4

‘Look After Yourself’: visualising obesity as a public health concern in 1970s and 1980s Britain

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Introduction

In 1978 the Health Education Council (HEC), a centralised non-governmental body responsible for health education services, launched a campaign to increase public awareness of the health problems caused by overeating, inactivity and smoking. Their campaign used television, poster and newspaper advertisements to encourage people to ‘Look After Yourself’ by eating less, exercising more and quitting smoking. It was devised as a ‘better health’ campaign that could unite risk factors for coronary heart disease (CHD) as well as other chronic conditions such as hypertension and diabetes into one central generic message.[1] A principal promotional tool of the campaign was to use visual images to redraw the boundaries of what constituted a balanced diet and demonstrate how a healthy lifestyle could be visually inscribed on the body. In this context obesity became a key marker of the unhealthy body, and its centrality in health education messages showcased the significance of individual behaviour to the public health agenda. The campaign reached a large proportion of the population through its multi-media approach, and later evaluation studies suggested it was successful in securing more widespread awareness of the routes to ‘better health’.[2]

The development of the ‘Look After Yourself’ campaign was the culmination of a major shift in public health that took place in the decades after the Second World War. The rise of risk factor epidemiology in

Western medical science and its importation into health policy-making from the 1960s instituted new styles of public health practice that focused on risk rather than direct causation.[3] This risk factor model focused on the role of lifestyle and behaviour across time, enabling a wide range of preventive programmes to identify individuals as important agents of change. This 'new public health' necessitated more effective and innovative methods for communicating with the public.[4] Virginia Berridge has emphasised the role consumerism played in health education programmes, with both the state and the self being important brokers in constructing individuals as self-regulated actors encouraged to modify their behaviour in ways that were sanctioned and supported by the state.[5] Population-level approaches to public health issues increasingly used the tenets of marketing and advertising to engage with at-risk individuals. In 1964, the Cohen report on health education published by the Central and Scottish Health Services Councils argued the need for health education to make more effective use of the mass media so that campaigns could productively influence individuals to act on the advice given and demonstrate 'self-discipline' in controlling their behaviours.[6] The centrality of mass media techniques to the construction of the new public health ensured that visual communication techniques became valued tools of persuasion.

Visual culture has much to offer historical examinations of public health. Historians of visual culture and medicine have examined depictions of disease in relation to the dichotomous relationship between the 'beautiful' and the 'ugly' body as an aesthetic norm.[7] Much of this research has focused on depictions of insanity during the eighteenth and nineteenth centuries and bodily representations of AIDS during the 1980s and early 1990s. [8] Yet, health education more broadly offers insights into how similar visual tropes for representing disease prevention utilised contemporary understandings of gender, beauty and the body to convey disease risk. The mid- to late twentieth century witnessed a distinct shift in the way the body was depicted for public health purposes with the adoption of a representational mode based on a new image of the body, itself enshrined in the concept of 'body image'.[9] Healthy behaviours were often gendered and coded in terms of bodily attractiveness, reinforcing the culturally contingent understanding that eating and the social body were inextricably linked.

Health education programmes also firmly established the idea that balancing individual diets and physical activity was essential to good health.

Such ideas of balance and selfhood permeated individualised notions of health education throughout the 1970s and 1980s. For heart disease prevention programmes, overweight and obesity were regularly constructed as an imbalance between caloric intake and energy expenditure, with the individual identified as the crucial agent in self-adjustment and self-improvement. Of course, this idea of dietary moderation for health preservation long pre-dated these post-war health education initiatives and had been evident since at least the early modern period in England, where dietetic culture was central to medical understandings of the self.[10] But personal body management techniques including the control of diet and exercise endured as an essential part of personal identity and social worth in post-war Britain, where the consumerist society contributed to the creation of new disease-focused diet cultures. The centrality of the self to risk factor epidemiology remained a salient aspect of post-war public health where the individual held new-found power in dictating health outcomes and contributing to chronic disease reduction.

This chapter examines the use of visual images to promote healthy eating as a tool of disease prevention in health education during the 1970s and 1980s across England, Scotland and Wales. It not only analyses the activities of the HEC, and especially its poster output, in reorienting nutrition as a major part of its activities, but also highlights the role of public information films and the work of the commercial television station ITV in providing ancillary educative content through the documentary format. These examples represent only a small proportion of the poster and filmic material produced during this time on the subject of nutrition, diet and chronic disease, but they reveal some of the ways in which scientific knowledge about dietetics and disease causation were entangled in a range of cultural and representational practices focused on tropes of gender, body image and the 'cult' of slimming. By coding disease risk in terms of particular visual attributes and specific practical preventive measures, these images functioned to express and articulate specific health ideologies. These ideologies promoted the idea that individualised health risks, often visualised by the obese body, could be overcome (at least in part) by complying with a

myriad of health advice that together would construct individual balanced good health.

Health education and nutritional health policy

From the 1960s onwards body weights in Britain rose steadily, and so too did associated diseases such as heart disease, hypertension and diabetes.[11] In this respect Britain was not unique but rather part of the wider international proliferation of chronic disease in the post-war period.[12] Various scientific studies, especially the Framingham Heart Study in the United States and the Seven Countries study, suggested a strong correlation between diets high in saturated fat and the increased incidence of coronary heart disease (CHD).[13] This had particular implications for the understanding of heart disease and the development of disease prevention programmes in many countries.[14] For Britain, it was integrated into epidemiologically based health policy-making. The concurrent rise of technocracy and the establishment of expert committees, which united scientists, medical professionals and government in influencing policy, were central to introducing epidemiological findings into policy-making, public health priorities and health education strategies.[15]

The Committee on Medical and Nutritional Aspects of Food Policy (COMA) was a key organisation in creating new health policies to address the emergent scientific understanding of the role diet was playing in CHD causation. Established in 1957 and chaired by the Chief Medical Officer, the Committee advised the government on 'medical and scientific aspects of policy in relation to nutrition.'[16] In 1965 the Committee was reconstituted and the word 'nutritional' was dropped from its title. This change reflected the wider range of issues coming under the Committee's remit, including the bacterial, toxic and carcinogenic risks posed by food. In January 1969 the Committee discussed a Scandinavian research paper on the topic of unsaturated fats and agreed that COMA could not endorse it without examining the problem in greater depth.[17] The COMA panel on diet and heart disease was subsequently established in 1970 to advise on the 'significance of any relation between nutrition and cerebro-vascular and cardio-vascular disease, and on any indications for future action.'[18] Its report, *Diet and Coronary Heart Disease*, released in 1974, recommended that people

should lower their consumption of fat, especially saturated fat; but the level of professional disagreement among panel members was such that John Yudkin, Professor of Nutrition and Dietetics at Queen Elizabeth University, included a caveat stating that the report 'exaggerated the possible role of dietary fat in causing I.H.D [ischaemic heart disease] and has minimised the role of sucrose'.[19] This debate severely limited the policy implications of the report. Its main impact related to advertising standards, giving COMA the power to reject any advertisement that made health claims unsupported by the conclusions of the report.[20]

Yet the environment in which this Committee was operating was dynamic and rapidly changing. The emergence of new lifestyle- and risk-focused community health coalesced with increased medical efforts to reduce rates of heart disease by emphasising prevention. In 1976 the Royal College of Physicians published a report on diet and cardiovascular disease recommending that saturated fat intake be lowered.[21] This coincided with the government's commissioning of various policy reports to better understand the health implications of diet. The Department of Health and Social Security (DHSS) published *Prevention and Health: Everybody's Business* in 1976, followed by *Prevention and Health: Eating for Health* in 1978. These documents emerged during a period of substantial challenges for the state in funding the welfare state.[22] In this context preventive medicine was viewed as a potentially cost-saving measure that might reduce pressures on financially stretched NHS services. Dietary recommendations were therefore conceptualised not only in a changing public health context, but also in a period of government retrenchment in health spending.[23] The National Advisory Committee on Nutrition Education (NACNE), established in 1979, similarly sought to determine pragmatic policy recommendations on diet and heart disease. It made more extensive recommendations for dietary change.[24] A second COMA panel updated their findings in 1984, which led to the development of the 'Look After Your Heart' campaign to replace the 'Look After Yourself' initiative, so that a more targeted message could be communicated to the public.[25] In this context, public health campaigning emerged as one platform for promoting overweight and obese body types as potential risk factors for coronary heart disease.

