



Food Research
Collaboration

The Community Eatwell scheme: Why it can only work as one piece of a jigsaw of interventions to tackle diet-related ill-health

By Victoria Williams

Food Research Collaboration Policy Insight
October 2022

FRC Policy Insights

The FRC Policy Insights are short reports highlighting gaps and opportunities for improvement in emerging food policy in the UK. The aim is to put detailed, specialist knowledge into the public domain at a critical time for the food system.

Brexit, Covid, the climate and environmental crises, the disruption to supply chains caused by the war in Ukraine, and the UK's acute cost-of-living crisis all have consequences for food policy.

In response, there have been new laws and policy proposals, covering all aspects of the food system, from land use and agriculture to health, trade, labour, technology and innovation.

While policy is being developed, there are opportunities for improvements and course-corrections. We hope these Policy Insights will help to inform that process. If you would like to contribute, please contact the [Food Research Collaboration](#).

Introduction

When it was launched in 2021 there was general agreement that the National Food Strategy Independent Review, *The Plan*,¹ set out both an ambitious vision for a healthier and more sustainable food system, and a comprehensive plan to address the interlinked challenges of health, climate, post-Brexit land use, economy and inequalities. In June 2022 the Government published its response, a Policy Paper labelled the *Government Food Strategy* (GFS),² to widespread

disappointment. Critics claimed that much of the vision and systemic thinking of *The Plan* had been lost, and that the proposals contained were inadequate to achieve much-needed food system transformation.³

However, even before the publication of the GFS, one of *The Plan's* recommendations – namely for a 'Community Eatwell' programme – had already been included in a separate UK Government policy, the Levelling Up White Paper, which committed to piloting Community Eatwell in England to tackle 'one of the biggest contributors to ill health: poor diet and obesity'.⁴ This Policy Insight considers the proposed Community Eatwell pilot scheme, both on its own merit and as part of a wider package of measures looking to address food-related health inequalities. It assesses what is proposed, the pros and cons, and what alternative measures might offer.

Context – low income, diet-related health and food access

We know only too well that statistically, the poorer you are, the worse you are likely to fare across many indicators,⁵ including employment and education as well as health. People living on low incomes are more likely to suffer, and die from, diet-related conditions including cancers, cardio-vascular disease, obesity and diabetes. There is a significantly widening gap in life expectancy between the richest and poorest people in the UK.⁶ We also know that poorer neighbourhoods have fewer fruit and vegetable retail outlets per head of population,⁷ particularly selling fresh produce.⁸ Even when there is access to fruit and vegetables, calorie for

calorie, processed foods high in fat, salt or sugar (HFSS) are one third of the cost of healthier foods, such as fruit and vegetables,⁹ making it hard for people on low income to access healthy diets.

Alongside, and in stark contrast to, the issues of poor physical and financial access to fresh fruit and vegetables, there is very easy access to highly processed HFSS foods, whether because of the higher concentration of outlets selling low-nutrient, calorie dense 'fast' food in lower-income neighbourhoods,¹⁰ or the overwhelming pressure to consume them due to the huge budgets being spent to promote them by big food brands. In 2017 the campaign group Obesity Health Alliance reported that top-spending crisp, confectionery and sugary drinks brands spent over £143 million on advertising their products.¹¹ In the same year the Government spent £5.2 million on its flagship healthy eating campaign 'Change4Life', and the NHS spent approximately £38 million on weight loss surgery.¹²

With the best will in the world, if you have limited money (which also affects whether you have fuel to cook), limited access to fresh produce, and are bombarded by adverts telling you to eat the junk food that is in plentiful supply on the high street, it's always going to be an uphill struggle to eat a healthy diet high in fruit and vegetables.

Could the Community Eatwell Programme offer a solution?

The policy proposal

The Community Eatwell programme, a targeted health intervention under the overarching objective of reducing all diet-related harms that have a 'social

gradient' (i.e., fall most severely on those suffering most deprivation), is in principle a sound proposition – as part of a suite of measures.

The pilot programme, as proposed in Recommendation 7 of *The Plan*, would give GPs the option to prescribe fruit and vegetables – along with food-related education and social support – to patients suffering the effects of poor diet or food insecurity.¹³ It is an example of 'social prescribing', which allows health professionals to refer patients to a range of non-medical services. In the UK, for example, a 'Green Social Prescribing' programme is being trialled which allows GPs to prescribe activities such as walking and gardening to improve patients' mental and physical health.¹⁴ *The Plan's* recommendation would see Community Eatwell trials taking place in seven Primary Care Networks (PCNs)¹⁵, where GPs, working with local agencies, would offer 'Eatwell Prescriptions' for free fruit and vegetables, alongside access to local interventions such as cookery classes, and support from personal behaviour-change programmes.

