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POLICY STATEMENT

EASL Policy Statement Reducing Alcohol Harms 2023

EXECUTIVE SUMMARY AND KEY MESSAGES

Aim: The aim of this European Association for the Study of the Liver (EASL) policy statement is to:

1. Urge policy-makers to reduce health-related, social and economic harms caused by alcohol by implementing evidence-based policies to reduce alcohol consumption in the general population, and

2. Empower health professionals, especially those working with liver disease, to use their collective voice to advocate and inform the public, policymakers, and people at risk regarding alcohol-related liver disease (ARLD) and other alcohol harms.

Main message: Europe is the highest alcohol-consuming region in the world and, as a result, has the highest level of alcohol harms. These harms include liver disease, seven types of cancer, alcohol dependence syndromes, psychiatric illnesses and suicides, heart diseases, injuries, and violence.

Evidence-based interventions that reduce population-level alcohol consumption are both effective and cost-effective at reducing deaths from ARLD and reducing other negative health, social and economic impacts of alcohol consumption. Nonetheless, many states have failed to implement these proven and effective measures, usually due to lobbying and interference by the alcohol industry.

The irreconcilable conflict of interest between the alcohol industry and health must be acknowledged and confronted. The alcohol industry should have no role in formulating public health and alcohol policy.

Key messages and recommendations:

EASL recommends that all European countries implement a strategy to reduce alcohol-related harms. A robust mechanism and infrastructure for the implementation of these measures should be established nationally to ensure effective coordination and independence from the alcohol industry.

The strategy should include:

1. Measures to reduce alcohol consumption in the general population.

- Reduce the *affordability* of alcoholic drinks by introducing a minimum unit price (MUP) for alcohol products, and increasing excise duties, both index-linked with inflation.
- A complete ban of alcohol *marketing* in all forms of media, including social and digital.
- A complete ban of alcohol *sponsorship* of sports and events.
- Restrict availability by implementing a health-orientated *licensing* system to restrict the time (hours and days) of alcohol sales; restrict density of alcohol outlets; establish structural separation in mixed trading outlets so alcohol is separate from other products; and enforce minimum legal purchasing age of at least 18 years. Alcohol retail monopolies have been a key method to achieve effective regulation of availability and to reduce harm from alcohol. Existing monopolies should be maintained, and other countries should examine the benefits of the monopoly system.
- Strict *enforcement* of drink-driving legislation.
- Countries should introduce mandatory *health warnings* on alcohol products. These evidence-based warnings should be highly visible, like those on tobacco products in many countries, and convey clear and strong messages regarding liver disease, death, cancer, and risks to the developing foetus during pregnancy.
- Countries should also introduce mandatory ingredient and nutrition *labelling* of alcohol products.

2. Actions in healthcare and community settings to prevent and treat alcohol-related liver disease (ARLD).

This should include screening to identify at-risk drinkers and asymptomatic liver disease at an early stage; the provision of brief interventions in healthcare and community settings to help people reduce consumption; bridging the treatment gap in Alcohol Use Disorder; an integrated approach to treatment that includes referral to specialized care through structured pathways; adequate training for healthcare professionals, including a focus on reducing stigma; greater attention and resources for ARLD from policymakers, funding agencies and pharmaceutical companies; and use of effective treatments to slow down disease progression in people affected.

In addition, we propose a levy on the alcohol industry to recoup the full costs of alcohol harms to the taxpayer and the state, analogous to the polluter pays principle.

This levy should be used to fund treatment for alcohol-related illnesses, support healthcare, social care and justice systems, and fund research, data collection and policy development regarding alcohol and its harms.

We also call on health professionals to advocate nationally for actions to reduce alcohol harms.

We urge them to familiarize themselves with our proposals and promote them at a national level among policymakers, health professionals and the public; to organize national alliances to co-ordinate activities; and to urge policymakers to act urgently to reduce the crisis of alcohol harms.

ALCOHOL-RELATED HARMS - THE COSTS TO SOCIETY

Alcohol causes huge personal and economic harms in Europe. The harms of alcohol correlate with population alcohol consumption. The WHO European region has the highest consumption of alcohol per capita, the highest prevalence of binge drinking and the lowest rates of abstention from alcohol in the world[1]. Across the region, alcohol causes almost 1 million deaths annually[2]. In the European region, alcohol causes approximately 115,000 premature liver-related deaths every year.[1] Deaths from liver disease, largely determined by population alcohol consumption, usually affect people in their prime working years. As a result, liver disease is the second leading cause of years of working life lost in Europe, after ischaemic heart disease.

Alcohol is a group 1 human carcinogen and strongly contributes to seven types of cancer including liver, oesophageal, colorectal, and breast cancers[3] , being associated with 740,000 new cancer cases each year globally.[4] In EU+ countries[a] in 2016, cancer was the leading cause of alcohol-attributable deaths (29%), followed by liver cirrhosis (20%), cardiovascular diseases (19%) and injuries (18%)[5]. There is no safe level of alcohol consumption for the risk of cancer and poor health. Light to moderate[b] alcohol consumption was associated with almost 23,000 new cancers in the EU in 2017, with more than a third (approximately 8,500) associated with a low level of alcohol consumption (<10g or 1 standard drink per day) [3].

Alcohol consumption during pregnancy can cause Foetal Alcohol Spectrum Disorder (FASD)- a continuum of irreversible birth defects/disabilities. The prevalence of FASD in the WHO European Region is alarmingly high at 19.8 per 1,000 children and young people (almost 2%)[6].

