Reducing alcohol related liver disease burden – it is time for political action
EASL Policy Statement on ALD

Executive Summary

Aim: The aim of this European Association for the Study of the Liver (EASL) policy statement is to inform policy makers of the health and economic burden that alcohol-related liver disease (ARLD) morbidity and mortality impose on society, and to define effective policies to reduce harmful alcohol consumption and related disease burden.

Main message: Alcohol-related Liver Disease is the major cause of liver disease in Europe, and since it depends mostly on harmful alcohol consumption, it is a preventable disease. It has been well demonstrated that several alcohol-related policies are both effective and cost-effective. Effective interventions include price-based policies, such as taxation and minimum unit pricing, restricting alcohol availability and marketing/advertising. Policies based on age-related vulnerability such as restrictions on alcohol access for young people are also effective.

Key messages

EASL recommends that all European countries:

- Introduce and implement a national alcohol strategy including rules on the commercialization and consumption of alcohol products, covering pricing, labelling and advertising.

- Adopt the EASL guidelines on Alcohol-Related Liver Disease [1], which recommend the implementation of population-level strategies such as raising prices on alcohol through excise taxes and pricing policies. They also recommend limiting the availability of alcohol, with restrictions on marketing and advertising. Brief clinical interventions should also be implemented as these have been shown to be effective in reducing alcohol consumption in a range of settings, most notably in primary care. Screening of patients with ARLD for cirrhosis should be performed in high-risk populations, such as those in alcohol rehabilitation clinics, or high-risk drinkers identified by their General Practitioner, using appropriate non-invasive tests.

Problem statement

According to the Global Burden of Disease, , 1,256,900 deaths occurred worldwide due to liver disease in 2016, of which 334,900 (27%) were attributable to alcohol.[2] Additionally, 245,000 liver cancer deaths were associated with alcohol intake (30% of all liver cancers deaths). In Europe, from the 35 countries included in the HEPAHEALTH report there were 38,378 deaths in the last year available (2012-2015) that were coded as alcohol related liver disease [3]. Liver disease accounts for significant health and economic losses, as two-thirds of potential years of life lost are working years

[4], which contrasts with other chronic diseases where onset and death generally occur at a later age.[4] Furthermore, of these 35 European countries 32 have experienced increasing prevalence in the levels of cirrhosis since 1990 [4].

Mortality from ALD is substantially greater for disadvantaged socio-economic classes, particularly for younger patients, resulting in major health inequalities.[5] Liver mortality is largely determined by population alcohol consumption,[6] with a direct correlation seen between overall alcohol consumption and liver mortality in 21 of 28 European Union (EU) member states[8]. Notably, the relationship between alcohol intake and cirrhosis is exponential for heavy drinkers.[7] Whilst binge drinking, as defined by drinking four drinks for women and five for men over a 2 hour period, is of concern, there are no robust data to suggest a disproportionate risk of developing ARLD.[9]

Societal factors affecting population level alcohol consumption have a large impact on liver mortality – with four fold reductions in France and Italy seen during a period of decreased consumption of cheap wine.[8] Marked increases in liver mortality have been also associated with modest increases in overall alcohol consumption, as seen in the UK when drinking patterns changed from weak beer consumed in public houses to the consumption of cheap stronger alcohol at home.[10,11] Effective policies to reduce alcohol consumption may reduce liver mortality quickly, as patients with ARLD usually die from acute-on-chronic liver failure driven by recent excessive alcohol consumption.[12] In Finland, rapid substantial increases in liver mortality occurred when Estonia joined the EU and import controls were relaxed, leading to an influx of cheap alcohol. A subsequent increase in taxation on alcohol and changes in alcohol availability curtailed the increased consumption seen and also reduced liver mortality.[8]

Minimum unit pricing (MUP) is perhaps the most studied policy as a result of legal challenges by the drinks industry. The Court of Justice of the European Union and the UK Supreme Court judged the policy to be more effective than comparable measures, as it was highly targeted at harmful and extreme drinkers, and was likely to reduce health inequality.[13–16] In the UK, over one third of alcohol is consumed by 4.4% of the population, i.e. high risk or extreme drinkers, where almost all alcohol-related morbidity and mortality is found.[10] In British Columbia, MUP reduced alcohol-related mortality by 32% within one year of implementation.[17] In May 2018, MUP was implemented in Scotland and a wide-ranging and thorough evaluation of the impact of the policy by the Scottish Government is awaited.

