

Introduction: publics and their health – historical problems and perspectives

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The nature of the relationship between publics and their health is a long-running concern for those involved in the improvement of collective and individual health. Attempts to secure the health of the population are one of the oldest forms of governmental action. Whether it be providing clean water or preventing the spread of disease, such efforts require the involvement of the publics these measures are designed to protect. While there are many excellent studies of the development and operation of public health systems and practices in different places and at different times, surprisingly little attention has been paid to who or what the ‘public’ in public health consisted of. The theoretical construction of the public within public health has been analysed from a range of perspectives, and there is historical work which has looked at the place of the public in public health in certain national contexts.¹ The question of how ‘the public’ or ‘publics’ might vary across time and place with respect to public health practices is, however, largely neglected. This collection aims to begin to address this gap by considering ‘who’ the public in public health was in a range of places and around a variety of public health problems.

The ‘who’ of public health is obviously a vast concern, and we do not attempt to provide a comprehensive answer. Instead, we offer a selection of analyses of how different groups were framed or became visible as what we call ‘problem publics’ in the twentieth and twenty-first centuries in specific locations in Europe, North America and South America. These ‘problem publics’ emerged in different forms and frequently took the shape of social issues that were defined as ‘problems’, before being attached or associated with different, often marginalised groups. Such ‘problem publics’

therefore functioned in a number of ways, both as representative of problems in and of themselves, but also as a way to further disempower or ‘other’ groups perceived to be ‘difficult’ by the polity. Problem publics could be groups of people with specific economic or political characteristics, such as the poor or migrant non-citizens. Problem publics could also be those whose behaviour was thought to pose problems for the wider community. This included people with communicable conditions, like HIV/AIDS, but also those who apparently needed to be persuaded to act more responsibly by, for example, using contraception or consuming low-fat food products. Publics also presented problems of governance, as issues such as violence came to be framed as public health problems, and older worries, such as which authorities should be responsible for dealing with public health at the local level, came into play. Publics could therefore have different characteristics that led to them being designated as a ‘problem’. This volume considers the multi-dimensional nature of this framing of these ‘problem publics’ in order to deepen our understanding of the ‘who’ of public health.

In this Introduction, we begin by examining the nature of ‘the public’ and ‘public health’ and how these changed over time. We then set out the key cross-cutting themes that this book will address before going on to summarise the contents of the chapters. We also reflect on what we think this book adds to our understanding of publics and their health. The COVID-19 pandemic has thrown the relationship between public health authorities and their publics into sharp relief. In order to prevent the spread of the virus, public health authorities in many countries exercised powers to severely curtail individual liberties. The public was also called upon to behave ‘responsibly’, whether that meant washing their hands, staying at home or wearing a face mask. Public health experts became public figures, as members of the public hungrily sought out data, advice and reassurance. The publicness of public health came under a renewed degree of scrutiny and debate. The chapters in this book were largely written before the COVID-19 pandemic, and as (at the time of writing) COVID-19 presents an ongoing public health issue, it is hard to anticipate how the story will end. Nonetheless, the chapters in this collection have much to say about the relationship between publics and public health that is applicable to COVID-19. We suggest that the ‘who’ of public health, and especially the

framing of some publics as ‘problems’, clearly pre-dates COVID-19 and anticipates some of the more recent issues.

By setting these subjects in a historical context, this volume will help deepen our understanding of the enduring complexities of publics and their health. Historical precedent has often been called upon to help understand the COVID-19 pandemic, and sometimes to predict what might happen next.² We provide no ‘simple lessons from history’ here, but we do believe that historical analysis can offer critical insight into the formulation of, and response to, public health problems. To this end, we have three core audiences in mind: historians, policy makers and public health practitioners. For historians, we build on the many excellent works that have analysed the development of public health systems and policies over the course of the nineteenth and twentieth centuries within largely national frameworks. By providing a range of different country and period examples of how public health and its publics are framed, we allow for comparison not only between countries and between times, but also show the diversity of publics and issues that can be defined as ‘problematic’. This insight is helpful to policy makers, who in the rush to deal with a global health emergency have sometimes lost sight of the potentially negative consequences of deeming specific publics or behaviours as ‘problems’. Stigmatising individuals or groups is a long-running trope within public health policy and practice, and this collection serves as a reminder that in the past this has been damaging and rarely achieved any degree of success. For public health practitioners, the essays not only point to the diversity of publics and their needs, but also to a similar diversity in who could be considered a public health ‘practitioner’. Much of this stems from the amorphousness of ‘public health’ and the ‘public’, and this collection also aims to bring some clarity to thinking about these categories that will be of value to all readers, whatever their professional or personal perspective.

