

PRESS RELEASE

Reducing the burden of alcoholic disease: expert calls for immediate global action

(Barcelona, 25 October 2010) According to the World Health Organization (WHO), alcohol consumption is responsible for 3.2% of global mortality and about 4% of years of life lost prematurely. The situation is even worse when Europe is considered alone, with 4% of global mortality and 7.9% of years of life lost prematurely attributable to alcoholic diseases. Speaking at the 18th United European Gastroenterology Week (UEGW) in Barcelona, Professor Helena Cortez-Pinto from the Hospital of Santa Maria in Lisbon called for the immediate implementation of more forceful measures to combat the increasing burden of alcohol misuse, saying, “It is time we applied similar strategies to those used to control tobacco misuse. There should be regulation of all alcohol promotion, sponsorship should be banned, and there should be far stricter surveillance on drink-driving.”

Europe is labouring under burden of alcohol-related harm

Disability Adjusted Life Years (DALYs) is a measure used by the WHO to evaluate the burden of a disease. It is calculated as the sum of the years of life lost due to premature mortality in the population, plus the years lived with disability for incident cases of the disease. Using this measure, it has been estimated that Europe has the highest alcohol-attributable DALYs, accounting for 11.6% of all DALYs (s. reference No.7).

“We have recently evaluated the burden and costs of alcohol-related harm in Portugal,” explained Prof. Cortez-Pinto. “We found that liver disease represented the main source of burden attributable to alcohol, accounting for 31.5% of total DALYs. This was far higher than road traffic accidents and even several types of cancer.”

Alcohol and liver disease: the facts speak for themselves

The importance of alcohol as a cause of liver disease is confirmed by data from the European liver transplantation registry showing that alcohol is responsible for one third of cases of cirrhosis leading to liver transplantation, and it is the second most common cause of liver transplantation. There is a strong correlation between alcohol consumption and mortality from liver cirrhosis, with several examples from history illustrating that fluctuations in alcohol availability and consumption lead to corresponding fluctuations in the incidence of liver cirrhosis.

“In Paris during World War II, for example, an 80% reduction in alcohol consumption occurred,” said Prof. Cortez-Pinto. “The effect on cirrhosis mortality was spectacular, with mortality reduced by more than 50% after 1 year, and more than 80% over 5 years. More recent studies in Europe have corroborated this finding.” Nevertheless, it is difficult to define precisely how much alcohol you can

drink. There is a large variation in the noxious effects of alcohol among the population, probably related to genetic predisposition. A suggested “safe” limit of alcohol intake has been 21 units per week in men and 14 units per week in women who have no other chronic liver disease (where a unit is defined as the equivalent of 8g of ethanol). However, other data suggest that less alcohol than this may be toxic in women, implying a lower threshold of no more than 7 units per week may be more appropriate.

How effective are harm-reduction policies and programmes?

Many policies and programmes have been developed in an attempt to reduce harm caused by alcohol. Information and educational interventions are inexpensive, but several systematic reviews have demonstrated that these interventions do not notably affect consumption levels or health outcomes. On the other hand, according to Prof. Cortez-Pinto, drink-driving policies seem to be particularly effective, especially if they are well implemented and rigorously enforced.

“Reducing the availability of alcohol seems to be one of the most effective measures,” she told journalists. “In fact, laws that set a minimum age for the purchase of alcohol show clear reduction in drink-driving casualties and other alcohol-related harm. Reducing the hours or days of sale also leads to fewer alcohol-related problems.”

Prof. Cortez-Pinto believes that alcohol marketing and pricing levels are of major importance if alcohol-related harm is to be reduced. “We know from longitudinal studies that exposure to alcohol advertising has an effect on the initiation of drinking in the young and on riskier patterns of youth drinking,” she said. “We also know that there is a strong inverse correlation between alcohol price and consumption: increasing alcohol taxes reduces alcohol consumption and related harm and increases government revenues.”

However, alcohol policies have been shown to fail, and probably the major reasons for this relate to a power imbalance between industry and health groups. According to Prof. Cortez-Pinto, alcohol producers are well organised and effective lobbyists for industry-friendly policies both nationally and internationally. She believes their major focus is to campaign *against effective strategies* and *for ineffective strategies*, and that they tend to fund *responsible drinking campaigns* that are strategically ambiguous and create networks that are active in the alcohol policy arena – spending millions of dollars on political and social donations in order to influence law making.

“I believe there is now a need to create forceful measures, including the regulation of all marketing, bans on sponsorship, and the implementation and strict surveillance of drink-driving laws,” she said. “I think it would be useful to have a Framework Convention for Alcohol Control, with support and pressure from a few committed countries, underpinned by a strong global network of non-governmental organisations. “These NGOs need to strengthen their international presence and learn from the tobacco-control arena,” she concluded.

REFERENCES

1. Anderson P, Chisholm D, Fuhr DC. Effectiveness and cost-effectiveness of policies and programmes to reduce the harm caused by alcohol. *Lancet* 2009;373:2234-46.
2. Welch C, Harrison D, Short A, Rowan K. The increasing burden of alcoholic liver disease on United Kingdom critical care units: secondary analysis of a high quality clinical database. *Journal of Health Services Research & Policy* 2008;13 Suppl 2:40-4.
3. Gilmore I. Action needed to tackle a global drink problem. *Lancet* 2009;373:2174-6.
4. Casswell S, Thamarangsi T. Reducing harm from alcohol: call to action. *Lancet* 2009;373:2247-57.
5. Cortez-Pinto H, Gouveia M, Pinheiro L, Costa J, Borges M, Carneiro AV. The Burden of Disease and the Cost of Illness Attributable to Alcohol Drinking—Results of a National Study. *ACER* 2010; 34:1442-9
6. Zatonski WA, Sulkowska U, Manczuk M, et al. Liver cirrhosis mortality in Europe, with special attention to Central and Eastern Europe. *European Addiction Research* 2010;16:193-201.(1)
7. Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y, Patra J. Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. *Lancet* 2009;373:2223-33.

Press contact

impressum health & science communication
Katharina Kegel
Adenauerallee 10
20097 Hamburg, Germany
E-mail: kegel@impressum.de
Tel.: +49 (0)40 – 31 78 64 10
Fax: +49 (0)40 – 31 78 64 64



UEGF Secretariat
UEGF Public Affairs
Committee
E-mail: office@uegf.org
Internet: www.uegf.org