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**Health Educatio**,**n**. **: Blaming the Victim?**

Jn Autumn 1986, the Undersecretary of State for Health, Edwina Currie,

suggested that the real cause of the poo rer health experienced by Northerners is their diet. Ill-health, she implied, has nothing to do with poverty and unemp loyment, and can best be tackled by 'impr essing upon people the need to look after themselves bette r' . Her predecessor , Ray Whitney, expressed similar views when ope ning a Health Education Council exhibition in September 1986:

'as a nation we must improve our record in reducing the number of deaths from Coronary Hear t Disease. Certainlythe govern ment has an important role to play

- which it is already playing - but realsuccess ca n only come .from the efforts of each of us as individuals. Experience in other countries shows that the sort of life we lead veryoften has a direct link with our life expectancy a nd that, for the great majority of us, our lifest yle is by far the most important factor in maint aininggood health.' 1

Edwina Currie's outburst was merely a less tactful version of a now familiar message echoed by mainstream hea lth educat ion materials. Despite the elaborate theoretical discussions which have ta ken place about the supposedly new discipline of ' hea lth promotion',2 the curre nt practice of healt heducationconsists of provid ing information about bow the individual's behaviour can harm their

health, rounded off with exhortations to behave more responsibly. Discussions abo ut 'co mmunity development' and 'self empowerment' emanating from academic departmen ts are largely drowned by the day to day business of relaying information about the need to change life styles, to use the health services more effectively, to bring up children bette r and generally to smarten up.

**Why health** education? The Department of Health and Social Security· pub lication ' Prevention and health: everybody's business'3 in 1976 heralded a resurge nce of interest in preventivemedicine in genera l and in hea lt h education in par ticular. Thisstemmedfrom a recognition that, historically, declining mortality rates are more strongly rela ted to improvements in livingstandards, in nutrition in housing, in working conditionsand in sanitation than in medical treatment. Th implicationwas that this would remain true in years to come. Thisassumption was st rengthened by the recognition that by and large the major diseases causing death in western societies, coronary heart disease (CHD) and cancers, are not by and large amenable to medical intervention once they have deve lo ped .

A further expectation was that prevention would be cheaper than acute medicine and so a shift of resources to prevention would save m\_oney. While many health workers were attracted by the pote nttal of health education to democratise and demystify medicine , as well as to improve the nation's health, 4 government agencies were clearly most impressed bythe possibility of savings.In 1977, DHSS suggested in ' Prevention and Health' that ' prevention could lead to a reduction of the burden on the services and of the high cost of the drugs bill' . 5

Health education materials and cam paigns are produced by many different

organ isations, but the Health Ed uca tion Co uncil(HEC) has been responsible for much of this work. In 1979 it launcihed the 'Look after yourself' campaign with booklets and 'Look after yourself' classes. Later, in 1983, the start of a ma jor campaig n against heart disease was marked by the \_publicat ion of 'Beating heart disease'. These activities emphasised the need for individuals to alter their diet, exercise patterns and smoking habits. While it was promised that making these changes in life style wo uld improve general health and well being there was a particular em phasis on avoid ing heart disease.

In 1985 this focus on heart disease culminated in ' Heartbeat Wales', an HEC

hear t disease prevention pro ject targetted at the Welsh population. Since then similar programmeshave been opened in Glasgow(G lasgow2000) and Northern Ire land (Change of Heart) leading to an all UK project, ' Look after your heart', launched in April 1987.

Are healthy l.ives an d hea lth y life styles synonymous? The 'Look afte r yourself' approach to preventing ill-health accepts the reality that smoking, poor diet and physic al inactivity can cont ribute to poor hea lth. By focussing on these issues, howe ver, it ignores other important causes of sickness. Although there is a growing body of research on the social causes of ill-health, much more research has been done on such factors as diet aod high blood pressure. The way tht Minister of Health, Tony Newto n, retreated behind the smokescree n of 'considera ble academic debate'6 when asked about the links between poverty and ill health showed that it is a politically sensitive area.

In Part 2, we showed the association between overa ll mortality rates and social

class as measured by the Registrar General's classification. While these data clearly demonstrate large and increasing inequalities in health there are problems in using social class for such ana lyses. There is a considera ble range of earn ing power within each social class, and substantial overlaps of occupational wage levels between classes.7 Social class is therefore a poor discriminator of material well being and may underes timate the true inequalities in health.