The move towards detailed advice campaigns reflected an effort to enlist consumers into adopting appropriate self-regulating health

behaviours. By persuading consumers to engage in self-regulatory practices that aimed to prolong life, public health was contributing to new 'practices of the self' that convinced people to interiorise health advice and show self-restraint,[26] while at the same time consuming more (albeit different) products to secure the continued success of the consumer society. Health consumerism demonstrated respect for the development of new diet markets and consequently the marketisation of nutrition and health itself.[27] In this process images were key. They repeatedly constructed and coded notions of acceptable health behaviour within established modes of representation – notably those pertaining to gender, beauty norms and the role of the individual. Thus, government-sponsored health education campaigns took into account the varied and changing social environments in which they were operating. Health messages were linked to contemporary notions of health and beauty because – as so succinctly put by Professor James Halloran of the Centre for Mass Communication Research in 1975 – '[a] "message" is not dropped into a social vacuum. It enters into an existing social network, an established system of norms and values, an ongoing process of interactions and relationships'.[28] It was in this changing policy context that health education and community health more generally appropriated visual representations as important components of advertising healthy nutrition and diet behaviours.

'Look After Yourself' and visualising the healthy body

As international scientific findings linking diets high in saturated fat with raised risk of heart disease were securing political purchase, so too were the ways such information was disseminated to the public. Health education was repeatedly identified as an asset to prevention by encouraging the public to adopt healthy living habits.[29] From 1973 the HEC was particularly concerned with the proliferation of overweight body types and obesity in Britain and the potential connection to heart disease.[30] Committed to the development and launch of a positive health campaign 'Look After Yourself' in 1978 across England and Wales,[31] the HEC intended to address the health effects of diet, lack of exercise and cigarette smoking in a shared campaign that aimed to educate the public on the interconnectedness of many risk factors in chronic disease aetiology.[32]

The 'Look After Yourself' campaign was designed by the Saatchi & Saatchi advertising agency, which had been working with the HEC on a variety of campaigns since the early 1970s.[33] These campaigns were notable for their use of the persuasive tools of the mass media, and used a combination of humour, shock tactics and hard sell to import contemporary advertising approaches from the commercial world into public health.[34] The poster material for the campaign was particularly focused on clear interaction between image and text, as well as on using one central image to convey or associate the message effectively to the viewer. One poster showed a large pair of men's plimsolls alongside the tag line 'You'd enjoy more sex if you had a pair of running shoes', which stereotyped the unhealthy middle-aged man while cynically suggesting that sex rather than health would incentivise behaviour change. This approach was viewed as distasteful by some, with Conservative MP Michael Shersby asking the House of Commons, 'is it suitable to be read by young children or many women who would find such an advertisement embarrassing?', and asserting his hopes 'that the HEC will concentrate on providing information which is based on hard evidence and not merely on opinion'.[35]

Nevertheless, the 'Look After Yourself' campaign continued to use visual images to reinforce the primacy of the 'beautiful' over the 'ugly' body as an aesthetic norm and to link it with conceptions of health, fitness and personal attractiveness. Posters used images of male and female bodies to discuss weight loss, diet and exercise in a context that emphasised culturally contingent understandings of sex appeal.[36] The poster 'Is your body coming between you and the opposite sex?' (Figure 4.1) displays an overweight man, in swimming trunks, standing at the poolside looking at a group of women in the middle ground, swimming and playing with a ball. The inclusion of a solitary man in the background of the image, ready to catch the women's ball, visually suggests that it is his fitness, slimness and involvement in physical activity that ensures nothing is coming between him and the opposite sex. Contrastingly, the foregrounded figure is turned away from the viewer, his body in profile to emphasise his rotund form and to guide the viewer's eye past him to the pool scene in the middle ground of the image.

The man was presented as both within and without the scene, removing him visually and metaphorically from the 'action'. Consequently, the poster suggested the existence of a barrier between healthy and

4.1 Is your body coming between you and the opposite sex? (Poster, Science & Society Picture Library, 10411400), 1978–80

unhealthy individuals in their ability to participate in a modern active life. This separation of the overweight male from other figures in the visual field underscores that overweight was not just a barrier between him and the opposite sex, but also from society more generally. The advice to eat a 'bit less food' and take a 'bit more exercise' suggests that a rebalance in diet and activity was needed to be attractive. This builds on nineteenth- and early twentieth-century understandings of physical energy expenditure that connected energy usage both at rest and at work with nutrient composition and caloric intake.[37] In this context balance was a scientific calculation that measured calories in relation to their expenditure. It also closely connected understandings of dietary balance with those of social 'modernity', where an individual's productive potential was linked to the ability of society to reduce social risks without restricting individual freedoms.[38] This poster is subconsciously connected to this longer heritage, similarly tying the post-war modern man with a particular understanding of dietary balance codified in terms of food intake versus energy expenditure as a social as well as a medical necessity. In juxtaposing the slim, swimsuited female bodies in the middle ground with the larger, overweight male figure in the foreground, as well as the depiction of a thinner man incorporated into the pool scene, the need to '*look* better and feel fitter' was framed as an aspiration for all and a reality for some.[39]