The patterns of alcohol consumption also impact the level of harm. The risk of cirrhosis increases exponentially with alcohol intake for heavy drinkers (4 or more standard drinks per day). In the EU, binge drinking is related to 1 in 3 road traffic fatalities and 1 in 6 suicides[8]. Alcohol consumption contributes to intimate partner violence, sexual assault and homicides. In Australia, a one litre increase in annual alcohol per capita consumption (APC) was associated with an 8% increase in the homicide rate.[9]

Alcohol consumption worsens health inequalities. Similar levels of alcohol consumption cause greater harm to the health of more disadvantaged people and their families than to wealthier drinkers. For example, in the UK, liver disease mortality in the more socially deprived area of Blackpool is five times higher (42.7 per 100,000) than rates in the wealthier area of Eden (8.2 per 100,000).[1] Adolescent drinking also negatively affects educational outcomes, worsening health inequalities.[10]

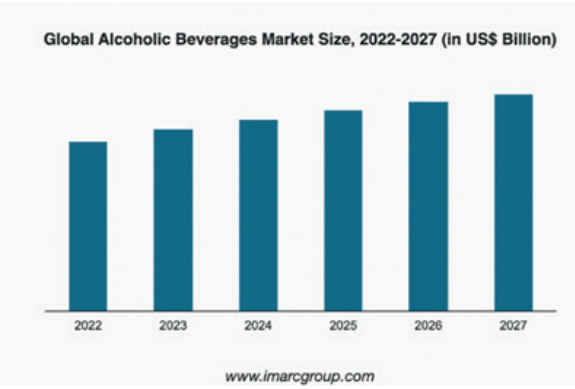
THE ALCOHOL INDUSTRY - A BARRIER TO POLICY IMPLEMENTATION

In their desire to maximize profits, the alcohol industry actively and aggressively obstructs policies to reduce alcohol harms.[11] They do this in the face of clear evidence of the effectiveness of these policies.

The *"significant and sustained opposition by economic operators in alcohol production and sales"*[12] reflects the fact that a large share of alcohol industry profit is generated by the alcohol consumption of heavier drinkers. For example, in higher-income countries, heavy episodic drinking occasions (binge drinking) make up approximately 65% of sales, and in middle-income countries, it is closer to 75%.[9]

Powerful and well-funded alcohol industry lobbying tries to exclude alcohol from nutrition labelling and opposes warning labels. A recent study found that over half (55·2%) of the 212 World Trade Organisation (WTO) member statements on national alcohol warning label policies used arguments from the alcohol industry, and that the public health interventions were described in these statements as lacking in evidence, scientifically inaccurate, restrictive, or overly broad.[13] It took almost 25 years for pregnancy warning labels to be introduced onto alcohol products in New Zealand, and in South Africa strong alcohol warning label regulations, signed into law in 2017, were repealed in 2020 after domestic and international pressure[14] .

Figure 1



The alcohol industry supports relatively ineffective or harmful policies to minimize any negative impact on their profits. These include education initiatives, such as responsible drinking initiatives in schools, which normalize alcohol consumption and are not effective in reducing alcohol harms, and support for national and international associations that promote "responsible drinking".[9] The industry also frequently overstates the extent of the economic and employment contribution of the alcohol industry. This is highlighted for example in a report from Ireland, arguing that the net exports of the alcohol industry is no more notable than the enterprise of the photographic apparatus; optical goods; watches and clocks, sector.[15] The industry has also been found to overestimate the risks of informal production/consumption of homemade alcohol consumption.[9]

The EASL-Lancet Commission (2021) highlighted the reluctance of governments to introduce policy and legislation to prevent liver diseases in general, ascribing this to the actions of vested interest groups and lack of public demand for action.1 To combat the influence of vested interests, effective models of public health policymaking must exclude vested economic interests from the agenda setting. The Framework Convention on Tobacco Control mandates the exclusion of the tobacco industry from policy making, and it is argued that a similar international framework is needed for alcohol.[9]

a. EU Member States, UK, Norway, and Switzerland

b. <20g of pure alcohol per day, which is equivalent to consumption of approximately <1·5 L of wine [12% alcohol by volume; ABV], <3·5 L of beer [5% ABV], or <450 mL of spirits [40% ABV] per week)

The most effective and cost-effective means to reduce death and harms from ARLD and cancers are interventions which reduce alcohol consumption in the general population.[1] Partial implementation of such policies correlated with a reduction in alcohol consumption, according to data for 15 European countries from 1990 to 2016.[10]

There is a strong economic case for investing in preventing harmful consumption and in treatment of alcohol use disorder. For every €1 invested in a comprehensive policy package to reduce population alcohol consumption, up to €16 is returned in economic benefits.[c 10]

Recommendation: All European countries should implement an evidence-based strategy to reduce population-level alcohol consumption, including actions on alcohol pricing and taxation, marketing, labelling, and availability. The strategy should be underpinned by a robust implementation mechanism. Importantly, formulation of alcohol policy should be completely independent from the alcohol industry.

I. Increase Price and reduce affordability of alcohol

Affordability is a key factor that influences alcohol consumption. Studies demonstrate that a 1% increase in the price of alcohol results in a 0.5% reduction in consumption. Since 2010, the affordability of alcohol has increased in the WHO European Region, reflecting increasing income, while the relative prices of alcoholic beverages have generally remained stable or fallen.[10]

Substantial evidence demonstrates the effectiveness of a Minimum Unit Price (MUP) in reducing alcohol harms. Direct evaluation in jurisdictions where this policy has been introduced, indirect evidence, and simulation modelling have demonstrated a reduction in alcohol consumption, especially among heavier drinkers, and reductions in alcohol-related hospitalisations and deaths. [16, 17] MUP has also been demonstrated to reduce health inequalities because it targets those heavy drinkers in whom alcohol harms are greatest, particularly in lower socio-economic groups. The recent HepaHealth 2 modelling study found that introducing a 1€ MUP for alcohol could reduce the burden of chronic liver disease across Europe. This policy intervention will address high levels of alcohol consumption amongst heavy and moderate drinkers, a key risk factor for chronic liver disease. [18] Excise taxes are also effective in increasing alcohol costs and reducing alcohol sales and harms.

Recommendation: Reduce affordability of alcohol products through introduction of an MUP (minimum price per gram of alcohol) and increased excise taxes on alcohol. Both MUP and excise taxes should be regularly reviewed and automatically increased in line with inflation and the observed effects on the rate of alcohol consumption and alcohol-related harms. This should ideally be done across all European countries in a coordinated manner, but countries should not delay introduction and implementation of this measure for the sake of unity.

