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Forgoing fat: food choice, disease prevention and the role of the food industry in health promotion in England, 1980–92

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On 8 July 1992, Virginia Bottomley, the Secretary of State for Health, announced the publication of the government white paper, *Health of the Nation*. It set out a programme for promoting health across the whole community by focusing on five target areas: coronary heart disease and stroke, cancers, mental illness, HIV/AIDS and sexual health and accidents. In announcing the paper to the House of Commons, Bottomley asserted that the strategic objectives of the white paper were:

> more than just the work of the National Health Service, vital though that is. It takes in the activities of every Department in Whitehall. It is for private companies and voluntary bodies, for local authorities as much as health authorities, for employers and trade unions, for organisations of every kind, and for individuals of every age. Working together, forming healthy alliances, is one of the central messages of *Health of the Nation*.[1]

This identification of the role private companies could play in securing the health of the nation alongside, and in addition to, the NHS marked an important recognition by government of the place commercial enterprise was playing in both shaping and delivering so-called 'healthy options' to the public. Within this government–industry collaboration, diet and nutrition were important areas of focus.[2] Throughout the twentieth century, food became increasingly identified by medical scientists as a potentially important factor in disease causation, ill health and reduced longevity.[3] Individual behaviours such as overeating and lack of exercise were emphasised as key contributors to the rise of chronic disease conditions

such as coronary heart disease, stroke, hypertension and diabetes.[4] Emergent anxieties over how to prevent or reduce the incidence of premature mortality caused by these diseases enabled public health and health education to play important roles in communicating the role of food in disease risk to the public. Therefore, food choice became loaded with a wider understanding of how diet could interact with health in the longer term.

Certainly, as epidemiological research into chronic disease causation identified high intake of particular nutrients or minerals (like fat or sodium) as harmful to health, retailers recognised the potential of products that reduced or removed these components in order to encourage consumers to make healthy choices. The National Health Service was an important proponent of low-fat diets in particular, urging at-risk patients to engage in new health behaviours and make better lifestyle choices by changing diet and taking more exercise. It promoted the idea that individualised health risks could be overcome (at least in part) by newly constructed health consumers complying with a myriad of health advice that included specific recommendations about food consumption. Alongside public health authorities, the NHS was creating a new understanding of who the target of public health initiatives was and what was expected of them in the realm of disease prevention.[5]

The focus on individual behaviours as key markers of disease risk enabled both the Department of Health and Social Security (DHSS) and the NHS to tout particular diets as not just important for those patients identified as at-risk, but also for the nation as a whole. The resulting emergence of public anxiety around the role of unhealthy foods in disease causation empowered food producers, manufacturers and retailers to co-opt the health education message to create new health food market bases centred on championing various foods as potentially disease-preventing.[6] This anxiety first converged around the emerging scientific understanding that fat, and particularly saturated fat intake, was having a detrimental effect on blood cholesterol, itself an important indicator of increased risk of heart disease.[7] The food industry was not immune to the retail potential of health in the food market, and health foods became an important new component of the food consumption landscape in the second half of the twentieth century.[8] At the same time, the food industry represented a powerful force for limiting change and

exercising regulatory influence, where changes to food product formulations for health benefits presented a challenge to their market base and/or profit margin.[9]

This chapter examines how state-sponsored claims about diet became transposed and reworked in the context of rampant consumerism and the popular understanding that preventive health can be bought on the high street. It demonstrates how government–industry cooperation enabled health education messages to be more effectively transmitted within a consumerist context, part of a rise in voluntary efforts the food industry was making to maintain their influential role within governmental policymaking. The chapter aims to examine what it means to buy health in the form of so-called healthier foods in the 1980s and 1990s and better understand how this corresponds (or not) to governmental priorities around heart disease prevention. It emphasises how the public was identified as gendered consumers and assesses what this focus means for how we understand public health more broadly throughout this time period.

This chapter uses the launch of low-fat milk as a case study to argue for the role the food industry played in reconceptualising the public as health consumers. Health consumerism has often been studied in relation to how patients were re-made as consumers in the second half of the twentieth century and how this impacted their ability to lobby for better healthcare services at local, regional and national levels.[10] However, this chapter argues that the public was also being constructed as consumers of health separately from concerns about rights, access and choice within service provision. Certainly buying health became increasingly commodified in this period, as concepts of lifestyle choice, behavioural modification and individual risk were subsumed into the commercial world of the food industry.

Examining the 'public' through the lens of consumerism complicates and broadens historical understandings of the role 'consumers' played within public health during the second half of the twentieth century. As Mold et al. have explored, public health was impacted by broader social, political and economic change during the post-war period, which saw the creation of new identity categories, such as gender, ethnicity and sexuality, which segmented understandings of a collective 'whole'.[11] The election of a Conservative government

under Margaret Thatcher in 1979 instigated the introduction of new policies focused on the economic and social position of individuals, such as the introduction of the internal market in the NHS, the privatisation of public bodies such as National Rail and the deregulation of financial markets. Neoliberalism, with its emphasis on marketisation, enabled citizens to be reworked as consumers, which impacted how the public and its health were viewed. This in turn reinvigorated the role the food industry was playing in promoting public health messages.[12]

Public health policy and the rise of low fat

From the late 1960s, saturated fat was increasingly pinpointed as a main contributor to heart disease causation, which itself was rapidly becoming the greatest cause of premature mortality amongst men in the United Kingdom.[13] During the 1980s the outcomes of longitudinal cohort studies in the US and Europe coalesced with increased governmental interest in heart disease and its cost to the NHS.[14] By the early 1990s the government, along with the NHS, the food industry and much of the popular medical press were promoting reduced-fat diets and low-fat products as especially beneficial to health. This created an important consensus on dietary advice that would remain deeply fixed for the remainder of the century, even as some epidemiologists and nutritionists began to more vocally extoll the benefits of low-calorie and low-carbohydrate diets instead of low-fat plans for reducing chronic disease.[15] Low fat therefore came to occupy an important position not only in governmental nutritional guidelines but also in the wider understanding of how health and diet were interrelated within consumerist models of food intake.

