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Consuming health? Health education and the British public in the 1980s

Alex Mold

Consumerism, with its associated values of individual choice, markets, and profit, has often been regarded as antithetical to the universal, collective, free-at-the-point-of-use National Health Service (NHS). Since the 1960s, numerous commentators have argued that it is inappropriate to apply consumerist ideology to health or to see patients as consumers.[1] Healthcare is unlike other consumer goods or services, as many patients lack the knowledge or capacity to assess what they need and its value.[2] Other critics take issue with the politics of inserting consumerism into healthcare, suggesting that it encourages selfish individualism on the part of patients and the prioritising of revenue over quality care among healthcare providers.[3] Despite these concerns, consumerist language, practices, and policies have become part of the fabric of health services in Britain. This was especially the case from the 1980s onwards, when various governments sought to reform the NHS along more market-orientated lines. The influence of consumerism, however, ranged beyond service structure and delivery. This chapter will consider the implications of the growing impact of consumerism on British health policy and practice by examining a series of health education campaigns conducted during the 1980s. Such an analysis will take into account how consumerist tropes were used in the framing and delivery of these campaigns, but also how 'consumers' received such messages.

Considering the relationship between consumerism, health education, and the public extends our understanding of the cultural

history of the NHS in two ways. Firstly, it draws attention to the place of disease prevention in Britain's health system. The NHS was not solely a curative health service orientated around primary and secondary care. The location of public health functions like health education, vaccination, environmental health, and disease surveillance changed over time. In the early days of the NHS, public health services were situated in local government.[4] After the reorganisation of the NHS in 1974, public health operations became formally part of the NHS, before moving back to the ambit of local authorities following the introduction of the Health and Social Care Act in 2012.[5] Irrespective of whether or not disease prevention efforts were formally part of the NHS, considering these in more detail helps deepen our understanding of the NHS in its broadest sense, by allowing us to see it in relation to other parts of Britain's health system. The second contribution that this chapter makes is to assess how the NHS interacted with wider social, cultural, and political shifts, as well as with the people it served. The growth of consumerism and the application of consumerist ideas to public services was one of the key developments in the nature of the welfare state in late twentieth-century Britain.[6] Seeing how this played out with respect to healthcare, and specifically disease prevention in the form of health education, offers a powerful insight into the reach and impact of such shifts on those designing and delivering initiatives as well as those receiving them.

In order to explore the relationship between health education and consumerism in 1980s Britain, this chapter will begin by assessing the growth of consumerism and its application to healthcare in the UK. The chapter will then move on to look at how consumerist ideas were manifested in public health policy and practice, and especially the impact that consumerism had on health education and health promotion. Consumerism represented a double-edged sword for health educators. Behaviours linked to consumerism, and especially the consumption of certain products, such as tobacco and alcohol, were linked to significant public health problems. Curbing such behaviours by encouraging people towards practices of 'sensible' consumption offered a potential way to address to these issues. Consumption was thus both a problem and a solution. To consider this conundrum in depth, the chapter will analyse two case

studies of health education campaigns conducted during the 1980s. The first concerns the promotion of 'sensible' drinking and the unit system of measuring and self-regulating alcohol consumption. The second focuses on an anti-smoking campaign directed at children. Assessing these campaigns and the response they were met with by various publics, especially when set in the context of other similar efforts, points to a number of different dimensions to the impact of a consumerist approach on health education. Such an approach allowed 'consumers' agency and the ability to reinterpret public health messaging in new ways, which were sometimes at odds with the original aims of the campaign. But framing health behaviours as the 'choices' of 'consumers' also underplayed the impact of the environment and social structure on health, suggesting that consumers had both too much agency and not enough. The chapter concludes by returning to this issue as a way to think about the cultural and social history of the NHS.

Health consumerism, the NHS, and public health, 1960s–1980s

The idea that patients could be understood as consumers was not unique to Britain in the 1980s, but it did take on particular practical and political significance in this decade.[7] Before the introduction of the NHS, patients, especially those with what Roy Porter described as the 'power of the purse', could operate as consumers in the medical marketplace.[8] Members of hospital contributory schemes also had some say in how hospital services were managed, although this was not usually described using the language of consumption.[9] The term 'consumer' was first applied to healthcare by health economists in the USA during the inter-war period.[10] In the UK, there was some interest in patient consumerism from health economists, but the concept was taken up with more enthusiasm by patient groups and think-tanks in the 1960s. Organisations such as the Patients Association (PA) believed that the language of consumption offered an opportunity to put forward a set of demands on the part of patients around issues including autonomy and consent.[11] Groups like the PA believed in pressing for more say for

patient-consumers in relation to their own treatment, but also on the nature of health services as a whole.

By the 1970s, the British government began to take on board some of the principles of organised consumerism and apply these to public services. Citizen-consumers were to be given more say in the design and delivery of state-run services. Healthcare was no exception. In 1974, as part of the reorganisation of the NHS, Community Health Councils (CHCs) were established across England and Wales (with similar arrangements in Scotland and Northern Ireland) to be the 'voice of the consumer'.[12] Although the effectiveness of the CHCs was highly variable, these did represent 'consumer' interests within the NHS until they were scrapped and replaced by other bodies in 2003.[13] As Ellen Stewart, Kathy Dodworth, and Angela Erica note in this volume, some of these new organisations were used by activists to put forward specific views and agendas, whereas others were seen to be 'expert' and not operating in the public interest. During the 1970s and 1980s, patient-consumer groups including the CHCs and the PA campaigned for a number of important consumer demands such as the ability to complain, access to information, and the codification of patients' rights.[14] Many of these demands came to at least partial fruition, but by the 1980s there were signs that the meaning and application of consumerism to health were beginning to shift. Both the Thatcher and Major governments adopted the language of consumerism and incorporated this within changes to the structure and delivery of the NHS.[15] The publication of the White Paper *Working for Patients* in 1989 and the subsequent introduction of the internal market in 1990 represented a shift towards a more marketised approach to running the NHS, with an emphasis on greater choice. Consumerism in health became more closely associated with markets and individual choice, rather than collective rights and autonomy.