Within a single industry, however , there is likely to be a more clearcut relationship between employment grade and economic position. A large study of civil.servants found that the overalldeath rate in a ten year period was three times greater in the lowest emp loyment grade than in the highest.*8* This was true for nearly a ll causes of death. Furthermore, the greater part of the differences in death rates from coronary heart disease could not beexplained bysmoking habits, obesity, seru m cholesterol, raised blood pressure or repor ted physical inactivity. Similarly the differences between the grades in the extent of smoking could not e plain the steep gradient in lung cancer mortality rates . Clearly the lifestyles are not the only factors which can influence death rates.

Edwina Currie singled out the people in the North of England as being in particular need of her advice to ' look after themselves better ' . This is despite the fact that the North of England already suffered higher death rates than most southern areas apart from London when stat istics were first compiled in the mid nineteenth century and has contin ued to have high rates ever since.9 10 These differences are seen for nearly all causes of death and remain evident even when

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allowance is made for the age and social classstructure of regional populations.11 Despite this, Edwina Currie implied that these differences are solely due to the bad habits of people living in the North. As it is unlikelytha t this behaviour relates in an identical way to all the causes of death, her explanation was vastly oversimplified. ·

Many people feel that the work they do damages their health. Despite the research evidence, however, the association between work and ill health islargely ignored outside discussions of specific occupational hazards, like asbestos. As early as 1958, American researchers reported that overwork was an independent and more important risk fact◊r for heart disease than diet, smoking, lack of exercise and a family history of heart disease.t 2 More recently a Swed ish report has shown an increased rate of hea rt attacks in shift workers compared to those with a more pleasant working e nvironment. 13 This difference could not be explained by facto rs such as smoking. Similar findings came from a larger analysis of deaths from heart disease across all occupational groups withinSweden. Hea rt disease was found to be the most common in groups of workers who had the least control over what they did at work and when they did it, but who were hardes t

pressed in terms of the actual demands of their jobs.14

T his discussion touches only brietly on the importance of social factors in the causation of ill health. Other research has shown the det rimental effec ts of unemployment and poor housing on health. Britain's Asian communitys uffers a pa rt icularly high rate of deaths from heart disease which cannot be explaioed by smoking, diet and blood pressure. This raises the possibility that factors such as the stress of living in a racist society are imp ortant determinants of ill health. 15

Clearly, simply att ributing the cause of d ise ase to people's lifestyles is inadequate. Suggesting that illness is ent irelydependent on individual behaviour focusses our attention away from the broader social dete rminants of ill heal th. Acting\_ alone we cannot avoid poverty, st ressful work, poor housing, unem ­ ployment and racism.

**Looking after our hearts.** Books, leaflets, talks and videos used in health ed ucation give no idea of the possibleimportance of economic, politicaland social factors in causing ill health. 'Looking after yourself' suggested that the only problem with the modern world is that we have it too easy:

' Although you inhabit an electronic, push-button, high-technology world, you still have a Stone Age body. It took millions of years of evo lution for the human body to become aaapted for primitive survival - for running, fighting, jumping, lifting, dragging, climbing - in orde r to hunt, trap and gather foo d. It simply hasn't had time to adapt to our modern mollycodd led way of life.'16

Coping wit h 'the stressesof everyday life' is best achieved by gentle rhythmic exercise. A photograph of the Medical O fficer of the HEC jogging pushes the point home.

The only possible cause of heart disease outside of the classic risk factors considered is 'stress'. The section in ' Bea ting Hea rt Disease' on stress starts:

'Most people would putstress at the top of the ir list of thi ngsthat are bad for the heart. It seems obvious that worry and anxiety, or frequent crises and rows can make your blood pressurego up and lead *to* a heart attack. But thisis still difficult to prove, partly because stress is almost impossible to measure and define. Howeve r, people who have a certain kind of personality - striving, ambitious, competitive, impatient , always pressed for time - seem to be mo re in danger of having a hea rt att ack than more relaxed, easy-going types. We call the first heart-risk type "T ype A" .'17

Dubious claims are the n made that Type A's have higher blood pressure and serum choleste rol levels. There is a higher proportion of people classified as Type A in high st at us than in lowstat us occupations. Strong competitive drive, hostilit y and impa tience are qualities which help social advancem ent io a free market economy. Indeed an editorial in the La ncet went so far as to hin t that havini fewe r people with Type A personalit ies might threaten our economic potential.1 Ye t it is not privileged businessmen but the peo ple at the bottom of the scale who are at the greatest risk of heart disease. Type A persona lity clea rly cannot account for the social class inequalities in heart disease:

Despite this, after briefly advising meditation and deep breathing, 'Beating heart disease' d ismisses the environmental determinants of healt h. Thisclears the way for advice to stop smoking,·eat a bette r d iet and exercise more.

