How important is it for epidemiologists to have a voice—to comment critically on public health issues? The International Epidemiology Association (IEA) has this journal as one means of communication but as we only publish six times a year, it is difficult to use this as a platform for topical issues of immediate importance. As a result, the IEA council produces Rapid Responses to provide members with comment and information. The most recent concerns a Texan lawsuit that recently ordered destruction of 5.3 million newborn blood samples, stored without the parents’ consent. The issues involved concern individual freedoms, the feasibility of consent and collective good, and are fundamental to future epidemiological research. Take a look at the Rapid Responses and if you have ideas that merit a rapid response please contact the IEA Secretariat at our web site http://www.ieatemp.com/contactUs.aspx.

Do interventions for preventing cardiovascular disease worsen health inequalities? This question was raised by World Bank researchers, Davidson Gwatkin et al., following publication of the first global burden of disease estimates by Murray and Lopez in 1997. The global burden of disease study demonstrated for the first time the massive contribution of non-communicable diseases to current and projected disease patterns and threatened to change the balance of funding priorities. Gwatkin's analysis compared the most wealthy 20% with the least wealthy 20% globally and found that the poor–rich gap would increase if the focus is shifted to prevention of non-communicable diseases. He concluded 'Caution is needed before policy-makers embrace the current shift in emphasis from communicable diseases among the young toward non-communicable disorders at older ages'. Job done. The greatest myth of all, perpetuated by those keen to see no change in priorities, is that the poor do not suffer from non-communicable disease—these are 'diseases of affluence'. Srinath Reddy was one of the few critical commentators at the time, highlighting the importance of non-communicable disease to the health of the poor. A 'business as usual' mindset resulted in the launch of the Millennium Development Goals in 2000 that have resulted in neglect of the non-communicable disease agenda and dominated health policy in developing countries in the face of compelling evidence of changing disease patterns. The World Bank has, after a decade, now reversed their position on the importance of prevention and control of non-communicable diseases.

In this issue, the same question is taken up again by McLaren and colleagues who speculate whether social inequalities in health will be increased by population prevention strategies that aim to move the whole distribution of risk in a beneficial direction. These authors argue that it depends on whether the intervention is 'radical or superficial'—contrasting the example of smoking where a health education campaign (e.g. in India) might be considered a 'superficial' intervention which will likely fail to reach illiterate people but be differentially taken up by early adopters of behaviour change who have the necessary social and economic resources. A 'radical' (or structural) smoking intervention would focus on the underlying reasons why people smoke—availability and pricing of tobacco, legislation on smoking in public places—and would be much less likely to result in increases in social inequalities in health and might even reduce them. The authors discuss current temptations to target vulnerable groups with behaviour change interventions that represent a variant of Rose’s high-risk strategy. Here the danger is that attempting to prevent disease at one end of the risk distribution leads to failure to implement population-wide approaches. The article is an essential reading for health policy makers in the developing world.

The story of Finland’s remarkable decline in coronary heart disease (CHD) over the last three decades is trumpeted in this issue. In the 1960s, Finland had the highest CHD rates in the world and this set in train the North Karelia study which aimed, through a range of population and high-risk strategies, to reduce the CHD rates. It is clear now, looking at the European scene, that Finland is no longer the sick man of Europe (see Figure 1). Top of the European league table is now the Russian Federation and Kazakhstan—along with many of the countries of the former USSR. Similar interventions to North
Karelia were attempted in the former USSR but clearly did not withstand the impact of massive social upheaval.8–11 A question of some interest to those of us working in developing countries— including countries of the former USSR—is whether investment in North Karelia style interventions is the right choice. Affordability and feasibility are issues but the main concern is the need to generate randomized evidence of benefit in developing countries themselves given the lack of evidence from randomized trials of health promotion interventions.12 The effects of non-randomized interventions in the workplace are encouraging13 but require further efforts to establish their costs and true effects.

It is hard to imagine a world without forest plots such as the dominance of systematic review methodology in clinical medicine and epidemiology. Those of us who were around before they were invented imagined that a Dr Forrest was responsible—a product of Richard Peto’s joke that they were named after Pat Forrest, a breast cancer researcher.14 We did not get the joke but it did cause some confusion and misspellings. One idea is that a forest plot helps to see both the wood and the trees. In this issue, we publish a review of the current use of forest plots which shows that Cochrane systematic reviews tend to misuse them (80% with three or fewer studies) and to present the studies mindlessly in alphabetic order rather than by some meaningful feature.15 This is an important empirical paper that should improve practice in this area.

Mendelian randomization has grown apace since our early publications in IJE16,17 with over 60 000 google hits in the last year. But nothing is new and our Reprint and Reflection is on RA Fisher’s Bateson lecture Statistical Methods in Genetics given in 1951.18 He defines the underlying principle of Mendelian randomization as follows:

...Providence has shielded the geneticist from many of the difficulties of a reliably controlled comparison. The different genotypes possible from the same mating have been beautifully randomized by the meiotic process.

Our reflections are by one of his last students, Walter Bodmer; his daughter Joan Fisher Box gives a brief history of his scientific development and David Finney focuses on experimental design.19–21 And if none of the above articles appeal, this issue’s Diversion surely will—‘Bored to Death?’ by Annie Britton and Martin Shipley.22 The Whitehall II civil servants cohort study had asked about being bored in the previous 4 weeks—surely a question that got past the more seriously minded investigators and was probably included to tickle jaded civil servants. Being bored is associated with higher risk of cardiovascular disease—but as the authors clearly state it must be a proxy for other risk factors. However, this did not stop the media picking up on the story (see CNN’s ultra serious reporting of the ‘top news’ story).23 Even our publishers, Oxford University Press, contacted us and requested that, in future, they would like to press release articles as newsworthy as this one.

Finally, it was sad to learn of the recent death of John Pemberton (aged 97), a founder of the ‘International Corresponding Club’, which became the IEA.24 As a medical student, he provided medical support to a 1933 hunger march (predating the more
famous Jarrow March of 1936) protesting against high unemployment. The experience prompted him to write his first paper on malnutrition in England. He was also one of the original medical team that set up the Boyd Orr cohort—probably the longest running cohort study involving the same investigator. Maurice Backett also died recently at the age of 93. He pioneered the integration of social science, medicine and health services into a new type of community health through which he inspired many, including me during my training at Nottingham University, where he held the foundation chair of community health. Together with Jerry Morris’s recent death, aged 99½ years, these deaths mark the end of the era of epidemiology arising out of a pioneer generation who were as concerned about social change as about their science.

References


