UK Health Forum Response to the Office for National Statistics
Alcohol mortality definition review

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About the UK Health Forum

The UK Health Forum (UKHF), a registered charity, is both a UK forum and an international centre for the prevention of non-communicable diseases (NCDs) including coronary heart disease, stroke, cancer, diabetes, chronic kidney disease and dementia. We focus on up-stream measures targeted at the four shared modifiable risk factors of poor nutrition, physical inactivity, tobacco use and alcohol misuse by developing evidence-based public health policy. We support policy implementation through advocacy, modelling and information provision to assist action by government, the public sector and commercial operators.

As a charitable alliance of 80 professional and public interest organisations working to reduce the risk of avoidable non-communicable diseases, the UKHF is uniquely placed to develop and promote consensus-based healthy public policy and to coordinate public health advocacy.
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UKHF welcomes the opportunity to respond to the Office for National Statistics Alcohol mortality definition review. We fully support the detailed response to this consultation by the Alcohol Health Alliance and have answered those questions which align with our areas of interest and expertise.

In summary we propose:

- A national alcohol mortality definition which allows comparison across the four nations of the UK and preferably, internationally.
- A consensus is drawn on common and comparable mortality definitions, guided by Public Health bodies within the four nations, including conditions with alcohol related attributes (wider measures).
- The ONS measure should continue to include conditions such as fibrosis and cirrhosis of the liver so as to avoid a misleading reduction in the number of recorded deaths due to alcohol.
- Adoption of the forthcoming International Classification of Disease -11th Revision (ICD-11) standards in order to facilitate international comparisons, and support monitoring needs such as those of the Sustainable Development Goals, as well as multiple data needs in health systems.

Answers to questions

Question 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?
Please explain your answer as far as possible with reference to specific public health, government policy and/or scientific needs for the information.

Comparable definitions of alcohol-related harm and long, comparable time series data are both important. However, at the present time, we would see the establishment of a comparable definition of alcohol-related mortality across the UK as being a priority. Comparable definitions of alcohol-related mortality would enable governments, public health agencies and researchers to evaluate more effectively, the impact on mortality of differing alcohol policies in different parts of the UK. Where possible, definitions used in the UK should also line up with international standards of best practice. Finally, it is important that the terms used by different agencies across the UK are identical and used to refer to the same thing. For example, 'alcohol related mortality' is used by the ONS in reference to a limited range of alcohol-caused deaths, whereas PHE uses the same term to

describe ‘all diseases where there is evidence that alcohol plays a contributory part in all or a proportion of deaths’ (quoted from page 4 of the ONS consultation document).

Furthermore, PHE uses the terms ‘narrow’ and ‘wide’ to differentiate between primary and secondary alcohol related admissions, a completely different usage to that between 100% and partially attributable mortality used by the ONS, 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. It may be easier to decide on the specific wording of the narrow and wide measures once final decisions have been made about which disease categories will be included within each measure.

Question 2: What are the relative merits of the current National Statistics definition, the Public Health England (PHE) narrow definition and the PHE wide definition?
Please explain your answer as far as possible with reference to specific public health, government policy and/or scientific needs for the information, and/or particular issues of statistical methodology.

The current National Statistics (NS) definition benefits from a longer time series, and 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); foetal 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 proposed 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. This type of death is included in the PHE narrow definition, but not in the proposed NS definition.
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. It is important to note that wider definitions should have a weighting attached, related to each condition's population attributable mortality.

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.

Question 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?

Please support your answer as far as possible with reference to expert opinion, epidemiological studies or other evidence. If appropriate, please state the specific ICD-10 codes you would prefer to be included or excluded, with reasons.

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 74) 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 amount 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, and could be done in a few representative liver centres, but would be incredibly important. Liaising with International agencies could be useful, for example the European Association for the Study of the Liver (EASL). UK specific fractions could be used to inform nationally, given variations in alcoholic liver disease patterns across Europe.

It is especially important to get this aspect of the definition right because, numerically, the decision to exclude these categories is the most important in the proposal. Excluding these categories would reduce the recorded number of deaths by 9% in Northern Ireland and Scotland and by 22% in England and Wales.

In addition, other conditions such as oesophageal varices and portal hypertension, which have a similarly high alcohol-attributable fraction, should be considered for inclusion in the NS definition.

Aside from the issue of deaths which have a high alcohol-attributable fraction, 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); foetal induced alcohol syndrome (dysmorphic) (Q86.0); and excess alcohol blood levels (R78.0). We support this aspect of option 3.

In addition, we are aware that the Royal College of Psychiatrists believe that 'T category' alcohol mentions relating to poisoning and trauma (T51.0 and T51.9) should also be included in the NS definition. We support this view. We also support the need to assess the contribution of both recent drinking and longer-term alcoholism within national mortality data, for example, suicide is relevant to both, as are traffic deaths (drivers, passengers and pedestrians) and recent drinking is relevant to drownings and fires.

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

Please explain your answer as far as possible with reference to specific public health, government policy and/or scientific needs for the information. If appropriate, please state the specific ICD-10 codes you would prefer to be included or excluded in a broader definition, with reasons.

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, with reporting expected later in 2017.

Question 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 – and 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 we believe that it should provide clear links to mortality figures calculated on the basis of the wide measure.

More generally, the International Coding of Disease -10thRevision (ICD-10) for liver conditions are seen by some as outdated, and the codes are not fit for purpose, with deaths with underlying fibrosis/cirrhosis often coded simply by the primary cause of death – greatly underestimating the burden of alcoholic liver disease. The 11th Revision of the International Classification of Diseases (ICD-11) is due in 2018. This revision is informed by a steering group which provides guidance through reviewing content to ensure up to date and adequate coverage of the full scope of health care diseases and related health conditions. Any changes to the ONS and government definitions presumably have to be commensurate with ICD-11, so it is worth noting that all the definitions might need reviewing again whenever ICD-11 is implemented in 2018.

A consensus on definitions is important. EU, WHO and OECD health data sets would all remain relevant for the UK so that cross country comparisons are possible, especially post Brexit. There are also consequences for medical professionals in training who may not get to see a harmonised approach in future years if consistency is not maintained. Ideally, inconsistencies in definitions should be resolved before Scotland brings in minimum unit pricing (and possibly Northern Ireland, shortly after) so the effects can be seen of what could be described as a 'natural experiment'. There would be multiple ways to explore the policy effects within Scotland and Northern Ireland, compared to the rest of the UK in terms of alcohol related harm and mortality – as long as there was consensus on the definitions. The case could be strengthened to introduce minimum unit pricing in England and Wales and this policy could potentially have a fast effect on mortality reduction.