to reduce the harmful use of alcohol[9] for submission to the World Health Assembly in May, 2010. The strategy should address both national actions and crucial worldwide issues, including the effect of trade agreements on alcohol use.

Despite the strong parallels with tobacco control and the success of the WHO Framework Convention on Tobacco Control,[10] there seems to be little immediate chance of WHO or member states supporting the complex process of developing a Framework Convention on Alcohol Control.[11] To gain traction, this framework will need dedicated support and pressure from a few committed countries, underpinned by a strong global network of non-governmental organisations.[3] Non-governmental organisations in the alcohol field need to strengthen their international presence and learn from the tobacco-control area.

The power imbalance between industry and health groups is a key reason for the continuing neglect of alcohol as a global health issue.[12] Other impediments include the absence of clarity on the alcohol control message, the political context that gives priority to an individual's responsibility for health, and the close connection of alcohol with many aspects of social and cultural norms. Generation of political priority for alcohol as a global health issue is the crucial next step.

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Action needed to tackle a global drink problem

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Postwar Britain smugly thought that alcohol misuse was someone else's problem. Despite earlier rumblings of concern in the health community, the wake-up call came in 2001 when the Chief Medical Officer reported that deaths from cirrhosis in the UK, predominantly caused by alcohol, were rising and set to overtake the European Union mean.[1] In some age groups, the increase was nearly ten-fold over one generation of 30 years. While our continental neighbours had succeeded in cutting back over this period, per-person consumption had almost doubled in the UK, fuelled by falling prices and increasing availability.[2] But 8 years after the nation's problem with alcohol was accepted, where are the policies to tackle it? In the UK they are largely absent, but some signs suggest a change; and the Series in *The Lancet* today is timely for the UK and other countries, both rich and poor.

Although cirrhosis is a good surrogate marker of damage and resonates with the public, the focus on physical diseases might overlook the huge burden of dependence, damage to third parties through passive drinking (so-called collateral damage), and the social and economic costs of alcohol misuse. This danger is made clear in today's first article, in which Jürgen Rehm and colleagues[3] estimate that 3·8% of all global deaths and 4·6% of global disability-adjusted life-years are attributable to alcohol. These numbers are almost certainly conservative, particularly for developing countries where illicit manufacture is poorly controlled and disease registers are limited.

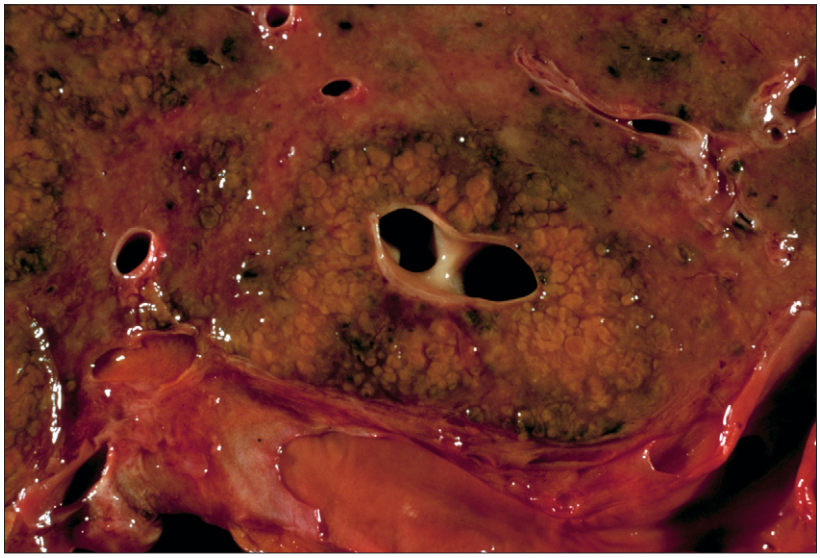
Sally Casswell and Thaksaphon Thamarangsi[4] make telling parallels with the fight against tobacco and the rearguard actions against a powerful, well-funded,

and organised industry. The aims might be different (eradication of smoking *vs* moderation of alcohol consumption), but arguments must not be subverted by discussions of cardiovascular benefit. Most countries report drinking well beyond the putative protective level, and any benefits are for older drinkers only. We also have to be clear that there is no level of consumption that is risk-free, as clearly shown in the million women study.[5] The increased risk of cancer over the 7-year follow-up was about 6% per 10 g of alcohol consumed daily. This finding might seem small but is largely unknown to most women, and hence people are not making informed choices.[5]