Alcohol is the most dangerous commodity marketed in Europe, second only to tobacco, whose marketing is more heavily regulated.[18]. Alcohol advertising has been regulated at EU level since 1989 (Television without Frontiers Directive and from 2007 Audio-visual Media Services Directive) describing the minimum standard for advertising in the EU. All Member States have regulations on alcohol marketing, however, the restrictions range from none (Belgium, Greece, Slovakia) to mainly self regulation (Austria, Cyprus, Denmark, Germany, Ireland, UK) to strict regulations (Estonia, France, Iceland, Norway, Sweden) across all media types and according to beer/wine/spirit.[19] There is a positive association between exposure to marketing and subsequent drinking behaviour and/or harmful consequences of drinking.[18] A systematic review of longitudinal studies, found an association between youth exposure to alcohol marketing and drinking behaviour.[20] Digital marketing may be particularly attractive to young people and more difficult to regulate.[21] The

European Commission concluded that marketing leads children to drink at an earlier age and drink more.[22] In general, alcohol marketing causes more harm to vulnerable populations, including children, adolescents, and those with alcohol dependence.[23]

We recommend that countries should move towards a comprehensive ban on alcohol advertising, promotion and sponsorship. Self-regulation by the alcohol industry is not effective, and regulations should be statutory.[18], as there is strong evidence that the alcohol industry has been successful in preventing implementation of effective policies, and in circulating misleading information to the public. Evidence suggests the control of alcohol marketing must be the responsibility of governments, independent of the alcohol industry, monitored by governments and civil society interested in Public Health.[18]

Around 75% of fatal cases present for the first time with an emergency hospital admission with end-stage or terminal liver disease [29], underlining the importance of early identification of patients with ARLD. The majority of individuals with ALD have normal liver tests [30]. therefore, early identification is reliant on the identification of at-risk groups. Screening for alcohol misuse followed by brief interventions is effective at addressing hazardous and harmful drinking in the emergency department and primary care [31–34], with numbers needed to treat being between 1:8 and 1:12.[33] Technological advances in the non-invasive assessment of liver fibrosis mean primary care could now diagnose liver disease in its early stages, and being informed of this diagnosis is potentially a highly effective intervention.[32,35,36]

While health labels on alcoholic drinks have shown little impact on behaviour, this may reflect the fact these have generally been small text warnings without rotation of messages, [37] as larger, more graphic labels have been shown to be highly effective in reducing tobacco sales.[38] It is also a consumer right to receive information about adverse health effects from foodstuffs, yet alcohol is exempt from this regulation, despite being a level one carcinogen. This is a reflection of lobbying by the drinks industry in the EU Parliament to exclude alcohol from nutrition labelling.

Recommendations

EASL suggests a National Alcohol Program to be implemented in each EU country that should include:

- Increase the price of alcohol through increases in excise taxes and other pricing policies.
- Consider a minimum price per alcohol gram, such that the minimum price of sale of an alcohol product (C) is calculated by multiplying the minimum price for alcohol per gram (A) with the amount in grams of the alcohol product (B): A x B=C. As an example in Scotland this price was set on 50 pence, but it can be different in each country.
- Excise taxes and minimum unit price should be regularly reviewed and revised upwards appropriately according to inflation and the observed effects on the rate of alcohol consumption and alcohol-related harms.

Labelling of alcohol products and notices in licensed premises

Implement mandatory labelling of the alcohol products, including:

- Health information aiming to inform the public of the risks of alcohol consumption, including cancer and risks consumption during pregnancy.

- Information regarding the caloric value expressed in Kilojoules and Kilocalories

Regulation of advertising and sponsorship of alcohol products

- Effective legislation to protect children and young people from the deleterious effects of alcohol marketing, good examples being France, Estonia, the Nordic Countries, Lithuania and the proposed new law in Ireland.
- Including:
    - Regulating sponsorship activities that promote alcoholic beverages
    - Restricting or banning promotions in connection with activities targeting young people
    - Regulating new forms of alcohol marketing techniques, for instance social media
- The above should be monitored by public health bodies who will uphold consistent enforcement and accountability. Self-regulation by the alcohol industry is not an appropriate tool to address alcohol marketing.

Structural separation of alcohol products in mixed trading outlets

- The obligation for mixed trade retailers to display and advertise alcohol products, in a separate area in a shop and/or behind the counter in a closed storage unit

Improved data reporting and recording, assessing policy effectiveness

- The introduction of standardised case-definitions, which should include the aetiology of liver disease. This could be achieved using 4 digit ICD-11 codes for liver disease. This is a major problem in countries where private medicine is common as insurance companies punish policyholders when they are labelled with a diagnosis of ARLD.

Personal interventions

- The introduction of screening for harmful alcohol consumption and the delivery of effective brief interventions in primary care, alcohol/addiction services, emergency departments, prisons, police custody, mental health services, sexual health services and other community settings
- Individuals who need support for alcohol problems should be referred to specialist alcohol services for comprehensive assessment and appropriate treatment
- The provision of non-invasive diagnostic tools in primary healthcare settings to detect liver fibrosis in the community

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