The importance of the past…

The importance of the past in public health

Virginia Berridge, Martin Gorsky

This issue contains a paper by Scally and Womack that emphasises the need to expand historical knowledge and understanding in the public health profession.

This editorial comments on a paper by Scally and Womack in the same issue.[1] It announces the establishment of a new journal series on history. It reports the launch of the Centre for History in Public Health at the London School of Hygiene and Tropical Medicine. It summarises the launch lecture on the importance of history in the assessment of globalisation. It argues for more involvement of history and historians in the teaching of public health professionals and for revision of the professional curriculum.

There are some recent and forthcoming developments on this front. The authors mention the lack of a regular historical series in public health journals, with the notable exception of the *American Journal of Public Health*'s long running ''Public Health Then and Now''. There will be a new historical series, ''Public Health Past and Present'' in the *Journal of Epidemiology and Community Health*. Contributions are welcome on any topic relevant to the subject. We hope to publish short research based papers that will enable historians to interact with the public health field and vice versa.

Exchanges between the two fields have been taking place in other ways. The launch of the new Centre for History in Public Health at the London School of Hygiene and Tropical Medicine in November 2003 has the aim of strengthening the links between historians and public health professionals. It builds on past joint work, for example the witness seminars and conferences on the Black Report on health inequalities, famous for being commissioned by a Labour government in the late 1970s and then ''buried'' by an incoming Conservative government; the career of Jerry Morris; and the ''great smog'' of 1952.[2]

The launch lecture of the Centre, given by Simon Szreter of the University of Cambridge was on ''Public health and security in an age of globalising economic growth: the awkward lessons of history''. Szreter proposed that there have been several earlier phases of globalisation in world history, including the colonial encounters of the early modern era and the massive expansion of world trade consequent upon industrialisation. He raised the question of what could be learnt from these earlier experiences about the implications of globalisation for world health. Was the effect broadly positive, with growth in trade and productivity increasing individual wealth and thus wellbeing? Or was it broadly negative, as urbanisation and greater mobility increased exposure to epidemic disease? Szreter argued forcefully that the evidence favoured the second scenario, and the message of his lecture was that only the countervailing forces of government and civil society could avert the deleterious health consequences of globalisation today.

His thesis was developed through a detailed exposition of the British case, which traced the development of a social welfare infrastructure that contributed to rising life expectation. He noted the beneficial impact of the poor laws in the 17th and 18th centuries, which he viewed as a key factor underpinning the productivity gains in the agricultural sector, which in turn provided the basis for Britain's early industrial take off. Turning to the 19th century, he then set out his attack on the McKeown thesis, which argues that improved nutritional status explains the greater part of the mortality decline from the last quarter of the century. Szreter's account foregrounds instead the role of public health reform, and he emphasised that this was not simply the result of initiatives by ''great'' individuals such as Chadwick and Snow. It was brought about by the committed work of local government officials and public health doctors, who in turn were responding to popular support for social action emanating from voluntary associations such as trade unions, friendly societies, and campaigning groups.[3] Democracy and a thriving civil society were therefore crucial to public health improvement. These are historical issues with many contemporary implications and correspond with the focus of networks at the local level that is also featured in the Scally and Womack paper.[1]

For further details of the Centre and its launch visit its web pages (http://www.lshtm.ac.uk/history).

Input such as this on the ''big picture'' from historians is vital. The Centre is a partner organisation in the history and policy web site (http://www.historyandpolicy.org), which aims to bring historical perspectives to bear on present day policy issues. Britain's Royal Historical Society recently organised a conference on the topic of ''What Can Historians Contribute to Public Debate?'' Historical interest is at a high point, at least among the public in the UK. Historians are drawn upon for comment on policy issues, as the coverage of the Iraq war has shown.

This interest extends to health matters. The British Secretary of State for Health, Dr John Reid, a historian by training, has recently published a pamphlet on localism in health that draws on local working class traditions of mutualism to justify the establishment of foundation hospitals.[4] The government's Wanless inquiry into public health is also taking historical analysis on board.

These developments are by no means unproblematic. The relation of history with policy can see policy agendas determining the lessons of history that are used. Historical interpretation and understanding can run the risk of becoming a policy poodle. Intense media interest in health crises can surprise and

Key points

- The journal is launching a new history series and contributions are invited.
- A new Centre for History in Public Health has been established at the London School of Hygiene and Tropical Medicine.
- Its launch lecture was a powerful historical critique of the connection between globalisation and economic growth. Civic society was historically important.
- History teaching for public health professionals is important but neglected in the professional curriculum. This needs to be remedied.