‘The public’ and ‘public health’

Any discussion of publics and their health involves the tricky matter of defining who or what is ‘the public’ and who or what is ‘public health’. This is a question some of us have grappled with elsewhere,

but it is worth re-examining here.³ Like the ‘masses’, there is no such thing as ‘the public’, only ways of seeing it.⁴ ‘The public’ is an amorphous category, difficult to define and subject to considerable change over time, place and context.⁵ In *Placing the Public in Public Health in Post-War Britain, 1948–2012*, Mold and colleagues asserted that there were three sets of meanings ascribed to the public in the context of health. Firstly, the public constituted the population or citizens of a particular place. Secondly, the public could operate as a space for action or intervention. Finally, the public was associated with collective values, often placed in juxtaposition to private interests.⁶ These broad categories are far from universal and were subject to change over time and place. The nature of citizenship, for instance, has fluctuated in terms of who is regarded as a citizen, and also what rights and responsibilities this confers.⁷ The public as a space for action is both time- and place-bound, and more universal. Habermas’s notion of the ‘public sphere’ was developed to describe the development of bourgeois society and sociability from the seventeenth century onwards, but this has been stretched to thinking about more contemporary ways of enacting publicness.⁸ Likewise, whilst there are some common elements to the values associated with ‘the public’, these move with the times, often in relation to what is considered ‘private’.⁹

The meaning or meanings of ‘public health’ are no easier to pin down. As Verweij and Dawson note, when the phrase ‘public health’ is used, it is often assumed to refer to one of two things: either the state of the health of the public, or the actions taken in order to protect this.¹⁰ As Mold et al. point out, both of these elements are influenced by three further sets of meanings. Firstly, public health is often defined by the challenges it faces. Secondly, public health operates as a system or set of systems. Finally, public health can function as a philosophy or outlook.¹¹ Once more, such categories are influenced by change over time. The major threats to the public’s health, for instance, shifted over the course of the last 200 years or so, with infectious disease largely being replaced by non-communicable conditions as the leading cause of morbidity and mortality.¹² Public health systems were also subject to considerable variance according to time and place.¹³ Likewise, the outlook of ‘public’ health systems and authorities changed over time. There are some common elements, such as surveillance, but other aspects, like the importance

of social justice in determining public health goals, seem to drift in and out of focus.¹⁴

The moving targets of ‘the public’ and ‘public health’ are further complicated when one considers the changing relationship between them. If we focus just on Britain from the nineteenth century onwards, it is clear that this was never a unidirectional dynamic with public health authorities exerting their power over voiceless publics. Although the mechanisms that existed to provide public representation were confined to white, middle-class men, there were other outlets.¹⁵ Opposition to measures such as compulsory vaccination, for example, could be found amongst the ‘respectable’ working classes as well as the educated middle classes.¹⁶ As patterns of death and disease changed, so too did the relationship between public health authorities and the public. Conditions like tuberculosis (TB) and venereal disease (VD) spread by personal contact, and so by the first half of the twentieth century, public health activity was increasingly directed towards examining the relationships between individuals.¹⁷ Behaviour change came to occupy a central place in public health policy and practice in the latter part of the twentieth century. The linking of many common conditions like lung cancer to individual behaviours like smoking meant that public health authorities felt the need to intervene in individuals’ lifestyles to an even greater degree than before.¹⁸ At the same time, developments in epidemiology enabled the break-up of the ‘mass’ of ‘the public’ into smaller groups thought to be more or less at risk of a particular condition, allowing new ‘problem publics’ to become visible alongside their associated ailments.¹⁹

For us, as authors of this introduction and editors of this collection, our previous research has primarily concerned itself with this post-war British story.²⁰ But this book takes a broader, more international perspective. In doing so we not only expand our own geographical horizons, but this global viewpoint also complicates and adds nuance to how historians, policy makers and public health professionals might think about public health and these myriad publics. As the recent COVID-19 pandemic has highlighted time and time again, public health is, and always has been, an issue that crosses borders. The essays in this collection reinforce this point by both underlining the national or regional specificity of particular public health issues, alongside their frequent entanglement with global concerns. By comparing and contrasting the different examples in

this collection, we can see that while in some contexts there has been a fragmentation of the unitary ‘public’, there were also myriad ways in which the public continued to exist on a collective as well as individual level. By looking in more detail at how public health authorities in different places and times thought about the public or various publics, we intend to shed further light on this dynamic.

