting (even if you are applying because you are pregnant and under 18, as it will help us see if you may be able to get vouchers after your baby is born):

◯ Income Support ◯ Income-related Employment and Support Allowance ◯ Income-based Jobseeker's Allowance

◯ Child Tax Credit (with a family income of £16,190 or less per year) ◯ Universal Credit (with a family take home pay of £408 or less per month)

4c Complete if you are 18 or 19 years old, in full-time education and pregnant

I am included in my carer's/carer's partner's claim for:

◯ Income Support ◯ Income-related Employment and Support Allowance ◯ Income-based Jobseeker's Allowance

◯ Child Tax Credit (with a family income of £16,190 or less per year) ◯ Universal Credit (with a family take home pay of £408 or less per month)

Please turn over HS01_V4

5 Your children: Please give details of any children (under 4) you already have (continue on another sheet of paper if necessary)

First name		Date of birth	D D M M Y Y Y Y
Surname			
First name		Date of birth	D D M M Y Y Y Y
Surname			
First name		Date of birth	D D M M Y Y Y Y
Surname			

6 Are you pregnant? ◯ Yes ◯ No

7 Please read this

Please read this if you are 16 or over, sign and date the form yourself. If you are under 16, ask a parent or carer to sign and date the form.

By signing:

- I declare that the information I have provided in this application form is correct and complete.
- I have read and understood the dos and don'ts of Healthy Start (described on page 9 of the Healthy Start leaflet).
- I agree to following these rules during any period I receive Healthy Start vouchers for myself or my family.
- I agree that the UK Health Departments can share information about me with other organisations to check that the information I have given is correct and to stop false claims (as described on page 9 under the heading 'Data protection').
- I understand that if I knowingly claim support from Healthy Start that I am not entitled to, this support may be stopped and I will be liable to reimburse the UK Health Departments the value of any vouchers and vitamin coupons I have received and used.

Signature

Name

Date D D M M Y Y Y Y

Now ask your health professional (usually your midwife or health visitor) to complete the statement below. You do not need to pay anything to have your form signed.

PART A

Part B: Health professional's statement

I certify that

(name of applicant)

date of birth (of applicant) D D M M Y Y Y Y

◯ **has consulted me about her pregnancy**

The expected date of delivery is D D M M Y Y Y Y

(please fill in full date).

AND/OR

◯ **I certify that the information (s)he has given in Part A, question 5 about his/her children is, to the best of my knowledge, correct.**

AND

◯ **I confirm that I have given him/her health-related advice.**

This form can be countersigned by any registered midwife, nurse or medical practitioner

Health professional's signature

Health professional's name

Date of signing D D M M Y Y Y Y

Surgery stamp or work address

Surgery postcode

GMC no./NMC pin (optional)

Applications for Healthy Start vouchers will not be accepted without a signature (or letter) from your health professional.

PART B

Appendix 2: Key words used in literature search

Healthy Start

Healthy Start UK

Rose Voucher Scheme

Special Supplemental Nutrition Program for Women, Infants and Children/WIC

Special Supplemental Food Program for Women, Infants and Children

Special Supplemental Program for Women, Infants and Children

Women, Infants and Children Program

These terms were combined with:

Association

Relationship between

Effect

Affect

Evaluation

Impact

In addition, the following search terms were used:

Food choice

Fruit and Vegetable Intake

Behaviour/behavior change

Food assistance

Food voucher

Food poverty

Food insecurity

Obesity

Nutrition policy

Right to food

Welfare

Infant feeding

Breastfeeding

Stigma

Paternalism

In-kind transfers/vouchers

Appendix 3: Demographic Characteristics of Parents in Leicester

Code	Receive benefits	Receive HS	Food Insecure	Pregnant	Ethnicity	No. of children	No of adults in home	Employment	Education	Age of oldest	Age
PL1	Yes	No	Yes	No	Indian	1	2	Part time	BA	7 months	28
PL2	No	No	Yes	No	English	4	4	Maternity leave	Less than A levels	13	27
PL3	Yes	No	No	No	Polish	3	2	Part time	A levels	12	31
PL4	Yes (sister)	No	No	No	English	2	8	Full time	BA or +	3	41
PL5	Yes	No	No	No	British Indian	4	2	No	A levels	10	35
PL6	No	No	No	No	Indian	1	4	No	A levels	9 months	27
PL7	No	No	No	No	Black Somali	1	2		Masters	7 months	27
PL8	Yes	No	Yes	Yes	Pakistani	0	3	No	A levels	NA	35
PL9	Yes (past)	Yes (past)	No	No	British Indian	5	2	No	A levels	15	37
PL10	Yes	No (applied)	No	Yes	Indian	0	2	Maternity leave	Less than A	NA	42
PL11	No	No	No	No	Indian	1	2	Part time	BA	11 months	34
PL12	No	No	No	No	Somalie	1	2		A levels	2 months	22
PL13	Yes (Father)	No	No	Yes	Indian	0	5	Part time	BA	NA	26
PL14	Yes	Yes	Yes	No	White British	2	1	No	BA	7	32
PL15	Yes	Yes	No	Yes	Black Caribbean	1	4		BA	Teen	20
PL16	Yes	No	No	No	Pakistani	2	3	No	BA +	5	29
PL17	Yes	Yes	No	No	Muslim	4	1	No	A levels	16	40
PL18	Yes (Mother)	No	Yes	No	Pakistani/Indian	6	3	No	A levels	16	22
PL19	Yes	Yes	Yes	No	British Pakistani	1	1	No	BA	4	32
PL20	No	No	No	No	Pakistani	5	2	Maternity leave	BA	16	31
PL21	Yes	No	Yes	No	Muslim/Asian	3	2	No	A levels	6	30
PL22	Yes	Yes	Yes	No	Asian	1	2	No	Less than A	3 months	32
PL23	Yes	No	No	No	Indian	1	2	Maternity leave	A levels	1	25
PL24	Yes	Yes	No	No	Bangladeshi	1	2	No	Less than A	1	33
PL25	Yes	Yes	No	No	British Indian	1	4	No	Masters	1	32
PL26	Yes	No	Yes	No	British Indian	2	2	No	BA +	4	29

Appendix 4: Demographic Characteristics of Parents in Camden

	Receive benefits	Receive HS	Food Insecure	Pregnant	Ethnicity	No. of children	No of adults in home	Employment	Education	Age of oldest	Age
PC1	Yes	No	No	No	White Kosovo	2	2	No	BA +	2	26
PC2	Yes	Yes	No	No	White British	1	2	Full time	A levels	1 month	33
PC3	No	No	No	No	Japanese/Canadian	1	2 or 3	Part time	BA	1	33
PC4	Yes	Yes (past)	NA	Yes	Black British	1	1	No	NA	NA	NA
PC5	No	No	No	No	White British	1	2	No	Masters	1	38
PC6	Yes	No	No	No	Brazilian	1	2	No	Masters	8 months	42
PC7	Yes	Yes	No	No	British Indian	1	2	Full time	BA +	10 days	30
PC8	No	No	No	Yes	White British	0	2	Full time	Masters	NA	34
PC9	No	No	No	Yes	White British	0	2	Full time	BA	NA	39
PC10	Yes	No	No	No	White Italian	1	2	Full time	BA	7 months	42
PC11	No	No	No	No	New Zealander	1	2	Full time	A levels	10 days	33
PC12	No	No	Yes	Yes	Black Caribbean	0	1	Full time	A levels	NA	32
PC13	No	No	No	No	Black Caribbean	1	1	Full time	NA	32	NA
PC14	No	No	No	No	White British	2	2	Maternity	BA	2	NA
PC15	Yes	No applied	Yes	No	Black British	1	1	No	Less than A	Under 1	26
PC16	No	No	No	No	White Dutch	1	1	Part time	BA	2	36
PC17	No	No	No	No	Chinese	1	2	Full time PhD student	PhD student	10 days	29
PC18	Yes	No	NA	Yes	White British	2	1	No	NA	21	NA
PC19	Yes (daughter)	No	No	No	Syrian	1	4	No	NA	2	57
PC20	No	No	No	No	British Asian	2	2	No	Masters	2	39
PC21	No	No	No	No	British Chinese	1	2	No	BA	8 months	36
PC22	Yes	Yes	No	No	White British	1	2	No	Less than A	1 month	28
PC23	No	No	No	No	Chinese	1	2	Full time PhD student		10 days	28
PC24	Yes	No	Yes	Yes	White **B**ritish	0	2	No	A levels	NA	29