The rise of low fat as an important aspect of modern food history is now starting to be effectively documented. It has been situated within a wider narrative of food consumerism that stemmed from the popularisation of vitamins in the early decades of the twentieth century and included the increasing demand for food choice and convenience in the post-Second World War years.[16] Within a US context, particular emphasis has been placed on the food product label, which has often acted as a medium by which to popularise scientific

and technical knowledge and to provoke new ways of thinking about food.[17] Xaq Frohlich, a historian of food labelling and risk argued that the turn to food labelling as an aspect of food policy integrated with a broader political shift toward neo-liberalism in 1970s American society.[18] Therefore, he maintained that nutrition labelling should be understood as an important aspect of a 'mobilisation of markets', which sought to make food choice, and consequently aspects of public health, an issue of individual responsibility. Furthermore, labels utilised the language of self-care, which had been continually propagated since the general acceptance of risk-factor epidemiology during the 1960s. Regulatory clashes over health labels on foodstuffs, especially those of the low-fat and low-calorie variety, resonated with broader cultural concerns in the post-war period about 'diseases of civilisation' and their relationship to the modern consumer. Certainly, as outlined by Frohlich, the long history of formal and informal classifications of ingestible products in the US throughout the twentieth century – whole foods, organic foods, health foods, medical foods, health tonics, vitamin supplements – further revealed this ambiguous boundary between food consumption and therapeutics. In a similar vein, Robert Fitzsimmons has examined the institutional interactions and core values of health claims, which have ensured that such products enjoyed an enthusiastic consumer base resulting in profitable new markets for the food industry since the 1980s.[19] Like Frohlich, he too has emphasised the significance of food labels in facilitating the link between particular nutrients and disease prevention through his assessment of the 'oat bran craze' in the US during the late 1980s. By focusing on the interactions between Quaker Oats and the Food and Drug Administration (FDA), Fitzsimmons outlined the importance of consumer confidence in branded products and the value of scientific evidence within modern consumerism.

This growth of science-based consumerism, and the place of product labels within this, was not solely an American phenomenon however. On the contrary, with the stabilisation and later major expansion of food supplies in the post-war period in Britain, there were increased market opportunities for the development of new healthy eating products and diet supplements. However, this particular aspect in the growth of nutrition-centred health concerns has remained notably absent from historical investigation within

a British context.[20] The importance of branded food products, as agents for the dissemination of health education information, should not be underestimated during a period when there was a shift from a focus on consumers only *eating* foods to consumers also *reading* foods. With the food industry recognising the potential of food packaging, and by extension the label, for transmitting knowledge about health, consumers were trained to learn how to read the label as a tool of choice.[21] Therefore, the influence of advertising methods – including packaging and branding – alongside consumer-orientated approaches was visible within the post-war British public health paradigm, where models of 'selling' health were central to public and privately led programmes of popular education.

Food choice became an essential element in the individualised public health of the post-war period, in particular from the 1970s. The virtues of particular foods were promulgated not only by DHSS and through primary and secondary care, but also through the machinations of corporate food advertising – within a food industry that viewed preventive health advice as a hitherto untapped financial resource, tying in as it did with a pre-existing diet culture focused on weight loss. By 1992 the National Food Survey recorded decreased consumption of liquid whole milk, red meat, poultry, eggs, fats, sugar, potatoes and bread. Increases were documented for low-fat milk, cheese, fruit and vegetables, low-fat spreads, cereals and brown bread.[22] Healthy convenience foods were developed with ready-made meals low in both fat and additives coming onto the market.

Creating a health education response

The gradual adoption of a policy position by the DHSS on the role of diet on disease aetiology has a complex history that impacted its inclusion within health education programmes.[23] It stemmed in part from changing approaches to public health, shifting modes of health surveillance, the position of the food industry and the very nature of the welfare state itself. Direct health education campaigns, which were focused on behaviour modification, represented one outcome of these new approaches. During the immediate post-war period, a probabilistic approach to health emerged. This was epitomised

by the growing scientific, political and social currency attributed to the concept of 'risk', with health and disease problematised in terms of behaviour. Alongside the emergence of quantitative methods to measure disease risk, national public health strategies incorporated the tenets of marketing – using the media to inculcate risk-avoidance behaviour in the population.[24] This 'new public health' agenda emerged from pre- and post-war approaches to public health, advertising, mass consumption and emerging networks of evidence–policy–advice.[25] Virginia Berridge has attested to the influence of the scientific and medical connection between smoking and carcinoma of the lung on the development of post-war public health. She argued that this new relationship between risk-factor epidemiology and state policy-making succeeded in characterising profound alterations in public health: a shift termed the 'new public health'.[26]

Both historical and social researchers then and now debated the emergence, influence and place of the 'new public health' in chronic disease discourse.[27] On the one hand, the approach centred personal preventive behaviours within disease prevention narratives – in turn facilitating the creation of new forms of health consumption. On the other, it homogenised health outcomes by focusing attention only on those determinants of ill health that could be controlled or modified by the individual. Tensions existed between positive interpretations of the 'new public health' which emphasised personal empowerment and choice, and negative readings that showcased it as a tool of surveillance with an inbuilt preponderance to victim blame and overlook the structural determinants of health such as socio-economic status, ethnicity and gender.[28]

Harry Oosterhuis and Frank Huismann have argued that since the 1970s, increasing healthcare costs, rising chronicity and the rise of neoliberalism within political discourse in both the UK and the United States collectively enabled the emergence of a 'neo-republican citizenship' that emphasised individual obligations vis-à-vis health.[29] Certainly, the 'new public health' placed the onus on the individual rather than society to improve health outcomes, particularly for chronic diseases. Yet, the NHS still provided an important counterpoint to individualist ambitions. The NHS offered wide-ranging health services that interrupted the construction of public health as purely individualistic. Through the NHS the state intervened in the

social health environment to allow citizens to achieve better health using methods that did not solely rely on individual responsibility to instigate behaviour change. This was particularly true for those chronic conditions that did not easily follow a 'healthism' discourse such as cancer and diabetes (although this did often feature in primary intervention strategies by the state).[30] Ultimately, for these diseases, monitoring, screening and early intervention programmes, as well as long-term management, became central components of preventive programmes throughout the 1980s and 1990s. These focused necessarily on service provision rather than relying on individual behaviour change in isolation.