Cross-cutting themes: problem publics

As the chapters in this book investigate the nature of the ‘public’ in public health, two key questions emerge: Who was this public, and why were public health authorities interested in them? One fruitful way of approaching these issues, made most explicit in Michael Lambert’s contribution to this collection, is to conceive of these public(s) as a ‘problem’, and therefore as ‘problem publics’. Why were they considered a problem by public health authorities? What qualities or characteristics did these publics have that made them a problem? How does framing these publics as a problem help us to understand the motives and ideologies of public health policy makers and practitioners? And what were the solutions that public health actors proposed to these problems?

Across the collection, there are some examples that not only illustrate this but also complicate our understandings of why public health actors viewed certain groups as problems. Needless to say, conceiving of these different groups as pejoratively framed in such a way helps make clear the moral, political and even ‘civilising’ intent of much public health work across the twentieth century. As Jonathan Metzl and Anna Kirkland have made clear, “‘health’ is a term replete with value judgments, hierarchies, and blind assumptions that speak as much about power and privilege as they do about well-being”.²¹ This collection therefore aims not to collude in such judgements by deeming various groups as ‘problems’, but rather to highlight this framing of publics as a way of unpicking who these groups were, and why they were being conceived of in this way.

Public health authorities designated publics as problematic for a range of reasons; their gender, their sexuality, their nationality or, frankly, the colour of their skin. But publics were also considered problematic for reasons beyond their identities. This was especially

the case for publics that refused to engage with the intentions of public health authorities. Some publics, for example, ate foods rich in fat or did not use barrier contraception (against public health advice). The ‘problem’ behaviours of some publics thus rendered the appeals of public health authorities moot. Finally, publics could be problematic by simply being in the wrong place; the wrong side of a border, the wrong part of town or by being designated ‘hard to reach’ in some way.

Indeed, many authors across this collection make clear that to talk of one unitary public – as everyone from prime ministers and presidents to public health practitioners and health educators has often attempted to – only makes sense as a form of rhetoric or public oration. Publics have always been fragmented and diverse, separated by identities such as class, gender or ethnicity, only occasionally coalescing as an imagined community in the minds of public reformers or welfare states. The resistant and divergent health behaviours of individuals and various groups arguably only fractured further any concept of a single ‘public’ in public health.

The artificiality of ‘the’ public is also echoed in the framing of some publics as ‘problems’. This collection suggests that publics could seem problematic to public health authorities across the twentieth century and across geographies in three main ways: first, because of their identity; second, because of their behaviour; third, because of their location. Publics usually became a ‘problem’ to public health authorities through a process of public health surveillance (sometimes leading to stigmatisation), but in some cases, groups have actively and vociferously advocated to make themselves more visible.²² These processes were not of course mutually exclusive, and these categories – of identity, behaviour and location – also intersected and interacted with each other. For example, in Johanna Folland’s chapter, were HIV positive gay men in the German Democratic Republic (GDR) problematic to public health authorities because of their queerness, their sexual practices, or because their HIV status was framed, at least initially, as representative of a geographically and politically othered ‘decadent West’ – or perhaps, all three?

Identity has played an important part in defining – and problematising – publics in public health across the twentieth century. For instance, gender was used as a key analytical category through

which to target public health interventions and build welfare states in the first half of the century, with mothers being held responsible for, variously, the vaccination of their children, the hygiene of their homes, or the diets of their husbands and dependents.²³ In this collection, as Jane Hand's chapter demonstrates, when food producers and supermarkets began to take an interest in using health claims to market their products in the 1980s, gendered assumptions about both women's bodies and their familial roles rendered them problematic, but also part of the putative solution. If 'societally constructed bodily "norms"'²⁴ meant that women were the most frequent participants in weight loss reduction programmes, their position as managers of the household also meant that they not only had responsibilities for the purse-strings but also for the waistlines of their family unit. Other types of identity are discussed throughout the collection; class, race and nationality are central issues across Michael Lambert's, Beatrix Hoffman's and Jennifer Gunn's chapters.