Appendix 5 Interview Questionnaire for Parents

1) Level of food insecurity
    a. Although household food insecurity is not consistently measured in the UK, it has been measured in the US using the current questionnaire since the 1990s (USDA ERS, 2012). The short form of the household food security scale has been tested and shown to provide reliable information about food insecurity with fewer questions, making it simpler to administer (Blumberg *et al.*, 1999; USDA ERS, 2012; Marques *et al.*, 2015).
2) Have you ever received Healthy Start vouchers?
    a. Approximately how much of the voucher is used to purchase infant formula?
    b. Approximately how much of the voucher is used to purchase milk?
    c. Approximately how much of the voucher is used to purchase fruits and vegetables?
3) How much do you think people in general in Britain would agree or disagree that people should feel ashamed to claim (5 is totally agree, 0 is totally disagree)?
    a. Child credit
    b. Healthy Start
    c. Rose vouchers
    d. Tax credits
    e. Jobseeker's allowance
    f. Housing benefit
4) Do you think people should feel ashamed to claim (5 is totally agree, 0 is totally disagree)?
    a. Child credit
    b. Healthy Start
    c. Rose vouchers
    d. Tax credits
    e. Jobseeker's allowance
    f. Housing benefit
5) People are generally treated with respect when they claim benefits (yes/no).
6) What government benefits have you received?
    a. Jobseekers Allowance
    b. Incapacity benefits (including Employment and Support Allowance)
    c. Income support
    d. Housing benefit
    e. Council Tax Benefit
    f. Child tax credit or Working tax credit
    g. Child benefit
    h. Healthy Start
7) Marital status
    a. Single
    b. Married/civil partnership/living together
    c. Separated/divorced/widowed
8) Employment status
    a. Full time--35 hours a week or more
    b. Part time--Less than 35 hours
    c. Not employed outside of home 9) Which applies to your home?
    a. Owned
    b. Rented from the local authority
    c. Rented from a private landlord
    d. Rented from a housing association/trust
    e. Other
10) What is the highest level of education completed?
    a. Bachelor's degree or Masters/PhD A-levels of equivalent
    b. Less than A-levels
    c. Other

11) What year were you born?
12) Number of people living in home
    a. Adults
    b. Children
    a. What are your children's ages in months?
    b. What is your children's sex?
    c. Pregnant
        a. Yes—due date?
        b. No
13) Ethnicity
14) What is your primary language at home?

Appendix 6: Ethics approval letter

Undergraduate, Postgraduate & Research Programmes

Economics

International Politics

16 February 2017

To whom it may concern:

Principal Investigator: Laurie Egger

Co-Investigator:

Project Title: **The Social Impact of Food Vouchers in the UK: Do Vouchers Contribute to an Equitable and Inclusive Food Policy?**

Start Date: February 2017

End Date: September 2019

Approval Date: 16 February 2017

This is to confirm that the research proposal detailed above has been granted formal approval by the Sociology Research Ethics Committee.

Project amendments

You will need to submit an Amendments Form to the Ethics Committee if you wish to make any of the following changes to your research:

(a) recruit a new category of participants;

(b) change, or add to, the research method employed;

(c) collect additional types of data;

(d) change the researchers involved in the project.

Adverse events

You will need to submit an Adverse Events Form to the Chair of the Committee, copied to the Secretary of Senate Research Ethics Committee (Anna.Ramberg.1@city.ac.uk), in the event of any of the following:

(a) adverse events;

(b) breaches of confidentiality;

(c) safeguarding issues relating to children and vulnerable adults;

(d) incidents that affect the personal safety of a participant or researcher.

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate, the researcher should also report adverse events to other relevant institutions, such as the police or social services.

Should you have any further queries relating to this matter, then please do not hesitate to contact me. On behalf of the Sociology Research Ethics Committee, I hope that the project meets with success.

Kind regards

Dr. Diana Yeh

Acting Chair of the Sociology Research Ethics Committee

Department of Sociology

City University London
Whiskin Street
London, EC1R 0JD
Email: diana.yeh@city.ac.uk

Appendix 7: November 2020 letter in support of Healthy Start

2nd November 2020

The Rt Hon Rishi Sunak, MP, The Chancellor of the Exchequer

The Rt Hon Matt Hancock, MP, Secretary of State for Health and Social Care

Dear Ministers,

The devastating impact that Covid-19 continues to have on food insecurity means that the Healthy Start Scheme has never been so important in safeguarding the health and nutrition of young families. 14% of UK families with children have experienced food insecurity in the past six months[1] which, combined with the UK's high levels of childhood obesity, looks set to further compound the poor health of the UK's children. **We are writing together as sector experts and healthcare professionals to call on the Government to put £115 million/year of additional funding towards improving the Healthy Start scheme by implementing the recommendations proposed in Part One of the National Food Strategy:**

