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History: a social science neglected by other social sciences (and why it should not be)

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This paper argues that the promotion of social science influence in policy-making has strangely neglected the discipline of history. Yet history has been expanding its role as a 'policy science' in recent years. While historians may not be able to employ some of the methodological tools of other social scientists, they nonetheless utilise analytical tools of their own which enable them to interpret the 'past' in a rigorous and meaningful way. It is thus possible to 'learn from history' without being reductionist or prescriptive. Specific examples are here drawn from the authors' fields of expertise—the history of health policy and public health, history of alcohol policy, the history of childhood—to illustrate the underlying argument.

Introduction

It is the central contention of this article that historical analysis has been relatively neglected by those working in the other social sciences; and that this is to the latter's detriment. Historians are called upon by, for instance, government departments to provide evidence and interpretation of the past in the light of present policy concerns, but this sort of activity seems to have so far gone unnoticed in social science circles. History is a potential additional source of strength for the sort of arguments and policy interventions made by other social scientists. Using our specialist interest in health history, a case is put forward for history not only as a social science in its own right, but also as a policy bedfellow for the other branches of social science. Some of the recent engagement of history—with the public, but primarily with policy—are outlined and case studies and methods are examined

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with the aim of seeking to persuade fellow social scientists that there is indeed something to contribute to the contiguous and complementary disciplines.

History as a public subject

Part of the problem may be the high current visibility of history as public entertainment and fellow social scientists may come across history primarily in this way. History is at an all-time high as a popular public subject in the UK (Berridge, 2003). Family history appeals to the expanding cohorts of the early retired as even a brief visit to local records centres or the National Archives at Kew will attest. On television, much programming relies on history for its staple diet. Colleges mount courses in public history, the branch of the discipline which deals with museums and similar forms of public engagement. History also has an expanding role as part of the Public Understanding of Science (PUS) movement. All these activities are important ways of reaching out to the public, of creating and also building on a general climate of interest in the past. And historians themselves have changed. The historian Raphael Samuel did not win universal approbation when he showed enthusiasm for the heritage industry. Historians agonised about whether it was 'real history' and whether the discipline would be 'dumbed down' if it appeared too popular. That stance has changed, partly as a result of the shifting landscape of academic life over the last 30 years. Nowadays historians are much more willing to appear in docu-dramas, to speak animatedly in front of medieval cathedrals, or tell us all about the history of water, or of the patient, on Radio 4. Leaders in their respective fields such as Marcus du Sautoy and Niall Fergusson command significant television audiences for the apparently esoteric subjects of the history of mathematics and the history of money. Many historians have, in short, realised that this sort of engagement is in the interests not only of the individuals concerned, but also of the discipline as a whole when academics have (rightly or wrongly) to show the 'impact' of their research, whether to external funding bodies or in exercises such as the RAE/REF.[1]

These activities can be broadly said to be 'advancing understanding' and adding to the richness of public experience and cultural capital. The model is essentially one of history engaging with the *public*, the general population, and, in the PUS model, helping them to understand the value and the provenance of science, health or medicine. However, the overt connection with contemporary issues is often slight.

History as policy analysis

There is also a different, although related, role for history. This is the use of history as a tool of *policy* analysis; as a way of directly feeding into policy discussions. It is nothing new for historians to be involved in policy-making (Fergusson, for example, has acted as a policy advisor to the American government). The classical education so beloved of Oxbridge, for instance, had very real implications for policy formation and practice when its products came to rule the Empire. Elizabeth Fee and Daniel Fox, writing in the early days of AIDS, reflected on history's past

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role as *the* policy science—and its decline (Fee & Fox, 1988). In the post-Second World War years, there was a 'golden age' of social science research influence in the 1960s and 1970s in which history to some extent shared. And social scientists themselves were more inclined than is perhaps presently the case to engage with historical issues to illuminate their own specialisms. Brian Abel-Smith, for instance, was prominent in the field of social policy and administration. But he also produced significant historical works, for example his history of the hospital system prior to the advent of the National Health Service (NHS) (Abel-Smith, 1964). More recently, historians have begun to take a revived interest in having policy impact after a period when some found the idea distasteful. In the UK, the History & Policy (n.d.) website and partnership has been important in encouraging historians to draw out the contemporary implications of their work. Current papers on that site include, for example, Glen O'Hara on the (purported) present debt crisis and David Feldman on immigration, while the magazine *BBC History* has a series where journalist Chris Bowlby has interviewed historians with policy-relevant findings—such as Alex Mold with her work on voluntarism (Mold, 2009). The partnership is initiating 'policy briefings' and meetings with politicians and civil servants, most recently with the Office of Civil Society on the topic of the 'Big Society'—or the nature of voluntarism, as historians might term it (History & Policy, n.d.).