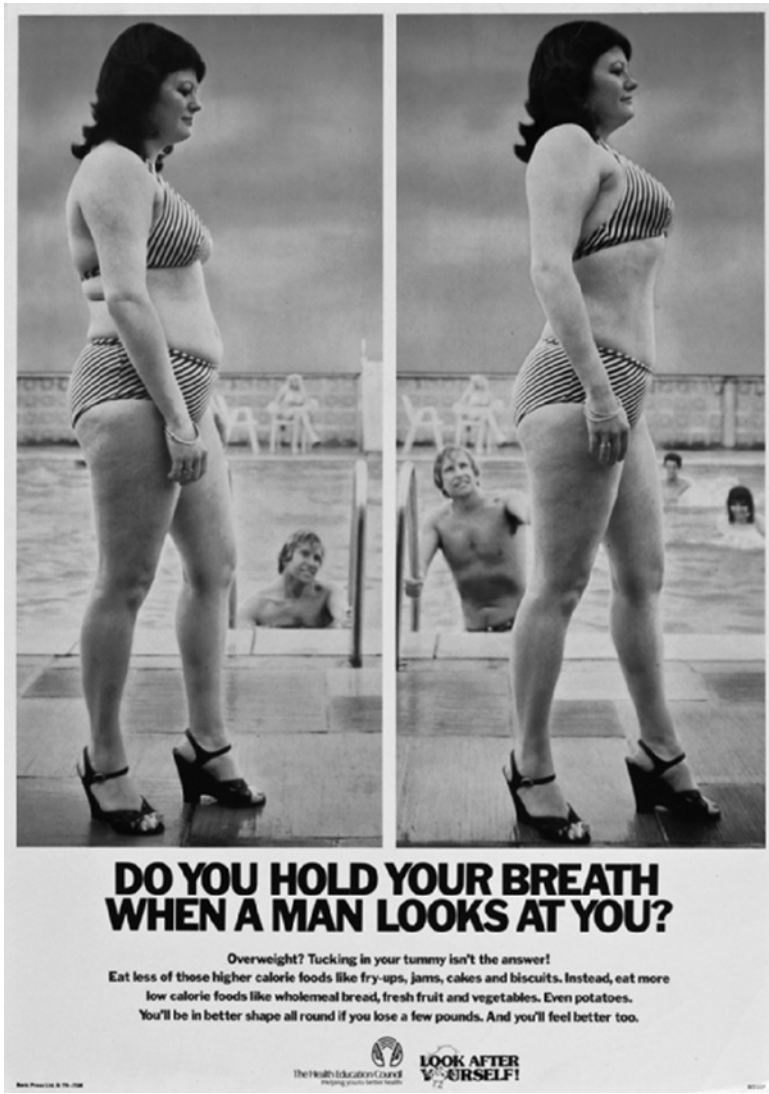
The poster visually and textually emphasised the centrality of the 'look' and 'looking' in society. Outward appearance was prioritised in visual terms over any genuine commitment to conveying specific instances of disease risk. The poster failed to reference any disease that would be affected by poor diet and lack of exercise. While HEC minutes reveal the campaign's commitment to reducing mortality rates from heart disease in particular, they expose a cautious approach to visualising disease risk openly.[40] The omission of any reference to specific health risks, especially in terms of mortality, was mirrored in other visual material produced for the 'Look After Yourself' campaign. The 'Do you hold your breath when a man looks at you?' poster (Figure 4.2) similarly avoided reference to disease types, instead fulfilling the campaign's aims to 'emphasis[e] … the benefits of good health not the disadvantages of habits … conducive to ill health'.[41] This absence of the diseased body from the visual components of the campaign, while still acknowledging the body 'at risk', marked a distinct break from previous

cultural expressions of disease typified by eighteenth- and nineteenth-century representations of madness and syphilis. Earlier representations had asserted that the diseased body was visually marked as ugly, for 'ugly' and 'diseased' were identical categories.[42] In these 'Look After Yourself' posters, however, the relationship between the binaries of beautiful/ugly and healthy/diseased was reconceptualised in new, risk-centred ways. The 'ugly' – overweight – body was no longer the 'diseased' body, but the body at risk.

The use of photographs in these posters was an important aesthetic choice. Figure 4.2 used the photograph in a 'before and after' arrangement to visually 'show' the visible effects that a controlled balanced diet coupled with increased exercise could have on the body. While it may appear that this particular example of the 'after' showed nothing more than improved posture and stomach muscle tension (implying that these photographs were taken just minutes apart), the textual message implied a more meaningful change. The poster suggested that 'Tucking in your tummy isn't the answer', calling into question its own visual elements. This ambiguity suggested that while this tummy-tuck approach to achieving the beautiful/healthy body was not a long-term solution, the same body shape was attainable by 'eat[ing] more low calorie foods like wholemeal bread, fresh fruit and vegetables'.

Such dietary habits were constructed in positive terms and used to demonstrate the importance of having control over the body. In this campaign, food was classified into binary categories such as good or bad, masculine or feminine, healthy or unhealthy, self or other.[43] This duality in health advice enabled the HEC, and by extension the state, to 'shape food preferences and beliefs in everyday life, to support some food choices and militate against others, and to contribute to the construction of subjectivity and embodied experiences'.[44]

The role of the state in this process raises questions about the nature of citizenship in 1970s and 1980s Britain. The rise of social citizenship,[45] which provided rights of welfare, healthcare and housing, was part of a broader ethical focus on the relationship between the individual and society. Public health proved especially fertile ground for the reworking of citizenship not purely in terms of the provision of rights but also the fulfilment of responsibilities by both citizens and the state.[46] Preventive medicine in particular was an object of two balanced parties: the state and the individual.[47] In the context of the 'Look After Yourself'



4.2 'Do you hold your breath when a man looks at you?' (Poster, Science & Society Picture Library, 10411688), 1980

campaign, the state was advocating a particular balance of duties, where the DHSS, through the HEC, assumed responsibility for informing and persuading the public to implement behaviour changes, and where the individual consented to institute lifestyle choices that promoted better health. In this way the state was an active agent in constructing the health citizen as a self-conscious consumer responding to scientific and state advice.

Rather than documenting behaviour change, the images comprising the 'Look After Yourself' posters imitated the 'real' as another educational tool that might inspire lifestyle change on the part of the viewer. By promoting the need to 'look better', both posters participated in the visual and psychological quest for bodily beauty. This contrasted with visual representations of madness in the eighteenth and nineteenth centuries and subsequent depictions of AIDS, which encouraged a sense of distance between the observer and the unhealthy subject of an image. This approach became more nuanced in the case of chronic disease.[48] In order to instigate behavioural change, public health relied on an internalisation of risk. The overweight or un-toned body was now used to bridge the distance between the healthy and the unhealthy, so that the majority of the population was framed as at risk and therefore targets for implementing individualised behavioural change.

Obesity on film

In the development of public health prevention programmes both film and television allowed the state to circulate a more nuanced message about obesity and health than could be achieved by poster output alone. The combination of moving image and voiceover created a different visual message from fixed images by firmly linking the specific health risks of obesity, alongside practices of prevention, with a clear narrative structure. The documentary film had long been an important mode of communication used by government to convey disease risk.[49] Despite the traditional narrative of a post-war 'collapse' in the British documentary film movement, the Central Office of Information (COI) continued to use public information films as a visual tool of health persuasion.[50] The COI in conjunction with the HEC, the Scottish Health Education Unit and the British Nutrition Foundation produced a short film entitled *A Way of Life* in 1976. Its production represented

a moment of national cooperation across England, Scotland and Wales in using film to disseminate knowledge of the risk factors associated with coronary heart disease. A dramatised documentary, it narrativised the importance of healthy eating habits and regular exercise as forms of preventative medicine. Filmic techniques associated with fiction were linked with those related to documentary realism. This allowed the COI to focus on dramatisation to achieve the individual-as-representative and therefore universalise the experience of the protagonist.

A Way of Life depicts the medical and lifestyle implications of ill health for a taxi driver who becomes involved in a near-fatal collision. It takes place over the course of a single day. Following hospitalisation, he is diagnosed with hypertension and his body weight is identified as an important contributory factor. He is referred to an obesity clinic where the many health problems associated with being overweight, as well as the difficulties linked with surgical procedures for the obese, are discussed at length. At twenty-two minutes, this film contributes to the documentary film tradition of producing educational shorts based on a single theme. The choice of obesity is noteworthy. At a time when the link between diet and any specific disease, such as coronary heart disease, was still affected by policy inaction resulting from the divided COMA report of 1974, publicising possible risk factors became the central method for discussing health and disease more generally. Obesity was therefore used as a risk factor through which a myriad of health issues, including diet, could be visualised, discussed and debated. Its close link with overeating and lack of exercise constituted an important intersection for discussing associations between diet and exercise, on the one hand, and diseases such as coronary heart disease and diabetes, on the other.