The impact of these wider shifts in relation to consumerism and health in Britain can be detected in public health policy and practice, and especially in its focus on the individual and their behaviour. By the second half of the twentieth century, it was becoming increasingly clear that the major threats to public health were no longer infectious diseases but were instead non-communicable conditions such as cancer and heart disease. From the 1950s onwards,

epidemiological research linked such conditions to individual behaviours like smoking, diet, and physical activity.[16] The response from public health authorities was to place greater emphasis on getting individuals to change their behaviour and adopt a healthier 'lifestyle'. This was to be achieved through health education. The 1964 Cohen report *Health Education* asserted that 'Health education must do more than provide information. It must also seek to influence people to act on that advice and information given.'[17] The report recommended that matters of 'self-discipline', such as smoking, overeating, and exercise, should be targeted through new methods, and especially greater use of the mass media. The government took on board Cohen's suggestions, and following the publication of the report a central quasi-governmental body, the Health Education Council (HEC), was established in 1968 to design and deliver health education campaigns.

Disease prevention, health education, and the role of the individual became cornerstones of public health policy. In the 1970s a flurry of government publications on the topic of prevention all emphasised individual responsibility for health through the adoption of good habits, and especially the careful consumption of products known to damage health, such as alcohol, tobacco, and fatty food.[18] Health education campaigns throughout the 1970s and 1980s were thus aimed at getting individuals to stop, or at least curb, these behaviours.[19] In 1976 the government report *Prevention and Health Everybody's Business* asserted that:

> the weight of responsibility for his own health lies on the shoulders of the individual himself. The smoking related diseases, alcoholism and other drug dependencies, obesity and its consequences, and the sexually transmitted diseases are among the preventable problems of our time and in relation to all of these the individual must choose for himself.[20]

Similarly, a few years later, in 1988, the Acheson report into the public health function in England noted that:

> in recent years there has been a significant shift in emphasis in the perception of the determinants of the health of the public. In the context of the rise in importance of such conditions as cardiovascular disease and cancer, this now focusses far more than before on

> the effects of lifestyle and on the individual's ability to make choices which influence his or her own health.[21]

The role of public health authorities was, according to the public health practitioners John Ashton and Howard Seymour, to 'help make healthy choices the easy choices'.[22] This could be achieved through regulation and legislative controls, but more often than not it was seen as the task of health education or health promotion. This emphasis on the individual and their ability to choose to modify their consumption patterns was based on a particular view of the individual as a rational, self-governing actor which mirrored ideas about the rational, self-determined consumer. Under the logic of what has been described as 'healthism', the maintenance of good health was both an individual responsibility and a personal choice.[23] Such a view encapsulated some of the principles of a certain type of consumerism, orientated around rationality and individual choice.[24]

An emphasis on choice was just one manifestation of the influence of consumerist thinking on health education. Health educators also began to adopt specifically consumerist techniques in the design, delivery, and evaluation of public health education campaigns. One of these approaches was what came to be described as 'social marketing'. Social marketing has been defined as 'the systematic application of marketing alongside other concepts and techniques, to achieve specific behaviour goals, for a social good'.[25] The term was first used in the USA in the early 1970s. Social marketing was essentially an attempt to take principles used in the selling of consumer goods and services, like product pricing, communication, and market research, and apply these to programmes designed to improve the social good, like public health promotion.[26] But social marketing was also representative of an explicit move to reimagine the public as consumers who would receive benefits in exchange for either purchased products (such as condoms or healthier food) or adopted behaviours (safer sex, healthy eating).[27] Campaigns that were defined explicitly as social marketing only really became common in the UK in the early 1990s, although they had been adopted earlier in places such as the USA, Canada, Australia, and New Zealand.[28] Nonetheless, many of the techniques found in social marketing campaigns, like a strong focus on consumer needs

and giving consumers something in exchange for their efforts, can be seen in health education efforts launched during the 1980s, as will be explored in greater detail below.

Intertwined with the development of techniques such as social marketing was a move away from focusing solely on 'health education' and instead locating this within a broader set of practices and approaches described as 'health promotion'. The emergence of health promotion was rooted in international developments. A report produced in 1974 by the Canadian Minister of Health, Marc LaLonde, was especially influential. *A New Perspective on the Health of Canadians* argued that improving living standards was at least as important as biomedicine for the public's health. This report was enthusiastically taken up at the global level, and a series of initiatives put forward by the World Health Organization (WHO) stressed the importance of health promotion.[29] In Britain, specialist health promotion became embedded within public health departments during the 1980s, and initiatives linked to WHO health promotion efforts, such as the creation of 'healthy cities', were put into place.[30] The *Ottawa Charter for Health Promotion*, published in 1986, shifted the focus of public health policy and practice away from individual disease prevention and towards wider, community-based efforts to improve health.[31] The impact of the environment and social structure on health began to be more widely recognised. Such a view was in contrast to the individual behaviour-focused efforts of much health education and, as we will see, was an important counterweight to more consumerist approaches to the public and its health. By the early 1980s, there was a tension within public health policy and practice as to whether to focus on getting individuals to make better lifestyle choices or to concentrate on improving the social structure and the environment in order to improve public health. Such conflicts can be observed in some of the health education campaigns produced during this period.