II. Eliminate alcohol promotion: Advertising, marketing, and sponsorship

Exposure to alcohol marketing increases the risk that young people will start to drink alcohol, or if they already drink, consume greater quantities. The EASL–Lancet Liver Commission (2022) has stated that the only effective means to protect children is through a complete ban on the marketing of alcohol and this statement is supported by other recent analyses of research and effectiveness of policy responses. [9,19]

Recommendation: Introduce a complete ban on alcohol marketing in all forms of media, including social and digital media and a complete ban on alcohol sponsorship of sports and events. We call for an end to all sports sponsorship by alcohol companies, as has been done successfully in France, and a ban on alcohol sponsorship of music events and other similar events.

III. Labelling and warnings on alcohol products

It is a consumer right to be informed about potential adverse health effects of foodstuffs, yet astonishingly and irrationally, alcohol is exempt from this regulation despite being a level one carcinogen (other level one carcinogens include tobacco smoking and asbestos). This is particularly concerning, since many people are unaware of the link between alcohol and many diseases and deaths, especially cancer. Larger, more graphic labels are highly effective in reducing tobacco sales. [20]

The 2021 European Commission's Beating Cancer Plan gave a "political commitment to leave no stone unturned to take action against cancer".[5] However, the law governing the labelling of alcohol products, the Food Information to Consumers (FIC) Regulation (EU) No 1169/2011 exempts nutrition and ingredient information on alcohol products over 1.2% alcohol content. The 2021 Beating Cancer Plan intended to resolve this anomaly by issuing a proposal for mandatory ingredient and nutrition labelling by the end of 2022, but EU citizens and MEPs are still waiting for the proposal.

Recommendation: We call on countries also to introduce mandatory health warnings on alcohol products. We also call for mandatory ingredient and nutrition labelling of alcohol products. Evidence-based warnings should be highly visible and convey clear and strong messages regarding liver disease, cancer, and risks during pregnancy to the developing foetus. The EU should create a library of such warnings for use by member states.

c. Converted from USD PPP using 2021 conversion rate. https://data.oecd.org/conversion/purchasing-power-parities-ppp.htm. Original text: "For every 1 US$ invested in a comprehensive policy package to reduce population alcohol consumption, up to €11 US$16 is returned in economic benefits".

IV. Availability of alcohol

Alcohol is not an ordinary retail commodity. It is addictive, mind-altering and causes cancer and a range of other diseases, and the sale of alcohol should not be treated in the same way as the sale of other food and household products. There is enormous variability in alcohol licensing systems and availability restrictions throughout Europe. Strengthening restrictions on alcohol availability is a key policy recommendation of several major evidence-based reports.[10,12,19]

Recommendation: We call on European countries to implement a licensing system to restrict the sale of alcohol through restrictions on hours and days of alcohol sales; restrictions on the density of alcohol outlets; prohibiting regular alcohol discounts; structural separation in mixed trading outlets; and minimum legal purchasing age. Alcohol retail monopolies have been a key method to achieve effective regulation of availability and to reduce harm from alcohol. Existing monopolies should be maintained, and other countries should examine the benefits of the monopoly system.

V. Drink-driving legislation

Strict enforcement of drink-driving countermeasures has been proven to reduce alcohol-related traffic accidents, including for example, lower blood alcohol concentration levels for young drivers and intensive random breath testing.[9,10,19]

Recommendation: We recommend strict enforcement of drink-driving countermeasures across all European countries.

RECOUP THE COST OF ALCOHOL HARM FROM THE ALCOHOL INDUSTRY

The economic cost of alcohol to society is enormous. The average estimated annual health expenditure for liver disease in the EU27+5 countries is €4.3 billion, and the impact of liver disease on the economy in these countries leads to the loss of the equivalent of 5 million full-time workers per year.[1] Economic costs of alcohol harms are estimated to be between 0.7% and 2.4% of GDP. [21,9,22] Overall, the fiscal cost associated with alcohol harms is equivalent to an additional tax of €162[d] per person per year.[10]

The economic cost of lost output due to illness and death from digestive diseases must also be considered. This effect is particularly striking in the case of liver cirrhosis which is mostly related to alcohol.[23]

There is a major injustice in that this enormous and unsustainable cost of alcohol harms is borne by taxpayers and citizens (including those citizens who are non-consumers of alcohol), whilst at the same time, the alcohol industry enjoys huge profits from the sale of its products without paying the downstream costs of alcohol harms to society. Although some of the costs are recouped through taxation on alcohol products, the tax revenue collected does not nearly cover the cost of alcohol harm. For example, in Ireland, the estimated annual cost of alcohol use to society is €3.7bn, far in excess of the excise duties (€1.2 bn) collected by the state. Indeed, in Ireland, the estimated cost to the state for each standard drink of alcohol is €1.18.[15]

Recommendation: To redress the enormous cost of alcohol harms to the state and taxpayer, we **propose that the alcohol industry is levied to recoup the costs of alcohol harms.** The windfall from the levy should be **used to fund treatment for alcohol-related illnesses, social care and justice costs, and data collection, analysis, and research.**

PREVENTING AND TREATING ALCOHOL-RELATED LIVER DISEASE (ARLD) IN HEALTHCARE AND COMMUNITY SETTINGS

Unfortunately, the diagnosis of ARLD is usually made when the person has advanced and often incurable disease. Late presentation and diagnosis of ARLD is the norm, compared with liver diseases from other causes, usually shortening life for the person affected.[24] Approximately 75% of people with cirrhosis were unaware of their condition or its seriousness until presenting as an emergency with liver failure, variceal bleeding, sepsis, or liver cancer.[25]

Policy measures to reduce alcohol consumption in the general population (see above) have been proven effective to reduce the incidence of ARLD. In parallel, a real plan must be established for the primary, secondary, and tertiary prevention of ARLD. That is, preventing people from getting liver disease (primary prevention), preventing those with early liver disease from progressing to cirrhosis (secondary prevention) and preventing people with cirrhosis from developing liver failure (tertiary prevention). At all stages, stopping or reducing alcohol consumption is the most important action.

