

Health is more than influenza

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The repeated pandemic health scares caused by an avian H5N1 and a new A(H1N1) human influenza virus are part of the culture of fear.¹⁻³ Worst-case thinking replaced balanced risk assessment. Worst-case thinking is motivated by the belief that the danger we face is so overwhelmingly catastrophic that we must act immediately. Rather than wait for information, we need a pre-emptive strike. But if resources buy lives, wasting resources wastes lives. The precautionary stocking of largely useless antivirals and the irrational vaccination policies against an unusually benign H1N1 virus wasted many billions of euros and eroded the trust of the public in health officials.⁴⁻⁶ The pandemic policy was never informed by evidence, but by fear of worst-case scenarios.

In both pandemics of fear, the exaggerated claims of a severe public health threat stemmed primarily from disease advocacy by influenza experts. In the highly competitive market of health governance, the struggle for attention, budgets and grants is fierce. The pharmaceutical industry and the media only reacted to this welcome boon. We therefore need fewer, not more "pandemic preparedness" plans or definitions. Vertical influenza planning in the face of speculative catastrophes is a recipe for repeated waste of resources and health scares, induced by influenza experts with vested interests in exaggeration. There is no reason for expecting any upcoming pandemic to be worse than the mild ones of 1957 or 1968,⁷ no reason for striking pre-emptively, no reason for believing that a proportional and balanced response would risk lives.

The opposite of pre-emptive strikes against worst-case scenarios are adaptive strategies that respond to emerging diseases of any nature based on the evidence of observed virulence and the effectiveness of control measures. This requires more generic capacity for disease surveillance, problem identification, risk assessment, risk communication and health-care response.¹ Such strengthened general capacity can respond to all health emergencies, not just influenza. Resources are scarce and need to be allocated to many competing priorities. Scientific advice on resource allocation is best handled by generalists with a comprehensive view on health. Disease

experts wish to capture public attention and sway resource allocation decisions in favour of the disease of their interest. We referred previously to the principles of guidance on health by the British National Institute for Health and Clinical Excellence (NICE),² cited as "We make independent decisions in an open, transparent way, based on the best available evidence and including input from experts and interested parties."⁸ Support from disease experts is crucial in delivering opinion, scholarly advice and evidence to a team of independent general scientists. But this team should independently propose decisions to policy-makers and be held accountable for them.

The key to responsible policy-making is not bureaucracy but accountability and independence from interest groups. Decisions must be based on adaptive responses to emerging problems, not on definitions. WHO should learn to be NICE: accountable for reasonableness in a process of openness, transparency and dialogue with all the stakeholders, and particularly the public.⁹

Competing interests:

None declared.

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