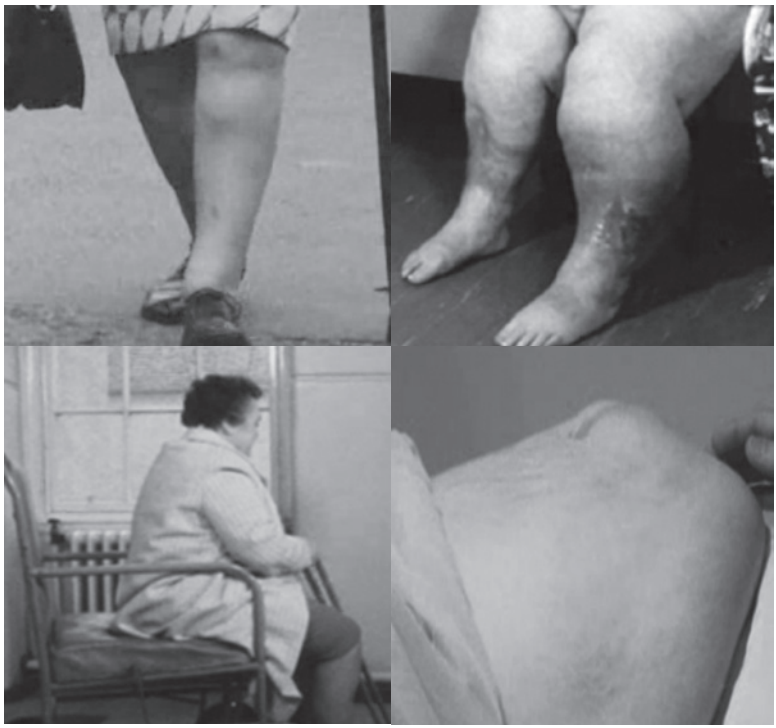
The majority of the film is set in the present day of 1976. We follow a typical journey in the protagonist's cab, becoming increasingly aware that he is suffering from sight problems. Distorted focus is used to display the driver's difficulty in negotiating his journey safely. The camera shots alternate between subjective point-of-view shots, unassigned close-ups and medium shots of both driver and passenger. Sudden cuts to black fragment and temporally unhinge the scene, creating an uncertainty as to what occurs in the interim. As a visual tool this device expresses a sense of what the driver's physiological responses *feel* like. Similarly, the noise of traffic is halted during the visual blackouts.

This technique serves to visualise and make audible these somatic symptoms.

As the film continues the driver is diagnosed with hypertension, linked to his weight. A doctor warns him, 'If you don't lose weight now, you would end up a permanent invalid … at best.' In contrast to the tactics of the later 'Look After Yourself' campaign, he laments that in contemporary culture 'too many people think the only reason to lose weight is to look more attractive'. Yet, he continues, the real stimuli – disease prevention and increased longevity – are repeatedly undermined or ignored: 'It's not just a matter of looks; being fat invites serious heart disease and heart disease can kill.' During these explanatory scenes, the doctor's interaction with the protagonist is visually interrupted by cuts to static images of the technology used by medical professionals to test for and treat coronary heart disease. After the protagonist's diagnosis he is referred to an obesity clinic for follow-up advice and further warnings.

The film's portrayal of an obesity clinic combines close-ups of overweight bodies separated into their distinct parts with a voiceover of real patients' opinions and thoughts on their respective body weights. These serve to situate the dramatised events concerning the taxi driver in a non-fiction, medical context, making the message of the film more pressing. Despite the focus on the taxi driver as a typical example of the proliferation of chronic disease in men, it is women that articulate these voiceovers. Therefore, the visual accompaniments (shown in Figure 4.3, Figure 4.4, Figure 4.5 and Figure 4.6) are implied to be female bodies. This gender dichotomy is particularly noteworthy considering that the death rates from diseases such as coronary heart disease and diabetes were rising more quickly for men than women during the 1970s.[51] However, in visual terms women were 50 per cent more likely to be overweight than men by age 30, and this only increased with age. Thus, the use of overweight female bodies to depict obesity visually was more striking, enabling a greater emphasis on 'fatness' as soft, white, wobbly and clearly comprehensible.

In a similar way to how the nexus between the beautiful/ugly and healthy/unhealthy was established in the posters discussed earlier, these sequences display the obese body as ugly and therefore unhealthy. The voiceover itself reinforces this position, with one interviewee highlighting how obesity makes her feel 'unattractive and nothing interests



4.3, 4.4, 4.5, 4.6 (clockwise from top left): Stills from *A Way of Life* (S. Clarkhall, Central Office of Information, 1976)

you'. This visual and oral linkage emphasises how the long-term effects of obesity on the body could have tangible effects on personal quality of life.

The visual display of female bodies and body parts in this segment is an interesting representational choice. At no point in the dramatic narrative is the body of the named protagonist shown unclothed. Yet it was permissible to expose the unnamed female body, often separated visually into specific body parts, whether legs or stomach. The aural interplay contextualises and elevates the visual power of the images. As the doctor prefaces this sequence, 'the fat person's life can be extremely unpleasant and you may not discover that until it's too late'. These images

are clearly linked, through the cinematic technique of the voiceover, to broader societal norms about personal attractiveness, body weight, self-control and self-esteem.[52] As seen in Figure 4.4, leg sores are depicted as one visually striking outcome of excess body weight. The camera zooms in to emphasise the sores themselves as they become the visual focus of the frame. This emphasis on an unsightly consequence of obesity is confirmed through a sense of inadequacy and personal failure that is revealed through the voiceover. It is autobiographical and used to authenticate the message of the dramatic format that underpins the film as a whole. By combining an aesthetic that emphasises the ugly and not the beautiful with the realist features of the docudrama, the film attempted to convey both information and alarm to encourage change in personal health behaviours. Despite using quite different visual techniques from the later 'Look After Yourself' campaign, and drawing very specific connections between diet, exercise, smoking and health outcomes, *A Way of Life* conformed to the same models of balance and selfhood that emphasised self-regulation, individual action and the role of lifestyle in disease prevention.

Investigative journalism and documenting nutritional health

Alongside documentary film, television was an important additional site for disseminating health information. In particular, current affairs programming provided the public with additional, non-government-sponsored advice about health, diet and disease. While televisual investigative journalism exposed different narrative foci for allocating responsibility for disease and health, the composition and visual arrangement of these documentaries revealed alternative notions regarding the role of individualism in the disease prevention process. They provided a counternarrative, emphasising how televisual media were engaging with broader health and social equality issues that impacted on health outcomes. Examining the structural and economic barriers to health was one part of this counternarrative, with poverty, environment, service delivery and healthcare access all contributing to the construction of another type of self – anyone unable to achieve balanced diets because of inherent health inequality. By examining a particular two-part edition of the current affairs programme, ITV's *This Week*, this section shows how community health and health education

were developing a disease prevention agenda of their own that included direct discussion of inequalities in health.