REDUCING THE INCIDENCE OF ARLD- IDENTIFYING PEOPLE AT RISK (PRIMARY PREVENTION)

In addition to reducing incidence of liver disease through reducing alcohol consumption at the population level, clear guidelines are needed in healthcare and community settings to identify people at risk of Alcohol Use Disorder (AUD), and to ensure appropriate referral for treatment. Brief clinical interventions to reduce alcohol consumption are effective and should be implemented in primary and secondary care, alcohol/addiction services, emergency departments, prisons, police custody, mental health services, sexual health services and other community settings. The EASL Lancet Commission report has recommended effective screening tools which can be used in these settings.[1]

d Converted from USD PPP using 2021 conversion rate. https://data.oecd.org/conversion/purchasing-power-parities-ppp.htm. Original was "US$232 per person per year"

REDUCE DISEASE PROGRESSION - SECONDARY AND TERTIARY PREVENTION

Bridging the treatment gap in Alcohol Use Disorder is essential to reduce Alcohol Related Liver Disease in people at risk. Abstinence or marked reduction of alcohol consumption are the key factors in preventing liver disease from progressing to cirrhosis and in determining improved survival in ARLD. However, despite increasing evidence of the effectiveness of both psychological and pharmacological treatments, the rate of treatment for AUDs is generally low.[26, 27] Recent studies show only approximately one in six people with AUDs receives treatment. [28]

Stigma of AUD is a substantial issue.1 Besides being a barrier to illness recognition and help-seeking, stigma endangers resource allocation and may affect how healthcare providers treat people with AUD. [29] Stigma complicates the conversations about alcohol in medical settings, and many people with AUD experience condescending and moralising behaviour from healthcare staff.

An integrated approach to improve long-term prognosis for those with ARLD should include early management by hepatologists, (alcohol specialist) nurses and addiction specialists, and referral to psychological and/or pharmacological treatment during hospitalization. Implementation of multidisciplinary, family- and person-centred Alcohol Care Teams integrated across primary and secondary care represents a step forward. [30, 31] The important role of nurses in treatment should also be supported.

To slow disease progression and to decrease the development of decompensated cirrhosis in people with advanced fibrosis, policymakers, funding agencies and pharmaceutical companies should devote greater attention and resources to ARLD, proportionate with the burden of the disease. Such funding should focus on development of better healthcare strategies and pathways, novel non-invasive biomarkers for early diagnosis of asymptomatic people at risk of advanced fibrosis, and clinical studies evaluating novel pharmacological agents aiming to slow down disease progression.

Given that the alcohol industry is responsible for the sale of alcohol to people who develop alcohol harms, the industry should be made responsible for the cost of treating alcohol harms. This is especially important as their products are sold without warnings of their harmful effects.

Overcoming professional barriers: Physicians, nurses, allied health professionals and other professionals in contact with people with AUD need the appropriate knowledge and skills to identify people at risk and make timely and appropriate referrals for treatment. EASL and other professional bodies have a role to play in improving education/training of its membership regarding AUD recognition and treatment, alcohol stigma, wider alcohol harm and efficacy of public health policies. This education should promote a person- and family-centred approach with emphasis on *Dignity and respect, Information sharing, Participation,* and *Collaboration*, and use of person-first language. [32]

A CALL TO ACTION FOR HEALTH PROFESSIONALS

The alcohol industry has a fundamental and irreconcilable conflict of interest when it comes to the health impact of their products. This conflict of interest must be acknowledged and confronted. The alcohol industry should play no role in formulating alcohol health policy.

Health professionals are in a unique position to rebut industry arguments. They can provide a trusted voice to describe the harms alcohol causes for citizens, and to outline evidence-based policies to reduce alcohol harms. Health professionals can play a key role in convincing policymakers and the public that alcohol consumption is not simply a matter of free choice, but that it is heavily influenced by commercial interests, and best addressed by state interventions.

This may require that health professionals undertake leadership roles and make a stand in the face of challenging alcohol industry opposition. This is a project that requires commitment and relationship–building with policymakers and legislators.

Although it is challenging, it is attainable, as examples of high-profile clinician-led campaigns in other countries have shown (e.g., Scotland, Ireland). Importantly such action will save lives; it will improve health. It will be a legacy any health professional could be proud of.

Recommendation: We call on health professionals to advocate nationally for evidence-based actions to reduce alcohol harms, as outlined in this policy document. We urge them to familiarize themselves with our proposals and promote them at the national level among policymakers, health professionals and the public; to organize national alliances to co-ordinate activities; and to urge policymakers to act urgently to reduce alcohol harms.

EASL ALCOHOL ADVOCACY AND POLICY GROUP

The European Association for the Study of the Liver (EASL) is Europe's foremost liver disease organisation. In the face of increasing prevalence and mortality rates for liver diseases in most countries, development and implementation of public health policy is critical in preventing and treating liver diseases. EASL is developing multiple initiatives to advance how we approach and treat liver diseases, including the EASL Alcohol Policy and Advocacy Group.

The group brings together 13 professionals from across Europe to develop alcohol policy and advocacy within the region on behalf of EASL. It is a sub-committee of EASL's Policy, Public Health, and Advocacy (PPHA) Committee, which provides the EASL Governing Board with scientific and policy expertise to help guide public affairs actions within the organisation. The EASL Alcohol Advocacy and Policy Group Membership includes two EASL PPHA Committee members. These and other members are listed below.

EASL PPHA Committee Members

Prof Maria Buti - EASL Public Health Councillor and Professor of Medicine and Consultant of Hepatology at the Hospital General Universitari Valle Hebron in Barcelona Spain

Prof Frank Murray - Consultant Hepatologist/Gastroenterologist at Bons Secours Hospital, Dublin, Ireland, Chair of Alcohol Action Ireland. (Chair of the EASL Alcohol Advocacy & Policy Group).

Other members

Prof Philippe Mathurin - Professor of Hepatology and Head of the research program on liver diseases at the University Hospital of Lille, France.

Dr Alastair MacGilchrist - Chair of Scottish Health Action on Alcohol Problems (SHAAP) and former Hepatologist at Royal Infirmary of Edinburgh, UK

Prof Tom Hemming Karlsen - Research Head, Division of Surgery, Inflammatory Diseases and Transplantation at Oslo University Hospital in Norway.

Horia Stefanescu - Senior Hepatologist at Institutul Regional de Gastroenterologie si Hepatologie (IRGH) in Cluj-Napoca, Romania.