In addition, departments and government institutions themselves appear to have become more sensitised to history. The research councils' knowledge transfer schemes have helped. One historian, James Nicholls, has been involved in the Department of Health's Alcohol Improvement Programme; while one of the present authors has given talks to civil servants and representatives of the third sector in both London and Edinburgh on the historical background to political devolution (and in particular the implications for social policy). The Rural and Environmental Land Use (RELU) research initiative saw a veterinary historian, Abigail Woods, temporarily located in the Department for Environment, Food and Rural Affairs (DEFRA), where she carried out a piece of commissioned historical research specifically for policy. Historians have presented evidence to Commons committees, for example Martin Gorsky's survey of patient involvement prior to and during the NHS, which came with recommendations about how to improve the relationship in the future (Gorsky, 2007). The former Chief Medical Officer (CMO), Sir Liam Donaldson, wrote a history of the CMO's office jointly with an historian, Sally Sheard (Sheard & Donaldson, 2005).

Cross-national differences

It is also significant that cross-national differences in the way in which history is used can be identified. The South African historian Shula Marks has drawn attention to the shifting fortunes of history in the South African context. In the 1970s and 1980s history was the 'queen of the social sciences' in South Africa since historical understanding of how the apartheid regime had been established was a source of fierce ideological battles. The establishment and work of the Truth and Reconciliation

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Commission, however, and somewhat paradoxically, marked a decline in this role for history. Direct personal experience, oral testimony in effect, rather than the interpretation of historians, became a key source of knowledge.[2]

In the United States, rather different routes to influence have operated, most notably the law court and the role of historical testimony as 'expert witness'. Asbestos litigation; the culpability of tobacco companies; lead poisoning and lead paint have all seen historians in the courtroom, sometimes giving evidence on both sides. This issue has been greatly divisive in the American historical profession, with historians nearly coming to blows over their opposing involvement. Discussing the relationship between 'Clio and client', one US historian came to the conclusion that the subtleties of history went out of the window when history entered the law court (Rothman, 2003).

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What can history contribute?

Such examples of recent interaction, debate and controversy could be multiplied. But this section now turns to convince a social science audience that history does have something specifically to contribute. Rather than well-meaning general statements, this will be approached through a number of case studies which illustrate the point.

Resistance to vaccination

One contemporary issue will be looked at first: that of resistance to vaccination. In recent times opposition to vaccination, such as that seen in Britain towards the combined measles, mumps and rubella (MMR) vaccine, has been widespread among the public. Many scientists and commentators have seen opposition to vaccination as stirred up by the media or as stimulated by research which purported to show a link between autism and the vaccine. Such arguments have stressed the culpability of scientists or the ignorance of the public. The public are seen as 'misled' or 'duped', with little sense of independent agency.

If one turns to history, however, a deeper and more nuanced understanding of such responses can be achieved. Vaccination against diseases such as smallpox began at the end of the 18th century, following the work of Edward Jenner. During the 19th century, legislation was introduced to govern vaccination. The first laws in the UK were passed in the 1840s, but the law enacted in 1853 that made it compulsory for all infants led to a 50-year campaign against what was considered a draconian intervention. Anti-vaccination leagues operated in many parts of the country and had widespread working-class support.

Historians who have examined anti-vaccinationist thought and practice have drawn attention to different popular attitudes to vaccination (Durbach, 2005). Whereas scientists and public health officials might see vaccination as an unmitigated good, anti-vaccinationists were afraid that the process of vaccination might introduce all sorts of diseases into the body of a young child. Different attitudes to childhood prevailed (on which see further below). Children were viewed as born in a perfect state

and vaccination might introduce serious imperfections, which could be moral as well as physical. Vaccination was seen as a means of transferring disease and immoral characteristics and making them hereditary.

There was particular concern about the role of the state and of compulsory vaccination. It was inequitable and imposed upon the poor. It was interventionist in a society in which many considered the role of the state merely to be that of a 'night-watchman'. There was much discussion about the division of scientific opinion about the efficacy of the process and also to the money made by members of the medical profession through it. They were paid for vaccinating and also for treating at great expense the diseases which it caused.