But it was also the behaviours of publics that made them problematic to public health. Many of these problematic publics are made up, as Deborah Lupton's work has suggested, of groups of 'individuals [who] fail to acquiesce in, conform or consent to the imperatives of [Foucauldian] governmentality'. The behaviours of such publics were 'ways of contesting or non-conforming to a set of established dictums at the site of everyday life'.²⁵ This demonstrates the tension between 'the public' as an analytic category and the agency of the individual actors that make up these sometimes sweeping categorisations (a theme that is returned to repeatedly throughout this collection). These apparently unhealthy behaviours – resistant to the imperatives of public health – included sexual practices considered 'unsafe', dietary habits that consisted of fatty foods or, as in the case of Martín Hernán Di Marco's chapter, violence and homicide. Indeed, this last example illustrates that public health authorities played an active role in defining what was problematic, and that these definitions – of what constituted a 'problem' for public health – shifted and were reconstituted throughout the twentieth century. As noted earlier, these definitions of unhealthy behaviours often overlapped with, and were reinforced by, different publics' identities.

It was, however, more than the identity or behaviour of publics that made them appear problematic. Again, as Di Marco's contribution

shows, it also mattered where these publics were placed. Sometimes this might have been a case of simple geographies; violence was constructed as a public health problem in Argentina from the 1980s onwards, for example, but not elsewhere. But as Gunn argues in her chapter, where publics were located – rural or urban – and which resources were allocated to them was a highly contested question in the interwar United States. Similarly, Hoffman’s chapter considers the rights of migrants to health care amid questions about what ‘place’ these publics were from. Likewise, Lambert’s examination of the British Conservative Prime Minister Harold Macmillan’s use of the phrase ‘our people’ illuminates these questions of place and public; who was public health for? Contemporary public health policy makers’ and practitioners’ use of the short-hand ‘hard to reach’ can also be viewed in this context as an othering device, demarcating the line between compliant citizens and out-of-place ‘problem’ publics.

But if the publics that public health authorities sought to define, address and sometimes exclude were mutable and contested, then the ‘public health’ that this collection discusses is hardly less complex. As some of us have suggested elsewhere, public health can be understood around three ‘core sets of meanings’:

Firstly, public health has often been understood in relation to the challenges that face population health. Secondly, public health can be described as a set of systems. Finally, public health can be thought of as a philosophy or outlook.²⁶

Conceiving of how publics are problematised helps to illustrate these first and third meanings, revealing both the population health challenges that were identified and the ideologies that underpinned the approach to meeting these. Many chapters in the collection aim to get to grips with this, for example Folland’s chapter, which critically asks the question of the GDR’s HIV/AIDS policies, ‘can socialist health be public health?’

But what of the second meaning, the systems of public health? Or, to put it more directly, ‘who’ is ‘public health’? This collection helps us to answer this question and highlights the important observation that ‘public health’ is and was rarely monolithic. All three meanings of public health have required partnerships between the state, the voluntary sector and even actors from the private sector. This latter point comes through most clearly in Hand’s chapter,

where the language and objectives of public health were co-opted – and some might say exploited – by private companies. Corporate interests such as Weight Watchers or Sainsbury’s supermarkets have acted as profit-seeking enterprises whilst simultaneously pursuing marketing policies that would seem to coincide with the interests of improving the public’s health. This marked a shift from the more familiar home of public health services, situated in local government bureaucracies as in Gunn’s chapter, or as part of the emergent welfare state, as in Lambert’s contribution. Indeed, Lambert argues that actions taken to safeguard public health could operate both as a feature of local intervention and of national rhetoric.

This collection therefore helps to understand how public health authorities viewed their publics, but also what this process of definition did to public health itself. Whilst public health as a philosophy and practice continued to play the same role in nation-building and state-definition as it had in the nineteenth century, it is clear from the chapters in this collection that the remit of ‘public health’, as well as the actors involved in its enterprise, had diversified throughout the twentieth century. The chapters in this collection illustrate these processes across geographies and time, from attempts to refine the focus of public health services (and contain budgets) in interwar America; to expanding the reach of public health authorities into areas traditionally inhabited by criminal justice in contemporary Argentina; to international collaboration between socialist and capitalist states in Germany during the AIDS/HIV crisis of the 1980s. By setting these sometimes contrasting and sometimes coinciding views and responses to publics and their health alongside one another, this collection aims to shed light on the framing of problem publics, and public health problems, at different times and in different places.