- **Increase the value of Healthy Start vouchers to £4.25 per week**
- **Expand the scheme to every pregnant woman and household with children under four in receipt of Universal Credit or equivalent benefits**[i]
- **Fund a communications campaign costing £5 million**

Healthy Start provides young pregnant women and low income families with children under the age of 4 in England, Wales and Northern Ireland with free vitamins for mothers and children, and food vouchers to purchase vegetables, fruit, pulses and cows' milk. Where families do not breastfeed their infants, vouchers can also be spent on first infant formula. Inadequate nutrition during the first 1,000 days of life can have life-long consequences, increasing the risk of cardiovascular disease, type two diabetes, and obesity.[2] Inequalities mean low-income families may struggle to access and afford a healthy diet. There are striking inequalities in fruit and vegetable consumption, with the highest income groups consuming about 1.5 portions per day more than the lowest.[3] During lockdown, poorer children both snacked more and ate fewer fruit and vegetables than their wealthier counterparts.[4]

There are compelling reasons to act immediately. The scheme is a targeted and efficient way to reach those who are most vulnerable and in need of support, and helps to deliver on Government commitments to address inequalities, support parents, and help the country to recover from Covid-19. **Expanding and improving the scheme offers opportunity for it to fulfil your 'levelling-up' agenda.**

Expanding the scope of the scheme to include a larger proportion of low-income families would benefit an additional 290,000 pregnant women and children under the age of 4.[5] In 2019, less than 50% of

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[1] Food Foundation: YouGov Plc Polling Data. Total sample size was 2,309 parents or guardians living with children under 18 years. https://foodfoundation.org.uk/new-food-foundation-data-sept-2020/. Published 2020.

[2] The first 1,000 days. https://thousanddays.org/why-1000-days/

[3] SHEFS. SHEFS, fruit and vegetables policy brief series. *Policy brief 1: Is the UK's supply of fruit and vegetables future proof?* 2020

[4] National Food Strategy. *National Food Strategy: Part One*. 2020. P.27.

[5] National Food Strategy. *National Food Strategy: Part One*. 2020

children (in England, Wales and Northern Ireland) living in poverty were entitled to support from the Healthy Start scheme, and only 33% actually received it due to implementation problems.[6] Expansion would also mean economies of scale for UK retailers who are already engaged with the scheme and would have a further incentive to add value. Iceland, for example, now offer all recipients redeeming their vouchers in store a free £1 bag of frozen vegetables. **The government as well as businesses must act to support the continued success of the scheme.**

Unfortunately, the value of the voucher has not increased since 2009, despite inflation during this period having increased by 3.1%.[7] With fruit and vegetables costing almost three times more per kilocalorie than less healthy foods[8] and vulnerable to price fluctuations, an increase in the voucher value now would enable better health outcomes for the future. **Therefore, we urge the government to increase the value of the voucher to £4.25 a week.**

For families to benefit from this scheme, a concerted effort is needed to reverse the trend of low take-up. In June 2020, the take-up rate dropped to 48% (251,547 beneficiaries), meaning that 272,080 eligible beneficiaries were not registered for the scheme. This is despite 30,000 retailers and all of the 'big four' supermarkets accepting the vouchers in store. Five years ago, take-up stood at 73% (374,896 beneficiaries). **Better communication and proactive promotion of the scheme through local authorities, health visitors, community organisations and UK retailers is required** to better notify and engage those who are eligible for the scheme. Accelerating the digitisation programme (delayed until October 2021) would also help to remove the time and administrative burdens that are significant barriers to uptake.

We are ready to help in whatever way we can. We know that the nutrition and health of mothers and young children will have profound and life-long consequences for children's futures. A fair start in life should be a key tenet of the government's 'levelling up' agenda. **Now is the time to act.**

Yours sincerely,

The Undersigned

Civil Society

Anna Taylor, OBE, Executive Director, Food Foundation

Andrew Forsey, National Director, Feeding Britain

Jonathan Pauling, Chief Executive, Alexandra Rose Charity

Ben Reynolds, Deputy Chief Executive, Sustain

Dr Helen Crawley, Director, First Steps Nutrition

Nicola Howard, Director, First Place UK

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[6] Food Foundation. *Children's Future Food Inquiry*. 2019

[7] Bank of England Inflation calculator. https://www.bankofengland.co.uk/monetary-policy/inflation/inflation-calculator Accessed: 29th September 2020

[8] Food Foundation. *The Broken Plate 2020 Report: the state of the nation's food system*. 2020.