In terms of implementation, *The Plan* suggests that the Government should invite PCNs to bid for the chance to design their own pilot programmes, tailored to local needs and 'building on existing neighbourhood initiatives'. It points out that before the pandemic, the Government spent £130 billion on the NHS every year, of which 95% was spent on treating illness, with just 5% going towards prevention. Diverting a larger percentage of the overall budget into prevention, it argues, is potentially a win-win, because by improving health it could reduce the need for expensive treatment. Funds could be used to invest in local infrastructure and facilities that make it easier to eat healthily and affordably, 'such as community kitchens, fruit and veg street markets, community farms and box schemes, and community cafés'.¹⁶

If the evidence from the pilots showed that these trials were significantly improving the diet and health of participants, while reducing the cost of medication, *The Plan* recommends that the Community Eatwell Programme should be rolled out across all 1,250 PCNs in England. It estimates that over three years, the average annual cost to Government for the pilot would be £2 million.

The idea is based on similar models in other countries: *The Plan* specifically refers to a scheme in the USA:

*'The Produce Prescription programme in Washington DC, for example, allows doctors to prescribe vouchers for fresh fruit and vegetables, along with cooking lessons, nutritional education and guided tours of shops and supermarkets to teach people how to shop cleverly. The scheme has been shown to increase consumption of fruit and vegetables and improve nutritional understanding. Of the 120 patients who received vouchers between 2012 and 2017, 50% lost weight over the course of a prescription.'*¹⁷

It sounds great, but is this idea transferrable? There are differences between the USA and UK in healthcare systems, food welfare programmes and cultural norms, particularly the substantial reliance in the US on food aid and the high levels of people living on low incomes with no healthcare insurance. This makes comparisons difficult and perhaps distorted. However, evaluations¹⁸ of the existing schemes in the USA have shown some positive outcomes for participants, although it is unclear if these changes are sustained after the participants have left the Produce Prescription programme.

Some potential downsides

Whilst on the face of it a Community Eatwell intervention could have benefits for individuals living on the lowest incomes and most affected by diet-related diseases, there are potential downsides. An important factor is that there are already many initiatives across the country, run by a variety of organisations, which aim to tackle these problems – and these initiatives need to be taken into account when planning new interventions. Given the continuing squeeze on the public purse, the Government must learn from experience to ensure any new intervention enhances the value of existing programmes in order to maximise impact whilst minimising costs. To achieve this, the following questions need to be answered satisfactorily.

1. Is it the best use of resources?

The annual £2 million cost estimated by *The Plan* may seem a modest price to pay for reducing both the burden of ill-health and the costs of treating it. However, this is the cost for the pilot programme alone. The annual costs would be far greater if the scheme were rolled out across all 1,250 PCNs. In addition, given the ongoing pressure on local resources (both statutory and in the voluntary sector), the costs of setting up and maintaining such a scheme need to be assessed in terms of its potential success in reducing health inequalities and related healthcare costs when compared with other options. These include scaling up existing interventions, such as restrictions on junk food advertising, continuation of the sugar tax to nudge recipe reformulation, Front of Pack (traffic light) nutrition labelling or introducing new measures such as a universal subsidy on fruit and vegetables (recent research suggests a universal subsidy on fruit and vegetables could improve intake by up to 15 percent¹⁹).

2. Will the pilot be sufficiently well resourced?

Still on costs, there is a risk that under-provision of resources could undermine the pilot's success. This type of intervention can be expensive and time-consuming to implement, particularly for those working at the local level. The recent transition of the Healthy Start scheme²⁰ from paper vouchers to a digital system demonstrated the costs, difficulties and complexity not only of implementation but also of maintenance.²¹ And as *The Plan* acknowledges, to be implemented effectively the Community Eatwell Programme would need supportive infrastructure. For example, we know that access to fruit and vegetables, particularly fresh produce, is more difficult in poorer neighbourhoods.²² Giving people whose budgets are already stretched prescriptions for free fruit and vegetables which entail spending money to get to the shops where they can use the prescriptions diminishes the value of the scheme and would possibly reduce uptake and therefore compromise success. To achieve the scheme's goals, the prescriptions might have to be accompanied by policies to ensure fruit and vegetables were accessible in the target areas. These might include trading and planning conditions that support the viability of fresh produce stalls and markets.

