Epidemiologists: clinging to coat-tails or donning them?

From BEN A LOPMAN1 and CLARENCE C TAM1,2

Sirs—In 2002, the US Department of Health and Human Services and the National Institutes of Health disbursed a combined $2.75 billion for biopreparedness and biodefence research.1,2 Investments in epidemiology, particularly for improving pathogen detection and incident response, are already underway. This recent focus on biodefence, however, is not universally welcome. According to Ezra and Mervyn Susser,3 a three-way division is emerging among epidemiologists: those favouring prioritization of biodefence, those who feel that it will divert attention, resources, and expertise from immediate public health problems, and those who suggest pragmatically that such investment can create a ‘coat-tail effect’, eventually benefiting all through improvement of disease surveillance infrastructures. Taking the latter view, the Susser argue that epidemiologists can contribute to defence against terrorism and call for an open discussion on the role of epidemiologists in the aftermath of 11 September 2001. Their question, ‘what’s an epidemiologist to do?’ is well-pointed, since it implies that epidemiologists themselves can, or at least should, steer the discourse about their collective future. In the short term, epidemiologists may have a limited say in the matter. Prioritization of biopreparedness is, after all, what the public and politicians want. We should, however, consider what this could mean, both now and in the future. And to do this, where better to start from than the past.

The uneasy alliance between public health and national defence stems from the state’s need to protect its population, trade, and colonial interests from infectious disease. In this sense, the current situation is not unique. Public health campaigns were crucial in establishing European colonial power in Africa and Asia, Japanese occupation in Taiwan, and American campaigns in Central America,4–6 while governments’ ability during the mid-20th century to simultaneously slash local public health budgets and fund research into potentially weaponizable agents has been linked to a national security–public health alliance that exploited irrational Cold War fears.7 Such activities have left indelible marks in geopolitical and cultural terms, yet their adverse effects remain largely unspoken and are limited primarily to their justification in terms of successful reductions in disease incidence. The argument for the coat-tail effect is based on the premise that the ends justify the means. The real questions, however, are what are the ends and who defines them. Claiming immediate public health successes while ignoring long-term societal impacts is short-sighted and naïve.

Returning to the present, the threat of terrorism, although not new, has not previously received much attention from epidemiologists. Franklin White’s call for an epidemiology of terrorism8 is thus interesting and worth exploring. However, a number of problems would confront an epidemiological approach to terrorism including, most basically, its definition. The US Army definition: ‘violence and the threat of violence exercised for political effect’,9 is valid yet very broad. Studying the causes and health impacts of all such violence would be a massive undertaking for epidemiologists, requiring the development of methods and causal frameworks deeply rooted in social theory and the expansion of epidemiology into political analysis. Epidemiology currently lacks such expertise. Furthermore, epidemiologists would have to accept responsibility for what to do with the findings of such enquiry, particularly when it becomes uncomfortable for the national security complex to which we are drawing ever closer. Most crucially, if we truly believe that the threat from terrorism is greater now than previously, and that we as epidemiologists can contribute towards its prevention, then our response must be global and multilateral. Anything else risks further dividing epidemiology along political lines that run counter to our public health interests. In an age of increasingly global health initiatives, our state-centred view of biodefence is incompatible with the ideal of ‘health for all’.10,11 The billions being spent by industrialized nations on national defence will not directly benefit those in other countries whose individuals experience the threat of infectious disease and violence on a daily basis, many of whom are at no lesser risk of terrorist acts.

And now to the future. The Global Fund to fight AIDS, tuberculosis, and malaria is widely regarded as the most significant international health collaboration to date. It also provides a prime example of the national security–public health nexus. The resulting surge in human immunodeficiency virus (HIV)/AIDS funding is unarguably a good thing for those affected by the pandemic and the motives behind the fund are now largely moot. Their consequences for epidemiologists, however, are

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not. That we owe the fund’s inception largely to the Clinton administration’s view of the AIDS pandemic as a national security threat\(^1\) says much about the questionable role of epidemiologists in driving the public health agenda. HIV/AIDS is seen as a transmissible threat and a destabilizing force to political and economic institutions which, in the context of increasingly globalizing capitalism, threatens the establishment of international markets.\(^6,13\) But are we to settle for a line of thinking which a disease is not prioritized unless it is perceived as a national security threat? Many of the same countries currently suffering the ravages of AIDS will, over the coming decades, increasingly bear the brunt of non-infectious diseases.\(^14\) Unlike HIV/AIDS, these are not perceived as transmissible threats or diseases of poverty. Instead, these diseases are considered a result of positive economic and health transition, despite the fact that 80% of deaths from atherosclerosis occur in low/middle-income countries.\(^15\) They are seen as reflections of societies with a substantial consumer class and our current emphasis on expensive therapies for their treatment will encourage the belief that countries in transition will continue to open up markets for these commodities.

If we are to keep our public health goals in sight, we must surely look beyond accepting financial handouts and move proactively into the future, towards the many imminent and urgent challenges that await us. Public health goals, independent of national security, should be valid ends in themselves for the state to engage. Relying on financial windfalls from other sectors implies an acceptance that health, a fundamental human right, is a secondary concern—that we must cling on to others’ coat-tails when we should be donning them ourselves.

References


Authors’ response

From EZRA SUSSER and MERVYN SUSSER

We are heartened by the vigorous responses to our call for epidemiologists to debate the implications of September 11 and its aftermath.\(^1\) The letter from Lopman and Tam\(^2\) is a good example, sharp and critical but constructive. We would underscore one of their points. More than ever, public health is a global endeavour, whereas the most powerful political structures are not; their base and interest is invariably national. As a result, even when in any particular instance public health and political objectives converge, there remains an inherent tension between the two.

To be true to the international mission of achieving ‘health for all’, our discipline must maintain a global and multilateral perspective, and cannot accept any narrowing of its focus to state-centred biodefence. Nonetheless, epidemiologists need to blend idealism with realism. While always eschewing crude opportunism, we are compelled to seek opportunities for improving public health. Our hand is strengthened when we can acquire political backing without losing sight of our distinct public health purpose.

References


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