The DHSS book,.' Avoiding heart attacks' gives a detailed account of its vie ws on the causes of coronary heart disease, with a chapter devoted to each life style risk fa ctor. T he re is no mention of social class ineq uali ties , work, une mployment or any other social factor. Four pages deal with stress and personality, which have ' unproven' status as risk facto rs. The section on stress concludes:

'Stress cannot be associated with a particular job or way of life butonly with the

way an individual responds to it... The fascinating aspect of the whole question of stress, however, is bow some people seem able to take in their stride " the slings and arrows of outrageo us fortune" while others are unable to cope with relatively minor buffetings. The differences between people and their response to life's challenges could be the missing dimension in the risk factors of cornnary heart disease'.19

The only mention of psycho-social factorsdeals with them as though they were a

problem of the individual and, therefore, yet a11other personal risk factor. The suggested way of dealing with this one is not by changing eating habits or exerting will power over the urge to smoke but by 'walking the dog'. The possibility that mate rial circumstances work against people's attempts to lead a 'healthy lifes tyle' is seldom considered.

Similarly , external social factors are excluded from other health education

materia ls. Stress becomes the ca tch-all category for everything which cannot be subsumed under the classic risk factors. When stress is mentioned, it is usually to deny that it plays a major part in causing heart disease. The Open University ' Hea lth y Eating'course includes a section on reducing risks for heartdisease.The only mention of non life style factors reads, 'personality and stress are not fully accepted as risk factors and are almost impossible to measure•. 20

These materials reflect the opinions expressed in the various' expert reports' on CHD prevenJion that have appeared over the past few years. T he World Health Organisation text 'Primary Prevention of Coronary Heart Disease' devotesonly a small space to 'psychological and social factors'. A short discussion of Type A behaviour is followed by the plea that 'the danger is that public and professional misconceptionsabout stress, whereby it is assigned a primary role in the .flenesisof CHD, may divert attention from demonstra ted needs in prevention.'

The reason why attention is given to stress, **if** only to deny its lmportance, is because the la y public consider it an importan t cause of heart disease. A survey carried out for the HEC revealed that stress was the most frequently mentioned cause of heart disease.22 This was reported in the HEC's newspaper as demonstra ting the crass ignorance**of** the general public under the headline' Heart disease risks ignored'.23 The HEC survey required people to volunt eer causes of

heart disease, which were then coded according to a preconceived scheme. This had separate categories for various diet related factors, such as bad/wrong diet, too much fat/sugar in the diet, high cholestero l, excessive drinking and being too fat. Dividing up the numbers of factorsassociated with diet in this way resulted in several separate groups, with relatively small numbers in each. This allowed the public's knowledge of a possible li nk between diet and health to be unde restimated, perhaps for polemical reasons.

In contrast to this, surveys which present possible risk factors to subjects and

ask whether they cause heart disease, or ask what change people would make in their lives to avoid heartdisease reveal highlevels of agreement with convent ional wisdom about life-style factors and ill health. 24 Where lay beliefsdiffer from what health educators hope peoplebelieve they tend to reflect reality. Beliefs about the

* preventa bility of disease are strongly related to social posi tion, with more fatalistic opinions being held by the poorest people.25 As we mentioned above,

this group has high mortality rates which cannot be explained by lifestyle fact,ors alone . The beliefs the refore d escr ibe the situation as it exists.

**Eat yourself fitter?** The over-riding importance attac hed to smoking, diet and physical inact ivity leading to the exclusion of politically cmbarassing social factors, is one aspect of what hascome to be known as victim blaming. Individuals are blamed for having themselves bro ught about any disease they suffer through irresponsible beha,•iour.

A second aspec t of victim blaming is demonstrated by the assumption that choices about what people eat, how much they exercise, or whether they smoke are freely made. Clearly th isis not the case. The choice to ind ulge in the 'dru gs of solace', tobacco and alcohol, is hardly made in a vacuum.26 Wide ranging social pressures come to bear upon people to adopt such behaviour. Not least of these are pressures generated by organ isatio ns with a vested interest in cigarette, alcohol and junk food consumption.