3. Is it wise to 'medicalise' low fruit and veg consumption?

It's clear that the whole population needs to increase consumption of fruit and vegetables: in 2018 only 28% of adults in the UK were eating the recommended five daily portions.²³ But trying to improve consumption among those living on low incomes by means of fruit and veg prescriptions risks

hindering improvements by 'medicalising' the problem. Fruit and vegetable consumption might become associated with illness, and be seen as something temporary. Once the fruit and vegetable prescription ended, the food cost issues faced by those living on low incomes that existed before being on such a scheme would re-surface, meaning that changes to dietary behaviour might not be maintainable, given that cost is a significant driver of food choices.

4. Who sets the rules?

Added to these reservations, there is the very tangled issue of how to determine what fruit and vegetables would be available on prescription and from which outlets. Food aid programmes' food lists are notorious areas for lobbying from the industry,^{24 25} and the Community Eatwell scheme would be no different. Should the three-year trial show positive outcomes, setting and maintaining the criteria would be another costly, time-consuming and ongoing element of rolling-out the scheme across the country.

5. Are there simpler ways to achieve the same goal?

Finally, do we need a prescription service to subsidise fruit and vegetables, or would it be easier, for example, to incentivise food retailers to offer subsidised fresh fruit and vegetables through a 'healthy eating club card', with the technology currently used by supermarket loyalty schemes? This could take advantage of seasonal pricing and offers, making fruit and vegetables more affordable to potentially the whole population, and would be working on a systems-wide preventative model. It would also diminish the stigma some people experience when using tokens or vouchers at the supermarket.

The Eatwell scheme can't stand alone

As a standalone intervention, the Community Eatwell Programme would benefit some targeted individuals. At a population level, though, it would be battling such a strong tide of unhealthy messaging and advertising, junk food culture, HFSS promotions, and cheap, unhealthy food neighbourhoods, that it would have very little impact. Without being part of a more systemic approach, it is unlikely to succeed on the scale that is needed.

However, as part of a wider set of interventions to reduce diet-related inequalities – as recommended in *The Plan* but not (so far) taken up in the *Government Food Strategy* – it would contribute to an interlocking set of measures that could encourage behaviour change, tackle the junk food cycle, reduce access to calorie-dense, low-nutrient foods, improve food environments, and promote lifestyles that acknowledge food as fundamental to health, particularly at an early age (although the recent FRC Policy Insight *The baby-shaped blind spot*²⁶ points out the lack of reference to early years in *The Plan*).

The need to dovetail with existing schemes

A key lesson from experience is that to make best use of squeezed resources and acknowledge the work already happening across the country, the Community Eatwell Programme should dovetail with existing schemes that support systemic change.

There are already great examples of projects and interventions that support people living on low incomes to eat well. Two examples that could be linked to social prescribing would be the Greenwich Cooperative Development Agency (GCDA) Fruit and Veg Stalls and the Rose Vouchers for Fruit and Veg programme. The GCDA Fruit and Veg stalls are located in various settings – such as outside in a playground – and usually run for an hour, weekly, offering a selection of affordable, seasonal fruit and vegetables.²⁷ The Rose Voucher Fruit and Veg scheme is an example of a place-based scheme supporting families with young children to access fruit and vegetables and receive support to help behaviour change through family centres (which distribute the vouchers).²⁸ The vouchers can only be spent at local markets or fruit and vegetable stalls, thus supporting the local food economy.

To encourage successful programmes at a neighbourhood level, the Community Eatwell Programme would require enough adaptability and flexibility to accommodate local needs and cultures, working with those organisations that know and understand their communities. Experience tells us that responding to the idiosyncratic needs of local communities is essential to successful intervention. Community and Voluntary Sector (CVS) organisations often provide a bridge between local communities and statutory sector services and can identify nuances that make the difference between communities using a service or not.

The FRC Policy Insight *A Place for Food*²⁹ suggests that if neighbourhoods were human-scaled, had mixed land uses, reasonable population densities to support local food businesses, space for food growing, and a walkable and cyclable design, they would help create more food-friendly conditions. It proposes that an

urban land use framework should be developed, to sit alongside the Government's proposed framework for rural land use. This could support planning for better health and wellbeing through organisations such as local food partnerships, which use joined-up approaches to transform food systems, bringing together food and health, local food economy, climate emergency and environmental concerns (See box).