Policy implications

Implications for training in public health.

almost overwhelm historians who get involved, as the valuable role of historical analysis in the 2001 foot and mouth epidemic showed.[5]

Scally and Womack's paper recalls the role of history teaching of public health professionals by Sidney Chave. They mention the history study unit we run at the London School of Hygiene and Tropical Medicine. Nevertheless history struggles to find a role in the increasingly crowded training curriculum. Search the UK Faculty of Public Health web site training sections and you will find little, if any, reference to history. Health economics, epidemiology, statistics, the ''behavioural sciences'' (not history) now take precedence. The emphasis is on the here and now—valuable, but it does not lead us to question how we got to the present and how the past may offer different models. This is an area that urgently needs to be looked at and to be built in more centrally to public health training. Some medical and public health schools already have professional historians in post and others could follow this example. The professional training curriculums could be revised to incorporate history.

There is still much that remains to be done to increase the interaction of history with public health. Multidisciplinary public health is the latest variant of a long series of historical reconstructions. Is it willing to subject itself to the lens of history?

ACKNOWLEDGEMENTS

We acknowledge the support of the Wellcome Trust whose historical research funding supports much of the work of the Centre for History in Public Health.

J Epidemiol Community Health 2004;**58**:728–729.
doi: 10.1136/jech.2003.019141

Correspondence to: Professor V Berridge, Centre for History in Public Health, London School of Hygiene and Tropical Medicine, London, UK; virginia.berridge@lshtm.ac.uk

REFERENCES

1 **Scally G**, Womack J. The importance of the past in public health. *J Epidemiol Community Health* 2004;**58**:751–5.
2 **Berridge V**, Blume S, eds. *Poor health. Social inequality before and after the Black Report.* London: Frank Cass, 2003.
3 **Szreter S**. The importance of social intervention in Britain's mortality decline c1850–1914: a reinterpretation of the role of public health. *Soc Hist Med* 1988;**1**:1–37.
4 **Reid J**. *Localising the National Health Service. Gaining greater equity through localism and diversity*. London: New Local Government Network, New Health Network, 2003.
5 **Berridge V**. Public or policy understanding of history? *Soc Hist Med* 2003;**16**:511–23.

Challenges for public health

Intervening in communities: challenges for public health

Helen Roberts

There is still a long way to go in developing and implementing sound interventions at a community level

There used to be a touching belief that public health interventions were exempt from the kind of scrutiny that we might normally expect to be a pre-requisite for messing around with peoples' bodies and their lives.[1] Even once it became accepted that physicians and surgeons could inadvertently do more harm than good, some areas of public health and health promotion occupied a privileged place. A few leaflets here, telling parents how to do their jobs better, a bit of social engineering there, trying to iron out a little local difficulty with housing or transport. What could be the harm in that? So long as people's hearts were in the right place, brains were not thought to need to be quite so fully engaged in changing communities as in changing lipid lowering medication.

All that is now starting to change. The public health field of the Cochrane Collaboration is producing guidelines for those working in public health; the UK Medical Research Council[2] has produced guidelines on complex interventions, including those delivered at a population level for health promotion purposes, the Campbell Collaboration, which is a sister collaboration to Cochrane, but producing reviews in education, social welfare, and crime prevention is looking at the effectiveness of policies and practices ranging from boot camps for young offenders to mentoring.

Over the past few years, randomised controlled trials of day care,[3] social support in pregnancy,[4] sex education,[5] and smoke alarms[6] are among the studies conducted in non-clinical settings, with a public health purpose. Epidemiologists and social scientists working in tandem have ensured that as well as reporting health outcomes, issues of process and implementation are also considered. The qualitative methods group in Cochrane is leading some of the work on this[7] at the same time as hierarchies of evidence are being challenged[8] with a greater focus on using the right kinds of methods and design for the particular question being explored. No longer are randomised controlled trials seen to trump other methods in all circumstances, or qualitative work seen simply as a way of trying to get the patients to comply, and understand why they don't.

No randomised controlled trial is entirely simple. However straightforward the intervention, human creativity and cunning knows no bounds in subverting random allocation. William Silverman's wonderful story of attempts to undermine a trial of the use of oxygen in premature babies illustrates this.[9] Different coloured marbles would be returned to the dish if they were the ''wrong'' colour for a baby thought to need the intervention; allocations in sealed envelopes would be held up to the light. Of course we don't do things that way these days, but if there are problems with even relatively straightforward interventions in relatively well organised clinical settings, the problems of large scale community trials are even greater.

Archie Cochrane was there first, of course. He described the gap between the scientific measurements based on randomised controlled trials and the measurements of benefit in the community. ''There is'', he wrote, ''a gulf which has been much underestimated.''[10] The article by Penny Hawe and her colleagues in this issue is therefore a welcome addition to the relatively sparse community trials literature to which her group has already substantially contributed.[11] Their piece,