Case study 1: *That's the Limit*

The over-consumption of alcohol was not a new problem during the 1980s, but the approach taken to educating the public about the

dangers alcohol posed took on a particular tone during this period. Alcohol had represented a threat to individual health and social order for decades, but it was only during the 1960s that this came to be defined as a public health issue. Research showed that rising alcohol consumption was linked to a number of health problems, such as cirrhosis of the liver. By the early 1970s, the government decided to take action, and the HEC was tasked with delivering a series of health education campaigns. Piloted in the north-east of England, these initially targeted alcoholics, then heavy drinkers, and finally all drinkers.[32] This approach was rooted in epidemiological evidence which showed that as the level of alcohol consumption within a population increased, so too did the prevalence of alcohol-related problems. Reducing alcohol consumption at a population level was therefore desirable. All drinkers, whether or not they had a 'problem' with alcohol, should be encouraged to reduce their consumption. In order to achieve this goal, a number of measures were considered by the government. Raising the price of alcohol through increased taxation was discussed, although ultimately rejected. This was seen as imposing an unfair penalty on the majority drinkers as well as being unpopular with the alcohol industry and the Treasury, which derived considerable revenue from the duty on alcohol. Instead, the government turned to health education and specifically the promotion of 'sensible drinking'. A consultative report entitled *Drinking Sensibly* was published in 1981. The document wanted to encourage the public to adopt 'sensible attitudes towards the use of alcohol'.[33] Although it was not entirely clear what these 'sensible attitudes' consisted of, it appeared that they were related to self-limiting the consumption of alcohol. *Drinking Sensibly* mentioned the Royal College of Psychiatrists' suggestion that drinkers restrict themselves to no more than four pints of beer, or four double spirits, or one bottle of wine a day.[34]

The setting of 'sensible' drinking limits and the communication of these to the public became a key feature of alcohol health education campaigns. Although there had been an attempt to define 'safe' drinking levels by the Royal College of Psychiatrists, official guidance on this issue first appeared in 1984 when the HEC published a pamphlet entitled *That's the Limit*. The pamphlet recognised that many people enjoyed drinking alcohol and that there was 'probably'

'nothing wrong' with a drink 'now and then'. Nonetheless, 'everybody' who drank was at 'risk'.[35] Yet *That's the Limit* was somewhat vague about what these risks were. The pamphlet mentions hangovers and accidents, as well as 'damage to your health, to your family and to your self-esteem', but these risks are not spelled out in any detail. Later in the pamphlet, there was an attempt to correlate drinking levels with potential harm. *That's the Limit* set out 'safe limits' for drinking. These were defined as two to three pints two to three times a week for men, and two to three 'standard drinks' two to three times a week for women. The pamphlet defined 'too much' alcohol as fifty-six 'standard drinks' a week for men and thirty-five 'standard drinks' for women. Individuals consuming alcohol above this level were told that 'It is rare for anybody drinking as much as this not to be harming themselves'. This harm included damage to the 'liver, brain, heart or nervous system' as well as the potential for dependence and personal problems such as damage to relationships and financial difficulties. The guidelines established by *That's the Limit* represented a more precise sense of what excessive alcohol consumption consisted of than previously, but there was still some ambiguity. It was unclear, for instance, exactly what a 'standard drink' consisted of. Readers were told this equated to a single measure of spirits or half a pint of beer, or a 'small' glass of sherry or a 'glass' of wine. There was no indication of the actual sizes of the glasses or the strength of alcohol these contained.

This lack of clarity can in part be explained by the fact that there was little agreement about what constituted a 'safe' or 'sensible' limit to alcohol consumption. A Department of Health and Social Security (DHSS) official, who reviewed a draft of the pamphlet before it was published, pointed out that the limit of two to three drinks two to three times a week was lower than that which had been suggested a few years earlier by the Royal College of Psychiatrists, four pints, or the equivalent, a day.[36] The same official pointed out that 'such limits are arbitrary' and 'the evidence on which these are based [is] not as good as we would wish'.[37] More broadly, there were tensions between the DHSS and the HEC over the correct approach to dealing with the public health problems posed by alcohol. This mirrored some of the wider conflicts between different agencies and their approaches within the

welfare state discussed by Gareth Millward in his chapter in this volume, but in this case there were also more specific reasons for disagreement. The HEC wanted to take a more aggressive stance on alcohol, including offering its support to a campaign group called Action Against Alcohol Abuse, something the DHSS saw as an improper use of funds.[38] Conflict also flared over other measures, such as the use of price increases to reduce levels of alcohol consumption. The HEC expected the DHSS to publish a report produced by a government think-tank that had suggested that taxation be used to control the price of drink, but the report was suppressed, although it was later published in Sweden.[39]