Nijole Gostautaite Midttun - President of the Lithuanian Tobacco and Alcohol Control Coalition.

Dr Peter Rice - Addictions Psychiatrist, President of the Board of Eurocare and Chair, Institute of Alcohol Studies (UK).

Florence Berteletti - Secretary General of the European Alcohol Policy Alliance (Eurocare).

Prof Helena Cortez- Pinto - President of United European Gastroenterology (UEG), Head of the Hepatology Unit and Professor of Medicine in the Clínica Universitária de Gastrenterologia, at Faculdade de Medicina , Hospital Universitário de Lisboa, Portugal.

Prof Marcin Wojnar - Professor of Psychiatry and the Chair of the Department of Psychiatry, Medical University of Warsaw, Poland.

Malene Barfod O'Connell - Member of the EASL Nurses and AHPs Task Force. Working at the Gastro Unit, Medical Division, Copenhagen University Hospital, Amager Hvidovre.

Mairead Heffron - Independent contractor and health policy and advocacy specialist, Dublin, Ireland.

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References

1. Karlsen TH, Sheron N, Zelber-Sagi S, et al. The EASL-Lancet Liver Commission: protecting the next generation of Europeans against liver disease complications and premature mortality. Lancet. 2022;399(10319):61-116. doi:10.1016/S0140-6736(21)01701-3

2. World Health Organisation Europe – Alcohol use. Accessed April 3, 2033. https://www.who.int/europe/health-topics/alcohol#tab=tab_1

3. Anderson BO, Berdzuli N, Ilbawi A, et al. Health and cancer risks associated with low levels of alcohol consumption. Lancet Public Health. 2023;8(1):e6-e7. doi:10.1016/S2468-2667(22)00317-6

4. Rumgay H, Shield K, Charvat H, et al. Global burden of cancer in 2020 attributable to alcohol consumption: a population-based study. Lancet Oncol. 2021;22(8):1071-1080. doi:10.1016/S1470-2045(21)00279-5

5. European Commission Europe's Beating Cancer Plan. 2022. Available online: https://ec.europa.eu/health/system/files/2022-02/eu_cancer-plan_en_0.pdf [accessed 07 Apr 2023].

6. Lange S, Probst C, Gmel G, Rehm J, Burd L, Popova S. Global Prevalence of Fetal Alcohol Spectrum Disorder Among Children and Youth: A Systematic Review and Meta-analysis. JAMA Pediatr. 2017;171(10):948-956. doi:10.1001/jamapediatrics.2017.1919

7. Roerecke M, Vafaei A, Hasan OSM, et al. Alcohol Consumption and Risk of Liver Cirrhosis: A Systematic Review and Meta-Analysis. Am J Gastroenterol. 2019;114(10):1574-1586. doi:10.14309/ajg.0000000000000340

8. Anderson, Peter (2007) Binge drinking and Europe. London: Institute of Alcohol Studies.

9. Babor, TF, Casswell, S, Graham, K, Huckle, T, Livingston, M, Rehm, J, et al. Alcohol: No Ordinary Commodity—third edition.

10. OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/6e4b4ffb-en.

11. Rice P. With evidence on alcohol policies being stronger than ever, now is the time for governments to act Institute for Alcohol Studies. Institute for Alcohol Studies. December 14, 2022. Accessed April 3, 2023. https://www.ias.org.uk/2022/12/14/with-evidence-on-alcohol-policies-being-stronger-than-ever-now-is-the-time-for-governments-to-act/

12. World Health Organisation Regional Office for Europe (2022). European framework for action on alcohol 2022–2025.

13. The Lancet Gastroenterology Hepatology. Shining a light on international alcohol industry lobbying. Lancet Gastroenterol Hepatol. 2022;7(4):275. doi:10.1016/S2468-1253(22)00060-7

14. The Lancet Gastroenterology Hepatology. Distilling the message: Irish plans for alcohol warning labels. Lancet Gastroenterol Hepatol. 2023;8(3):199. doi:10.1016/S2468-1253(23)00014-6

15. Alcohol Action Ireland. (2022) Alcohol market review 2022. Raising the bar: an examination of the alcohol market in Ireland. Dublin: Alcohol Action Ireland. Accessed April 3, 2023. https://alcoholireland.ie/aai-publishes-alcohol-market-review-2022/#

16. No place for cheap alcohol: the potential value of minimum pricing for protecting lives. Copenhagen: WHO Regional Office for Europe; 2022.

17. Maharaj T, Angus C, Fitzgerald N, et al. Impact of minimum unit pricing on alcohol-related hospital outcomes: systematic review. BMJ Open 2023;13:e065220. doi: 10.1136/bmjopen-2022-065220

18. Retat L, Webber L, Jepsen P, et al. Preventing liver disease with policy measures to tackle alcohol consumption and obesity. Journal of Hepatology (to be published 2023) Atiq O, Tiro J, . . . Singal AG. An assessment of benefits and harms of hepatocellular carcinoma surveillance in patients with cirrhosis. Hepatology 2017;65:1196-1205 (PMID 27775821).

19. The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

20. Brennan E, Dunstone K, Vittiglia A, Mancuso S, Durkin S, Slater MD, et al. (2022) Testing the effectiveness of alcohol health warning label formats: An online experimental study with Australian adult drinkers. PLoS ONE 17(12): e0276189. https://doi.org/10.1371/journal.pone.0276189

21. Anderson, P. & Baumberg, B. (2006) Alcohol in Europe. London: Institute of Alcohol Studies

22. Rehm J, Mathers C, Popova S, et al. (2009) Global burden of disease and injury and economic cost attributable to alcohol use and alcohol- use disorders. Lancet, 373, 2223– 33.