Regardless, it was through this generalised emphasis on the individual that education and persuasion found a new social climate within print, radio and television advertising as the international proliferation of chronic diseases continued apace. As Berridge has suggested, the wartime and immediate post-war emphasis on civic responsibility and ideas of citizenship was replaced by a focus on propaganda and persuasion utilising consumerist practices.[31] Augmented by the Report of the Royal College of Physicians of 1962, which addressed the scientific links between smoking and lung cancer, the focus on epidemiology during the 1960s and the growing concern over chronic disease mortality resulted in a wider public policy agenda.[32] Central government linked medicine and consumerism at the public health level through the focused emergence of the role of the individual.[33] Utilising a new emphasis on individual persuasion, much state health education and health policy moved in a distinctly consumerist direction. As part of this consumerist shift, advertising methods were subsumed into governmental information services and central agencies began utilising the commercial techniques of market research to assess the nature of public opinion.[34]

The issue of smoking and lung cancer was the first chronic condition to receive a media- and consumerist-focused approach in public health. Certainly, the legitimation of this link over the following decade set in motion a new public health mandate focused on individualism in disease prevention within the 'risk society'. Stemming from these developments, the government slowly began to frame heart disease within behavioural and individual health indicators. Yet, the single-issue and 'common enemy' approach to

disease causality assisted in elevating the smoking and lung cancer link to national prominence during this period. Heart disease did not so easily fit these single modes of causality, nor did it have a similar international position in public health terms before the mid-1970s.[35] Indeed, it was not until mortality rates from cardiovascular disease superseded all others that the government began to address it seriously in epidemiological terms.[36]

The Health Education Council (HEC) held an important role in publicising healthy behaviours to the population. Established in 1968 the HEC was a national, non-governmental body that replaced the Central Council for Health Education as the main vehicle for disseminating population-level health information.[37] From 1973 the Health Education Council became particularly concerned with the proliferation of overweightness in Britain, which it recognised as an important risk factor for heart disease.[38] Whilst there were very high mortality rates from lung cancer during this period, the steady increase in coronary heart disease, particularly during the 1960s, ensured that the HEC extended their promotion activities to include the risk factors associated with coronary heart disease.[39] The work of the HEC in the field of diet and heart disease was greatly influenced by the findings of governmental expert committees, which filtered scientific findings into the area of policy.[40]

Throughout the 1970s and 1980s, numerous expert committees reported on the issue of diet and heart disease, which collectively indicated a general acceptance of the need to reduce saturated fat in the national diet.[41] At the same time, the DHSS published their own policy papers on the issue. Both *Prevention and Health: Everybody's Business* (1976) and *Prevention and Health: Eating for Health* (1978) tentatively made new dietary recommendations about the role of saturated fat in heart disease causation and emphasised public health campaigning as one approach to promote this advice.[42] As a result, the HEC launched the 'Look After Yourself' Campaign in 1978 which was designed to increase awareness of heart disease and how to reduce susceptibility. It was replaced by the 'Look After Your Heart' Campaign in 1987 which operated on a more targeted heart health remit and included significant food industry cooperation in achieving its aims.[43] The move towards detailed advice campaigns therefore reflected an effort to enlist consumers into adopting appropriate health behaviours, in addition to a respect for

the development of new diet markets and consequently the marketisation of nutrition and health itself.

Retailing healthy lifestyles

At the same time that medical science was identifying the potential role of saturated fats in the likelihood of developing coronary heart disease, the British food-retailing environment was undergoing significant change. As a recipient of Marshall Plan aid in the 1950s, Britain had been required to introduce American-style business models into their post-war reconstruction programme.[44] Recent historical research has recognised the influence of this 'Americanisation' in transforming aspects of the British consumer society and in particular, the introduction of self-service retailing in grocery shops and the associated rise of the supermarket.[45] Self-service retailing involved customers choosing pre-packaged products from supermarket shelves rather than asking a grocer to weigh and package produce to the individual specification of each customer. Sainsbury's was an early adopter of this approach to food retailing with its first supermarket branch opening in Croydon in 1950.[46] Throughout the 1960s and 1970s, Sainsbury's continued to expand its self-service stores, consolidating its grocery premises by applying the large, centralised supermarket and hypermarket model familiar today. By 1987 self-service in supermarkets accounted for almost three-quarters of the total grocery market, representing the increasing power of the supermarket over product provision and food choice.[47] This had important implications for how both the food industry and government might best influence consumer eating habits and encourage the development, marketing and sale of healthier food options.

The two largest retailers, Sainsbury's and Tesco, began developing nutrition programmes in the late 1970s, reflecting the increasing recognition amongst retailers of the power of health as a sales approach.[48] Both supermarket chains were early adopters of nutrition labelling on their own-brand range of products.[49] In January 1985 Tesco was the first to announce its intention to develop product labels, publicising that:

> [p]roducts with a health benefit will be highlighted by the use of a distinctive logo. We hope that our healthy eating programme will

> stimulate the public awareness of the need to eat sensibly. The aim is not to dictate to people what they eat, but to help them understand what they are eating.[50]

Later that year, Sainsbury's introduced the 'Sainsbury's System' of nutrition information that comprised colour coding to indicate the health benefits of individual products according to food composition. So, foods high/rich in a particular component, for example, fibre, were coloured brown, those low/reduced, for example, salt, were coded blue and those with zero, for example, sugar or fat, were coloured green.