This Week was first launched in 1956, was renamed *TV Eye* from 1978–86, and reverted to the title *This Week* from 1986–92. It was committed to investigative journalism with a 'social conscience'.[53] Operating in a shifting context of increased welfare state retrenchment, recurring NHS funding crises and the widespread existence of health inequalities, such current affairs programming constituted an important transmitter and translator of Conservative government policies aimed at 'roll[ing] back' social services to end the 'dependence culture'.[54] The airing of the two-part *Lessons from the Dead* and *Lessons for the Living* was instigated by the publication of a report carried out by the Heartbeat Wales initiative in 1987.[55] Heartbeat Wales was a pilot project conducted by the HEC from 1982 to 1987, when it was extended nationwide as the 'Look After Your Heart' campaign. The programme's opening dialogue clearly identified the imminent publication of this report into mortality statistics in Britain as the necessary impetus for carrying out its own independent inquiry into the health of the British population.

The programme focused on Sheffield as a case study to highlight the growing inequity in health that was evident in Britain at the time. The choice of Sheffield can be situated within a longer history of the city being identified as a region with poor health resources under the NHS.[56] This was one of the areas deemed in need of reform by the Resource Allocation Working Party (RAWP) system in the 1970s. RAWP struggled to bring about meaningful change in inequality, in part because it was a purely technical solution,[57] and because Conservative political priorities were focused on a 'two-nations' approach between North and South, which enabled the South East to benefit most from a Thatcherite emphasis on 'localism, self-help, entrepreneurship and marketisation'.[58] For investigative journalism, this continued inequality in health, especially in the North of England, enabled producers to showcase how inequality could be broken down to the individual and local level. The limited study carried out by the investigators of *This Week* used various visualisations of statistical information, first-person interviews and explanations of the structures of local health planning to illustrate similar health inequalities.[59] It used its ability to find the 'human face behind the news story' to imply that the same findings would apply to the rest of the country. The structure and content of the programme

showed an awareness (at least in production terms) of the multi-faceted nature of disseminating information about individualised health behaviour at a national level, while at the same time appreciating the need for region-specific health practices that facilitated targeted services. To this end, the host Jonathan Dimbleby asserted that Sheffield was not unique and that 'as in other deprived areas of Britain, the poor are destined to grow up with an average life expectancy five, six or even seven years below that of the rich'.[60]

In the context of current affairs programming, *This Week: Lessons from the Dead* and *Lessons for the Living* framed disease in terms of a rich–poor divide. Recognition of such a divide gained national prominence with the publication of the Black Report (1980), which explored the social distribution of mortality and morbidity in the thirty years since the establishment of the National Health Service.[61] It documented widespread disparities between rich and poor in terms of health, which were not being adequately addressed by the NHS. Presented as it was to an incoming Conservative government intent on cutting public expenditure, the report was at first delayed, but later published with a short print run on a bank holiday weekend and with only limited same-day press coverage.[62] This resulted in a media furore with accusations of a cover-up, greatly increasing public awareness of the role that socio-economic status and poverty were playing in terms of mortality.[63]

In opposition, the Conservatives had bemoaned a focus on inequality, instead promoting the New Right perspective that inequality was not inherently structural but rather the outcome of personal choice, which could therefore be overcome by individual commitment, skill, energy and motivation.[64] This assessment maintained that poor conditions acted as a stimulus to encourage people to work harder, while the prospect of superior conditions was a further motivation. Thus, unsurprisingly, the Black Report prompted little in tangible policy terms, and by the mid-1980s the Director of the HEC, David Player, commissioned a follow-up research paper. The resultant *The Health Divide* (1987) was published directly by the HEC and further emphasised these health inequalities.[65] Together, the Black Report, *The Health Divide* and the Heartbeat Wales report received considerable press attention, thus provoking further televisual coverage.[66] Moreover, *Lessons from the Dead* suggested that heart disease could also be framed

in terms of poverty and socio-economic status, complicating understandings regarding dietary excess and affluence.

Of the two-part *This Week* programme, *Lessons from the Dead* focused on the issue of health inequalities in 1980s Britain. It employed a number of visual tools aimed at exemplifying the health problems facing the nation in uncomplicated terms. In particular, the programme illustrated the widening gap in health issues and the probable effect on mortality by dividing a group of schoolchildren in a playground into two separate groups. Through narration, viewers are informed that those on one side represent the more affluent sections of Sheffield society, while the much greater number on the other side symbolise those from lower socio-economic backgrounds. In slow motion the children then fall to the ground. The glaring numerical difference emphasises that, as the voiceover states, 'these deaths are not evenly shared by the population of Sheffield'. As simply articulated by Dimbleby: 'If you live in a poorer part of the city then you are more than twice as likely to die before the age of retirement than if your home is on the richer side of town.'

These children are later used to illustrate how important good health in early life and childhood is in reducing premature mortality. The camera pans across their faces in close-up to make their youth more readily apparent to the viewer, underscoring issues of age and life expectancy in the context of health inequalities. The visualisation of these mortality statistics and their inherent inequity stress that just as 'healthy children make healthy adults' (as was stated in the lead-in interview to this section) the opposite is also true, that 'conversely, sick children make sick adults'. While the socio-economic background of the children involved in these visualisations of health inequity is unknown, it remains noteworthy that children served as an indicator of this disparity. Building on a visual lineage established during the Second World War and continued into the 1950s and 1960s of depicting children to emphasise health risk, by the 1970s and 1980s medical scientists were increasingly identifying childhood itself as a key period during which predisposition to disease is determined. A leading article in the *British Medical Journal* in April 1970 focused on obesity in childhood, addressing not only the dangers of obesity developmentally, but also its long-term effects on adult health.[67]

By focusing certain scenes on the child, *Lessons from the Dead* was not only coding premature mortality in terms of long-term risk but also identifying children as a central focus of disease prevention. The use of children as a metaphorical tool in this programme was particularly pertinent. As deaths from chronic diseases proliferated, possible causal links between childhood obesity and malnutrition motivated medical research.[68] These links in turn received press attention, particularly in the scientific and medical columns of local and national newspapers.[69] If predisposition to diseases was determined in infancy and/or childhood, then the onus of responsibility lay with the mother, who was still socially coded as the primary caregiver in society.

In exploring the many multi-faceted causes of health inequality in Britain, the programme identified numerous social, environmental and financial factors as contributing to the extension of a health divide between rich and poor. In contrast to the 'Look After Yourself' and 'Look After Your Heart' campaigns, which stressed individual action to redress imbalances between diet and exercise, *Lessons from the Dead* constructs the self as subject to external forces that inhibit the ability to act individually in improving health. As Martin Moore and Alex Mold suggest in Chapters 2 and 3, the role of the individual, as part of a broader collective, was central to public health approaches to disease prevention by encouraging the individual to demonstrate self-restraint in bodily management practices.[70] This contrasts with the message of *Lessons from the Dead*, which focused on limited employment opportunities, low pay and lack of education as additional contributory factors when investigating the widespread presence of chronic disease among lower socio-economic groupings.

To discuss and develop these topics further the programme used a range of instructive dissemination techniques including interviews, explanatory film shorts, footage of health planning and filmed examples of community health projects such as mobile cervical cancer screening units. In particular, Dimbleby conducted a number of short interviews with female factory workers from Sheffield in their workplace environment, thereby establishing the health of women as centrally important in improving mortality statistics in relation to socio-economic status.