23. Anderson P, Dalziel K, Davies E, et al. Survey of digestive health across Europe: Final report. Part 2: The economic impact and burden of digestive disorders. United European Gastroenterol J. 2014;2(6):544-546. doi:10.1177/2050640614554155

24. Shah ND, Ventura-Cots M, Abraldes JG, et al. Alcohol-Related Liver Disease Is Rarely Detected at Early Stages Compared With Liver Diseases of Other Etiologies Worldwide. Clin Gastroenterol Hepatol. 2019;17(11):2320-2329.e12. doi:10.1016/j.cgh.2019.01.026

25. Williams R, Aspinall R, Bellis M, et al. Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis [published correction appears in Lancet. 2014 Dec 20;384(9961):2212]. Lancet. 2014;384(9958):1953-1997. doi:10.1016/S0140-6736(14)61838-9

26. Carvalho AF, Heilig M, Perez A, Probst C, Rehm J. Alcohol use disorders. Lancet. 2019 Aug 31;394(10200):781-792. doi: 10.1016/S0140-6736(19)31775-1. PMID: 31478502.

27. Connery HS, McHugh RK, Reilly M, Shin S, Greenfield SF. Substance Use Disorders in Global Mental Health Delivery: Epidemiology, Treatment Gap, and Implementation of Evidence-Based Treatments. Harv Rev Psychiatry. 2020;28(5):316-327. doi:10.1097/HRP.0000000000000271

28. Mekonen T, Chan GCK, Connor J, Hall W, Hides L, Leung J. Treatment rates for alcohol use disorders: a systematic review and meta-analysis. Addiction. 2021;116

29. Carvalho AF, Heilig M, Perez A, Probst C, Rehm J. Alcohol use disorders. Lancet. 2019;394(10200):781-792. doi:10.1016/S0140-6736(19)31775-1.

30. Moriarty KJ. Alcohol care teams: where are we now?. Frontline Gastroenterol. 2019;11(4):293-302. Published 2019 Aug 14. doi:10.1136/flgastro-2019-101241

31. Williams R, Aspinall R, Bellis M, et al. Addressing liver disease in the UK: a blueprint for attaining excellence in health care and reducing premature mortality from lifestyle issues of excess consumption of alcohol, obesity, and viral hepatitis [published correction appears in Lancet. 2014 Dec 20;384(9961):2212]. Lancet. 2014;384(9958):1953-1997. doi:10.1016/S0140-6736(14)61838-9

32. Shi, H.D., McKee, S.A. & Cosgrove, K.P. (2022) Why language matters in alcohol research: Reducing stigma. Alcoholism: Clinical and Experimental Research, 46, 1103– 1109. Available from: https://doi.org/10.1111/acer.14840

Annex I - Major Recent Policy Reports

Since the previous EASL (2019) statement on reducing the alcohol-related liver disease burden was published, several important reports have called for evidence-based policy measures to reduce alcohol harm in Europe.

The WHO European framework for action on alcohol 2022–2025[1] highlighted six evidence-based priorities for action: alcohol pricing, alcohol availability, alcohol marketing; health information (with specific focus on labelling); health services response; and community action. This framework reaffirms the WHO Global Action plan[2] aim of a 10% relative reduction in per capita alcohol consumption by 2025 in Europe.

The framework also called for stronger political commitment by member states, noting the underutilization of the powerful tools of the Global strategy to reduce the harmful use of alcohol (2020) and the European action plan to reduce the harmful use of alcohol 2012-2020.

Europe's Beating Cancer Plan (2022)[3] addresses alcohol as a key modifiable risk factor for cancer and outlines specific actions to reduce harmful alcohol consumption (flagship initiatives on prevention). This includes a review of EU tax legislation on alcohol, a commitment to propose a mandatory indication of the list of ingredients and the nutrition declaration on alcoholic beverage labels before the end of 2022 and of health warnings on labels before the end 2023.

This is in addition to support to member states for implementing brief clinical interventions and best practices and capacity building activities to reduce alcohol consumption. It also calls for action aimed at reducing the exposure of young people to alcohol marketing – working with member states and stakeholders to encourage self and co-regulatory initiatives.

In recent years, some countries[4] have introduced minimum pricing policies[5] which target the cheapest alcohol products, typically consumed by the heaviest drinkers and young drinkers. In 2022, WHO published its report on minimum pricing[6], highlighting that we now have evidence from systematic reviews, modeling studies and real-life implementation scenarios which demonstrate reductions in alcohol consumption (particularly among heavier drinkers) following introduction of minimum pricing.

It also notes the compatibility of minimum pricing policies with European law, citing the high-profile legal challenge from the alcohol industry (compatibility of minimum unit pricing -MUP legislation with EU law challenged) in United Kingdom (Scotland). In Dec 2015 the Court of Justice of European Parliament found that the MUP legitimately pursued a public health objective and therefore was appropriate and necessary.

The 2022 WHO report highlights the effectiveness, but underutilization of pricing and taxation measures and recommends that MUP be used in combination with other complementary policies including taxation to reduce alcohol consumption and harms.

The 2021 OECD report on Preventing Harmful Alcohol Use[7] highlighted the damage alcohol-related disease causes to population health, healthcare budgets and the economy, noting that drinking more than 1/1.5 drinks a day leads to substantial additional costs for the healthcare system.

It also demonstrates the economic impact of harmful drinking on adolescents- lower education outcomes affect the formation of human capital, economic growth and social welfare, and worsen inequalities.

The report highlights the excellent return on investment in tackling harmful alcohol consumption, through using policy packages built around the "PPPP" approach. Such an approach includes actions to protect children from alcohol promotion, policing to limit alcohol-related injuries and violence; primary care to help people with harmful patterns of alcohol consumption; and pricing to limit the affordability of cheap alcohol.

Such packages, the report predicts, would save 4.6 million life years annually across 48 countries, save USD 28bn (PPP) in health expenditure- approximate 0.5% of health expenditure. For every 1 USD invested in a comprehensive policy package, up to USD 16 are returned in economic benefits.

The 2022 EASL Lancet commission report[8] gives a snapshot of liver disease in Europe and proposes actions to improve liver health in Europe. The report highlights alcohol as one of the major drivers of liver related morbidity and mortality. It notes that 50% of end-stage liver disease is due to harmful levels of alcohol consumption. The Commission recommends introduction of a minimum unit price (of €1/cl of pure alcohol) across all EU countries to reduce the harmful use of alcohol.