Beatrice Merrick, Chief Executive, Early Education

Dr Ilana Levene and Dr Vicky Thomas, Paediatricians and Co-founders, The Hospital Infant Feeding Network

Dr Cheryll Adams, Executive Director, Institute of Health Visiting

Dr Natalie Shenker, Director, The Human Milk Foundation

Laurence Guinness, Chief Executive, The Childhood Trust

Kim Roberts, CEO, HENRY

Helen Gray and Clare Meynell, Joint Coordinators, World Breastfeeding Trends Initiative (WBTi), UK Steering Group

Sally Bunday, MBE, Founder, Hyperactive Children's Support Group

Dr Marie Bryant, Chair of the Board of Trustees, Association for the Study of Obesity

Amy Calvert, Innovation manager, Good Food Barnsley

Dr Naomi Maynard, Project Development Lead, Together Liverpool

Ped Asgarian, Director, Feeding Bristol

Mandy Chambers, Project Manager, Rural Action Devonshire

Megan Mehnert, FOOD club coordinator, FOOD Clubs Bristol & BANES

Dr Matthew Philpott, Executive Director, Health Equalities Group

Sam Gillett, Head of Impact and Delivery, St John's Foundation

Melissa Green, General Secretary, The Women's Institute

Katie Palmer, Programme Manager, Food Sense Wales

Michele Shirlow MBE, Chief Executive, Food NI

Professor Graham MacGregor, Chairman of Consensus Action on Salt and Action on Sugar

Professional Bodies

Andy Burman, Chief Executive, British Dietetic Association (BDA)

Professor Russell Viner, President, Royal College of Paediatrics and Child Health (RCPCH)

Christina Marriott, Chief Executive, Royal Society for Public Health (RSPH)

Clare Livingstone, Professional Policy Advisor, Royal College of Midwives (RCM)

Dr Cheryll Adams, Executive Director, Institute of Health Visiting (IHV)

Dr Arianne Matlin, Head of Health and Science Policy, British Dental Association (BDA)

Directors of Public Health

Sarah Muckle, Director of Public Health, City of Bradford Metropolitan District Council

Dr Rupert Suckling, Director of Public Health, Doncaster Council

Rachel Spencer-Henshall, Strategic Director – Corporate Strategy, Commissioning and Public Health, Kirklees Council

Dr Bruce Laurence, Director of Public Health, Bath & North East Somerset Council

Sam Crowe, Director of Public Health, Dorset & BCP Councils

Professor Virginia Pearson, Chief Officer for Communities, Public Health, Environment and Prosperity, Director of Public Health, Honorary Clinical Professor, University of Exeter College of Medicine and Health, Devon County Council

David Regan, Director of Public Health, Manchester City Council

Matthew Ashton, Director of Public Health, Honorary Professor, Public Health and Policy, University of Liverpool, Liverpool City Council

Eileen O'Meara, Director of Public Health and Protection, Halton Borough Council

Rebecca Nunn, Consultant in Public Health, London Borough of Barking and Dagenham

Carole Furlong, Director of Public Health, Harrow Council

Alice Wiseman, Director of Public Health, Gateshead Council

Academia and local government

Dr Debbie Weekes-Bernard, Deputy Mayor for Social Integration, Social Mobility and Community Engagement, Greater London Authority

Rumaysa Jassat, Children's Health Promoter, Leicester City Council

Milly Carmichael, Health Improvement Officer - Food Poverty, Claire Davies, Public Health Development and Commissioning Manager, and Sarah Heathcote, Development and Commissioning Manager, BANES Council

Councillor Steve Fritchley, Leader of Bolsover District Council, Bolsover District Council

Dr Clare Relton, Senior Lecturer in Clinical Trials, Institute of Population Health Sciences, Barts and London School of Medicine

Dr Megan Blake, Senior Lecturer, Department of Geography, Sheffield University

In their own words

Why does Healthy Start matter?

"£3.10 is not a lot, it's better than nothing of course, but a higher value would make a difference. If we had £4.25 a week from Healthy Start we could buy milk which would help, and more fruit and veg. It's enough for a week, but only for one child and I have three."

Carolina, Southwark

"I've had the vouchers for about a year and they've definitely made a difference to our family with what we can buy. Having the vouchers means when I go shopping I can buy more fruit and veg and make different meals. I can also give my children fruit for their snacks. We felt a big effect from the coronavirus and lockdown, everything changed completely, and it was harder to get what we needed."