Edwina Currie has claimed that 'the government is playing its part' in the campaign to red uce smok ing. Accepting contributions from tobaccocompanies to Conservative Party funds is only one aspect of how governments play their pa rt. Norman Te bbit told workers at a Rothmans factory that the Conservatives do not want to stop cigarette advertising. 'If we give in to the people who wan! io stop smokiJJg, then we will have to givein to those people who want to stopdtinkin g, O( taking sugar in tea because it is fattenin g, 0( s kii ng because it is supposedly dangerous.'27 The government also plans to subsidise the production of Skoal Bandits, which are tobacco sache ts fo( sucking, to the tune of £1 millio n.28 Yet these can lead to mouth cancer as well as to cigarette smoking via nicotine addiction. The way the full economic and political power of the tobacco companies is used to ensure a continued marke t for cigarettes belies the myth of freely made choices.29

In the next sectio n wedescribe the forces whichconstrain people from cnoosing a healthy diet. The case of the National Advisory Committee of Nutrition EducatioJJ (NACNE) report, which recommended an unequivocal shift in the British diet, illust rates the degree to whic h truly free choice is discouraged. The

NACNE report was first suppressed, then, at the hands of the food industry adviso rs to the DHSS and the Ministry of Agriculture, Fisheries and Food, its status was downgraded from that of an official stateme nt to a mere advisory document.

Two yearsafte r th is, Dr Donald Acheson, DHSS' Chief MedicalOfficer,gavea presid en tial address0JJ ' Preventionand Government' at the 1985 an nual meeting of the British Association for the Advancement of Science. In it, he said:

' another example of co-operation betwee n Government Departments in the interest of heal th is the recent report on " Die t and Cardiovascular Disease"- the so called COMA repo(t which makes a numbe r of recommendations particula rly in respect of d ie t with the aim of reducing the incidence of coronary heartdisease. Obviously **the** recommendations have implica tionsfor the food indust ry as well as the general population and it was the refore significant that the report was welcomed by the Ministe rs in MAFF as well as by the Health Departments. It is

hoped that advice which \_tra nsla tes science into choices for diet in everyday terms will soon be published .' 30 '

The 'guide in everyday terms' referred to by Dr Acheson was the Jo int Advisory Council on Nutrition Ed uca tion (JACNE) report. Thiswas basedon the advice of the COMA commitlee , which was considerably less st ringent than that of NACNE. Yet thre e weeks before Dr Acheson's speech welcoming the JACNE report, the Sunday Times reported that he had put pressure on Dr John Garrow, who chaired the JACNE to change the report in a way which wo uld dimin ish the ne ga ti ve impact of the committee 's advice on the consumption of butte r, milk a n d meat. These are the most impo rtant sources of animal fat, which is believed to caL1se h ea rt disease . Even the Sunday T imes was driven to demurely comment

that 'the food industry makes major co ntrib utions to Co nservative Party funds'.31 T he translation of 'science into choices for diet in everyday terms' is clearly not as straightforward or innocent as **it** sounds.

**Health and government policy.** Exhorta tio ns to loo k aft e r yourself ig nore the existence of de terminants of ill-hea lth which can only be tackled thro ug hchanging government policy. This is clearly the case for food, tobacco and alcohol po lic)'. But it is also true of the policies which allow fo r the existence of mass' unemployme nt, poverty and de regulated working e nvironments. On many occasions , the gove rn ment makes decisions which have detrimental effects on health and then tries to tackle the consequences thro ugh victim blaming hea lth ed uca tio n. ·

For example, over Christmas 1986 the De pa rt ment of T ra nsport launched a campaign against drunken driving. In an attempt to persuade peopleto leave their cars at home, it used the sloga ns 'don' t ge t a ba n get a bus' and ' use a bus for

Christmas' . T he very same Department of Transport had pushed thro ugh legisla tion de reg ulating and privatising the bus se rvice earlier in1986,'lead ing to a situatio n where unprofitable late nig ht and rural se rvices were not runninf,' In

many areas there were noservices from before Christmas until Jan uary2 nd.3 The

sloga ns were guarantee d to fall on deaf ears.