These arguments from the 19th century bring a realisation that anti-vaccination feeling is not new. Anti-vaccination movements have had a long history. But there is more to it than that. Rather than condemning such sentiments out of hand, it might be a good idea to try and understand them in the context of the time in which they operated, and also in relation to present-day concerns. In particular, there is a long history of concerns about safety; about vaccination and children's health; and about the inequitable application of vaccination. Such factors could feed into contemporary understanding of opposition to vaccination.

There are indeed some beginnings of interest in this history in the contemporary global public health research community. Vaccination now figures high on the list of public health interventions The issue of' trust' is now seen as crucial, when in the past it was off the agenda.[3] Some public health researchers seem aware that the past may have something to tell them. A recent global health student at London School of Hygiene and Tropical Medicine (LSHTM) has used the School vaccination collection, which contains examples of anti-vaccinationist thought, for a student dissertation under the supervision of David Heymann, a public health leader with a long track record in this area (Fitchett & Heymann, n.d.). Heymann himself has spoken about vaccination as both past present and future strategy.

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Health policy: the cases of public health and of hospital policy

At the time of writing, the NHS is in the process of reorganisation in England (the fact that different approaches are being taken in Scotland, Wales, and Northern Ireland is both historically significant and the result of preceding historical processes). Public health is to be relocated within local government, resuming the position it held before 1974, when it transferred into the NHS as a medical speciality. The history of that relationship with local government is thus of relevance. But it is also a disputed history and an example of how interpretation of evidence is important in using historical analysis. In a recent overview, presented to the Commons Health Committee Enquiry into Public Health, Berridge and Gorsky drew attention to the long history of the location of public health in local government, but also to controversy about how well it had operated (Berridge & Gorsky, 2011). The local government role dated back to the origin of the local public health official, the Medical Officer of Health, in the local health boards in the mid-19th century. By the interwar years,

these officers were running an extensive health and social care system. There is much historical debate about how well this system operated. Many in the public health field later saw it as a 'golden age', when their powers and achievements were at their height. Infectious disease mortality was firmly in decline, with rates falling from around 350 per 100,000 in 1917 to 150 in 1937, to about 10–20 in 1957. Public health was a clearly identifiable aspect of public life, with many Medical Officers of Health (MOHs) well-known local figures heading amply staffed departments, including health visitors, clinicians, bacteriologists and sanitary inspectors. Their tenured appointments conferred some political independence in dealing with elected councillors and their annual public health reports presented local health statistics and helped set policy agendas.

The 'golden age' interpretation is open to criticism. Despite central grants, disparities in local taxable wealth meant there was consistent variation between places in resources for health, and hence quality of services. Integrated working between the public sector and voluntary agencies was also poor in many areas. Arguably too, public health failed to meet the challenge of the 1930s depression. Most MOHs were silent on poverty's impact on ill-health, ignoring the emergent literature on malnutrition, and were conservative in their approaches to prevention, for example failing to adopt diphtheria immunisation despite international evidence of its efficacy. Tragically high levels of maternal mortality represent another failure. There were risks of 'overstretch' imposed by responsibility for curative health services, and the loss of public health's once distinctive advocacy role, as MOH activities increasingly overlapped with those of general practitioners.

Recent historical interpretations strike a balance between these views. Analysis of local financial statistics reveals rising real investment in public health in many areas despite national economic difficulties, albeit many poorer places remained disadvantaged (Levene *et al.*, 2004). Variations were not solely determined by rateable wealth, but could also reflect local expenditure choices made by council politicians working alongside MOHs. The extent to which health policy was directly determined by local electoral preferences remains uncertain.

Against the charges of 'overstretch' can be set the benefits of integration of preventive and curative services, for example in the school medical service and in infant and maternal welfare. Moreover, new municipal clinics and general hospitals advanced equity of access, with health increasingly understood as a right of citizenship. Examples can be found of innovation (for example, in health education), active vaccination policies and concern for the sick poor. Often MOHs were constrained both by limited local resources, uncooperative politicians, and hostility from doctors in the private and voluntary sectors towards collaborative working. Their failures must also be attributed to the weak Ministry of Health, which provided little vision or leadership and was 'a career backwater', unattractive to civil service high-fliers.

