CHAPTER 6

Conclusion

Abstract In the Conclusion, we reflect on some of the important changes and continuities over time and consider the implications that these have for our understanding of the 'public' and of 'public health', now, and in the past. We do this by focusing on three areas: the place of the public in public health; the nature of public health policy and practice; and finally, the relationship between these. We locate these changes and continuities within the context of a larger debate about citizenship in post-war Britain. The multi-dimensional nature of the relationship between state and citizen within public health is just one of a number of broader implications of imagined publics and their interaction with public health.

Keywords The public · Public health · Citizenship

Since 1948, the nature of the public, public health and the relationship between these, has changed considerably. We have shown how imagined publics were brought into being by public health policymakers and practitioners, and how these publics both reflected and challenged conventional categories, identity-based or otherwise. Some of these publics, in certain circumstances, we suggested, were able to 'speak back' to public health and so alter its practice and outlook. And yet, we argue, despite all of these changes, 'publicness', as both an object and a concept, remains. What,

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then, has stayed the same, and what has altered? In this chapter we reflect on some of the key changes and continuities over time and consider the implications that these have for our understanding of the 'public' and of 'public health', now, and in the past. We do this by focusing on three keys areas: the place of the public in public health; the nature of public health policy and practice; and finally, the relationship between these. We locate these changes and continuities within the context of a larger debate about citizenship in post-war Britain.

1 The Place of the Public

The public had always occupied an important place within public health policy and practice but there was something different about the ways in which the public was thought of, and the actions it was required to take, in the latter part of the twentieth century. For instance, although the Victorian interest in 'habits' could be thought of as analogous with the post-war focus on 'lifestyle', there are points of departure too. From the mid-1950s onwards, individual behaviour was increasingly seen as the primary cause of disease in and of itself, not just as a way of spreading or exacerbating it. Moreover, post-war public health authorities asserted that these behaviours could be found throughout the population (albeit not evenly) and not just among the poorest. The mapping of individual disease-causing habits onto the entire population suggested a different relationship between the public and public health to what had gone before. Members of the public were expected to take on a greater role in guaranteeing their own good health and that of the collective. But, the rise of 'healthism' and the 'entrepreneurial self' can be taken too far (Crawford 1980; Miller and Rose 1990). As we demonstrate, there was still a place within public health policy and practice for thinking about and addressing external influences on health, such as social structure and the environment. Moreover, some members of the public actively rejected calls to self-manage their health.

Indeed, one consequence of a greater interest in the behaviour of the public was to bring the agency of publics into sharper focus. In the past, certain publics had agency, such as anti-vaccination groups or aggrieved rate-payers during the late nineteenth century. What was different about the agency of the public in the post-war period was the ways in which this became both an object of analysis and a tool with which to improve the public's health. Efforts to engage the public in the improvement of their own health and that of others became more important both as a way of

preventing ill-health, but also as a means to cement the bond between state and citizen. At the same time, the agency of the public was not a homogenous entity. Although a greater range of publics were ascribed agency than in the past, the nature of this agency, and its interaction with questions of identity, was uneven. As we demonstrated, certain publics, such as white, middle-class men, appeared to have had more capacity to 'speak back' to public health than other, more marginalised publics, but that did not mean resistance was confined only to the most privileged groups within society. The key change, then, was not just the enhanced interest in the public and its conduct, but also the space or spaces this opened up for a variety of publics to create their own meanings and actions.

2 The Nature of Public Health

In many ways, thinking about the place of the public within public health was not a new concern for policymakers and practitioners. A long-running tension for public health authorities was how to balance the needs of the individual with those of the collective. Whether it concerned restricting personal liberty (vaccination, compulsory treatment), limiting trade (quarantine and *cordon sanitaire*) or appealing to individuals and groups to take action (health education), those working to improve the public's health were well accustomed to making trade-offs between the micro and the macro. Public health policy and practice required thinking at different levels, of the individual and the collective. One area where such multiple formulations played out was in the discourse around risk. This was not a new concept, but it did come to acquire greater significance in the thinking and practice of post-war public health than it had done previously. Risk discourse was manifested in two principle dimensions: in relation to the population, and in relation to the individual. Post-war epidemiology became increasingly concerned with the calculation and assessment of the risk of developing certain diseases among population groups. Technological changes also meant that risk calculations were increasingly sophisticated, according them greater scientific credibility. However, when this was translated into public health policy and practice, campaigns often tended to focus on the individual, and his or her risk of developing a particular condition, rather than on the whole population. This could be thought of as mirroring individualist ways of thinking about citizens and publics, but population level approaches to risk did not disappear entirely. For instance, a population level view of alcohol consumption suggested that levels of harm con-

nected to alcohol were related to the amount of alcohol consumed within a population. In order to reduce harm, all drinkers, and not only those at significant risk of ill-health, should be encouraged to drink less (Bruun 1975). Risk, then, was of individual and collective importance, and central to many elements of post-war public health and its view of the public.