In addition to the use of colours and logos, both Sainsbury's and Tesco comprehensively labelled their own-brand packaged products with more detailed information in the form of nutrition data tables, especially from the early 1980s.[51] Research by the British Market Research Bureau in 1984 showed that although eighty-two per cent of respondents agreed with the importance of knowing exactly what food contains, sixty-one per cent said that reading ingredients lists took too long. Only twelve per cent said they always looked at the ingredients.[52] Yet, the *National Health Survey* just two years later demonstrated that the number of women shoppers *always* reading labels had reached twenty per cent, reflecting a growing interest in understanding the components of packaged foods.[53] Whilst the *Survey* omitted class analysis within their study, examinations of purchasing choices by supermarkets themselves suggest that middle-class shoppers in particular were most engaged in better understanding food composition and enacting healthier food choices.[54] The *Survey* also revealed that information on sell-by dates, additives and ingredients, rather than health information or nutritional composition, were the main reasons most shoppers consulted food labels. Those specifically looking for nutrition information regarded vitamin content to be most important followed by fat, protein and energy value.[55] This significance placed on vitamin content over other nutrient values perhaps best reflects the continuing dominance of vitamin science within consumer sales cultures, building as it did on over half a century of persistent vitamin marketing.[56]

In 1975, twenty per cent of packaged goods in supermarkets were own-label brands and by 1987 this had grown to thirty-three per cent.[57] At first, own-label products were developed for basic packaged groceries with the large supermarkets positioning themselves

in the marketplace on the basis of price. But with price competitiveness becoming an increasingly important element in supermarket profitability from the mid-1970s, product quality and convenience were also identified as key to satisfying consumer requirements.[58] As part of this shift, there was a greater demand by consumers for healthier options and the supermarkets were well positioned to develop nutritionally modified products at a far more competitive price than those provided by a major manufacturer. Recognising the shifting place of diet within national health guidance, both Sainsbury's and Tesco were involved in a large-scale reformulation of their own-label ranges. During the financial year 1986–87, Tesco reformulated 350 own-label products, with the company declaring its 'commitment to producing all own brand products which follow the principles recommended by [the governmental expert committee] COMA [the Committee on Medical Aspects of Food and Nutrition Policy]'.[59] All major supermarkets were now selling own-label reduced sugar and salt baked beans, reduced salt canned vegetables and vegetable stock, as well as canned fruit in fruit juice rather than syrup.[60] Many also developed nutritional variants in the dairy sector. Sainsbury's was particularly active in this area with the development of some entirely new products such as low-fat milk, non-dairy cream, low-fat yoghurt and half-fat cottage cheese.[61]

By 1986 most of the leading supermarkets were producing explanatory leaflets on various topics relating to healthy eating and product choice. In the case of Sainsbury's milk range, numerous leaflets were produced between 1981 and 1983 that emphasised the place of their own-brand product range in allowing consumers to make healthier choices. In using educational leaflets to advertise product ranges, supermarkets were often ahead of branded goods manufacturers in adopting health education models – such as leaflet creation – that sought to use textual and visual information to inform healthy food choices.[62] *Making More of Milk*, for example, extolled the virtues of Sainsbury's milk range, emphasising that:

> These days, more and more people are becoming increasingly aware of what they eat and the need for a healthy diet, and today's milk has an important role to play in these plans. It's full of vitamins, protein and calcium. And there are plenty of types of milk to satisfy dieters, too. At Sainsbury's you can buy many varieties of milk. And you can

> be sure that whatever diet or menu you have in mind, you'll find the milk at Sainsbury's to suit.[63]

The circulation of leaflets like *Making More of Milk* within stores was widespread throughout the 1980s, as supermarkets used them as a sales tool and to inform consumers about their products in a longer format than a short television, magazine or newspaper advertisement could achieve.

In January 1988, Jacqueline McCluney of the Food Policy Research Unit at the University of Bradford reported that among a sample survey of 576 shoppers, twenty-nine per cent said they had received information on healthy eating from a supermarket.[64] Certainly, this type of information appears to have had considerable reach, although perhaps not at those groups the government most wished to target – middle-aged men from lower socio-economic groups. In 1987, Tesco claimed that over twenty-one million of their free leaflets on healthy eating had been distributed to customers in stores and that this uptake was mainly by younger and higher socio-economic groups.[65] Both Sainsbury's and Tesco's sales data showed that consumers were enacting the information they read about healthy eating issues. A marked increase in the sale of virtually all products associated with a healthier diet was recorded between 1980 and 1985.[66] Clearly, in the absence of a central programme by government, British food retailers were playing an increasingly influential role in communicating information about diet and health to the public.

Vitapint: the first low-fat milk

In 1981, Sainsbury's launched Vitapint, the first low-fat milk to be marketed in the UK. As a liquid milk offering, it was launched as a weight-loss solution for people looking to reduce or eliminate saturated fat in their diet. Made from fresh pasteurised skimmed milk and whole milk with added skimmed milk powder and vitamins A and D, it was marketed as having 'less than half the fat of normal milk but with all the goodness'. Its success enabled Sainsbury's to maintain overall milk sales at a time when national consumption of liquid milk had declined by over twenty per cent between the 1970s and the 1990s.[67] The same period witnessed year-on-year increases

in the popularity of semi-skimmed and skimmed milks with concurrent decreases in liquid whole milk. Skimmed milk sales surpassed whole milk in 1993 and thereafter continued to dominate the milk market.[68] The British Nutrition Foundation has used such statistics to suggest that it has been these types of small changes in consumer purchasing choices that have acted as drivers for healthier shopping baskets.[69] The role of the supermarket in this cannot be underestimated, as they forged a new role for themselves in providing products with identifiable health benefits to the public. Reflecting the preoccupation amongst the scientific community with investigating the role of saturated fat in disease causation, it is perhaps unsurprising that fat was the nutrient most targeted by supermarket product development divisions in the first instance. To this end, Sainsbury's took the initiative in developing their own low-fat dairy range that could compete with 'big brands', local milk delivery services and the own-brand offerings of their supermarket competitors.

