# International regulation of alcohol

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fracture who is willing to wear them most of the time.

The NHS has plans to increase the availability of measures to prevent injury that do not rely on the action or adherence of the older person.[8] However, the introduction of electronic surveillance into practice has been difficult because of organisational complexity and lack of efficacy and acceptability.[9] Devices that detect sudden changes in posture or provide continuous visual monitoring are technically feasible but have not been adequately tested in daily practice.[10 11] Automatic alarms and surveillance systems must be in action at all times and places, including the shower and toilet, and have a high sensitivity and low false alarm rate.

Impact absorbent floor coverings can reduce the impact of the fall without affecting stability,[12] but they need pragmatic testing in high risk settings. Testing will be expensive and require partnerships between commercial enterprises and research centres.

Fleming and colleagues' study should trigger an alarm. People over 90 and those with even subtle cognitive impairment are vulnerable. We can lower the risk of falling and of injury by developing plans for individuals. But in the longer term, we need collaborative research between health professionals, particularly rehabilitation staff, and the commercial sector.


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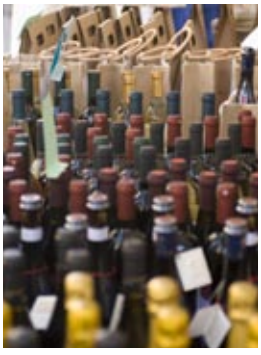
# International regulation of alcohol

## A framework convention is needed, as for tobacco control



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Cite this as: *BMJ* 2008;337:a2364
doi: 10.1136/bmj.a2364

The World Health Organization's Commission on Social Determinants of Health has just issued its main report,[1] which lays out an ambitious programme of actions to tackle health inequity. The commission notes the substantial contribution of alcohol to injury, disease, and death worldwide,[2] and it proposes that WHO and member nations should use the 2005 framework convention on tobacco control as a model for alcohol control. We agree that it is time to adopt such a framework.

The commission's work underscores the urgent need for international agreements that promote alcohol controls throughout the developing and developed world. Increasing affluence in the fastest developing regions of the world—East Asia, the Pacific region, and South Asia—has led to increased alcohol consumption, along with a higher burden of harm caused by alcohol. These increases foreshadow future trends in consumption and harm for other developing countries—such as those in Africa, Central America, and South America—if and when increased affluence makes them attractive untapped markets for global alcohol producers and distributors.[3 4]

In developed countries, alcohol is widely and readily available, and the real prices (minutes of work needed to buy one drink of alcohol) have decreased. Greater availability causes more health and social harm,[5] and the increase in availability seems to be associated with greater health inequity.[6 7] At the same time, the spread of free market ideology and intergovernmental trade agreements has undercut the ability of nation states to control alcohol related harms through controls on marketing, monopolies, and tax policies.[8] To counterbalance the globalisation of alcohol trade, we need international agreements that protect public health.

The irony is that we know more today than ever about which strategies can effectively control alcohol related harms.[5 9] But policymakers have been slow to put this knowledge into practice. Policies that tax alcohol and restrict its availability, marketing, and distribution—thereby reducing alcohol related harm—are strongly supported by evidence. Evidence that such policies can also reduce related health inequities is limited but growing.[7] Despite this knowledge, policymakers still rely mainly on public information campaigns and education programmes, most of which have been shown to be marginally effective.[5]

A framework convention for alcohol control would protect public health in three ways. Firstly, such a convention could place restraints on international trade in alcohol. Although most alcohol is consumed in its country of origin,[3] alcoholic drinks are still an important trade item. Current international trade agreements and dispute adjudications tend to treat alcohol like any other commodity. This ultimately

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**Competing interests:** None declared.
**Provenance and peer review:** Commissioned; not externally peer reviewed.

breaks down national and local controls on the alcohol market[10 11]—the very policies that can effectively promote public health. In a globalising world, one of the strongest arguments for international agreements is the need to control cross border trafficking of alcohol. A framework convention for alcohol "would provide an international community of support" for effective policies and could "add weight to the defence of such policies under trade disputes."[12]

Secondly, the adoption of a framework convention for alcohol control is likely to have persuasive effects across all levels of government and society. Most provisions in the current framework for tobacco are voluntary—countries signing up are urged to consider the measures but do not have to implement them. Nevertheless, such international treaties become calls to action and road maps to help legislators and governments to learn about and implement effective evidence based policies.[13]

Finally, framework conventions commonly become a base of operation for a secretariat and oversight committees charged with making the mechanisms and provisions of the convention more effective.[13] A secretariat for the convention could, for example, establish an international clearing house of information on evidence based approaches to alcohol control, thus providing an infrastructure for knowledge sharing between countries and regions.

Alcohol is the only strong psychoactive substance in common use that is not controlled internationally. Tobacco has the 2005 framework convention, plant based drugs have the 1961 single convention, and psychopharmaceuticals have the 1971 convention on psychotropic drugs. We now have sports doping conventions for psychoactive substances used as performance enhancers.[14] Yet the global health and social burdens attributable to alcohol are greater and affect the poorest populations and nations of the world disproportionately. The WHO commission's call to apply the model of the framework convention on tobacco control to control of alcohol is well founded and timely.

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# Global research for health

## Should tackle health needs and inform policy

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**Provenance and peer review:** Commissioned; not externally peer reviewed.

Cite this as: *BMJ* 2008;337:a2733
doi: 10.1136/bmj.a2733

Last week delegations from 59 governments, international agencies, and researchers met in Bamako, Mali, to discuss the state of global health research. It was an opportunity to review progress since their last meeting, four years earlier, in Mexico City, and to set an agenda for the future.[1] The meeting in Mexico is widely seen as a turning point, where the importance of research tackling the greatest health needs was emphasised, and where a strategy for meeting these needs was proposed.

Arguably, in a world with scarce resources efforts should be focused on where they can do most good. To make this happen, those attending the conference in Mexico advocated greater investment in research on health systems and policy, the development of national health research policies, and the incorporation of evidence into health policy.

The consensus is that some progress has been made since Mexico. Funding for health systems and policy research has increased, and some politicians now accept that evidence based policies are desirable.[2] Yet we still have much to do. The births, lives, and deaths of many of the world's population remain unrecorded.[3] Large scale programmes and healthcare reforms are still implemented without evaluation.[4] The reasons why they succeed or fail are often unknown. And large parts of the world are effectively untouched by health research.

One purpose of a meeting like this is to facilitate dialogue among groups of people who might not otherwise meet. In this it succeeded. Governmental delegations heard about the opportunities offered