Chapter summaries

Jennifer Gunn begins our examination of publics and their health through an exploration of how circumstances at the ‘grassroots’ shaped the practice and definition of public health, the publics it served, and the problems they faced. Gunn’s chapter deploys a case study of US interwar public health practice and governance, observing how Minnesota health officers responded to the demands of

multiple publics. These included the public that needed but could not afford care, the public of professional experts and the public that paid their taxes, and through such responses, defined public health. Similar themes in a different locality are explored in the book's second chapter, by Michael Lambert. He examines continuity and change in the ways multiple publics and their health needs were defined by public health discourses at the local and ministerial level, offering the reports of junior public health officials commissioned by senior Medical Officers of Health, which were circulated throughout England and Wales, as his case study. By assessing the treatment of problem populations particularly, the chapter demonstrates the importance of local health professionals in shaping discourse, practice and policy beyond Whitehall. Together the two chapters invite readers to consider how local definitions of public health needs, and perceived obstacles to them, shaped national agendas for the public and its health.

Sexual health provides an especially fruitful area for examining the construction of 'problem publics', as Johanna Folland's chapter demonstrates. Folland considers how East Germany responded to HIV/AIDS during the 1980s. By scrutinising how East German health professionals worked to gain entry into the 'global AIDS community', Folland's chapter highlights the importance of the global stage in shaping definitions and practices of public health and its publics, once again zooming in on a specific public, while expanding the spatial dimensions of the analysis offered. Using HIV/AIDS as a case study, Folland demonstrates that definitions of the public and its health were produced through a process of finding shared ground and negotiating conflicts between socialist and neoliberal conceptions of the public and its health. Certain tensions though, as Folland argues, were nearly insurmountable: what did it mean to speak of 'public' health as a distinct arena of health promotion in a state-socialist context, where all-encompassing health systems such as the one the GDR was trying to build were not meant to be defined by a public/private divide?

Moving away from the socialist principles of the GDR, Jane Hand's chapter examines the role of private companies in promoting public health in England, as individuals were defined en masse as the cause and solution to public health problems. Using the rise of 'low fat' milk products in the 1980s and 1990s as a case study,

Hand considers the role played by the food industry in the promotion of preventative health practices and the place of the individual in guarding public health. The chapter shows that as public health authorities encouraged behaviour change and better lifestyle choices, the food industry responded by creating a variety of new products, especially from the 1980s, that claimed to be low fat, low calorie, high fibre and fortified. Public health campaigning and food retailing interacted to communicate disease risk to consumers within the broadened context of consumerism, mass marketing and the neoliberal state. As a result, Hand argues the popular understanding that preventive health could be bought on the high street emerged.

The place of the individual in relation to the public's health is approached from a very different perspective by Beatrix Hoffman, in Chapter 5. Hoffman examines historically the treatment of immigrant and migrant publics' right to health under international law. Hoffman looks at the ways the judicial protection of human rights was unevenly applied, with non-citizen publics often regarded as threats to public health, rather than as publics deserving of rights. In particular, the chapter scrutinises debates in the United Nations Committee on Economic, Social and Cultural Rights and the World Health Organization over whether and how to apply the social right to health in populations that move across national borders. The chapter pays particular attention to the tensions arising between universalistic notions of the right to health as applying to 'everyone' and some member nations' concerns around border protection and the desire to limit health care expenditures to their own citizens. Through this discussion of migrant health rights and international law Hoffman illustrates how categories of citizenship complicate notions of 'the public' in public health, showing how legal frameworks can be used to define non-publics (or non-citizens) as problems.

In the sixth chapter, Martín Hernán Di Marco assesses the processes which have led to the definition of a new public health problem in Latin America over the last four decades: violence. While violence as a problem is not new, its redefinition as a public health issue is. Di Marco points to the increase in the volume of scientific literature related to violence and the publications of national and international organisations (such as the World Health Organization and the United Nations Office on Drugs and Crime) as instigating increased attention to violence as a public health issue. This

scrutiny has in turn led to the creation of institutions focused on monitoring and intervening to prevent violence. Di Marco also points to the proliferation of violence as a mainstream topic on the public agenda, not only in media debates, but also as a key structuring component in the social representations of the population. Scrutinising Argentina particularly, Di Marco examines these factors from both a constructivist and objectivist approach, illuminating tensions between the different explanations for the rise of violence as a public health problem.