Vitapint represented the first Sainsbury's product to contain nutritional information in a now-familiar grid format, which would become fully incorporated into their food-labelling programme later in the decade. This grid outlined the nutritional composition of Vitapint, dividing it into energy by kilocalories and kilojoules, protein, carbohydrate and total fat by gram and a list of vitamins and minerals by percentage of daily amount. The inclusion of a nutritional chart on the packaging of Vitapint was a voluntary measure, reflecting Sainsbury's own internal priorities about creating a new role for themselves in the provision of health information to their customers. This iteration for Sainsbury's was very detailed. Competitors such as Tesco and British Home Stores were relying more on the use of generalised nutrition statements such as 'average per 100g' of energy, carbohydrate or fat during this time period.[70] The publication of the reports of both the National Advisory Committee on Nutrition Education (NACNE) in 1983 and the second Committee on the Nutritional and Medical Aspects of Food (COMA) in 1984 encouraged food producers more broadly, and supermarkets specifically, to provide in-depth nutritional data to consumers, including the breaking down of fat into saturated, mono-unsaturated and polyunsaturated.[71]

This reflected a wider context of public interest in food content from not just a health perspective, but also from a food standards

and safety standpoint. In the 1980s food policy became increasingly politicised as food activists and non-governmental organisations repeatedly brought issues of food policy-making to public attention.[72] The NACNE Report in particular prompted a wave of public interest and outcry over the impact food was having on health in the early 1980s.[73] By the end of the decade scandals over food contamination and adulteration, particularly in relation to eggs and salmonella, listeria in soft cheeses and the outbreak of BSE, encouraged the press in particular to ask if consumers were informed enough about food to protect themselves from disease.[74] Within this context, packaging and labelling represented one way that consumers could be more effectively informed about the contents of food.

Certainly, packaging was used by Sainsbury's as a key communicator of health information to consumers. While accompanying leaflets were often distributed to coincide with a product launch, the packaging of the product itself represented an important way to disseminate key ideas about the product and its health-giving attributes. In the case of Vitapint, Sainsbury's used its packaging as a tool of engagement with the consumer. The central visual component was the measuring tape used as a banner across the centre front of the packaging. This visually linked the product with weight loss and when combined with the textual explanation 'less than half the fat of normal milk but with all the goodness', emphasised the potential role for the product within a personalised weight loss regime. The launch packaging depicted the measuring tape with traditional inch measurement markers – 26–28–30 – but a reconfiguration of this less than a year later depicted the measures as 14–16–18, no longer reflecting realistic measurements but instead women's standardised British dress sizes.

Visually explicit, but textually implicit, the packaging targeted women as its key market, signalling not just the role of women as the main food purchasers within UK households in the 1980s, but also their cultural connection to weight loss programmes during this time period.[75] Weight loss reduction programmes were predominately targeted at women and diet clinics were largely organised for and attended by women.[76] Therefore, Sainsbury's use of the measuring tape reflects a consumer culture preoccupied with dieting as a female-centred pursuit. Feminist scholarly work has repeatedly emphasised the pressure on women to subscribe to a vast array

of socially constructed bodily 'norms'.[77] Yet the cultural practices of dieting, fitness and image management worked together with an image culture that encouraged women (and later men) to see themselves and their personal appearance as inadequate and consequently in need of improvement.[78] The development of low-fat – as well as low-carbohydrate and low-calorie – products corresponded with this cult of slimming, representing an important secondary site of health engagement, removed from disease prevention as a key motivator for behavioural change.

Within this health promotion focus, the public that was being targeted to instigate behavioural change was often a highly gendered one, reflecting wider consumerist and societal understandings of the role of women within food purchasing contexts. Throughout the twentieth century, women in domestic settings had been identified as key agents in maintaining familial health.[79] By the 1970s and 1980s, this responsibility involved transferring health education centred on risk, behavioural change and individual responsibility to shopping and eating habits. As Sean Nixon's work on market research and women in post-war Britain elucidated, throughout the 1950s and 1960s, women were the main purchasers of household food products and little changed in the following decades.[80] Public health campaigns designed by both government and private industry promulgated a visual language around ideas of health and beauty. The emergence of sedentary lifestyles and convenient and speedy methods of cooking and eating coincided with a proliferation of images of beautiful bodies.[81] Thus, in the post-war period, body management was associated with disease prevention as a way of achieving the ideal body based on dietary reform, athletic exercise, exposure of the skin to sun and clean air and personal cleanliness, amongst others.[82] Therefore, the awareness of the close link between diet, lifestyle and health, which had typified epidemiological public health in the post-war period, was not new within twentieth-century public health but was instead appropriating a new disease prevention focus.

Public–private cooperation

By promoting their low-fat milk within the rubric of both body management and disease prevention, Sainsbury's was an early advocate of

applying health promotion techniques to its marketing practice. This type of activity would become increasingly important to both the food industry for creating market segmentation in a highly competitive environment and the government in influencing the purchasing habits of the health consumer. This symbiotic relationship between industry and government in communicating disease risk found formal acknowledgement in 1988 when the Health Education Authority (the successor of the HEC) established its Commercial Department. Its aim was to work actively with the food industry and exploit its access to the public within the purchasing environment in order to communicate health education advice and information and to influence positively the advice that industry was giving. Because up to eighty per cent of purchasing decisions were made at the point of sale, the HEA viewed the supermarket as a positive setting to promote consistent and accurate health education messages.[83] Consequently, the HEA developed a set of nutritional criteria, which were incorporated into its commercial guidelines in order to ensure that the foods promoted encouraged a healthy, balanced diet – foods that could be endorsed included those that reduced saturated fat, increased fibre, reduced sugar and cautioned against significant salt intake.

By partnering with the food industry, the HEA developed a campaign model that focused on one major annual initiative. This approach involved uniting the work of supermarket chains, food manufacturers, local health educators and the mass media. It focused on promotional techniques such as advertising, public relations, point-of-sale activities (e.g. in-store displays) and sales promotions to convey its health message.[84] The first annual campaign for this partnership was Less Fat Fortnight, launched in June 1989 as part of HEA's Look After Your Heart programme. It created alliances between the Look After Your Heart campaign, local health educators and the commercial sector to promote the message that simple dietary changes would reduce the risk of coronary heart disease. The HEA used its position to secure the involvement of twenty-three retailers, manufacturers and trade associations, with each responsible for funding their own activities. In addition, Less Fat Fortnight was actively supported by 134 health education units, dieticians and environmental health officers, with a further twenty-six agreeing to distribute materials despite not being directly involved in the campaign.

