04/08/2017

Alcohol Focus
SCOTLAND

RESPONSE TO OFFICE FOR NATIONAL STATISTICS CONSULTATION ON ALCOHOL MORTALITY DEFINITION REVIEW

1. What is the relative value to users of statistics of more comparable definitions of alcohol-related harm across government, versus a longer comparable time series?

Levels of and trends in alcohol related harm are important issues for national and local governments, for health organisations and for the public. Mortality rates are among the best indicators of wider alcohol harm and these have been influential in the development of policy responses in Scotland and the UK, particularly over the past 10 years. International and UK country comparisons are widely cited.

Longer comparable time series data is useful in demonstrating long term trends in alcohol-related harm, which enables patterns of harm to be detected, such as the alcohol 'epidemic' experienced by Scotland from the 1990s. These trends are important in establishing what the drivers of change may be over the long term.

However, we believe that the establishment of a comparable definition of alcohol-related mortality across the UK is a priority. Comparable definitions of alcohol-related harm would enable governments, public health agencies and researchers to effectively evaluate the impact of alcohol policy on public health across different parts of the UK, as well as allowing for international comparison.

Comparable definitions also present an opportunity to ensure clarity and consistency in the use of key terms by all agencies across the UK. For example, 'alcohol-related mortality' is used by the ONS in reference to a limited range of deaths caused by alcohol, whereas Public Health England (PHE) use the same term to describe "all diseases where there is evidence that alcohol plays a contributory part in all or a proportion of deaths."[1]

Furthermore, PHE uses these terms to differentiate between primary and secondary alcohol-related admissions, a completely different usage than that of ONS, which is between deaths that are wholly and partially attributable to alcohol. This is a source of potential confusion. We would suggest that, over the course of this work, the specific terms used to describe both a 'narrow' and a 'wide' measure are agreed across the UK, aligned with international best practice.

2. What are the relative merits of the current National Statistics definition, the Public Health England (PHE) narrow definition and the PHE wide definition?

The current National Statistics (NS) definition benefits from a longer time series, allowing comparable monitoring of alcohol mortality over time and across countries in the UK. This is particularly important for Scotland due to the substantial increase in alcohol mortality which started in the early 1990s. Most significantly, continuing with this definition would prevent any confusion or belief that alcohol-related deaths have suddenly fallen, which could limit the action on tackling alcohol-related harm that policy-makers take.

Another merit of the current NS definition is that, unlike the PHE narrow definition, it includes all deaths with an underlying cause of fibrosis and cirrhosis of the liver. Whereas the ONS suggests that this is a limitation of the current definition, we believe that it is important that a narrow definition continues to include these categories – we explain our reasons in our response to question 3.

The PHE narrow definition benefits from the inclusion of a number of wholly attributable causes of death not covered by the current NS definition, including alcohol-induced pseudo-Cushing's syndrome (E24.4); alcoholic myopathy (G72.1); alcohol-induced chronic pancreatitis (K85.2); fetal induced alcohol syndrome (dysmorphic) (Q86.0); and excess alcohol blood levels (R78.0). As these causes of death are wholly attributable to alcohol, there seems to be no justification for their exclusion from the NS definition, and the ONS is right in proposing to include these causes of death in its revised definition (option 3).

In addition, the PHE narrow definition includes causes of death which the public would reasonably assume are related to alcohol. For example, a driver over the legal limit who dies in a single vehicle accident would reasonably be considered by the public to be a death related to alcohol.

The PHE wide definition benefits from its use of alcohol attributable fractions, meaning it is not forced to exclude certain disease categories on the basis that not all deaths in these categories are due to alcohol. This means that diseases such as certain cancers, where we know that a proportion is caused by alcohol, can be recorded as the cause of death.

Overall, the PHE wide definition provides governments and public health agencies with a 'truer' picture of the numbers dying as a result of alcohol. Effective policies to tackle mortality rates are more likely to follow when governments and public health agencies have this fuller picture.

3. Should the National Statistics definition of alcohol-related deaths be kept as it is (option 1), replaced with the PHE definition (option 2), replaced with the proposed definition of alcohol-specific deaths (option 3), or changed in some other way?