The NHS settlement left public health in local government but with much reduced powers and responsibilities. This was due both to political expediency and legitimate concerns about the capacity of local government to meet health goals deemed nationally optimal. Nonetheless, it would be incorrect to conclude that public health within

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local government achieved nothing in the post-war years. A dynamic MOH with a clear vision could still achieve a great deal. For example, Dr Paddy Donaldson (father of the former CMO), as MOH in Teesside in the late 1960s and early 1970s, began to inaugurate screening clinics and to work closely with local general practitioners (Donaldson, 2000). Similarly, Dr Ian McQueen, MOH in Aberdeen during the 1964 typhoid outbreak, used the media in an innovative way (Diack & Smith, 2005).

More specifically on hospitals, recent historical investigation has shown that hospital provision before the NHS was a complex mixture of public and voluntary sectors. The former embraced, prior to the Second World War, poor law institutions, hospitals run by local authorities and a range of specialist bodies. Voluntary hospitals, meanwhile, were supported by charity and ranged from the great teaching hospitals to local cottage hospitals. Access and level of care varied widely and Aneurin Bevan's 'nationalisation' of the hospitals under the National Health Service Act was an attempt to bring order to what was widely seen to be chaotic and inequitable. Of course whether or not such order was actually achieved is another topic of considerable historical research. And it should also be stressed that not all aspects of pre-NHS hospital provision were negative. Some of the more 'progressive' local authorities tried hard to enhance hospital care and were moderately successful in doing so (Levene *et al.*, 2011). More pertinently for present purposes, though, what this sort of analysis might help us understand in the present is that too great a disaggregation of the hospital system, in terms of control and finance, did result in the past in problems of access and was not successful in delivering services in all circumstances to all people. It was not for nothing that Bevan's wish was to create a health service that was universal, comprehensive and free at the point of consumption. It was, rather, the direct outcome of immediately preceding historical situation. An understanding of such historical events and processes might make for a rather more informed debate than is presently taking place over NHS reform in England.

Such a review of historians' writing on public health and on hospitals is, indeed, directly relevant to current discussions about NHS reform for it highlights the central point that historical input need not simply be the injection of 'facts'. Rather, informed historical interpretation, based on as wide a range as possible of historical evidence, can throw light on present policy proposals. The end-point is not to claim that a particular policy line is 'right' or 'wrong' in the light of such historical evidence—historical contexts are, by definition, always different—but involves a judicious assessment of the balance of options. This mode of analysis can be attractive to policy-makers who are the constant target of 'interests' with agendas on which they seek to present 'the evidence'.

Alcohol policy

If one turns to a third example, that of alcohol policy, it can be seen how historians did impact on a recent Commons Health Committee discussion. Historians who gave evidence to that Committee in 2009 disputed the idea that Britain had

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always been a 'hard drinking society'. This misrepresentation of the past had been common in discussions of the increase in alcohol consumption and of 'binge drinking' in the early 21st century. This level of consumption was said to be 'part of the national character', a type of enduring national characteristic that could not be changed. However, when historians gave evidence to the Committee, they pointed to times when British alcohol consumption had declined (House of Commons Health Committee, 2010). Two periods stood out: the long decline that began in the 1870s and which lasted until the 1960s; and the particularly sharp decline during the First World War. Discussion of these two examples threw up factors relevant to the present. The late 19th century onward period of declining consumption had occurred at a time of rising real wages and living standards, in other words, just the time when one might have expected consumption to rise and not decline. What led to the opposite effect? Here historians have pointed to the wider social context. The public house was becoming less central to working-class life as the main leisure activity. There were Bank Holidays; alternative pursuits such as football, sports and walking; and free education. In the interwar years when the decline continued, leisure time activities such as the cinema and holidays with pay took people away from the pub, alongside moves by the drinks industry to establish the 'improved public house', the pub as a family place serving food and with a greater range of activities.

The First World War accelerated this decline because of the substantial restrictions introduced by the wartime Central Control Board on opening hours; the strength of drinks; buying rounds of drinks; and control of the trade in certain areas. The decline in arrests for drunkenness was substantial, as was the decline in deaths from cirrhosis of the liver. The First World War example shows that government action can make a difference, in this case stimulated as it was by the wartime crisis. The Committee report published in 2010 took these arguments on board. They showed that drinking patterns were not immutable and that a mix of government action and wider social factors could bring about change. Other historical work has drawn on alcohol history and the history of temperance to point to possibilities for intervention and action in the present day (Berridge, 2005a).