In the course of these interviews the camera focused on cigarette smoking as a central concern. Two of the three women were smoking while being interviewed, and when this was addressed by the

programme (through a cut-in to a close-up on an ashtray filled with cigarette ash rather than a direct interview question) one female interviewee explained her attitude: 'Gives me a bad health, smoking, but I need to smoke because I can't have any other pleasure out in life like going for a drink or anything else so I turn to cigarettes.' When asked how many she smoked a day, she responded 'forty, fifty a day. I should cut down really but it's one of the hazards of life. I have cigarettes instead of drink.' This personal approach to what constituted sufficient risk and how individuals assessed and balanced risky behaviours suggests that alcohol consumption could be traded for cigarette smoking as a justifiable vice. Prioritising one habit over the other allowed her to achieve a personal balance. From the 1960s, British public health policy conceptualised alcohol consumption within the epidemiological model of public health and measured it against concepts of lifestyle choice and behavioural risk.[71] As Alex Mold suggests, redefining alcohol in the same health policy rhetoric as smoking and unhealthy diets ensured that it was similarly constructed as personalised and individualised in the preventive approach of public health.[72] Therefore, during the 1970s and 1980s in Britain diet was being identified as just one among a number of factors considered to be contributing to high mortality rates from chronic disease. The government employed a multi-factorial approach that sought reduction in *all* personal behaviours considered detrimental to health.

The programme demonstrated that some health advice was being successfully communicated to the public, especially in the area of diet and food. When the interview discussed diet, the interviewee not only listed her daily dietary intake but also conceded that this 'junk food', which was the mainstay of her diet, is 'no good for you'.[73] Another female contributor agreed, but asserted that there were financial constraints on attaining a healthy diet and that on low incomes better quality food products were not an option.[74] In this context, dietary balance had been priced out of reach, and calls to engage the individual to self-regulate were not only impractical but also impossible. This counternarrative of inequality was shown to be structural, based on poverty, deprivation and environment. While the programme did not comment explicitly on the need for healthier, better diets for those on low incomes, it did imply that such improvements were necessary to break the fundamental link between poverty and poor health. The

programme acted to provide information by highlighting and emphasising hazards to health and signalling ways to engage in healthier personal behaviours. Lived experiences therefore complicated prescriptive calls to the individual promoted by government campaigns and calls for dietary balance. While 'Look After Yourself' may have been successful in raising the profile of better health and communicating that message to the public,[75] the ability of individuals to act on this advice was more complex and multi-factorial.

This is particularly visible in *Lessons for the Living*, which spends much of its investigative content examining the health outcomes of North Karelia in Finland – a region where coronary heart disease prevention programmes had been particularly successful and mortality rates had dropped dramatically. This comparative element enabled the programme to demonstrate successful community interventions at work, emphasising the role that prevention could play in Britain alongside management and curative practices. By interviewing the Karelia Project's team leader, Pekka Purka, *Lessons for the Living* stressed that treatment did not really affect mortality statistics. Instead, it maintained that prevention was key. In line with the types of advice the programme espoused, Purka declared that the best advice was to stop smoking, change diets to reduce blood cholesterol, and reduce blood pressure.

Throughout the 1960s and 1970s, as quantitative methods of measuring disease risk became central to health policy creation, national public health strategies incorporated the use of the media to inculcate risk-avoidance behaviour in the population. From the late 1970s in particular, current affairs journalism had forged a role for itself in bringing issues of healthcare and health provision to a national audience. *This Week* alone had covered thirty-three different healthcare and medical topics in dedicated programmes between 1979 and 1987. Therefore, both *Lessons from the Dead* and *Lessons for the Living* contributed to a wider trend in current affairs programming, which enabled health promotion and the provision of specific and detailed health information to be provided to the public unrestricted by government policy or DHSS priorities. *This Week: Lessons from the Dead* and *Lessons for the Living* can be read as manifestations of health education shrouded in the mantle of current affairs programming. This emphasises the place that

audio-visual forms of education can occupy in understanding how health behaviours are communicated to the public beyond the confines of government initiatives.

Conclusion

At the time that *This Week: Lessons from the Dead* and *Lessons for the Living* were broadcast, public knowledge about diet and chronic disease risk was firmly embedded in British social culture. A decade of public information campaigning had successfully transmitted the message that diet was a central risk factor and that individuals were responsible for reducing their own risk. Because risk was increasingly internalised and invisible, health educators used obesity as an externally visible risk factor for discussing a variety of chronic diseases, especially heart disease. These messages were framed in terms of an ugly/beautiful divide that emphasised gender and personal attractiveness. Balancing dietary intake and physical exertion not only for health, but also to secure bodily beauty, was an essential organising practice and metaphor through which the HEC sought corrective measures on the part of the public.

In this risk factor model, new conceptions of balance and the self were formulated by a variety of actors including government, scientists and the mass media. While different models of balance were promoted, they all relied on some form of self-regulation – some reworking of how selfhood was related to healthiness and disease prevention. The individualisation of risk in this period enabled the state to reframe individuals as a new type of health citizen incorporated into a balanced conception of rights and responsibilities. This meant persuading the individual to act as a self-conscious and self-regulated consumer engaged in healthful behaviours, thereby establishing a new social contract with the state.

The centrality of persuasion to the 'new public health' agenda ensured an important role for health education in public health, especially in its ability to incorporate and utilise mass media techniques to speak to the public. Visual forms of communication were fundamental in the way health education constructed the individual-at-risk as the key arbiter of change. The 'Look After Yourself' campaign alongside the public information film *A Way of Life* emphasised how visual representations were

central to health education on chronic disease in the 1970s and 1980s. Eating less and exercising more were presented as straightforward and easy methods to rebalance personal risk. Perhaps unsurprisingly at a time of government retrenchment, both 'Look After Yourself' and *A Way of Life* reinforced the primacy of the individual over and above any potential need for increased service provision in the NHS. They emphasised simple prescriptive changes and placed responsibility firmly with the citizen-consumer.

While it is clear that government-sponsored public health messages were penetrating and remaking perspectives on health, individuals still acted independently to reinterpret these messages for themselves in highly personalised contexts. They produced their own balance of risk that challenged the view that behaviour change was easy. Especially in socially deprived communities, access to healthy foods could be compromised by a number of inherent health inequalities. *This Week: Lessons from the Dead* and *Lessons for the Living* were able to show a counternarrative about chronic disease risk and the place of the individual. Its production by commercial television allowed *This Week* to discuss the wider determinants of ill health and examine their impact on chronic disease causation. By focusing on health inequalities, it served to undermine the efficacy of the government's focus on individual responsibility and suggested that wider social and structural changes would be needed alongside education to make any great inroads into disease prevention.

An emphasis on balance, especially in terms of diet and exercise, provides important traction on understanding the disparate and personalised ways health advice was consumed and practised during the 1970s and 1980s. *This Week* presented different perspectives on balance, selfhood and regulation. While contributors to the programme were well aware of the health risks posed by smoking, drinking and eating nutritionally poor food, they were involved in a trading of risks to achieve a personal balance that took account of their financial and social situations. This form of balance was less explicitly focused on adjusting dietary intake in relation to energy expenditure, evident in the 'Look After Yourself' campaign and *A Way of Life*. Instead, balance in this context involved offsetting risk factors against one another in very personal ways. This complicates our understanding of the place of the self in post-war public health and exposes the importance of recognising

how health messages were internalised, reworked and adopted in specific social and cultural contexts.

