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’s 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 supremacy 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 nexus. A case control study involving French Canadians in Montreal, Quebec, Canada. Cancer 1997;80:858–64.


not. That we owe the fund’s inception largely to the Clinton administration’s view of the AIDS pandemic as a national security threat\(^1\) say 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 in 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


DOI: 10.1093/ije/dyg261