The success of this alliance led to the creation of a much larger campaign, Food for the Heart, a month-long initiative in both 1990 and 1991, which used the food industry as a key channel to reach the public. It brought together national retail activity with local health educators as well as local and national media. The campaign aimed to help educate consumers about eating less fat and more fibre which would prompt them to change their behaviour by purchasing healthier foods, while also encouraging companies to make compositional and labelling changes to their products. It was targeted at social classes C2DE, encompassing the working classes, and in particular, men aged between thirty-five and fifty-four years of age.[85] Campaign evaluation comprised a Look After Your Heart general public tracking study, shoppers' exit survey, consumer focus groups, an employers' qualitative survey, workplace case studies, a commercial partners' study, a health professionals' workshop and a health professionals' study.[86] The Shoppers' Exit Survey in 1991 indicated that sixty-one per cent of those interviewed recalled the Food for the Heart campaign, a figure which compared favourably with thirty-one per cent at the end of the 1990 campaign. Of those, fifty-six per cent remembered the 'eat less fat' message and forty-four per cent the 'diet/eat healthily' message whereas only seven per cent recollected the 'eat more fibre' message.[87] The Food for the Heart Campaign was replaced by Enjoy Healthy Eating in 1992, which sought to address more actively the difficulty its predecessor had in communicating knowledge about fibre. It focused on promoting an 'eat more fibre-rich starchy foods' message by emphasising that meals should be centred around foods such as bread, pasta, rice and potatoes.

Collectively these initiatives aimed to show rather than tell the public how to enact its message. Health Education Authority evaluations of the Food for the Heart campaign found that seventy-five per cent of responders agreed that 'this promotion is more trustworthy than others because it is backed by the HEA who is not trying to sell its own products' and seventy-one per cent agreed that 'this sort of promotion helps me to think about what healthy foods to buy'.[88] These comments illustrated how important both retailers and food manufacturers had become in communicating healthy eating and disease prevention messages to the public by the early 1990s.

This type of public–private cooperation became increasingly formalised with the publication of the *Health of the Nation* white

paper in July 1992, which created a comprehensive strategy for promoting health across the whole community and included the establishment of the Nutrition Task Force (NTF) in October of that year.[89] The NTF's remit was to 'draw up a co-ordinated programme of action to implement the nutritional aspects of the Government's health strategy, to promote co-ordination and co-operation between all interested parties and to establish mechanisms for monitoring and evaluating progress'.[90] It brought together a wide range of expertise including food manufacturers and retailers, caterers, health professionals, consumers and the voluntary sector to work with government departments, recognising the role of the food and drinks industry in health promotion and re-establishing their place in communicating better nutrition to the public.

Conclusion

By the early 1990s, the food industry had been fully included in governmental approaches to health promotion pertaining to diet. The *Health of the Nation* white paper explicitly outlined the role government was creating for the food industry in reducing rates of chronic disease. It demonstrated the ways in which health policy was beginning to be formulated around reduction targets to encourage manufacturers to limit the amount of, in particular, saturated fat in their products. *Health of the Nation* targets for fat included a reduction in the number of grams of fat in the average diet from eighty-nine to seventy-eight for women and 111 to ninety-seven grams for men.[91] An Eat Well action plan, proposed by the Nutrition Task Force in 1994, aimed to investigate the technical limitations of implementing fat reduction policies.[92] Concerns included taste, palatability, consumer acceptance and the impact of legislative restrictions, such as compositional standards in reducing fat content.[93] This emphasises the inherent difficulties governments faced in translating advice into action on the part of the consumer.

Healthy eating targets, especially in terms of saturated fat intake, were part of advice-giving strategies but individuals continued to exceed these, even when campaign evaluations suggested widespread knowledge of the 'reduce fat' message.[94] This suggests that individualised motives for engaging in disease prevention behaviours

through healthier food choice were more multifaceted than the straightforward internalisation of governmental health advice and the performance of its instructions. Tensions existed between the constructed categories of the 'individual', the 'consumer' and the 'public'. The construction of the public as a group of health consumers within this context, was part of an idealised interpretation of the role the rational individual could and should play en masse in enacting healthy eating practices.

While policy and practice have continued to largely focus on health education to encourage individuals to change their behaviour, the food industry has become much more embedded in this process. The types of so-called 'healthy alliances' that emerged in the late 1980s and early 1990s between government and industry represented a new form of public–private cooperation that continued well into the 2000s. This was especially clear in the lasting role supermarkets such as Sainsbury's and Tesco played in providing consumers with health education resources – particularly leaflets – and the expanding range of products sold according to their health-giving properties.[95] In addition, supermarkets repeatedly emphasised their corporate social responsibility credentials within the food industry by adopting voluntary measures aimed at improving health. In particular, supermarkets included front-of-package nutrition information from 2006 – often in the form of the 'traffic light system', which aimed at easily visualising the energy, fat, salt and sugar content of pre-packaged foods.[96] As a public health approach, this public–private cooperation revealed one type of public that was being formulated in relation to disease prevention. The health consumer within the food purchasing environment was viewed by government and industry alike as a key object for realising the twin ambitions of encouraging individual behaviour change (evidenced through increased health food sales) while simultaneously communicating with a wider public on disease-preventing issues on the population level.

Rather than a top-down process, health education was diverse and multilateral with supermarkets like Sainsbury's forming important ancillary roles in transmitting health advice to the consumer. The development of low-fat milk, in the form of Vitapint, reflects how communicating diet and disease risk to the public was often twinned with dieting information within consumer culture.[97] The

supermarket was implicitly envisaging a (primarily) female public within its health product development, counter to the governmental focus on middle-aged men as the group most at risk from premature mortality from heart disease. Women were seen as the targets of such messages, reflecting both their place in society as the primary food purchasers and their apparent predisposition to adhere to slimming meal plans. These cultures of dieting were therefore viewed by both government and industry as soft targets for health campaigning because they built on important pre-existing systems of transmitting knowledge about nutrition and health.[98] The success of low-fat milk, like Vitapint, beyond their launch, especially with their later incorporation into supermarkets' standard milk offering, reveals the power of health to sell products beyond their initial target consumer base. That by 1993, low-fat milk had surpassed whole milk as the national bestseller and that this has remained the case demonstrates how important the health message around fat had become to the sale and consumption of basic foodstuffs.

