Colds, international policy and inequalities

Suffering a common cold is a frequent and universal experience. In this issue we reprint D’Arcy Hart’s 1943 Lancet report of a trial of Patulin for the common cold, which many now consider to be the first example of a modern, multi-centre controlled clinical trial, an accolade previously accorded to the 1948 MRC trial of streptomycin for tuberculosis. Patulin is a mould of a penicillin species found on apple skins, initially thought to be a highly effective treatment for the common cold, although the rationale for snorting mouldy apple skin as a cold cure remains obscure—perhaps an apple a day keeps the doctor away? The trial findings were probably disappointing for the investigators; but as D’Arcy Hart’s recollections in Chalmers’ The trial reports were probably disappointing for the investigators; but as D’Arcy Hart’s recollections in Chalmers’

The protagonists of Patulin were willing to accept the findings of a trial of 1300 people; the placebo group did better with a 4% difference (95% CI 0.9%, –8.9%) in percentage cured or improved at 48 h. An improvement in cure/improvement rate of <1% attributable to Patulin had been excluded. In the modern era of mega-trials, no doubt a sample size calculation would have been conducted, and given the ubiquity and economic costs of the common cold, an increase in cure/improvement rate as small as 1% would be deemed to be worth detecting with the usual 90% power at a significance level of 5%: result total sample size 78,000 people! Those who were true believers might well have disregarded the small trial findings presented here and demanded a bigger trial to exclude a 0.5% treatment effect.

Our theme this issue is Inequalities. A medical student in his feedback on one of our courses stated: ‘Social medicine is rather tedious. It is obvious that the poor get sicker, so why bang on about it?’ The biblical words ‘the poor are always with us’4 are often used as an excuse for limiting the political and social action required to reduce inequalities in wealth and in health and reflect my student’s disinterest in an apparently insoluble problem. However, the context of the biblical story highlights the way in which people (in this case Judas Iscariot) hide their own greed and self-interest behind a supposed concern for ‘the poor’. This echoes much international social and economic policy enacted by the major industrial countries; policies such as debt relief have the appearance of doing good but are linked to other policies that protect the interests of the wealthiest. In the UK, our Department for International Development has shown great interest and skill in making such linkages: £342 m (US$496 m, Euro461 m) of aid money in India is to be used for restructing and reform that will make 20 million people landless, contributing to increased poverty; in Zambia £0.7 m (US$1 m, Euro0.9 m) will be spent on nutrition programmes but £56 m (US$81 m, Euro76 m) on privatization of its copper mines.5 The USA does the same, but with surprising frankness: ‘the principal beneficiary of America’s foreign assistance programs has always been the United States. Close to 80% of the US Agency for International Development’s contracts and grants go directly to American firms.’6 Maurice King’s essay review in this issue is relevant here with its focus on demographic entrapment and his notion of a ‘population policy lockstep’ that makes debate on population policy taboo.7

So, no apologies for maintaining a focus on inequalities. As epidemiologists, we have a particular interest in understanding the causal mechanisms by which social inequalities influence health. It may seem that this indicates a lack of interest in attempts to intervene or evaluate the effects of national and international policies on inequalities. However, without a good understanding of causal mechanisms, intervention can only be speculative and ill-founded. In this issue, using British data on the social class gradient in coronary heart disease risk, it is concluded that a population-wide strategy of primary prevention is better than targeting efforts on reducing social inequalities.8 Our commentator, Michael Marmot, takes issue with this position,9 making good use of the debate about the control of tuberculosis in which the causative agent, M. tuberculosis, is but one corner of the agent-host-environment triangle—effective primary prevention will require multiple approaches. There are no magic bullets for the alleviation of health inequalities.

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