Such examples show history in a different light. Historians have acted not simply as 'fact grubbers', uncovering interesting material that can be used in a rather vague way to illuminate the present, or to draw parallels with the past. Here history has operated, in both qualitative and quantitative forms, as a means of analysing issues in the past and of looking at how those factors can be transferred into discussion in the present. This is history as analysis and interpretation rather than bald 'fact'.

Children and children's health

The final example is that of children and their health. It was noted above that one of the objections to vaccination policy in the 19th century derived from a particular view of childhood. And, as sociologists of childhood have been pointing out for some time, there is strong evidence that childhood is in some sort of way socially constructed.

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Taken together, what this suggests is that the way society views children and childhood changes over time. This in turn has profound policy implications that can be illustrated by reference to changing views of children's health. So, for instance, in the early part of the 20th century legislation was passed that instituted the school meals and medical services (Harris, 1995; Stewart, 1999). This was done not simply, or even primarily, for altruistic reasons, the poor health of children at the time notwithstanding. Rather, at a time of fierce and increasing international rivalries, children were seen as the future of the Empire. If they were in poor condition, then Britain's imperial, military and economic hegemony would be increasingly challenged. It is revealing to contrast this with present policy concerns that focus not on the lack of food, but rather on its quality and quantity, and their linked outcomes. There is, though, a thread of continuity which is that the malnourished (as opposed to undernourished) child, possibly obese, might not be able to participate fully in the labour market on reaching adulthood.

In terms of psychological health, meanwhile, there has been a shift from seeing the child as either 'innocent' or inherently 'corrupt' to a position whereby the very condition of childhood is seen as pathological—that is, it has been medicalised. Childhood is thus inherently 'dangerous' in that the child is exposed to all sorts of psychological threats, from without and within, which can lead at any point to some sort of emotional or psychological problem. The condition of childhood thus has to be constantly monitored and measured for the good not only of the child itself, but also for its family and broader society. In so doing, particular versions of science and medicine are to be employed as well as surveillance and other observational techniques (Armstrong, 1995; Turmel, 2008; Stewart, 2009). Again, this has significant implications not only for health policy directed at children, but also for other fields such as education and social work.

Such examples highlight another function way whereby historians might input into policy formation, namely through injecting an awareness that even something as apparently immutable as childhood has to be seen in the context of the society in which children live and the ways which that society views them. Once again, the aspiration would be for policies which were at least sensitive to the broader context and nuanced accordingly.

Historical methodology

A key difference between history and some other social sciences is that historians do not generate data, and it is impossible in historical research to design an instrument that will elicit the dataset required. Historians are always reliant on surviving sources and cannot design a questionnaire to elicit standardised information (Berridge, 2005b). However, some research techniques are comparable; oral history interviews and 'witness seminars', for instance, have similarities to the in-depth interviews and focus groups used by social researchers. The purposes of these research methods, however, differ significantly from other social science usage.

Historians use two broad categories of data in order to analyse past events:

- Primary sources are the materials left by people who lived in the past.
- Secondary sources are the books and articles written by historians based on the primary sources.

A first task in research is to survey its *historiography*. Historiography is what historians have already written on the topic. This gives an idea of what arguments have been made and what areas looked at. Here a potential problem is encountered in that historians are themselves products of their own societies and historical periods, and thereby their assumptions. To put it another way, the questions historians ask of the past will themselves be shaped by the social and cultural context in which they operate. An obvious, but telling, example here is that of women who were, in the phrase of a pioneering historian of women's history, until the 1970s largely 'hidden from history' (Rowbotham, 1973). Historians, like other social scientists (or natural scientists, for that matter), may have their own preconceptions according to, for instance, religious or political standpoints. Nonetheless an examination of the existing historiography establishes the framework for looking at the primary sources.

A range of primary sources can then be used. For the sake of clarity; three types are identified here:

- Documentary.
- Quantitative.
- Oral.

In practice, historians often use a combination of different source material and rarely rely on one type of source alone. Documentary sources are a key resource for historical work but can be misunderstood by social scientists. If one imagine oneself in a health-care setting such as a clinic, doctor's surgery or hospital, or sitting in the office of the Minister of Health, one can list some of the materials, the primary sources, that might be used by historians in 100 years time to reconstruct and analyse what is currently happening in these settings. In the health setting, there might be, for example, posters encouraging healthy eating or medical records. In the Minister's office there might be a memo from the CMO about the progress of an anti-malaria campaign or a report on hospital reorganisation from an independent research body. This list could continue. The Minister, for example, might write his/her autobiography after leaving office. What has been identified are all primary documentary sources. There is a wide range of such sources:

- Official sources such as state and local government reports and papers.
- Newspapers, journals and literary sources.
- Letters and personal papers.
- Visual evidence such as art and artefacts. Most historians concentrate on verbal documents using words, but the term can also be applied to visual materials as well.