Indeed, it appears that the DHSS won the battle with the HEC, for a tougher stance on alcohol, including measures like price increases, did not materialise. Instead, the setting of alcohol consumption limits and communicating these to the public became a cornerstone of alcohol education policy. Three years after the publication of *That's the Limit* a new version appeared, issued by the HEC's replacement, the Health Education Authority (HEA). This pamphlet contained similar content but with a few significant changes. The title of the pamphlet remained the same, but the cartoon character of a man holding a pint of beer on the front cover asked readers 'What is *your* limit?' instead of 'What is *the* limit?' (my emphasis). This more personalised message gave a less absolute sense of 'the limit' to alcohol consumption and acknowledged that this might vary from person to person. The mode of address also suggested that alcohol consumption was something the individual should take responsibility for. At the same time, the new version of the pamphlet provided a more specific sense of what an absolute limit to alcohol consumption might consist of. 'Standard drinks' were replaced by 'units'. A unit of alcohol was equal to 10 ml or 8 g of pure alcohol, or about half a pint of beer. The unit was a measure first used in the 1970s to allow for comparison in longitudinal surveys of drinking levels.[40]

The HEA's use of the unit and the levels at which safe drinking were set were in line with recommendations made in a series of reports published in 1986–87 by the Royal College of Psychiatrists, the Royal College of Physicians, and the Royal College of General Practitioners. Each report suggested that sensible limits to drinking

equated to twenty-one units a week for men and fourteen units a week for women. The Royal College of Physicians' report, entitled *A Great and Growing Evil*, set out a wide range of health and social consequences resulting from the over-consumption of alcohol. The report suggested that the more alcohol consumed, the greater the risk. The setting of these limits was, however, somewhat arbitrary. Although the guideline levels were related to the relative risk of cirrhosis of the liver, as many critics have pointed out, these were not 'scientific'.[41] In a much-cited statement, a member of one of the expert committees involved in setting the limits said that they had 'plucked a figure out of the air', although he later asserted that he stood by the committee's recommendations.[42] The provision of health advice, as discussed by Jennifer Crane in her chapter in this volume and by Stewart, Dodworth, and Erica, was, and remains, controversial and often involved multiple bodies and actors with different agendas. The sensible drinking limits were intended to provide a guideline that the public could easily understand, and the unit system meant that individuals could be more readily located along a continuum of harmful drinking, something which also allowed the size and scale of the national drinking problem to be assessed.[43] Nonetheless, the dominant understanding of alcohol problems as expressed through publications like *That's the Limit/ That's Your Limit* was to frame this as an individual problem rectified by moderate consumption. Individual consumers were expected to make the 'right' choices.

Case study 2: 'Nick O'Teen vs. Superman'

A narrative of choice and consumption can be detected in other health education campaigns from this period too. The Nick O'Teen campaign, which was an anti-smoking initiative targeted at children aged seven to eleven, also employed the language of choice, but there were aspects to the campaign which reveal other ways in which consumerist approaches had become enmeshed in the design and delivery of health education. The Nick O'Teen campaign was launched on 26 December 1980. It consisted of advertisements on television and in comics and magazines which featured a battle

between Superman and the evil Nick O'Teen as he attempted to recruit children to his army of smokers.[44] This campaign was not the first attempt to deal with children's tobacco use. Juvenile smoking had been a concern since the early twentieth century, when it was linked to hooliganism and bad behaviour.[45] The identification of the link between smoking and lung cancer in the 1950s led to the first moves to dissuade adults from smoking.[46] Some anti-smoking material produced during the 1960s targeted young people, but it was not until the 1980s that there was a consistent effort to educate children about the dangers of smoking. This was prompted by evidence which seemed to suggest that smokers took up the habit at an early age. In 1977 the Royal College of Physicians published a report, *Smoking or Health*, that asserted that some children started smoking as young as the age of five, and that one in three regular smokers had taken up smoking before the age of nine.[47] A junior minister at the DHSS, Sir George Young, was especially concerned about these statistics, so he secured £500,000 for the HEC to mount an anti-smoking campaign targeted at children, and this formed the basis for the Nick O'Teen campaign.[48] The HEC commissioned the renowned advertising agency Saatchi and Saatchi to design the campaign; the members decided to feature Superman because they saw him as 'a good guy without being soft. He's timeless, incorruptible and admired by kids and by using an existing character to which children can relate we get over the problem of handing down authoritarian messages from adults.'[49]

Looking at a selection of the materials produced as part of this campaign and how it was framed and delivered points to some of the limitations of a consumerist understanding of audiences and their responses. The first of these limitations concerned the nature of the child and the extent to which children were viewed as being capable of acting as consumers able to make the 'right' choices. The HEC appeared to have been ambivalent about whether or not children were able to operate as rational consumers when it came to smoking. This ambivalence came through strongly in the aims of the campaign, which were summarised by David St George, a research officer at the HEC. He stated that 'The aims of the Superman campaign are to resonate with and strengthen

anti-smoking attitudes which already exist in the target group, and to help them subsequently resist peer-pressure by providing them with an imaginary role-model to which they can relate.'[50] Children were seen as especially susceptible to peer-pressure and thus in danger of making 'bad' choices. Yet other elements of the campaign suggested a more dynamic understanding of children's agency. The HEC wanted to encourage active participation by children in propagating and strengthening the anti-smoking message. Freddie Lawrence, Chief Information Officer at the HEC, said that the campaign should:

> a) reinforce existing attitudes already favourably disposed to anti-smoking; b) 'enlist' their active participation in a frank battle between 'good' and 'bad' rather than merely give information and c) use the opportunity to communicate fairly sophisticated health messages to an audience whose future smoking behaviour will be determined to a great extent by their attitudes and knowledge now.