The symbiotic relationship between government and industry constructed the consumer as a 'public' within public health. Heart disease in particular, with its continuously publicised links to saturated fat intake, enabled consumers to be identified as the key 'public' that could and should enact healthy eating behaviours. For other chronic conditions, particularly cancer, this overt consumerist framing of prevention was more difficult to create. Cancer screening, first for breast cancer and later for cervical cancer, relied on an interventionist public health discourse centred on service provision and personal attendance at screening appointments. The 'public' in this scenario was not an inherent 'consumer' but rather a responsible preventive agent in much the same way as the moderate drinker or the ex-smoker had been constructed since the 1960s and 1970s. The 'public' within public health was a shifting and moving target depending on the ambitions and focus of the governmental agenda. The 'consumer' became one of many important constructs within public health that enabled the place of the individual to be elevated within societal understandings of disease causation and risk. Emerging as it did alongside the rise of neoliberal ideologies, the consumer within public health facilitated a broad new role for commercial entities in promoting healthy behaviours that reinforced, or indeed enacted, governmental health policy.

In this way, the development of health education, and later health promotion in Britain pertaining to food and heart health, was more complex and layered than is often understood. Buying health emerged as a commodity in the second half of the twentieth century as concepts of lifestyle choice, behavioural modification and individual risk were incorporated into the realm of the food industry. The 'public' as the target of health information was segmented so that information about diet and health could be communicated within existing forms of food marketing, building on sales data. This ensured that in the case of low-fat milk, women consumers rather than at-risk male sufferers were central objects. The role of powerful entities like supermarkets to guide and influence the way consumers interpreted health advice around food represented a significant watershed in how consumerism, health and government interacted from the 1980s. This shift from health education as purely a governmental responsibility to health promotion as a key element of food consumerism altered the ways in which government and industry collaborated within, and beyond, public health. The formation of health promotion priorities away from the DHSS and the Ministry of Agriculture, Fisheries and Food complicates our understanding of how information on food and health was communicated to the public in the late twentieth century. Consequently, not only did food become medicalised but medicine also became increasingly receptive to the persuasive forces of food advertising and promotion.

Notes

1 Virginia Bottomley, *Health of the Nation*. House of Commons Debate, 8 July 1992, vol. 211: cc. 335–51, available at: https://api.parliament.uk/historic-hansard/commons/1992/jul/08/health-of-the-nation [accessed 15 January 2019].

2 For more on government–industry collaboration and food marketing see: Jane Hand, 'Marketing Health Education: Advertising Margarine and Visualising Health in Britain from 1964–c.2000', *Contemporary British History*, 31:4 (2017), 477–500.

3 See: David F. Smith (ed.), *Nutrition in Britain: Science, Scientists and Politics in the Twentieth Century* (London: Routledge, 1997) and David F. Smith and Jim Philips (eds), *Food, Science, Policy and Regulation*

in the Twentieth Century: International and Comparative Perspectives (London: Routledge, 2000).

4 For more on how the targeting of individual behaviours became important to health policy-making see: Virginia Berridge (ed.), *Making Health Policy: Network in Research and Policy after 1945* (Amsterdam: Rodopi, 2005).

5 For more on how the public has been constructed in public health campaigns see: Alex 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), 612–36.

6 Hand, 'Marketing Health Education', 477–500; Robert Fitzsimmons, 'Oh, What Those Oats Can Do: Quaker Oats, the Food and Drug Administration, and the Market Value of Scientific Evidence 1984 to 2010', *Comprehensive Reviews in Food Science and Food Safety*, 11 (2012), 56–89; Tim Lang, 'Going Public: Food Campaigns during the 1980s and early 1990s', in Smith (ed.), *Nutrition in Britain*, pp. 238–60.

7 Mark W. Bufton, 'British Expert Advice on Diet and Heart Disease c. 1945–2000', in Berridge (ed.), *Making Health Policy*, pp. 125–48; Élodie Giroux, 'The Framingham Study and the Constitution of a Restrictive Concept of Risk Factor', *Social History of Medicine*, 26:1 (2012), 94–112.

8 Gyorgy Scrinis, 'Nutritionism and Functional Foods', in David Kaplan (ed.), *The Philosophy of Food* (Berkeley, CA: University of California, 2012), pp. 269–91; Gyorgy Scrinis, 'Functional Foods or Functionally Marketed Foods? A Critique of, and Alternatives to, the Category of "Functional Foods"', *Public Health Nutrition*, 11:5 (2008), 541–5.

9 The role of private companies in exercising influence over government to protect their own interests is only starting to be looked at within the history of medicine in the UK. Some early work on the scope of the Boots Pharmacy Archive points to the active role such companies played in carving out working relationships with government in the post-war period. See: Anna Greenwood and Hilary Ingram, 'Sources and Resources "The People's Chemists": The Walgreens Boots Alliance Archive', *Social History of Medicine*, 4:1 (2018), 857–69.

10 Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester University Press, 2015); Glen O'Hara, 'The Complexities of "Consumerism": Choice, Collectivism and Participation within Britain's National Health Service, c. 1961–c.1979', *Social History of Medicine*, 26:2 (2013), 288–304.

11 Alex Mold, Peder Clark, Gareth Millward and Daisy Payling, *Placing the Public in Public Health in Post-War Britain, 1948–2012* (Basingstoke: Palgrave Macmillan, 2019).

12 Deborah Lupton has explored this facet of health consumerism, particularly in relation to how multinational corporations have used their product ranges and promotion capacities to support health education goals. However, her work suggests that this is merely coincidental, rather than a designed aspect of public–private cooperation inherent to health promotion techniques. See: Deborah Lupton, 'Consumerism, Commodity Culture and Health Promotion', *Health Promotion International*, 9:2 (1994), 116–17. She also touches on these themes in: Deborah Lupton, *Food, the Body and the Self* (London: Sage, 1996).

13 Bufton, 'British Expert Advice on Diet and Heart Disease c. 1945–2000', pp. 125–48; Mark W. Bufton and Virginia Berridge, 'Post-War Nutrition Science and Policy Making in Britain c. 1945–1994: The Case of Diet and Heart Disease', in Smith and Philips (eds), *Food, Science, Policy and Regulation in the Twentieth Century*, pp. 189–206.