Bushra, Liverpool

"Without the Healthy Start vouchers we would be in a dilemma with what we can buy, we have to balance every decision. It's painful to see your child crying when you know you can't buy them the food they need. When the vouchers reduce after the child turns one it's hard as they are eating more and you've got used to being able to give them what they want, but then we have to stop and so they get upset. The children want expensive food like strawberries, but we can't always afford this."

Zeid, Liverpool

[i] "Equivalent benefits" is a term drawn from the Department of Work and Pensions. It covers any of the legacy benefits which Universal Credit is replacing, i.e. working age Jobseeker's Allowance (income-related), Employment and Support Allowance (income-related), Income Support, Child Tax Credit, Working Tax Credit and Housing Benefits

Appendix 8: Letter from DHSC to eligible recipients

MRS TEST TEST
97 TEST STREET
BURNLEY
BB12 0XX

19 May 2015

Dear Mrs Test

Because your family is receiving Child Tax Credits or benefits you may be able to apply for Healthy Start. Healthy Start is a Government scheme that provides vouchers for free milk, fruit and vegetables and infant formula to pregnant women and children under 4. You qualify for Healthy Start if you are 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 (with a family income of £16,190 or less per year), or
- You or your family get Universal Credit (with a family take home pay of £408 or less per month)

OR:

- You are pregnant and under 18 years of age.

A leaflet giving more information about Healthy Start and an application form is enclosed. To apply, you need to complete the form and get it signed by your midwife or health visitor. It's really easy and the vouchers could help towards the cost of buying healthy foods.

Telephone our helpline on 0345 607 6823 if you have any questions about the application form and we will be happy to help.

Yours sincerely

HEALTHY START ISSUING UNIT
0345 607 6823

3313772
SD040

Pre-Filled Application Form for Healthy Start Vouchers

Please check and complete your and Health Professional signatures

(If you or your family receive Working Tax Credit, you do not qualify for Healthy Start unless you are pregnant or under 18.)

Applicant Details	**Partner Details**
XX123456X	XX123456X
TEST TEST	SETEST SETEST
97 TEST STREET	97 TEST STREET
BURNLEY	BURNLEY
BB12 0XX	BB12 0XX

Your Children

CHILDONE TEST	05/05/2000
CHILDTWO TEST	05/10/2002
CHILDTHREE TEST	05/11/2004

Benefits

Income Support	☐	Income Related Employment and Support Allowance	☐
Income Based jobseekers allowance	☐	Child Tax Credit (with a family income of £16,190 or less per year)	☐
None of these Benefits	☐	Universal Credit (with a total family income of £408 or less per month)	☐

Are You Pregnant Yes ☐ No ☐

Please read this

If you are 16 or over sign and date the form yourself.

If you are under 16, ask a parent or carer to sign and date this form.

By Signing:

- I declare that the information is correct and complete
- I have read and understood the dos and don'ts of Healthy Start (described on page 9 of Healthy Start leaflet)
- I agree to follow these rules during any period I receive Healthy Start vouchers for myself and for my family
- I agree that the UK Health Department can share information about me with other organisations to check the information I have given is correct and to stop false claims (as decribed on page 9 under heading Data Protection)
- I understand that if I knowingly claim support from Healthy Start that I am not entitled to, this may be stopped and I will be liable to reimburse the UK Health Department the value of any vouchers and vitamin coupons I have received and used

Your signature _____

First name _____ Surname _____

Telephone No. _____

Email Address _____

Date of Birth ____ / ____ / _____ Date of Signing ____ / ____ / _____

Please turn over HS01

Now ask your Health Professional (usually your midwife or health visitor) to complete the statement below. You do not need to pay anything to have your form signed. Applications for Healthy Start Vouchers will not be accepted without a signature (or letter) from your Health Professional.

I certify that TEST TEST

Date of Birth ____ / ____ / _____

○ ***has consulted me abour her Pregnancy*** The expected Delivery date is ☐

And/Or

○ ***I certify that the information (s)he has given overleaf about them and their children, is to my knowledge, correct***

And

○ ***I confirm that I have given him/her health-related advice***

Health Professional Signature _____

Health Professional Name _____

Date of signing ____ / ____ / _____

Surgery Stamp

☐

Surgery Postcode _____

GMC no./NMC pin (optional) _____