The HEC viewed children as agents with the capacity to act independently, but they were also presumed to be particularly affected by their emotions. Fighting the '"glossy" smoking image', Lawrence argued, would take more than the potentially 'dull and authoritarian' '[h]ealth education messages' because, as he explained: 'It is easier to sell the delights of chocolate bars, and persuade children to go out and buy them, than it is to sell them the concept that "smoking is bad"'.[51] Children were seen as having some agency and ability to make right choices, but also as especially vulnerable to sales tactics and peer-pressure.

The paradoxical influence of consumerism can additionally be detected in the design and delivery of the campaign and the response to it from its intended audience. The campaign was a multi-pronged effort that made use of a range of different media and materials. Alongside a thirty-second television cartoon commercial which aired over Christmas 1980, there were full-page advertisements that featured in a range of children's comics and magazines for ten weeks from 11 January 1981. The magazine-based advertisements included an invitation for children to join Superman in his fight against Nick O'Teen. Children were asked to fill in and post a coupon with their name and address, and in return they would

receive a pack containing: a poster; an eight-page comic book; a badge; an individually numbered certificate stating that they had joined Superman in his fight against Nick O'Teen; and the chance to enter a poster-making competition in which successful entrants could win prizes, including a Raleigh bicycle. The packs were also sent to 21,000 primary schools. The invitation to send off for a Superman pack and the encouragement to enter a poster competition with prizes and to sign a certificate indicating they had joined the 'fight against Nick O'Teen' was illustrative of a participative approach to involving children in the campaign itself. In return for these actions, children received something tangible – a poster, certificate, comic book, a prize. Such tactics were a precursor to a social marketing approach where the consumer received a product and an intended health benefit, in this case not smoking as well as becoming part of an 'anti-smoking lobby'.[52]

Such consumerist tactics could, however, backfire. The Nick O'Teen campaign achieved a high degree of visibility, but its reception was unstable. In the first two months, 200,000 children requested a pack, a number that rose to 800,000 as the campaign continued into 1982. A series of surveys of random samples of children also suggested that the message got through to its recipients. A survey of 300 children who had returned the coupon and received the pack found that 92 per cent had retained the poster and 90 per cent cited the message correctly or nearly correctly.[53] Another survey, conducted in 1983, almost a year after the last phase of the campaign ended, found that 73 per cent of children were able to recall the main message without prompting.[54] There were some elements of the evaluation and response to the campaign, however, that might have raised concerns within the HEC. When asked why they had sent off for the pack, 55 per cent of children surveyed said that it was because they liked Superman, and 47 per cent because they liked the anti-smoking message. When asked about the certificate, 48 per cent saw it as enrolling them in Superman's fight against Nick O'Teen, 19 per cent believed it was connected with them discouraging smoking in others, and just 15 per cent saw it as a personal pledge never to smoke.[55] What this suggested was that some children may simply have sent off for the pack or put the poster on their wall because they liked Superman,

and not because they were engaged with the campaign's message. Something similar had happened with an earlier government campaign to warn children of various hazards including strangers and drowning. The 'Charley' films, launched in 1973, featured a cartoon cat that encountered various dangers. Research suggested that children who had viewed the films remembered the cat, but not the behaviours they were supposed to adopt.[56] In the case of the Nick O'Teen campaign, there was an added dimension connected to the materials themselves. The production of desirable consumer goods (the poster, comic, and badge), featuring a commercial character in a format that children were used to consuming for pleasure, opened up the possibility that the audience could ignore, or at least not take much notice of, the health education message.

Problematising choice and consumerism

The instability of health education messages and the potential for consumers to interpret such material in their own ways was beginning to be recognised in relation to other campaigns too. During the 1980s, researchers started to investigate why it was that large sections of the public apparently refused to change their behaviour in order to improve their health and that of the public more broadly. A key piece of research was conducted in South Wales just after the miners' strike. The epidemiologist George Davey Smith and the anthropologists Stephen Frankel and Charley Davison evaluated a health promotion campaign that was intended to inform the public about their risk of developing heart disease and what they could do to reduce this risk.[57] The researchers found that the public's beliefs about heart disease and risk were made up of a mixture of official messages interwoven with ideas derived from the mass media and the experiences of friends and family. Indeed, these were crucial to how people understood risk and thus how they responded to health education campaigns. The team noted that:

> [a]n aged and healthy friend, acquaintance or relative – an 'Uncle Norman' – who has smoked heavily for years, eats a diet rich in

> cream cakes and chips and/or drinks 'like a fish' is a real or imagined part of many social networks [...] A single Uncle Norman, it seems, may be worth an entire volume of medical statistics and several million pounds of official advertising.[58]

'Uncle Norman', and a degree of fatalism about the inevitability of sickness and death, allowed people to continue to indulge in behaviours that they knew had negative health consequences. The public could resist health promotion messages when these did not chime with their lived experiences, or when they ran counter to other kinds of desires. If healthy living could be framed as a choice, then so could unhealthy living.[59]

Other research at the time and since has called into question the language of choice in such settings. Were these really choices? If so, what factors shaped them? Were individuals free to choose? Looking at why the public continued to make unhealthy choices exposed a range of reasons, both individual and structural. In a now classic study of young mothers who smoked, the sociologist Hilary Graham found that there were complex links between women's financial circumstances, caring, and smoking. For the women she spoke to, smoking was a way of coping with poverty and the demands of motherhood.[60] Smoking rates, as was increasingly obvious by the 1980s, were strongly correlated with socio-economic status, with the poorest in society the most likely to smoke. Other kinds of negative health behaviours, from obesity to drug taking, followed a similar pattern. The reasons for this are complex and are still being unpacked today, but at the very least it problematises the notion of choice in relation to health behaviour. The ability to make choices is even further destabilised in situations where there may be an element of dependence or addiction involved, as is the case with drink, drugs, smoking, and possibly food as well. As Avner Offer has pointed out, the existence of obesity undermines the notion that consumers always behave in rational ways.[61] What this suggests is that the persistence of behaviour-related public health problems cannot simply be ascribed to individual choice. Such 'choices' (if we can even call them that) are shaped by factors beyond the control of the individual.