We do not believe any of the main 3 options are optimal.

We are concerned that the proposed definition (option 3) would lead to a misleading reduction in the number of recorded deaths due to alcohol, as it would remove deaths caused by cirrhosis and fibrosis where a specific alcohol diagnosis has not been made.

Liver medicine specialists note that many people with alcohol-related liver disease will not have undergone a full assessment including an accurate diagnosis in their lifetime. This means that, whereas the ONS's consultation document states that up to a third of cirrhosis cases may not be alcohol-related, this may be inaccurate. While the consultation states that cirrhosis due to obesity and hepatitis is increasing, alcohol remains the cause of the considerable majority of unspecified fatal liver disease (K73 and K74) in the UK.

There has not been a recent UK study of cirrhosis and fibrosis deaths and there is a need for further research on the number and proportion of these deaths due to alcohol before a decision can be taken to exclude these categories. We would recommend that the ONS and/or public health agencies (e.g. PHE) commission work to provide reliable data on attributable fractions for categories K73 and 74. This research would be cheap and easy to do via a few representative liver centres, but would be incredibly important.

It is especially important to get this aspect of the definition right because removing these categories would have a dramatic impact on the numbers of alcohol-related deaths. In Scotland and Northern Ireland, this would result in a 9% decrease in the number of alcohol-related deaths, and in England and Wales a decrease of 22%.[2] Such a decrease may result in confusion or provide a misleading

indication that alcohol-related deaths have suddenly fallen, which could have negative consequences for action on tackling alcohol-related harm.

For consistency, we believe that other conditions such as oesophageal varices and portal hypertension, which have a similarly high alcohol-attributable fraction[3], should be considered for inclusion in the NS definition.

Aside from the issue of cirrhosis and fibrosis deaths, the NS definition does need to include alcohol-induced pseudo-Cushing's syndrome (E24.4); alcoholic myopathy (G72.1); alcohol-induced chronic pancreatitis (K85.2); fetal induced alcohol syndrome (dysmorphic) (Q86.0); and excess alcohol blood levels (R78.0). We support this aspect of option 3.

Any narrow definition will not measure the full burden of alcohol mortality and therefore should be complemented by a wide definition.

4. Should the National Statistics definition include both narrow (alcohol-specific) and wide (alcohol-related or alcohol-attributable) options?

There is a need for both a narrow and a broad measure, but it is not necessary for both measures to be reported by the ONS. It is appropriate for ONS to take on the task of a reliable narrow measure which allows for monitoring of trends across time, in different parts of the UK and, as much as possible, international comparisons.

The broad measure is complex because the alcohol-attributable fractions change with time and place. The task of estimating the broad measure sits best with public health bodies such as Public Health England and the Scottish Public Health Observatory. Consensus should be reached on which conditions to include and the most appropriate methodology.

Work is underway to update Alcohol Attributable Fractions as part of the Scottish Burden of Disease study[4], with reporting expected in 2017.

5. Do you have any other comments on indicators of alcohol-related deaths or related issues?

We welcome the opportunity to respond to this consultation – we believe it is important to have a comparable definition of alcohol mortality across the UK.

We understand the need for a narrow definition consisting of data which can be swiftly collected and published, and which does not need to be combined with calculations of alcohol-attributable fractions. However, a wide definition is equally important as it provides a 'truer' picture of mortality attributable to alcohol. We believe that, when the ONS releases annual figures on alcohol mortality, it should be clear in stating that its figures are based on a narrow definition, and that it should provide clear links to mortality figures calculated on the basis of the wide measure.

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[1] Office for National Statistics (2017), *Alcohol mortality definition review,* Office for National Statistics, p.4
[2] Office for National Statistics (2017), op cit pp.11-12.
[3] Grant, I., Springbett, A. and Graham, L. (2009) *Alcohol attributable mortality and morbidity: Alcohol population attributable fractions for Scotland*. Online: NSS ISD.
[4] See http://www.scotpho.org.uk/comparative-health/burden-of-disease/overview