Many historians use material collected in *archives*, which include:

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- Official government archives.
- Specialist archives (e.g. the archives of trade unions).
- Local history archives.
- Newspaper archives.

Some of these archives will be generally open and accessible, while others may be more difficult to access. Digitised archives and other primary material are becoming much more common.

Quantitative sources. Some of the sources listed above may provide statistics about the past. There may be published statistics about causes of death and how these have changed over time. In Britain, the General Register Office was established in the 1830s; thus long time series are available. Statistical sources are also available within documentary material, for example, hospital yearbooks which can be analysed to look at changes within the hospital over time. Records of lunatic asylums and mental hospitals have been analysed by historians to show the patterns of who was admitted to the asylum, how long they stayed and whether they were readmitted. This kind of statistical analysis has contributed to discussions about the function of the asylum in the past and how it changed or was experienced differently by different sets of people.

A major approach within history using quantitative material is that of *historical demography.* Historians have used parish registers of births and deaths in order to assess the causes of population increase which fuelled the Industrial Revolution and the rise of cities in Britain in the 19th century. Such demographic work has concluded that population increase and industrialisation in the late 18th and early 19th centuries in England were driven by a rise in fertility rather than by a decrease in mortality. Such conclusions have implications for those considering population increase in countries outside Britain today, although obviously the specific social, cultural and political contexts have to be taken into account when making comparisons. Historical demography is also of particular relevance to contemporary debates in Britain about the implications, for example for pensions, of an ageing population.

Historians are especially aware of the need to look critically at their sources. Questions have to be asked which enable you to assess the significance and meaning of each source. What you are trying to do is to understand the standpoint of the person who produced the document and how it sheds light on the issues. This does not mean that documents which show 'bias' should be discarded—in reality, this would be impossible. In the past, as now, everyone has a point of view and this may influence what is produced. You might think that more technical sources, for example, data series or patient records, are 'unbiased', but they are not a full record of the truth either. The section has discussed problems with data series; and patient records do not state everything about a patient. They inevitably leave out more about the person than they include.

Much human experience is neither quantified nor written down. Oral accounts can be revealing and usually these are gathered from individuals through interviewing.

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This limits current research to those who have been born within the last 90 years. However, there are also oral history archives in some countries where earlier interviews have been deposited and are available to researchers. There are different forms of oral history interviewing. Three types can be identified:

- Life history interviews.
- Key informant interviews.
- Witness seminars.

Life history interviews are an important use of oral history. The new social history of medicine tried to look at what was called 'history from below'. It wanted to reconstruct the experience of people who did not appear in the documentary sources. Lay people or patients have been interviewed about health experiences, or women practitioners and patients, who have been largely absent from the historical record. This use of history has spread widely and has been used by local history groups. It is also used in the care of the elderly in some countries; reminiscence professionals encourage elderly people to talk about their life histories as a means of maintaining mental alertness and interaction with others.

In key informant interviews people may be interviewed because they have played a role in events, such as a scientific discovery, the establishment of a speciality or key health policy decision-making. The idea is not to explore the interviewee's whole life history, but rather their involvement in a particular set of events.

Witness seminars are a relatively recent development within oral history. They are rather like a focus group in social science research. Participants are those who have been involved in a particular set of events; they discuss these events in a group discussion, which is then recorded and transcribed. The interaction between participants sometimes achieves more than might emerge from individual face-to-face interviews. Witness seminars for health topics have so far mainly dealt with events in countries in the West. For example, one seminar has considered the changes in abortion law in Britain in the 1960s; another has looked at the 1979 Black Report on inequalities in health, what led to government disapproval and the subsequent impact of the report on health research.

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How historians use sources

The discussion about documentary, qualitative and oral history sources makes it clear that all these sources must be used with care and their limitations appreciated at the outset. The historian's main task is the uncovering and examination of such evidence, but this must then be compiled into a coherent analysis accessible to outside readers.

