and Human Services for bioterrorism preparedness, part of over $1bn in nationwide funding announced in 2002.[8] Similarly, North Dakota's Governor Hoeven announced $300 000 in funding for preventing heart disease and stroke[9]; this can be compared with the $7m designated for bioterrorism preparedness in the state. Owing to funding for prevention of bioterrorism, state health departments increased by 132% the number of staff in epidemiology to work on preparedness for infectious disease and terrorism between 2001 and 2003.[8] But with this increase in funding came additional mandates related to bioterrorism, with 66% of health departments struggling to allocate time for general planning and 55% having problems establishing even basic systems for disease surveillance.[6]

More recently (in March 2005), the *New York Times* said surveillance for anthrax "rattled the stock market [and] set the White House on alert."[10] A subsequent article reported that congressional auditors had found that FBI funds designated for investigating fraud in health care seemed to have been improperly shifted to other purposes, including fighting terrorism, over the past three years.[11] In defence, Joseph L Ford, the FBI's chief financial officer, said the attacks of 11 September 2001 "demanded an instant, 100 percent commitment toward counterterrorism."[11]

The responses to the perceived importance of the threat go even further. For example, the Pentagon has proposed that it should be exempted from aspects of the clean air and hazardous waste recovery acts, including capping its "legal liability for cleaning up polluted sites once it sells land to a new owner, and allowing military areas that do not meet national air standards to remain that way for an additional three years."[12] And Associated Press reported that 34 of the military bases that have been shut down since 1988 are on the Environmental Protection Agency's superfund list of worst toxic waste sites (most of them have been on the list for at least 15 years) and none are completely cleaned.[13]

These observations are not intended to diminish the tragedies of 11 September 2001 or 7 July 2005 or other terrorist actions or catastrophes, nor to negate the importance of developing effective and humane ways of making sure such tragedies are not repeated. Nor do I intend to suggest that all the blame for catastrophic or everyday events should be attributed to any government, or that any quantity of redirected funds could completely erase these events. It is certainly justifiable for governments to appropriate substantial funds to prevent potential future threats to our security. But public funding for current threats should not be compromised. Predictable tragedies happen every day. We know strategies to reduce deaths from tobacco, alcohol, poor diet, unintentional injuries, and other predictable causes. And we know that millions of people will die unless we protect the population against these routine causes of death.

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British drinking: a suitable case for treatment?

Cut tax on low alcohol drinks, curb drink driving, and offer brief interventions

Papers pp 541, 544

The rising consumption of alcohol per capita in Britain over the past 20 years has produced large increases in the prevalence of alcoholic cirrhosis, alcohol related violence, and heavy alcohol use, costing the British economy around £30bn ($55bn; €44bn) a year.[1] About 7.5% of men and 2.1% of women in Britain are dependent on alcohol, among the highest rates in the European Union.[2]

Two papers in this issue show that two relatively brief psychosocial interventions—motivational enhancement treatment and social network therapy—are effective and cost effective in treating alcohol dependence, when delivered under routine clinical conditions in the NHS.[3 4] The UK government could realise its stated aim of increasing access to effective treatments for alcohol dependence by investing in these interventions.

BMJ 2005;331:527–8

Britain also urgently needs to reduce the high rates of high risk drinking that produce dependence, health problems, and public disorder. Epidemiologists see the key drivers of rising consumption as the reduced price of alcohol, its increased availability, and its extensive promotion in British cities.[5 6] These changes have resulted from the enthusiasm for deregulation that is shared by governments in most developed countries, now treating alcohol like any other commodity.

The UK government's new alcohol policy,[1] which includes "partnership" with the alcohol industry, shows all the hallmarks of regulatory capture[6] in that it embraces the industry's diagnosis and preferred remedies for the "alcohol problem." The problem, in the industry's view, is a "minority" of drinkers who engage in antisocial behaviour and put their health at

risk; the preferred remedies are public education about safe drinking, improved policing, better treatment for alcohol problems, and self regulation by the alcohol industry—the policies which evidence suggests are the least likely to reduce problem drinking.[5–7]

The UK government has foregone the use of the most effective policy to reduce hazardous drinking: using taxation to increase the price of the beverages containing the highest concentrations of alcohol.[5] It justifies this decision by saying that increased price has not been shown definitely to reduce harm due to alcohol,[1] an assertion at odds with the views of the world's leading researchers on alcohol.[5 8]

The government has also rejected any policies that would reduce the availability of alcohol. Instead, it embraces the paradoxical idea that allowing drinking for up to 24 hours a day for seven days a week will reduce binge drinking and public disorder. It believes that, somehow, longer trading hours will help to create a continental drinking culture in Britain. This proposal has caused understandable consternation among British judges, police, the Royal College of Physicians, medical researchers, and alcohol experts.[8–10]

Experience in Australia suggests that even a government bent on deregulation could do better.[7] Over the past two decades Australia has expanded alcohol availability, liberalised trading hours, and not increased overall taxation on alcohol. In 1980-2000 in the United Kingdom per capita alcohol consumption increased by 31%, but in Australia it fell by 24%—as did many of the indicators of alcohol related harm that increased so steeply in the United Kingdom.[7]

Australia has imposed lower taxes on low alcohol (less than 3.8%) beer than full strength beer. Also, all states defined drink driving as driving with a blood alcohol concentration over 0.05% (rather than 0.08% as in the United Kingdom). Drink driving laws have also been enforced vigorously by well publicised, large scale random breath testing in the largest states. The immediate and sustained reduction in deaths and serious injuries from road crashes that followed the introduction of random breath testing in the largest Australian state ensured strong public support for continuing the policy.[11] Low alcohol beer now accounts for 40% of all beer consumed in Australia.[7]

The UK government could avoid the worsening epidemic of public drunkenness by not increasing alcohol availability, by lowering taxes on beverages with lower alcohol concentrations, and by reducing the limit for blood alcohol when driving to 0.05%.

If the UK government remains deaf to the arguments of its critics, it should honour its promise to evaluate the effects of its policies. Then it would have the necessary evidence to drop policies that have failed and replace them with policies that have a chance of reducing (rather than merely preventing further rises in) alcohol related harm.

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Regulating the drugs industry transparently

The UK government has not gone far enough in responding to a critical inquiry

Over the past 10-15 years, drug regulatory authorities in the United Kingdom and elsewhere have streamlined and accelerated the review of new drugs in response to claims by the pharmaceutical industry that over-regulation was stifling innovation.[1 2] Despite these policies, the number of new molecular entities—a standard measure of innovation in the industry—submitted to regulatory authorities in the European Union or United States or launched on the world market has fallen overall during the past decade.[3–5]

Between 1993 and 2004, almost double the number of drugs were withdrawn from the market in the United Kingdom each year due to lack of safety than in the previous two decades.[6] The withdrawal of rofecoxib in 2004, affecting millions of patients, remains an enormous public health issue, as do public concerns about the safety of the widely prescribed selective serotonin reuptake inhibitors.[7 8]

In this context the House of Commons Health Select Committee began its wide ranging inquiry into the influence of the pharmaceutical industry, publishing its findings on 5 April 2005.[9] Although the committee acknowledged that the industry makes excellent contributions to medicine and the UK economy, the report also highlighted important concerns about the independence of drug regulation from the interests of the industry; the need to create conditions in which the industry will produce more drugs offering significant therapeutic advance; the industry's over-promotion of its products to doctors; our limited knowledge of drug induced illness; and the cloak of secrecy around UK regulation during the past

BMJ 2005;331:528–9