14 In particular, the Framingham Heart Study and the Seven Countries Study were especially influential in health policy-making circles. See: Luc Berlivet, '"Association or Causation?" The Debate on the Scientific Status of Risk Factor Epidemiology, 1947–c.1965', in Berridge (ed.), *Making Health Policy*, pp. 37–74.

15 From the 1980s, alternative diet plans, often promoted by individual doctor 'personalities', such as the Atkins Diet (which promoted a low-carbohydrate diet plan) became particularly successful in the UK. Similarly, Weight Watchers and Slimming World programmes promoted low-calorie diets through individualised counting systems. While many of these diets were promoted to women seeking to lose weight, they also demonstrate how systems of belief in relation to food intake and weight gain were being constructed in relation to low carbohydrate and low calorie as well as low fat. See: Ann F. La Berge, 'How the Ideology of Low Fat Conquered America', *Journal of the History of Medicine and the Allied Sciences*, 63:2 (2008), 139–77 and Jessica 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.

16 Rima D. Apple, *Vitamania: Vitamins in American Culture* (New Brunswick, NJ: Rutgers University Press, 1996); Sally M. Horrocks, 'The Business of Vitamins: Nutrition Science and the Food Industry in Inter-War Britain', in Harmke Kamminga and Andrew Cunningham (eds), *The Science and Culture of Nutrition, 1840–1940* (Amsterdam: Rodopi, 1995), pp. 235–48.

17 Xaq Frohlich, 'Accounting for Taste: Regulating Food Labeling in the "Affluent Society", 1945–1995' (unpublished doctoral thesis, Massachusetts Institute of Technology, 2011) and Fitzsimmons, 'Oh, What Those Oats Can Do', 56–89.

18 Frohlich, 'Accounting for Taste'.
19 Fitzsimmons, 'Oh, What Those Oats Can Do'.
20 See: Hand, 'Marketing Health Education'. For more on use of commercial archives see: Greenwood and Ingram, 'Sources and Resources: "The People's Chemists"'.
21 For more on this development in the US context, see Frohlich, 'Accounting for Taste'. For more on how consumers learnt to shop for health, also in a US context, see: Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill, NC: University of North Carolina Press, 2016), pp. 321–59.
22 MAFF, *Household Consumption and Expenditure: Annual Report of the National Food Survey Committee*, HMSO 1989 and 1992.
23 This was also the case for smoking and lung cancer, other cancers more generally and heart disease during 1950s Britain. See: Virginia Berridge, 'The Policy Response to the Smoking and Lung Cancer Connection in the 1950s and 1960s', *Historical Journal*, 49:4 (2006), 1185–209 and Elizabeth Toon, '"Cancer as the General Population Knows It": Knowledge, Fear and Lay Education in 1950s Britain', *Bulletin of the History of Medicine*, 81:1 (2007), 116–30.
24 Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford: Oxford University Press, 2007).
25 For more on this idea of evidence–policy–advice see: Kelly Loughlin, 'Whatever Happened to Health Education?: Mapping the Grey Literature Collection Inherited by NICE', *Social History of Medicine*, 21:3 (2008), 561–72; Kelly Loughlin, 'Networks of Mass Communication: Reporting Science, Health and Medicine in the 1950s and 1960s', in Berridge (ed.), *Making Health Policy*, pp. 295–322. It is useful here for discussing more generalist changes in governmental policy with regard chronic disease.
26 Berridge, *Marketing Health*, pp. 185–207; Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage, 1996).
27 Dorothy Porter, 'Calculating Health and Social Change: An Essay on Jerry Morris and the Late-Modernist Epidemiology', *International Journal of Epidemiology*, 36:6 (2006), 1180–4; Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkeley and Los Angeles, CA: University of California Press, 2011).
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31 Berridge, *Marketing Health*, p. 53.
32 Virginia 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; Porter, *Health Citizenship*; Huisman and Oosterhuis, *Health and Citizenship*; Mold, *Making the Patient-Consumer*.
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36 Berridge, *Marketing Health*, p. 50; Bufton, 'British Expert Advice on Diet and Heart Disease c. 1945–2000', pp. 125–48.
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55 Anon, *National Health Survey*.
56 Apple, *Vitamania*; Horrocks, 'The Business of Vitamins', pp. 235–48.
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69 Foster and Lunn, 'Food Availability and Our Changing Diet', 213.
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95 From the early 1990s, Tesco undertook a large-scale and long-term product reformulation process. In particular, its own-brand cereal offerings were redesigned to include significantly reduced amounts of sugar and salt and upon completion were advertised and promoted in line with these changes. See: Sonia Pombo-Rodrgiues, Kawther M. Hashem, Feng J. He and Graham A. MacGregor, 'Salt and Sugars Content of Breakfast Cereals in the UK from 1992–2015', *Public Health Nutrition*, 20:8 (2017), 1500–12. Sainsbury's was proactive in developing new low-salt product ranges, as well as organic and gluten-free ranges in the early years of the 2000s. For example, see: Sainsbury's Archive, 'Foods with Added Health Benefits' leaflet, 2000, SA/MARK/ADV/3/5/3/28; Sainsbury's Archive, 'Sainsbury's Healthy Eating Is Healthy Business' leaflet, 2002, SA/SC/34; Sainsbury's Archive, 'Sainsbury's Organic Foods booklet', 1997–1999, SA/MARK/ADV/3/5/3/19/2.

96 Debra Van Camp, 'Adoption of Voluntary Front of Package Nutrition Schemes in UK Food Innovations', *British Food Journal*, 112:6 (2010), 580–91; Debra Van Camp, Diogo M. deSouza Monteiro and Neal H. Hooker, 'Stop or Go? How Is the UK Food Industry Responding to Front-of-Pack Nutrition Labels?', *European Review of Agricultural Economics*, 39:5 (2012), 821–42.

97 This has also been demonstrated in government health education campaigns, particularly the Health Education Council's Look After Yourself campaign (1978–87), which emphasised the importance of healthy eating not only for reducing chronic disease risk but also for dieting and looking attractive. See: Hand, 'Look After Yourself'.

98 The Look After Yourself campaign utilised similar cultures of dieting to communicate a better health message in the late 1970s and early 1980s. See: Hand, 'Look After Yourself'.