Conclusion

The problematic nature of choice and individual behaviour raises larger issues about the relationship between consumption and public health and what this can tell us about the social and cultural history of the NHS. Consumerist approaches to public health had a dichotomous impact on 'consumers' and their agency both individually and collectively. Consumerism helped to open up a space for individuals and groups to have more say in their healthcare and that of others, but it also made individuals more responsible for their own health in that they were expected to make healthy choices. Consumerist behaviours undoubtedly contributed to public health problems, but these could also be their solution – as in the promotion of 'sensible' or 'moderate' drinking. Although there was a contrasting strand of research and activism that pointed to the impact of the environment, industry, and social structure on health, this was never as prominent as the choice narrative. Yet as members of the public began to behave more like consumers, they were also able to assert their own agency. This could take the form of refusing or reinterpreting public health messages, taking on some aspects and rejecting others, or simply enjoying the products associated with such campaigns without engaging with the messages they were supposed to be communicating. In crude terms, consumerism could be both 'good' and 'bad' for public health: it allowed individuals more agency at the same time as failing to acknowledge the limitations of such an approach.

Understanding the conflicting legacy of consumerism for health helps us to see the history of the NHS in a broader cultural and social context. Healthcare in Britain in this period was influenced by a range of external developments, such as the rise of consumerism, that were unevenly applied and had uncertain effects. This was especially pertinent in areas of the health service that sat within the health system but were not necessarily part of the NHS in its formal sense, such as disease prevention, health education, and health promotion. The maintenance and improvement of health became a task for a much greater range of actors and agencies than those which made up the constituent parts of the NHS. This alerts

us to the fact that the NHS was, and continues to be, more than a collection of hospitals and general practitioners' surgeries, health professionals, managers, and patients. The NHS could also replicate, reinforce, and reinterpret wider social, economic, cultural, and political shifts, such as the incorporation of aspects of consumerism. In this way the NHS constituted a health system that was more than a system: it was a unique a cultural and social force in its own right.

Notes

1 Early critics include Richard Titmuss, 'Choice and the Welfare State', in *Commitment to Welfare* (London: George Allen, 1968), pp. 138–52; Margaret Stacey, 'The Health Service Consumer: A Sociological Misconception', *Sociological Review Monograph*, vol. 22 (1978), pp. 194–200.
2 Peter Shackley and Mandy Ryan, 'What Is the Role of the Consumer in Health Care?', *Journal of Social Policy*, vol. 23, no. 4 (1994), pp. 517–41; Deborah Lupton, Cam Donaldson, and Peter Lloyd, 'Caveat Emptor or Blissful Ignorance? Patients and the Consumerist Ethos', *Social Science & Medicine*, vol. 33, no. 5 (1991), pp. 559–68.
3 Fedelma Winkler, 'Consumerism in Health Care: Beyond the Supermarket Model', *Policy and Politics*, vol. 15, no. 1 (1987), pp. 738–57.
4 Jane E. Lewis, *What Price Community Medicine? The Philosophy, Practice and Politics of Public Health since 1919* (Brighton: Wheatsheaf Books, 1986).
5 Martin Gorsky, Karen Lock, and Sue Hogarth, 'Public Health and English Local Government: Historical Perspectives on the Impact of "Returning Home"', *Journal of Public Health*, vol. 36, no. 4 (2014), pp. 1–6.
6 Matthew Hilton, *Consumerism in 20th Century Britain* (Cambridge: Cambridge University Press, 2003); Mark Bevir and Frank Trentmann, *Governance, Consumers and Citizens: Agency and Resistance in Contemporary Politics* (Basingstoke: Palgrave Macmillan, 2007).
7 Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester University Press, 2015).
8 Roy Porter, 'The Patient's View: Doing Medical History from Below', *Theory and Society*, vol. 14, no. 2 (1985), pp. 175–98.