Post-war public health's focus on risk can be seen as a reflection of both the changing nature of the challenges it faced, and a shift in the outlook of those involved in public health policy and practice. The impact that these changes had on the public health 'system' are hard to disentangle from other developments. As Tom Crook points out, public health 'systems' were complex and dynamic in the early part of the twentieth century, but there is a good case to be made that these became even more complex and dynamic as the century progressed. The widening of public health authorities' gaze to include more of the everyday lives of ordinary people meant that an even broader range of behaviours, settings and activities could be considered within the compass of 'public health'. At the same time, as the state was 'rolled back' from many areas of health and welfare provision, the variety of actors involved in ensuring good public health increased. 'Who' public health authorities were became harder to discern as 'what' public health consisted of broadened.

3 The Relationship Between the Public and Public Health

The relationship between the public and public health did not play out in isolation from other developments. Indeed, this can be seen as an exemplar of the fluctuating interaction between the state and citizen. The precise kinds of citizenship operating within post-war public health can be broken into three categories: hygienic, social and consumer. Hygienic citizenship was about modernity, order and standards of behaviour, especially, but not only, related to cleanliness. It was a concept identified by historians interested in public health during the late nineteenth and early twentieth century particularly in the colonial context (Anderson 2006; Bashford 2003). But hygienic citizenship was applied at home too, in both the inter- and post-war periods (Welshman 1997; Bivins 2015). This can be seen, for instance, in the continued interest by Medical Officers of Health in food hygiene and domestic cleanliness throughout the 1950s and into the 1960s (Mold 2018). Personal hygiene was also a key element of health education efforts that aimed to promote morality and good citizenship in the immediate

post-war decades. Hygienic citizenship was, to some extent, a hangover from the pre-bacteriological revolution era, when cleanliness was required in order to prevent the spread of disease. However, the emphasis on health as both a personal responsibility and collective duty can be found in other, later, formulations of public health citizenship too.

The balance between individual rights and collective responsibilities was central to notions of social citizenship. According to the key authority on social citizenship, T. H. Marshall, social rights permitted the citizen access to a minimum supply of essential social goods and services (such as medical attention, shelter and education), to be provided by the state (Marshall 1992). The NHS, and the other achievements of the 'classic' era of the British welfare state (from 1945 to 1975), appeared to offer a kind of social citizenship based on collective rights. Social citizenship was rooted in pre and immediate post-war ideas of social medicine. Dorothy Porter suggests that social medicine was the means through which health could be included in Marshall's social rights on which citizenship in the 1950s would be based. But, she argues, such ideals were rapidly undermined. From the mid-1950s onwards, social medicine became less concerned with the impact of social structure on health, and more concerned with individual behaviour (Porter 2002). Yet, as we pointed to throughout this book, ideas about collective and individual rights and responsibilities did not go away within public health policy and practice, nor did they disappear within public understandings of health.

Nonetheless, by the late 1970s, social citizenship as an organising concept appeared to be being eroded by consumer citizenship. Consumerism as applied to health was about a set of ideas and policies orientated around autonomy, representation, complaint, rights, information and choice (Mold 2015). Of all of these, it is choice that is most often associated with consumerism, and the value that seems to have frequently trumped all the others. Choice did feature in public health policy and practice, particularly in health education campaigns that emphasised the need to make 'healthy choices' (Hand 2017). Yet, this progressive narrative, of one form of citizenship replacing another, can be upset. Elements of hygienic citizenship persisted, and indeed were reborn in the wake of the HIV/AIDS epidemic (Armstrong 1993). Social citizenship continues to underpin many collective efforts to ensure good health. Consumer citizenship was not entirely unique to this period, and, we argue, nor did it totally crowd out other forms of citizenship. Just as there are many publics, so

too there are many different ways of thinking about individuals and their relationship to and with the state (Grant 2016).

One example of the overlapping of various forms of citizenship can be seen in the public health survey. In the immediate post-war period, public health surveyors relied on individuals' sense of public duty to garner enough respondents. This notion of duty was based on the post-war social contract, which emphasised responsibilities as well as rights. The right to access to public services, like education and healthcare, was balanced with responsibilities such as using these in a rational manner. Many would argue that this form of social citizenship held until the 1970s, when the welfare state, and the values which underpinned it, came under attack. The emergence of more individuated approaches to public services (whether these be termed 'neoliberal', 'consumerist' or 'entrepreneurial') led to a shift in the types of surveys being conducted and the actions of the surveyed population. Public opinion, for instance, came to matter more, as an object to be surveyed and as something to be taken into account when designing public health policies. However, that did not mean that 'publicness' disappeared. Surveyors still found willing subjects, and collective responsibility had not been eclipsed entirely by individual choice.

The multi-dimensional nature of the relationship between state and citizen within public health is just one of a number of broader implications of imagined publics and their interaction with public health. For historians and social scientists, we suggest that our analysis highlights the dynamic processes that go in to making up people and practices, and that these are not unidirectional. Similarly, for public health practitioners today, it is important to recognise that there has long been and continues to be a multiplicity of publics, and these should be allowed to speak, even if what they are saying is sometimes hard to hear.

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