A s-econd example is the issue of cold weather paymentsduring the cold spell in Janua ry 1987. The DHSS had made the regu la tions about cold weather payments for old age pensioners more stringe nt in late1986. If these regulations had applied in 1986, only£ 1.8 million would have bee n paidout rather than theactual figure of

£4 million. The average tempe rature had to be more than 1.5 degrees below freezing for a whole calendar week before applications could be made. There was a pubtic outcry, and amidst this, the government announced payments of £5 per week, based on predicted te mpe ra tures. No pe rma nent change has, however, been made in the regulatio ns, so the re is no long term commitment to a more adeq uate system of payment. What is more, afte r a general election, the government may be less disposed to yield lo public opinion in the short term.

Although they were not guaranteed money, old age pensioners were given plenty of advice. An HEC booklet 'Keeping Warm in Winter' suggests things you could do for yourself to save money:

* If it is really cold and you are worried a bout the amount of heat you are using, move to one room for living and sleeping, and heat only that one ... Do not wash

your hands or dishes under running water. Put the plug in or use a bowl... If you have all your blankets in use and are still cold, layers of newspaper between them will he lpm.

The inconsistency between the actu.11 nature of the cause of ill-health and the

attempts to deal with the problem by health education is obvious. Cold related disease amongst badly off pensioners cannot simply be prevented by advice, nor can people take buses that do not run. With otherdiseases these relationships are less obvious, but they still exist. Changing behaviours cannot occur in a society where the interests vested in maintaining them are strong. Nor can lifestyle changes , by themselves, e radicate premature disease.

The effective prevent ion of ill-healt h requires concerted action at the level of

public policy. Charles Webster, who was com missioned to write the official history of the NHS, has long argued that there should have been a preventivewing of the NHS from its conception. Seen in' t his light, the ann\_o u ncement in November 1986 that the HEC was 10 be re plac d, in i;\pril \_1987 by a Special Health Authority, directly accountable to t.he DHSS, might " have seemed a positive initiative. Agencies prom9ttiog health cle\_,irly require clost!r connections with government bodies. Im.proving health does qot\_see m 10 be 1l,1e pri 1'f!e reas on for this change, however. The British Medical .Journal suggested tt1al a'. major impetus for the takeover was DHS.S' concern that the HEC was becoming tOO political in its attacks on the alcohol industry . .

One of the first people appointed! to the new Authority was Anoe Burdus, an

advertising executive with links with the tobacco and alcohol industries. JACN E is to be wound up. Its chairperson, Dr John Garrow, an influen tial critic of government food policy, was one of the HEC members not selected to be a member of the new Authority. Other 'food experts' of a different type have been

found to be more suitable appointments fo r the new Aut horit,y They are Carey

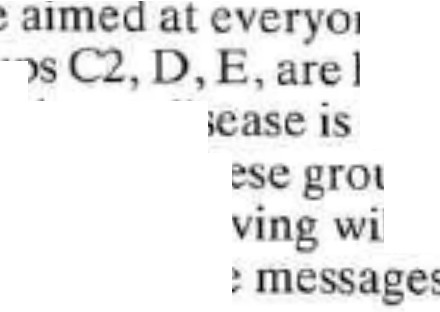
Dennis, a senior Tesco executive, and Caroline Waldegrave, a managing director of Prue Leith's School of Food and Wine, who is married to junior environment minister William Waldegrave. 35

The first venture by the new Special Health Authority is the 'Look after your

Heart' campaign, to which we referred earlier. This is a classic victim blaming project. It aims to:

'raise people's awarenessof the risk factors relating tO Coronary Heart Disease, and to put across simple messages about how to reduce the risk. It could be described as a national call to arms to beat heart disease, Britain's number one killer... The rate of premature death and illness can be reduced bysimplechanges in everyday lifestyles-changingdiet, taking regular exercise, stopping-smoking. This will be the theme of the new cam paign. It will not be focussed exclusively on the prevention of heart disease, but will encourage the adoption of healthier lifestylesin general.'36

This ' nationa l call to arms' is being made through a high profile campaign using television, newspapers, radio. Its publicity materials include badges, T -shirts, and booklets and it is seeking positive endorsement by well known personalities, and consumer groups. What is its strategy for tackling social class inequalities in health?

'The ' L o f tclf You r He art " ca mpaign will b ome groups, mainly the low r cio- nomi r u

with healt h m age and ad ice . Th prcv I nc f he a r t di amongst the e group . pedal ff rt will b m d to re h th ampaign m age ... new easy-t -read 6uide to h l thy Ji available fr m th tart of the camp ig n. It ill ntai n impl

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Th hard to r ach peopl in the lower social class group ar n t o unawar e f the victim blamin natu r f u h matt ria l a the :{ S might like to thin .37 It i not knowledge about th relation hip betw en life tyle factors and Lll health that they lack but the powe r to deal cffectiv I with the cau es of ilJ- hca lth .