The benefits of joined-up action: an example

In 2018, the Brighton and Hove Food Partnership (BHFP) ran a healthy weight programme for the local Public Health team. The outcomes were greatly enhanced through clients being exposed to a range of other food-related activities also run by the Food Partnership. This increased participants' understanding of their relationship with food and gave a better grasp of the issues of poverty and the affordability of healthy diets. The Partnership was also able to weave in sustainability messages (e.g. talking about sustainable sourcing for oily fish or seasonality for vegetables). BHFP's network of connections and community-based approach (e.g. partnering with community / cultural venues and organisations to run programmes) meant that people were able to link to other activities at these organisations and venues (e.g. delivering the service in partnership with the local football team community outreach charity was key, as they had high credibility with children and young people and offered participants the chance to join their activities).

Conclusion

As with existing social prescribing for gardening and other wellbeing activities, the Eatwell prescriptions for free fruit and vegetables should be considered components of an education and behaviour change 'toolkit', a support mechanism to help people overcome the complex barriers they face when trying to access a healthy, balanced diet as part of a healthy lifestyle. They should not be seen as a supplement for inadequate incomes.

Measures such as social prescribing stress individual responsibility, and seek to change personal behaviour to tackle what are in reality societal problems. The risk is that focusing too much on this type of intervention draws policy, debate and resources away from the structural, long-term drivers of diet-related ill-health and food poverty: low incomes, poor housing, unemployment and low educational attainment.

The Community Eatwell Programme is a sound idea only when considered as part of a suite of interventions that supports a move towards more healthy and sustainable food systems – the essence of *The Plan*. These would include policies to tackle structural issues (for example by raising incomes, cutting junk food advertising, planning better for healthy food neighbourhoods, subsidising sustainable farming for healthier foods, and aligning trade policy with health, environmental and agricultural policy). Only systemic change can counter the huge promotions budgets and cultural influencing power of the large food brands and retailers.

The new Government has the opportunity to revisit *The Plan* and reconsider whether it would not only be more cost-effective but also more ethically sound to be working towards improving diets across the population, using regulations and policy change, rather than targeting interventions at specific groups. This might involve adapting existing interventions that improve foods and food environments, such as requiring the reformulation of unhealthy foods, imposing taxes on HFSS food manufacturers (building on the success of the Soft Drinks Industry Levy),³⁰ regulating high street planning to encourage healthy eating and discourage HFSS food outlets,^{31 32} subsidising street markets and local retailers to carry affordable fruit and vegetables,³³ and ensuring benefit payments and the minimum wage are based on a minimum income standard costed to include a healthy and sustainable diet.³⁴

Many years' experience in community food work indicates that behaviour change intervention programmes alone are not enough. They will help some individuals, whilst the individuals are participating in the programme. However, ensuring they have financial capacity to maintain new eating habits is also essential, as are structural interventions that move us from unhealthy food environments to health-promoting food systems.

Understandably the new Government is busy, so I would point it in the direction of the National Food Strategy Independent Review, *The Plan*, which has a very comprehensive list of recommendations to get started with.

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Victoria Williams is co-founder and Director at Food Matters, an independent food systems transformation charity.

Her interest in food was sparked young, and for most of her career she has focussed on food justice and food access issues, concerned with how the voices of marginalised and vulnerable communities are heard and listened to in the sustainable food systems movement. Her work has always centred on testing ideas, pilot initiatives and supporting programmes so the best of them can take root and flourish.



Her current work centres on food and criminal justice through Food Matters' Inside and Out prison food reform programme, and food partnership development through the Sustainable Food Places (SFP) programme. SFP is a nationally and internationally recognised programme supporting the development of local, cross-sector food partnerships and food strategies delivering citizen-led food systems transformation.

She has led on developing local food partnerships for over 20 years, a journey that started in Brighton, where she is now Chair of the Brighton & Hove Food Partnership. She is also a trustee at Sustain: the alliance for better food and farming, and a member of the Brighton and Hove Allotment Federation Liaison Committee.

With thanks to our funders



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We are grateful to the Esmée Fairbairn Foundation for funding our work.

Please cite this Insight as:

Williams, V. (2022) *The Community Eatwell scheme: Why it can only work as one piece of a jigsaw of interventions to tackle diet-related ill-health*. Food Research Collaboration Policy Insight.

ISBN: 978-1-903957-76-9



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