In the Afterword that concludes this volume, Tom Crook reflects on the different constructions of publics and their problems in the previous chapters. He does so by locating them within the wider literature on public health and government over the *longue durée*. The relationship between public health authorities and the public has often been fraught. The COVID-19 pandemic has brought these tensions to the surface, as Crook shows, but these are not new problems. Considering the construction of and response to ‘problem publics’ in a range of places and at different times adds depth and nuance to our appreciation of the processes that go into making publics and their problems.

Taken together, these chapters explore various facets of the definition of public health problems as well as the making of problem publics. By delineating the elements that contribute to the construction of problem publics in various contexts, we can obtain a better understanding of who the public in ‘public health’ was thought to be, across multiple geographies in the twentieth century. This is an important historical question, but one that also has contemporary relevance as publics have come to play an ever more important part in shaping public health systems, and also in combating public health issues. The engagement of ‘healthy publics’ is seen as central to a ‘fifth wave’ of public health improvement.²⁷ This collection, by historicising the construction of ‘problem publics’, allows us to set these developments in context.

Notes

- 1 See, for example: John Coggon, *What Makes Health Public? A Critical Evaluation of Moral, Legal and Political Claims in Public Health*

- (Cambridge: Cambridge University Press, 2011); M. F. Verweij and Angus Dawson, 'The Meaning of "Public" in "Public Health"', in M. F. Verweij and Angus Dawson (eds), *Ethics, Prevention, and Public Health* (Oxford: Clarendon Press, 2007), pp. 13–29; Alex Mold et al., *Placing the Public in Public Health in Post-War Britain, 1948–2012* (London: Palgrave Macmillan, 2019).
- 2 Amy W. Forbes, 'Covid-19 in Historical Context: Creating a Practical Past', *HEC Forum* (2021), 1–12, doi: 10.1007/s10730-021-09443-x; Mary E. Fissell et al., 'Introduction: Reimagining Epidemics', *Bulletin of the History of Medicine*, 94:4 (2020), 543–61; Jeremy A. Greene and Dora Vargha, 'Ends of Epidemics', in Hal Brands and Francis Gavin (eds), *COVID-19 and World Order: The Future of Conflict, Competition, and Cooperation* (Baltimore, MD: Johns Hopkins University Press, 2020), pp. 22–39, <https://muse.jhu.edu/chapter/2696551> [accessed 23 September 2020]; David S. Jones, 'History in a Crisis – Lessons for Covid-19', *New England Journal of Medicine*, 382:18 (2020), 1681–3, doi: 10.1056/NEJMp2004361.
 - 3 Mold et al., *Placing the Public*, pp. 7–31.
 - 4 David Cantor, 'Representing "the Public": Medicine, Charity and the Public Sphere in Twentieth Century Britain', in Steve Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain: 1600–2000* (London: Routledge, 2002), pp. 145–68.
 - 5 Verweij and Dawson, 'The Meaning of "Public"'; Coggon, *What Makes Health Public?*; Janet Newman and John Clarke, *Publics, Politics and Power: Remaking the Public in Public Services* (London: Sage, 2009).
 - 6 Mold et al., *Placing the Public*, pp. 7–14.
 - 7 Dorothy Porter, *Health Citizenship: Essays in Social Medicine and Biomedical Politics* (Berkeley and Los Angeles, CA: University of California Press, 2011); Harry Oosterhuis and Frank Huisman, 'The Politics of Health and Citizenship: Historical and Contemporary Perspectives', in Huisman and Oosterhuis (eds), *Health and Citizenship: Political Cultures of Health in Modern Europe* (London: Pickering & Chatto, 2014), pp. 1–44.
 - 8 Jürgen Habermas, *The Structural Transformation of the Public Sphere: An Inquiry into a Category of Bourgeois Society* (Cambridge, MA: MIT Press, 1989); Steve Sturdy, 'Introduction: Medicine, Health and the Public Sphere', in Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain*, pp. 1–24; Axel Bruns and Tim Highfield, 'Is Habermas on Twitter? Social Media and the Public Sphere', in Axel Bruns, Gunn Enli, Eli Skogerbo, Anders Olof Larsson and Christian Christensen (eds), *The Routledge Companion to Social Media and Politics* (Abingdon: Routledge, 2016), pp. 56–71.