Historians do not start out with a hypothesis to be tested. The approach is deductive through interaction with the source material. Evidence is always fragmentary, either because it has not survived (librarians and archivists are presently working on how to ensure the survival of communications media such as emails for the benefit of future historians and other researchers) or because it has been selected in particular

ways for deposit in an archive; or because historians themselves have to be selective with respect to the material with which they engage. Historians working on more recent history in particular can find that they are overwhelmed by the amount of material and cannot possibly use it all. Historians must therefore be careful that they are weighing up different types of evidence and make sure they are not constructing an analysis that simply confirms their own preconceptions.

Historical 'truth' is the existing consensus among historians based on corroboration from the sources. There are thus many areas of controversy in history, in particular in health where such discussions often have implications for the present. Historians argue over interpretation for two main reasons:

- New sources, techniques or methodologies allow new questions to be asked and answered.
- Each particular generation will rewrite its history and different theories will influence the nature of the arguments made.

One particular example of this process is the historical debate about what is called the 'McKeown thesis'. Thomas McKeown argued that the decline in mortality visible during the late 19th century could not have been the result of health technologies or of public health interventions, but was the outcome of better nutrition and higher living standards at the end of the century (McKeown, 1976). Simon Szreter has examined the classification of disease data in this period and has argued that certain diseases actually declined earlier than the official statistics would lead one to believe (Szreter, 1988). Such reclassification leads to the conclusion that public health interventions did play a greater role and that better nutrition alone cannot be a sufficient explanation for mortality decline. This controversy in history has present-day implications. It could impact on international agencies and their donor strategies; it reintroduces the importance of state activity (as a major driver of environmental improvements, for instance) rather than placing stress only on the role of the market to drive improvements in public health.

Therefore doing historical research is not just a question of 'uncovering the facts' as a kind of historical detective story, but of discovering and examining evidence and then of presenting that evidence in a coherent analytical form. History is both a body of knowledge and an area of disputed and changing interpretation. It is not simply the written record of the past, but an argument about the past, which can be relevant to the present.

Folk history and social science

One of the dangers of using history is that the field can be crowded. History is perhaps unusual as a discipline in that many people think they can practise history without formal training or understanding. Historical examples are plucked out of the air to provide 'context' or to show that 'nothing has changed' or that there are 'historical parallels'. This sort of talk does not get one very far. Particular health fields have

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their own folk history that tend to be impervious, or unaware of the work of historians. In the public health field, for example, which is historically conscious, the 19th-century 'heroes' Edwin Chadwick and John Snow are much better known than the more relevant history of public health after 1945. Policy-makers are fond of invoking a standardised view of the past when it suits, exemplified by the invocation of Aneurin Bevan by Labour politicians in debates on the NHS.

Social scientists do use history. In a study of policy-makers' use of history, one of us (Berridge) found that social science advisers on health policy were using history. But these interventions were often uninformed by the latest historical research and interpretation (Berridge, 2008). The historian Helen King has recently drawn attention to the way in which historical facts are generated, presented and evaluated in the media. Historians are often relatively powerless against those facts. She used the recent claims that some 18th-century men midwives had had their subjects murdered in order to provide the illustrations for their atlases of obstetrics to show how new technology could aid the deprofessionalisation of history (King, 2011). In a parallel example, the myth that Queen Victoria used cannabis goes marching on, although Berridge (2003) demolished this 'fact' eight years ago.

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Conclusion

This article has sought to do four things. First, to suggest that history (in the sense of the scholarly interpretation of the past), as researched and written by historians, has much to offer both the other social sciences and those concerned with policy formation and implementation. Second, to show how particular examples drawn from recent historical scholarship help illuminate contemporary health policy. Third, to illustrate how historians go about doing their work, and the weaknesses but also the strengths of their methodologies. Fourth, and finally, underlying all this is our response, as professional historians, to Professor Canter's call to engage with 'discussion and dialogue, both within the social sciences and across to humanities, science and engineering' (Canter, 2011 , p. 4). It is in this spirit that we would encourage colleagues, from whatever discipline, to dispute, qualify or even agree with the points we have made.

Notes

1. For example, see *The Guardian* (2011, front page) highlighting new 'public intellectuals' who had won an Arts and Humanities Research Council (AHRC) competition to promote media discussion of research. Many of the winners were historians.
2. Shula Marks's comments were made in a paper ('The responsibilities of the historian') given at a conference organised by the Royal Historical Society in 2002.
3. Conversation between Virginia Berridge and vaccination researchers, June 2011, LSHTM.

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