Notes

1 The National Archives, London (hereafter TNA) FP 1/5, FP 1/6, FP 1/7, Health Education Council papers: Health Education Meetings 1977, 1978, 1979.
2 J. Thomas, 'Look after yourself: monitoring the effects of a campaign', *Journal of Human Nutrition*, 33:5 (1979), 376–82.
3 L. Berlivet, 'Association or causation? The debate on the scientific status of risk factor epidemiology, 1947–*c*.1965', in V. Berridge (ed.), *Making Health Policy: Networks in Research and Policy after 1945* (Amsterdam: Rodopi, 2005), pp. 39–74; G. M. Oppenheimer, 'Becoming the Framingham Study 1947–1950', *American Journal of Public Health*, 95:4 (2005), 602–10; R. A. Aronowitz, *Making Sense of Illness: Science, Society, and Disease* (Cambridge: Cambridge University Press, 1998), pp. 111–44.
4 V. Berridge and K. Loughlin, 'Smoking and the new health education in Britain 1950s–1970s', *American Journal of Public Health*, 95:6 (2005), 956–64.
5 V. Berridge, 'Medicine and the public: the 1962 report of the Royal College of Physicians and the new public health', *Bulletin of the History of Medicine*, 81:1 (2007), 286–311.
6 Central Health Services Council and Scottish Health Services Council, *Health Education* (London: HMSO, 1964).
7 S. Gilman, *Picturing Health and Illness: Images of Identity and Difference* (Baltimore: Johns Hopkins University Press, 1995); P. Burke, *Eyewitnessing: The Uses of Images as Historical Evidence* (London: Reaktion Books, 2001), pp. 9–20.
8 S. Gilman, *Seeing the Insane* (Lincoln and London: University of Nebraska Press, 1995); Gilman, *Picturing Health*, pp. 51–66 and 115–72; A. Ingram and M. Faubert, *Cultural Constructions of Madness in Eighteenth-Century Writing: Representing the Insane* (Basingstoke: Palgrave Macmillan, 2005), pp. 170–201; R. Cooter and C. Stein, 'Coming into focus: posters, power, and visual culture in the history of medicine', *Medizinhistorisches*, 42:2 (2007), 180–209.
9 Gilman, *Picturing Health*, pp. 33–50 and 115–72; J. J. Brumberg, *The Body Project: An Intimate History of American Girls* (New York: Vintage, 1988), pp. 97–137.
10 S. Shapin, 'How to eat like a gentleman: dietetics and ethics in early modern England', in C. E. Rosenberg (ed.), *Right Living: An Anglo-American*

Tradition of Self-Help Medicine and Hygiene (Baltimore: Johns Hopkins University Press, 2003), pp. 47–8.

11 T. Khosla and C. R. Lowe, 'Height and weight of British men', *Lancet*, 1:7545 (1968), 742–5; J. N. Morris, J. A. Heady, P. A. B. Raffle, C. G. Roberts and J. W. Parks, 'Coronary heart disease and physical activity of work', *Lancet*, 48:8 (1953), 1485–96; J. Morris, 'Coronary thrombosis: a modern epidemic', *The Listener*, 8 December 1955, pp. 995–6.

12 E. Giroux, 'The Framingham Study and the constitution of a restrictive concept of risk factor', *Social History of Medicine*, 26:1 (2012), 94–112; G. Weisz, *Chronic Disease in the Twentieth Century: A History* (Baltimore: Johns Hopkins University Press, 2014), pp. 171–232; J. Madarász-Lebenhagen, 'Perceptions of health after World War II: heart disease and risk factors in East and West Germany, 1945–75', in M. Fulbrook and A. I. Port (eds), *Becoming East German: Socialist Structures and Sensibilities after Hitler* (New York: Berghahn, 2013), pp. 121–40; C. Timmermann, 'Appropriating risk factors: the perception of an American approach to chronic disease in the two German states, *c.*1950–1990', *Social History of Medicine*, 25:1 (2012), 157–74.

13 A. Keys, *Seven Countries: A Multivariate Analysis of Death and Coronary Heart Disease* (Cambridge, MA: Harvard University Press, 1980); W. G. Rothstein, *Public Health and the Risk Factor: A History of an Uneven Medical Revolution* (Rochester: University of Rochester Press, 2003).

14 J. M. Parr, 'Obesity and the emergence of mutual aid groups for weight loss in the post-war United States', *Social History of Medicine*, 27:4 (2014), 768–88; D. Lupton, *Fat* (London: Routledge, 2012); A. Offer, 'Body weight and self-control in the United States and Britain since the 1950s', *Social History of Medicine*, 14:1 (2001), 79–106.

15 V. Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford: Oxford University Press, 2007), pp. 132–60.

16 TNA MH 56/442, Correspondence – 'Mr Sinson', 1961.

17 M. W. Bufton and V. Berridge, 'Post-war nutrition science and policy making in Britain', 1945–1994: the case of diet and heart disease', in D. F. Smith and J. Phillips (eds), *Food, Science, Policy and. Regulation in the Twentieth Century: International and Comparative Perspectives* (London: Routledge, 2001), p. 211.

18 DHSS, *Annual Report of the Chief Medical Officer for 1970* (London: HMSO, 1971), p. 115.

19 DHSS, *Diet and Coronary Heart Disease: Report of the Advisory Panel on the Committee on Medical Aspects of Food Policy (Nutrition) on Diet in Relation to Cardiovascular and Cerebrovascular Disease* (London: HMSO, 1974).

20 Bufton and Berridge, 'Post-war nutrition science', p. 212.

21 Ibid., p. 211.
22 R. Klein, 'The crises of welfare states', in R. Cooter and J. Pickstone (eds), *Companion to Medicine in the Twentieth Century* (Routledge: London and New York, 2003), pp. 159–62.
23 Public expenditure suffered real terms cuts in both 1976/77 and 1977/78: R. Lowe, *The Welfare State in Britain since 1945* (London: Palgrave Macmillan, 2005), pp. 333–4.
24 For more on the recommendations of NACNE and the hostile government reaction, see Bufton and Berridge, 'Post-war nutrition science', pp. 213–17.
25 The COMA panel was deemed more acceptable to the DHSS than NACNE because the evidence against saturated fat fell short of proof and guidelines could therefore remain tentative. See: Bufton and Berridge, 'Post-war nutrition science', p. 215; DHSS, *Annual Report of the Chief Medical Officer of Health for 1988* (London: HMSO, 1989), pp. 49–53.
26 E. Hofman, 'How to do the history of the self', *History of the Human Sciences*, 29:3 (2016), 8–24.
27 J. Hand, 'Marketing health education: advertising margarine and visualising health in Britain from 1964–*c*.2000', *Contemporary British History*, 31:4 (2017), 477–500.
28 I. Sutherland: *Health Education – Half a Policy, 1968–1986: Rise and Fall of the Health Education Council* (London: Health Education Authority, 1987), p. 11.
29 DHSS, *Prevention and Health: Everybody's Business* (London: HMSO, 1976).
30 TNA FP 1/1, 'Health Education Council meetings', 1973.
31 TNA FP 1/10/1, 'Health Education Council discussion paper', 1981.
32 TNA FP 1/5, FP 1/6, FP 1/7, 'Health Education Meetings', 1977, 1978, 1979.
33 Berridge and Loughlin, 'Smoking and the new health education', pp. 960–2; A. Mold, 'Everybody likes a drink. Nobody likes a drunk': alcohol, health education and the public in 1970s Britain', *Social History of Medicine*, 30:3 (2017), 622.
34 A. Fendley, *Saatchi & Saatchi: The Inside Story* (New York: Arcade Publishing, 1995), pp. 35–7.
35 M. Shersby MP, 'Debate: preventive medicine', House of Commons, 12 June 1978, col. 766.
36 'Debate: "Look After Yourself" (Health Campaign)', House of Commons, 11 July 1978, col. 477.
37 A. Rabinbach, *The Human Motor: Energy, Fatigue and the Origins of Modernity* (Berkeley: University of California Press, 1992), pp. 130–3.