It calls for a complete ban on marketing of alcohol in all social and digital media, citing research that shows the exposure to alcohol marketing increase the risk that young people will start to drink alcohol, or if they already drink, consume greater quantities. The Commission calls for interventions regarding stigma affecting healthcare seeking behavior, funding, and discrimination. The report also calls for non-viral liver diseases to be classed as Non-Communicable Diseases, and for a chronic care model to be applied to reduce liver-related mortality, including highlighting the importance of nurse-led care for people with established liver disease.

The 2018 EASL HEPA Health Project report[9] evaluated the epidemiological burden of liver disease in the wider European region, presented data on the main risk factors for liver disease and reviewed effective public health interventions to improve liver health. This project highlighted evidence that fiscal policies were the most effective at targeting alcohol consumption, in particular MUP and volumetric taxes. It also found that evidence favoured a full regulatory approach to alcohol marketing, in particular to children and young adults.

Further it found that there would be a greater effect if spatial and temporal availability of alcohol was regulated. The report also recommended individual level approaches - including screening and behavioural approaches to reduce harmful alcohol use.

A further EASL Hepahealth II report[10] (to be published in 2023) also supports the introduction of MUP to reduce the effects of liver disease. From the modelling of the impact of implementing different policy scenarios, including MUP, in Romania, the Netherlands and France, the authors concluded that single policies such as 70p MUP will have a significant impact on population health over time, and that a combination of complementary measures and coordinated policy scenarios have a greater impact in shifting unhealthy consumption patterns.

The third edition of the book Alcohol - No Ordinary Commodity was published in 2022,[11] and provides a critical review of the scientific evidence related to alcohol control policy from a public health perspective. It presents epidemiological evidence showing that alcohol is no ordinary consumer product, and that it is a major contributor to the global burden of disease, disability, and death in high-, middle- and low-income countries.

The book also describes trends in the alcohol industry marketing influence as the industry has become consolidated into a small number of transnational corporations expanding operations in Asia, Africa and Latin America.

A review is presented of strategies to reduce alcohol related harm. The authors conclude that implementation of evidence-based alcohol policies that better serve the public good are clearer than ever before because of accumulating knowledge on which strategies work best.

The most effective strategies, based on this review, are pricing and taxation strategies that decrease affordability, and restrictions on the physical availability of alcohol.

A total ban on alcohol marketing is also found to be an effective strategy to reduce consumption. In addition, drink-driving countermeasures, brief interventions with at-risk drinkers and treatment of drinkers with alcohol dependence are effective in preventing harm in high-risk contexts and groups of hazardous drinkers.

The authors also highlight that given conflicting interests between profit (of the alcohol industry) and health, working in partnership with the alcohol industry is likely to lead to ineffective policy.

1 World Health Organisation Regional Office for Europe (2022). European framework for action on alcohol 2022–2025.

2 Global strategy to reduce the harmful use of alcohol. Geneva: World Health Organization; 2010. Available from: https://www.who.int/publications/i/item/9789241599931 [accessed 07 Feb 2022]

3 European Commission Europe's Beating Cancer Plan. 2022. Available online: https://ec.europa.eu/health/system/files/2022-02/eu_cancer-plan_en_0.pdf [accessed 07 Apr 2023].

4 13 countries have some form of min pricing policies, 11 in WHO European region (Ireland and Slovakia are the only EU countries. The countries are: Armenia, Australia, Belarus, Canada, Ireland, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Slovakia, Ukraine, United Kingdom (Scotland), Uzbekistan

5 Minimum price on an alcoholic beverage sets a fixed price level below which a specific volume of a finished product cannot be sold, while MUP (Minimum Unit Price) is more specific and sets a level below which a fixed volume of alcohol (such as a standard drink) cannot be sold.

6 No place for cheap alcohol: the potential value of minimum pricing for protecting lives. Copenhagen: WHO Regional Office for Europe; 2022.

7 OECD (2021), Preventing Harmful Alcohol Use, OECD Health Policy Studies, OECD Publishing, Paris, https://doi.org/10.1787/6e4b4ffb-en

8 Karlsen TH, Sheron N, Zelber-Sagi S, et al. The EASL-Lancet Liver Commission: protecting the next generation of Europeans against liver disease complications and premature mortality. Lancet. 2022;399(10319):61-116. doi:10.1016/S0140-6736(21)01701-3

9 European Association for the Study of Liver Disease. HEPAHEALTH Project Report. Risk Factors and the Burden of Liver Disease in European and Selected Central Asian Countries. 2018

10 European Association for the Study of Liver Disease. Preventing liver disease with policy measures to tackle obesity and alcohol consumption. 2023

11 Babor, Thomas F and Casswell, Sally and Graham, Kathryn and Huckle, Taisia and Livingston, Michael and Österberg, Esa and Rehm, Jürgen and Room, Robin and Rossow, Ingeborg (2022) Alcohol: no ordinary commodity: research and public policy. Oxford University Press.

Annex II - Table of main recommendations from recent reports

	EASL 2019 Policy Statement on Alcohol Related Liver Disease	The EASL–Lancet Liver Commission: 2021	Babor et al 2022	WHO: SAFER [12]	WHO European Framework for action on alcohol 2022-2025	European Beating Cancer Plan 2022	EASL Hepahealth II 2023 (to be published)
Price	Pricing and taxation policies Including Minimum Unit Pricing	Minimum price of €1/cL of pure alcohol	Best Practice: Alcohol taxes that decrease affordability. MUP Good practice	Raise prices on alcohol through excise taxes and pricing policies	Pricing and taxation (including MUP) to make alcohol less affordable	Review of EU legislation relating to the taxation of alcohol and cross- border purchase of alcohol products	An MUP of 0.70p may show the greatest impact in reducing the effects of liver disease
Health information and labelling	Mandatory labelling of alcohol products (including health information and caloric value)				Health information, with a specific focus on alcohol labelling (e.g. statutory labelling requirements including nutrition and ingredients and health warnings)	Proposal for mandatory labelling of the list of ingredients and nutrition declaration on alcoholic beverage label (before end 2022) as well as health warnings before end 2023	
Alcohol Marketing	Regulation of advertising and sponsorship of alcohol products	Complete ban of alcohol marketing in all social and digital media "only effective means to protect children is through a complete ban on the marketing of alcohol and HFSS foods"	Best practice: Complete ban on alcohol marketing Good practice: Partial bans on alcohol marketing	Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion	Restricting marketing - prevent and reduce the risks of harms associated with marketing of alcohol in traditional and digital contexts, recognizing that a global and comprehensive approach is required	Reduce the exposure of young people to online marketing of alcoholic beverages through monitoring the implementation of the Audio-visual Media Service Directive Provisions	
Availability	Structural separation of alcohol products in mixed trading outlets			Strengthen restrictions on alcohol availability	Reducing availability: national licensing systems; restrictions on outlet number and density and days and hours of sale; min age restrictions; consideration of restrictions around sporting and cultural events including minors;		