Opinion poll h that th overn me n 's he Ith ecord i an lcctoral liabili ty . publicit campaign cla iming that il.1-h alth *i* cau ed b irr espo nsi ble b ha io ur b Ive th g ve rnm nt om guil t hi single th r d runs thr ou h dwina urrie comments and the 'Look ft r ur He ar t' cam paign. ln an e le ti n

ye r it loo as though w will be force fed until w belie e that health i · only a matter f individual eh i u r and not any re pon ibility of the g ve rnme n t. The irector of a pre ure gro u p, th or nary Pr ve n tio n Group aid on radio program e th t p ople wi th heart di ea ,. ere victim of th fr own

ignoranc .38It eems w may become victim f ur educators.

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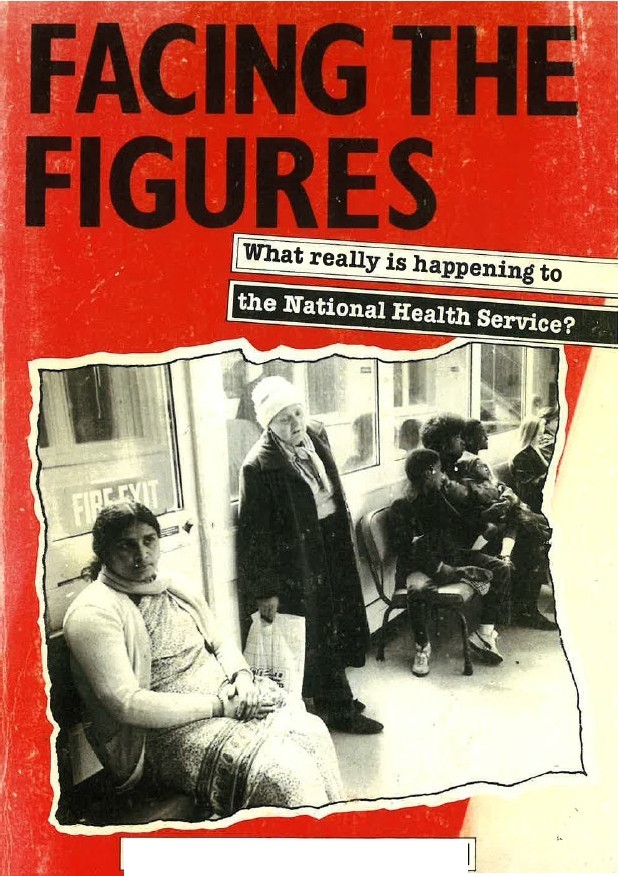
**Food, health and welfare**

Mentions of food and health usually evoke imagesof brown riceand vegetables on one hand and sausage, chips and an additive-laden instant pudding on the othe r. It is hoped that this section encourages the reader to see beyond the individual's chbice of food to the connections betwee n poverty, diet and health, the food industry and government control of the food supply.

Classic diet-health research of the last thirty years has focused on the diseasesof 'over -nutrition' . These studies, for all their weaknesses, 1 support a growing consensus on the ideal nutrient balance of a diet conducive to health and well-be ing. The BMA 's 1986 report ' Diet, Nutrition and Health', for instance, gives dieta ry objectives regarding intakes of: ener gy; to tal , saturated and polyunsaturated fats; salt;fibre; sugar; alcohol and complex carbo hydra tes. The objectives echo the preoccupations of those who see heart disease, stroke, cirrhosis, large bowel cancer and dental caries as the main diet-related and hence preventa ble diseases.

Despite reports such as the BMA's, the individ ualistic approach to disease prevention of our medical and scientific elites still prevails. It is reflected in their reluctance to de mand policy changes likely to disturb political force.s. It is certainly not merely disagreemen t about the validity of the evidence linking diet to disease which leads to this conse rvatism for the evidence here is stronger than that supporting many accepted routine medical procedures.

The powerful campaigning work of a small group of people, including Philip James (Director of the Rowett Nutrition Research Institute, Aberdeen) and Caroline Walker (nutritionist, ex-City and Hackney Health Authority), has



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