- 9 David Marquand, *Decline of the Public: The Hollowing Out of Citizenship* (Cambridge: Polity Press, 2004); Newman and Clarke, *Publics, Politics and Power*.
- 10 Verweij and Dawson, 'The Meaning of "Public"'
- 11 Mold et al., *Placing the Public*, pp. 16–21.
- 12 Abdel R. Omran, 'The Epidemiologic Transition: A Theory of the Epidemiology of Population Change', *The Milbank Quarterly*, 83:4 (2005), 731–57; George Weisz, *Chronic Disease in the Twentieth Century: A History* (Baltimore, MD: Johns Hopkins University Press, 2014).
- 13 Tom Crook, *Governing Systems: Modernity and the Making of Public Health in England, 1830–1910* (Oakland, CA: University of California Press, 2016).
- 14 Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854*, 1 Reissue edition (Cambridge: Cambridge University Press, 2010).
- 15 James G. Hanley, 'The Public's Reaction to Public Health: Petitions Submitted to Parliament, 1847–1848', *Social History of Medicine*, 15:3 (2002), 393–411; Deborah Brunton, 'Policy, Powers and Practice: The Public Response to Public Health in the Scottish City', in Sturdy (ed.), *Medicine, Health and the Public Sphere in Britain*, pp. 171–88.
- 16 Nadja Durbach, '"They Might as Well Brand Us": Working-Class Resistance to Compulsory Vaccination in Victorian England', *Social History of Medicine: The Journal of the Society for the Social History of Medicine*, 13:1 (2000), 45–62.
- 17 David Armstrong, *Political Anatomy of the Body: Medical Knowledge in Britain in the Twentieth Century* (Cambridge: Cambridge University Press, 1983).
- 18 Virginia Berridge, *Marketing Health: Smoking and the Discourse of Public Health in Britain, 1945–2000* (Oxford: Oxford University Press, 2007).
- 19 Nancy Krieger, *Epidemiology and the People's Health: Theory and Context* (Oxford and New York: Oxford University Press, 2014).
- 20 Mold et al., *Placing the Public*; Hannah J. Elizabeth et al., '"Injections-While-You-Dance": Press Advertisement and Poster Promotion of the Polio Vaccine to British Publics, 1956–1962', *Cultural and Social History*, 16:3 (2009), 315–36; 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 (2016), 612–36; Alex Mold and Hannah J. Elizabeth, 'Superman vs. Nick O'Teen: Anti-Smoking Campaigns and Children in 1980s Britain', *Palgrave Communications*, 5:116 (2019); Peder Clark, '"Problems of Today and

- Tomorrow”: Prevention and the National Health Service in the 1970s’, *Social History of Medicine*, 33:3 (2020), 981–1000; Peder Clark, “What Else Can You Expect from Class-Ridden Britain?”: The Whitehall Studies and Health Inequalities, 1968 to c.2010’, *Contemporary British History*, 35:2 (2020), 235–57; Hannah J. Elizabeth and Daisy Payling, ‘From Cohort to Community: The Emotional Work of Birthday Cards in the Medical Research Council National Survey of Health and Development, 1946–2018’, *History of the Human Sciences* (2021), doi: 10.1177/0952695121999283; Alex Mold, ‘Food Hygiene, Public Health Education and Citizenship in Britain, 1948–1967’, *Medical Humanities* (2021), doi: 10.1136/medhum-2020-012120.
- 21 Jonathan M. Metzl and Anna Kirkland (eds), *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010), pp. 1–2.
- 22 For example, see Grace Redhead, “A British Problem Affecting British People”: Sickle Cell Anaemia, Medical Activism and Race in the National Health Service, 1975–1993’, *Twentieth Century British History*, 32:2 (2021), 189–211.
- 23 Gisela Bock and Pat Thane (eds), *Maternity and Gender Policies: Women and the Rise of the European Welfare States, 1880–1950s* (London: Routledge, 1991); Seth Koven and Sonya Michel (eds), *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge, 1993); Anne Digby and John Stewart (eds), *Gender, Health and Welfare* (London: Routledge, 1996).
- 24 Quote from Jane Hand’s chapter in this collection, see p. 110.
- 25 Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body* (London and Thousand Oaks, CA: Sage Publications, 1995), p. 133.
- 26 Mold et al., *Placing the Public*, p. 16.
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