	EASL 2019 Policy Statement on Alcohol Related Liver Disease	The EASL–Lancet Liver Commission: 2021	Babor et al 2022	WHO: SAFER [12]	WHO European Framework for action on alcohol 2022-2025	European Beating Cancer Plan 2022	EASL Hepahealth II 2023 (to be published)
Treatment and early interventions	Personal interventions (screening, referral to specialist alcohol services, non-invasive diagnostic tools for detecting liver fibrosis in community)		Best practice: Treatment and early intervention	Facilitate access to screening, brief interventions, and treatment	Widespread implementation of screening and brief intervention programmes in primary health care settings	Support Member States in the implementation of evidence-based brief interventions;	
Drink Driving Measures			Best practice: Low BAC levels for young drivers; intensive breath testing, random where possible; intensive Supervision programmes	Advance and enforce drink driving counter measures			
Other important actions	Improved data reporting and recording, assessing policy effectiveness				Community action	Best practices and capacity building (support from commission to member states to be increased in this area)	

12 The SAFER technical package: five areas of intervention at national and subnational levels. Geneva: World Health Organization; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Annex III - Professional Barriers

Professional barriers to reducing alcohol harm in general and ARLD in particular

Hepatologists and other health professionals treating patients with ARLD often suffer from 'learned helplessness', which hampers positive change in both clinical care and policy development.

At a clinical level, many hepatologists are pessimistic about prospects for successful treatment of alcohol use disorder (AUD). AUD treatment is poorly understood by health professionals, both the range of treatments and the potential for success.

This is compounded by a bewildering array of referral routes to multiple providers. The capacity of AUD treatment services is often inadequate, contributing to the failure rate and creating a vicious cycle of low expectation and inadequate investment.

Patients with ARLD and other alcohol disorders suffer a great deal from stigma. Health professionals can be unwitting contributors to such stigma, perhaps through misunderstanding of the nature of addiction, as well as a lack of knowledge about treatment options.

Health professionals are still poorly informed about current knowledge of alcohol harms beyond liver disease, such as cancer and cardiovascular disease.

This may limit their ability to successfully counsel patients, which may also be influenced by their own relationship with alcohol.

At a specialist society level, ARLD does not feature highly in publications in research journals or at specialist society conferences, considering the dominance of alcohol to causing liver disease and death in Europe.

There is a perception that alcohol-related research is not favoured by funding bodies, and unlike 'competing' conditions such as viral hepatitis and Non-alcoholic Fatty liver disease (NAFLD), there is little interest from the pharmaceutical industry.

What research there is tends to focus on pathophysiology and treatment of complications. Important as these are, they do not influence prognosis as strongly as successfully discontinuing alcohol consumption.

Most clinicians do not get involved in health policy. Many are unaware of the strength of the positive evidence for effective alcohol public health policies (e.g. WHO SAFER recommendations) to reduce population alcohol consumption and prevent ARLD and other alcohol harms).

Annex IV - The Scottish Story

Doctors have played a crucial role in the change of direction and increase in ambition of alcohol policy in Scotland.

In Scotland, alcohol deaths rose dramatically in the 1990s and 2000s. The alcohol-specific age-standardised mortality increased from 12.2 per 100,000 to a peak of 28.5 per 100,000 in 2006. Initially there was little awareness of this, even within the speciality areas most affected, such as hepatology and mental health.

However, work by NHS Scotland Information Statistics Division led by Lesley Graham, a public health doctor with a background in general practice, highlighted this increasing mortality and morbidity, followed in 2006 by a paper in the Lancet by McCambridge and Leon.

These studies gave concerned professionals a basis to raise awareness of the rising tide of harm from alcohol. A group of psychiatrists, hepatologists, public health doctors and general practitioners developed Scottish Health Action on Alcohol Problems (SHAAP) which with the support of the Medical Royal Colleges and Faculties established harm from alcohol as one of Scotland's major challenges.

The WHO framework for effective alcohol policy had little influence on local policy makers until local clinicians used it as a basis for their advocacy work.

Alcohol industry interference is the most important barrier to effective alcohol policy development and implementation. Public relations specialists advised that the role of clinicians in countering industry influence was crucial.

Public trust in the medical and nursing professions helped the advocacy campaign and health organisations were able to present issues and solutions in ways which other campaigners could not.

Skilled strategists joined SHAAP as directors to form a successful partnership with the clinicians. Close cooperation with other alcohol advocates led to a coalition of health organisations whose coordinated work helped create an environment where ambitious policy makers were able to develop ideas and subsequently legislation in line with international best practice and responsive to local circumstances.

in 2007 SHAAP published 'Alcohol: price policy and public health' whose recommendations included a minimum unit price for alcohol.

In 2009 the Scottish Government published a comprehensive strategic framework entitled Changing Scotland's Relationship with Alcohol'. In 2010 they brought in legislation to end irresponsible promotions such as multi-buy discounts and 'happy hours', and in 2012 passed a law to introduce minimum unit pricing.

This was not enacted until 2018 due to repeated legal challenges from the Scotch Whisky Association, all of which failed. The Scottish Government also invested in support and treatment services and established a brief intervention programme.

Alcohol-specific deaths in Scotland have fallen from that peak of 28.5 per 100,000 in 2006 to 18.6 per 100,000 in 2019.

Policy makers need sound evidence, good direction, and reliable support to make good alcohol policy and clinicians and professional organisations have a key role in this.