9 Martin Gorsky, 'Community Involvement in Hospital Governance in Britain: Evidence from before the National Health Service', *International Journal of Health Services*, vol. 38, no. 4 (2008), pp. 751–71.
10 Nancy Tomes, 'Patients or Health-Care Consumers? Why the History of Contested Terms Matters', in Rosemary Stephens, Charles E. Rosenberg, and Lawton Burns (eds), *History and Health Policy in the United States: Putting the Past Back In* (New Brunswick, NJ: Rutgers University Press, 2006), pp. 83–110; Nancy Tomes, *Remaking the Modern Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill, NC: University of North Carolina Press, 2016).
11 Alex Mold, 'Repositioning the Patient: Patient Organizations, Consumerism, and Autonomy in Britain during the 1960s and 1970s', *Bulletin of the History of Medicine*, vol. 87, no. 2 (2013), pp. 225–49.
12 Health Minister Keith Joseph in the House of Commons, Hansard, House of Commons, vol. 858, col. 380 (19 June 1973).
13 Christine Hogg, *Citizens, Consumers and the NHS: Capturing Voices* (Basingstoke: Palgrave Macmillan, 2009).
14 Alex Mold, 'Patients' Rights and the National Health Service in Britain, 1960s–1980s', *American Journal of Public Health*, vol. 102, no. 11 (2012), pp. 2030–38.
15 Alex Mold, 'Making the Patient-Consumer in Margaret Thatcher's Britain', *Historical Journal*, vol. 54, no. 2 (2011), pp. 509–28.
16 Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford: Oxford University Press, 2007); Gerald M. Oppenheimer, 'Profiling Risk: The Emergence of Coronary Heart Disease Epidemiology in the United States (1947–70)', *International Journal of Epidemiology*, vol. 35, no. 3 (2006), pp. 720–30; Robert Aronowitz, 'The Framingham Heart Study and the Emergence of the Risk Factor Approach to Coronary Heart Disease, 1947–1970', *Revue d'histoire des sciences*, vol. 64, no. 2 (2011), pp. 263–95.
17 Central Health Services Council and Scottish Health Services Council, *Health Education* (London: HMSO, 1964), p. 9.
18 *Prevention and Health*, Cmnd 7047 (London: HMSO, 1977); Department of Health and Social Security, *Prevention and Health, Everybody's Business: A Reassessment of Public and Personal Health* (London: HMSO, 1976); Peder Clark, '"Problems of Today and Tomorrow": Prevention and the National Health Service in the 1970s', *Social History of Medicine*, vol. 33, no. 3 (2020), pp. 981–1000, https://doi.org/10.1093/shm/hkz018.

19 Alex Mold, '"Everybody Likes a Drink. Nobody Likes a Drunk": Alcohol, Health Education and the Public in 1970s Britain', *Social History of Medicine*, vol. 30, no. 3 (2017), pp. 612–36; Jane Hand, 'Marketing Health Education: Advertising Margarine and Visualising Health in Britain from 1964–c.2000', *Contemporary British History*, vol. 31, no. 4 (2017), pp. 477–500; Virginia Berridge and Kelly Loughlin, 'Smoking and the New Health Education in Britain 1950s–1970s', *American Journal of Public Health*, vol. 95, no. 6 (2005), pp. 956–64.
20 Department of Health and Social Security, *Prevention and Health*, p. 38.
21 *Public Health in England: The Report of the Committee of Inquiry into the Future Development of the Public Health Function*, Cm 289 (London: HMSO, 1988), p. 2.
22 John Ashton and Howard Seymour, *The New Public Health: The Liverpool Experience* (Buckingham: Open University Press, 1988), p. 22.
23 R. Crawford, 'Healthism and the Medicalization of Everyday Life', *International Journal of Health Services: Planning, Administration, Evaluation*, vol. 10, no. 3 (1980), pp. 365–88; Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body* (London and Thousand Oaks, CA: Sage Publications, 1995); David Armstrong, 'Origins of the Problem of Health-Related Behaviours: A Genealogical Study', *Social Studies of Science*, vol. 39, no. 6 (2009), pp. 909–26.
24 Nike Ayo, 'Understanding Health Promotion in a Neoliberal Climate and the Making of Health Conscious Citizens', *Critical Public Health*, vol. 22, no. 1 (2012), pp. 99–105.
25 Jeff French, 'Introduction', in Jeff French et al. (eds), *Social Marketing and Public Health: Theory and Practice* (Oxford: Oxford University Press, 2010), pp. xi–xiv (p. xi).
26 Aiden Truss, Robert Marshall, and Clive Blair-Stevens, 'A History of Social Marketing', in French et al. (eds), *Social Marketing and Public Health*, pp. 19–28.
27 Franklin Apfel, 'Health Communication', in Liza Cragg, Maggie Davies, and Wendy Macdowall (eds), *Health Promotion Theory* (Maidenhead: Open University Press, 2013), pp. 141–57, at p. 148.
28 National Social Marketing Centre, *It's Our Health! Realising the Potential of Effective Social Marketing* (London: National Consumer Council, 2006).
29 Heather MacDougall, 'Reinventing Public Health: A New Perspective on the Health of Canadians and its International Impact', *Journal of Epidemiology and Community Health*, vol. 61, no. 11 (2007), pp. 955–9.