38 Rabinbach, *The Human Motor*, pp. 292–5.
39 Italics added by this author.
40 TNA FP 5/1, 'Health Education Council discussion paper', 1977.
41 TNA FP 5/1, 'Health Education Council discussion paper', 1977.
42 Gilman, *Picturing Health*, pp. 33–66.
43 D. Lupton, *Food, the Body and the Self* (London: Sage, 1996), pp. 1–2.
44 Lupton, *Food, the Body and the Self*, p. 2.
45 T. H. Marshall, *Citizenship and Social Class and Other Essays* (Cambridge: Cambridge University Press, 1950).
46 D. Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkley: University of California Press, 2011), pp. 204–20; J. K. Seymour, 'Not rights but reciprocal responsibility: the rhetoric of state health provision in early twentieth-century Britain', in A. Mold and D. Reubi (eds), *Assembling Health Rights in Global Context: Genealogies and Anthropologies* (Oxford and New York: Routledge, 2013), pp. 24–5.
47 Seymour, 'Not rights but reciprocal responsibility', p. 34.
48 Gilman, *Picturing Health*, pp. 51–66 and 115–72.
49 T. Boon, *Films of Fact: A History of Science in Documentary Films and Television* (London: Wallflower, 2007); T. Boon, 'Health education films in Britain, 1919–1939: production, genres and audience', in G. Harper and A. Moor (eds), *Signs of Life: Cinema and Medicine* (London: Wallflower Press, 2005), pp. 45–57; S. Anthony and J. G. Mansell, *The Projection of Britain: A History of the GPO Film Unit* (Basingstoke and New York: Palgrave Macmillan, 2011).
50 This 'collapse' consensus has come under revision. See: P. Russell and J. P. Taylor, *Shadows of Progress: Documentary Film in Post-War Britain* (London: BFI, 2010); B. Winston, *The Documentary Film Book* (London: British Film Institute, 2013).
51 DHSS, *Diet and Coronary Heart Disease* (London: HMSO, 1976), p. 26.
52 Various contributors, *A Way of Life*, 11.58–12.40 minutes.
53 P. Holland, *The Angry Buzz: This Week and Current Affairs Television* (London: I. B. Tauris, 2006), pp. xiv–xv.
54 Lowe, *The Welfare State in Britain since 1945*, pp. 332–3.
55 Heartbeat Wales operated concurrently with the last phase of the 'Look After Yourself' campaign. TNA FP 1/14, 'Health Education papers', 1982/3; TNA FP 1/15, 'Health Education Council papers', 1983.
56 J. Welshman, 'Inequalities, regions and hospitals: the Resource Allocation Working Party', in Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience since 1750* (London: Routledge, 2006), pp. 221–41.
57 Welshman, 'Inequalities, regions and hospitals', p. 238.

58 J. Mohan, 'Uneven development, territorial politics and the British health care reforms', *Political Studies*, 46:2 (1998), 326.
59 *This Week: Lessons from the Dead* (ITV, 1987).
60 Ibid.
61 W. D. Dressler, 'Explaining health inequalities', in C. Panter-Brick and A. Fuentes (eds), *Health, Risk and Adversity* (Oxford and New York: Berghahn Books, 2009), p. 175.
62 V. Berridge, 'Introduction: inequalities and health', in V. Berridge and S. Blume (eds), *Poor Health: Social Inequality Before and After the Black Report* (London: Frank Cass, 2003), pp. 1–12.
63 V. Berridge, 'The Black Report: interpreting history', in A. Oliver and M. Exworthy (eds), *Health Inequalities: Evidence, Policy and Implementation Proceedings from a Meeting of the Health Equity Network* (London: The Nuffield Trust, 2003), available at www.nuffieldtrust.org.uk/sites/files/nuffield/publication/health-inequalities-mar03.pdf, accessed 4 May 2014.
64 M. Thatcher, 'Speech to the Institute of Socio Economic Studies: Let our children grow tall', 15 September 1975, available at www.margaretthatcher.org/document/102769, accessed 28 November 2017.
65 M. Blythe, *David Player in Interview with Max Blythe*, MSVA 032.
66 P. James, 'Their life in their hands', *Guardian*, 16 October 1980, p. 14; P. Chorlton, 'Closing the class health gap', *Guardian*, 9 September 1981, p. 4; A. Veitch and N. Hart, 'How the government buried its dead reckoning', *Guardian*, 30 July 1986; J. Sherman, 'Report confirms strong link between deprived areas and poor health', *The Times*, 18 September 1986, p. 3; A. Veitch, 'Health chief put under pressure over report ban', *Guardian*, 26 March 1987, p. 4; Anon., 'Health report "not suppressed"', *Guardian*, 27 March 1987, p. 9; R. Wilkinson, 'Does poverty equal poor health?', *The Times*, 2 April 1987, p. 14; S. Hughes and A. Kirkwood, 'Ill-times for improving the nation's health', *Guardian*, 3 April 1987, p. 10.
67 Anon., 'The overweight child', *British Medical Journal*, 2:5701 (1970), 64–5.
68 Ibid.; J. J. Nora, 'Identifying the child at risk for coronary heart disease as an adult: a strategy for prevention', *Journal of Paediatrics*, 97:5 (1980), 706–14; D. J. P. Barker and C. Osmond, 'Infant mortality, childhood nutrition and ischaemic heart disease in England and Wales', *Lancet*, 327:8489 (1986), 1080.
69 For example: Anon., 'Children face heart risk', *The Times*, 18 April 1972.
70 Mold, 'Everybody likes a drink', pp. 612–36. J. Hand, 'Visualising food as a modern medicine: gender, the body and health education in Britain, 1940–1992' (PhD dissertation, University of Warwick, 2015). George Weisz provides a useful counter to this, suggesting that individualism fitted

less comfortably in British models of public health: Weisz, *Chronic Disease in the Twentieth Century*, pp. 196–7.

71 V. Berridge, R. Herring and B. Thom, 'Binge drinking: a confused concept and its contemporary history', *Social History of Medicine*, 22:3 (2009), 597–607; B. Thom, *Dealing with Drink, Alcohol and Social Policy: From Treatment to Management* (London: Free Association Books, 1999); Mold, 'Everybody likes a drink', pp. 612–36.

72 See Chapter 3.

73 *This Week: Lessons from the Dead* (ITV, 1987).

74 Ibid.

75 Thomas, 'Look after yourself', pp. 376–82.