The UK's concentration on binge-drinking youngsters and the antisocial or criminal consequences of heavy drinking has allowed politicians to project the problem onto a small part of the population, which no doubt suits the marketing strategies of the drinks industry. When the Chief Medical Officer in England called for a minimum unit price for alcohol,[6] the proposal was instantly dismissed by Prime Minister Gordon Brown in saying we "don't want the responsible, sensible majority of moderate drinkers to have to pay more or suffer because of the excesses of a small minority".[7] However, setting a minimum price of 50 pence per unit would likely increase the average weekly spend on alcohol of moderate drinkers by only 23 pence per week, but would decrease the consumption by underage and heavy drinkers by 7·3% and 10·3%, respectively. The estimated benefits would be a reduction of 100 000 hospital admissions per year in England and a decade's health saving of £1·37 billion.[8]

Most is at stake in developing countries, insidious change being highlighted by Casswell and Thamarangsi's case study of Thailand,[4] in which a traditionally low alcohol-consuming culture has been transformed with a 33-fold increase in consumption per person over 40 years into a country in which 8·1% of disability-adjusted life-years lost are attributed to alcohol. This transition has happened through permissive, indeed industry-friendly, governmental policies on production, marketing, and availability of alcohol.

So how do we help our politicians to increase their efforts and implement the effective and cost-effective policies described by Peter Anderson and colleagues?[9] In the UK, it took 40 years from the Royal College of Physicians calling for a ban on smoking in public places to governmental action, which is an indictment of our effectiveness as advocates.[10] The Royal College of Physicians has recently called together more than 25 non-governmental organisations with an interest in the health consequences of alcohol misuse to form the UK Alcohol Health Alliance.[11] It is too soon to claim success, but the benefits of agreeing policy priorities across a wide range of challenges has to be a good start. We need to replicate this sort of model within nations and across nations. The European Commission has set up an Alcohol and Health Forum,[12] which is a start but will need to prove rapidly that it is more than a platform for industry to flaunt its social responsibility credentials.



Science Photo Library

Liver cirrhosis

Today's call to action by Casswell and Thamarangsi sets the challenge to counter a leading cause of preventable premature death and a major factor in health inequalities, with a disproportionate burden in poor countries. A Framework Convention on Alcohol Control seems a long way off, but it will not happen at all unless health professionals speak out to give our governments the courage to adopt life-saving policies that tackle price, availability, and marketing of alcohol. This Series of three remarkable articles leaves no excuse for avoiding the issues—we must speak out.

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A case study in how harmful alcohol consumption can be

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In their analysis of the role of alcohol in Russian mortality in *The Lancet* today, David Zaridze and colleagues[1] provide a case study in how harmful to health widespread heavy drinking in a population can be. As dramatic as the results are, they are not an indicator of the total harm to the society, since they exclude many social problems from drinking and harm to people other than the drinker. The lesson has broader applicability than in eastern Europe and northern Asia alone, because many other societies—both industrialised and indigenous—have had periods with drinking patterns similar to those in Russia in the 1990s. Even in modern societies with well-developed health-care systems, pervasive heavy drinking can result in a public health crisis.

Reuters

Villager distils moonshine vodka in village of Negnevichi, Belarus

Zaridze and colleagues used a method similar to the classic US study of alcohol and mortality[2] that first noted a J-curve relation between alcohol consumption and total mortality, and that also established the importance of patterns of drinking. Zaridze combined death records, coded by ICD-10 (International Classification of Diseases and Related Health Problems 10th revision) between 1990 and 2001, inclusive, in three industrial cities, with interviews with family members about the amount and pattern of drinking of the decedent. 27 underlying causes of death that the investigators judged beforehand might be substantially affected by alcohol or tobacco use were compared with the aggregate of all other underlying causes of death to derive cause-specific relative risks for levels of alcohol exposure compared with the lowest level of drinking.

The study makes two main contributions. The first is to establish beyond reasonable doubt the important role of alcohol in the steep rise in mortality in Russia during the early 1990s, and a subsequent rise from 1999 to 2004. There has been general acceptance that alcohol had an important role in the fall in mortality after 1984 in the Soviet Union, because there were few factors other than the antialcohol campaign of 1985–88 to account for the change. However, among many other societal changes, the role of alcohol in the rise in mortality during the 1990s was not so clear.[3] Figure 2 in Zaridze and colleagues' study settles this issue, by showing how strongly the trends in overall mortality in the three cities during the 1990s were affected by deaths from causes strongly attributable to alcohol. The investigators argue, partly on the basis of their results and partly on