

In addition, some donors who recommend the collection of mortality data as an outcome indicator have so far been unwilling to provide the funds necessary for such validations.

Retrospective assessment of mortality can be useful for documenting the severity of past conditions to advocate additional resources or to hold accountable those responsible for the excess mortality. The most important function of mortality monitoring, however, is to provide timely data that can be used to improve programmes that aim to prevent deaths in the immediate future. Checchi and Roberts correctly point out that prospective collection of mortality information is much better for this purpose. Mortality rates from prospectively collected data can provide much more recent estimates of mortality. Such mortality information can be collected in many ways, such as counting new graves in an arranged burial place, consulting religious leaders to whom deaths are reported, counting deaths by enlisting community

health-workers already hired for other tasks, or tracking materials distributed for burial ceremonies, such as shrouds, coffins, or extra rations for funeral feasts. These methods do not always pose excessive resource demands. They have been routinely recommended for many years,^{5,6} and have regularly been implemented in emergency relief. Because of the potential biases described by Checchi and Roberts, retrospective assessment should not be the first choice to measure mortality in emergencies. It should be reserved for situations in which no prospective data-collection system exists or mortality in the distant past is of primary concern. Public-health professionals charged with the care of populations in an emergency should always consider the implementation of a prospective mortality-reporting system as a high-priority component of emergency relief.

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I declare that I have no conflict of interest. The findings and conclusions in this Comment are mine and do not necessarily represent the views of the funding agency (the CDC).

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British livers and British alcohol policy

See *Articles* page 52 In today's *Lancet*, David Leon and Jim McCambridge¹ show that data which is routine can nevertheless be shocking. The UK used to be known to alcohol researchers for its relatively low rate of liver cirrhosis deaths. But Leon and McCambridge show that Great Britain has recorded the steepest rise in rates in western Europe. By the turn of the millennium, the rates in England and Wales had reached the middle of the European pack; those in Scotland were approaching the

top position. Recent newspaper reports suggest the rise is accelerating.² Leon and McCambridge's table 1 shows about a 21% rise in the 1990s, while the mortality figures for 2004 show an 18% rise in deaths from alcohol-related diseases (mainly cirrhosis) just since 2000.³

While beverage type, as mentioned in the paper, and pattern of drinking^{3–6} might both affect the risk of developing cirrhosis, there is no doubt that the

cumulative amount of alcohol consumed has a primary role. But the UK Government has turned a determined blind eye to the problem and has failed to make the reduction of the population's alcohol intake a policy goal. Through the new alcohol licensing law and the official guidance on it, the national government has also done its best to tie the hands of local government on this issue. Thus the new licensing law for England and Wales rules out public health as a goal of licensing; as the official guidance on the law says,

"there is no power for the licensing authority to attach a condition [to the license] which is merely aspirational . . . For instance, conditions may not be attached which relate solely to the health of the customers rather than their direct physical safety".⁷

This official insouciance is aided by the paucity of the evidence base for alcohol policy in the UK. Leon and McCambridge mention the problem of "the absence of high-quality alcohol consumption data, particularly on a regional and national basis". Not only are there no regional alcohol sales statistics, there is also no credible estimate of the unrecorded alcohol being imported from across the Channel; responses on travellers' imports in a population survey commissioned from Sweden⁸ gave an amount larger than official estimates of the total of untaxed alcohol, including large-scale smuggling as well as travellers' imports.⁹ UK drinking surveys have, until recently, been unsuited to reporting on binge drinking, which meant that the analytical report underlying the alcohol strategy for England¹⁰ relied on figures from the same Swedish study.¹¹ In the well-developed international literature studying the impacts of alcohol policies,¹² UK studies are conspicuously rare. Despite promises to the contrary, there is still no provision by the Government for studies to evaluate the effects of the new licensing law.

Leon and McCambridge's troubling findings suggest it is now time for a change of approach. The goal of improving public health should not be "merely aspirational". One starting-point would be for the UK Government to get serious about funding policy-relevant alcohol research. Australia, Canada, and the USA, among others, have government-funded centres that focus on social, epidemiological, and policy research on alcohol; the UK does not. With such centres and other research funding, an evidence base for policy can be built. Evidence-based practice could

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become, as it was once before,¹³ the watchword for alcohol policy in the UK.

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I declare that I have no conflict of interest.

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