30 Peter Duncan, 'Failing to Professionalise, Struggling to Specialise: The Rise and Fall of Health Promotion as a Putative Specialism in England, 1980–2000', *Medical History*, vol. 57, no. 3 (2013), pp. 377–96; Alan Petersen and Deborah Lupton, *The New Public Health: Health and Self in the Age of Risk* (London: Sage Publications, 1996).
31 World Health Organization, *The Ottawa Charter for Health Promotion* (Ottawa: World Health Organization, 1986).
32 Mold, '"Everybody Likes a Drink. Nobody Likes a Drunk"'.
33 Department of Health and Social Security, *Drinking Sensibly* (London: HMSO, 1981), p. 7.
34 Royal College of Psychiatrists, *Alcohol and Alcoholism* (London: Tavistock, 1979).
35 Health Education Council, *That's the Limit*, alcohol information pamphlet (London: Health Education Council, 1984).
36 The National Archives, London (TNA), JA 384/1, Department of Health and Social Security, 'Geoffrey Finsburg to Minister for Health & Secretary of State, Re. HEC', 1982.
37 TNA, JA 384/3, Department of Health and Social Security, 'R. J. Waman to Mrs Pearson, HEC Pamphlet "That's the Limit"', 1983.
38 TNA, Department of Health and Social Security, 'Geoffrey Finsburg to Minister for Health & Secretary of State, Re. HEC'. See also Alex Mold, 'Alcohol, Health Education and Changing Notions of Risk in Britain, 1980–1990', *Drugs: Education Prevention and Policy*, vol. 28, no. 1 (2021), pp. 48–58.
39 Central Policy Review Staff, *Alcohol Policies in the UK: The Report of the Central Policy Review Staff* (Stockholm: Sociologiska Institutionen, 1982); TNA, JA 384/1, Department of Health and Social Security, 'Letter from AM Pollitt, Chief Administrative Officer, HEC to Margaret Pearson', 1982.
40 David Ball, Richard Williamson, and John Witton, 'In Celebration of Sensible Drinking', *Drugs: Education, Prevention, and Policy*, vol. 14, no. 2 (2007), pp. 97–102; Clare Herrick, *Governing Health and Consumption: Sensible Citizens, Behaviour and the City* (Bristol: Policy Press, 2011), pp. 156–8.
41 Ball, Williamson, and Witton, 'In Celebration of Sensible Drinking'.
42 Richard Smith, 'A Row Plucked out of the Air', *Guardian*, 22 October 2007, www.theguardian.com/commentisfree/2007/oct/22/arowpluckedoutoftheair (accessed 2 October 2015).
43 James Nicholls, *The Politics of Alcohol* (Manchester: Manchester University Press, 2009), pp. 212–13; Betsy Thom, *Dealing with Drink:*

Alcohol and Social Policy in Contemporary England (London and New York: Free Association Books, 1999), pp. 129–30.

44 Alex Mold and Hannah J. Elizabeth, 'Superman vs. Nick O'Teen: Anti-Smoking Campaigns and Children in 1980s Britain', *Palgrave Communications*, vol. 5, no. 1 (2019), pp. 1–12.

45 Matthew Hilton, '"Tabs", "Fags" and the "Boy Labour Problem" in Late Victorian and Edwardian Britain', *Journal of Social History*, vol. 28, no. 3 (1995), pp. 587–607; John Welshman, 'Images of Youth: The Issue of Juvenile Smoking, 1880–1914', *Addiction*, vol. 91, no. 9 (1996), pp. 1379–86.

46 Berridge and Loughlin, 'Smoking and the New Health Education'.

47 Royal College of Physicians, *Smoking or Health* (London: Royal College of Physicians, 1977).

48 Wellcome Archive, London, NICELOND\CPHE\PUBHLTH, HEC Superman Anti Smoking Campaign (1978–1981), NICE box no. 469, Health Education Council, 'Press Release: Children's Help Sought in Fight against Smoking, 12 December 1980', 1980.

49 Wellcome Archive, HEC Superman Anti Smoking Campaign (1978–1981), Health Education Council, 'Handwritten Draft of Briefing on Campaign', no date.

50 Wellcome Archive, HEC Superman Anti Smoking Campaign (1978–1981), NICE box no, 469, Health Education Council, 'Letter from Dr David St George, Research Officer, HEC to Mr HC Seymour, Area Health Education Officer', 1980.

51 Wellcome Archive, HEC Superman Anti Smoking Campaign (1978–1981), NICE box no. 469, Health Education Council, 'Superman Anti-Smoking Campaign, by Freddie Lawrence, Chief Information Officer', 1980.

52 Wellcome Archive, HEC Superman Anti Smoking Campaign (1978–1981), Health Education Council, 'Freddie Lawrence, Anti-Smoking Advertising Proposal', 1982.

53 Micheal Jacob, 'Superman versus Nick O'Teen – a Children's Anti-Smoking Campaign', *Health Education Journal*, vol. 44, no. 1 (1985), pp. 15–18.

54 Wellcome Archive, HEC Superman Anti Smoking Campaign (1978–1981), Carrick James Market Research, 'An Assessment of Levels of Awareness and Understanding of the Superman Anti-Smoking Campaign among Children Aged 7–12', 1983.

55 Jacob, 'Superman versus Nick O'Teen'.

56 Jennifer Crane, *Child Protection in England, 1960–2000: Expertise, Experience, and Emotion* (Basingstoke: Palgrave, 2018), pp. 84–5.

57 S. Frankel, C. Davison, and G. D. Smith, 'Lay Epidemiology and the Rationality of Responses to Health Education', *British Journal of General Practice*, vol. 41, no. 351 (1991), pp. 428–30; Charlie Davison, George Davey Smith, and Stephen Frankel, 'Lay Epidemiology and the Prevention Paradox: The Implications of Coronary Candidacy for Health Education', *Sociology of Health & Illness*, vol. 13, no. 1 (1991), pp. 1–19.

58 Charlie Davison, 'Eggs and Sceptical Eater', *New Scientist*, no. 1655 (1989), p. 45–9.

59 Lupton also talks about resistance and especially working-class reframing in *The Imperative of Health*, esp. pp. 138–42.

60 Hilary Graham, 'Women's Smoking and Family Health', *Social Science & Medicine*, vol. 25, no. 1 (1987), pp. 47–56.

61 Avner Offer, 'Body Weight and Self-Control in the United States and Britain since the 1950s', *Social History of Medicine*, vol. 14, no. 1 (2001), pp. 79–106.