



Committee on Data Collection, Indicators and Definitions

2nd Meeting

Luxembourg, 1 September 2009, room HTC 00/091

SUMMARY REPORT

I. Welcome and introduction

Participants were welcomed by the chair, Mr Nick Fahy, Head of the Health Information Unit (DG SANCO – C2). The summary report from the first meeting was agreed by all members of the Committee. The aim of the second meeting was to finalise discussions on previously agreed key indicators for the collection and analysis of data on alcohol consumption and alcohol-related health harm and agree on indicators for the five priority themes identified in the Communication on the EU strategy to support Member States in reducing alcohol related harm¹. Members who could not participate in the meeting sent their comments in advance. The Committee took them into consideration during discussions.

II. Key indicators

During the first meeting the Committee Members unanimously agreed on the three key indicators for the collection and analysis of data on alcohol consumption and alcohol-related health harm. These are:

- For volume of consumption: Total yearly per capita (15 years+) consumption of pure alcohol,
- For pattern of consumption: Harmful drinking,
- For alcohol-attributable health harm: Alcohol-attributable years of life lost.

Agreement for the third indicator was, however, depending on further information on methodology for calculating alcohol-attributable years of life lost.

Alcohol-attributable years of life lost

Jürgen Rehm explained the methodology for calculating alcohol-attributable deaths and burden of disease. A technical document prepared by him had been circulated to Committee members prior to the meeting.

Many diseases are completely attributable to alcohol (i.e. if there were no alcohol the disease would not exist), others partly attributable. For estimating the extent of the involvement of alcohol, relative risk estimates are used to calculate an 'alcohol attributable fraction' which is

¹ http://eur-lex.europa.eu/LexUriServ/site/en/com/2006/com2006_0625en01.pdf

then applied. Both potentially detrimental and potentially beneficial effects of alcohol consumption are covered by this methodology.

The committee agreed to use this methodology, which is fully in line with the Comparative Risk Analysis which is ongoing within the WHO Global Burden of Disease Study. Modelling of risk is to be continuous. In light of that the decision was also taken to do the discounting of years of life lost due to disability (YLD). There was consensus that the calculation of this indicator should be done centrally, however, ensuring transparency of the methodology.

Total yearly per capita (15 years+) consumption of pure alcohol (volume of consumption)

Information on volume is available for every country. It is collected by the WHO. All calculations made by WHO are subject to verification by the relevant governments before being published. Special provisions are made in calculating volume of consumption for countries with a large tourism industry.

This indicator was reconfirmed by the Committee.

Harmful drinking²

Harmful drinking had been determined at the first meeting to be defined as 6 or more drinks (60+ grams), monthly or more often, during the past 12 months.

This indicator was reconfirmed by the Committee.

III. Indicators addressing priority themes

The five priority themes (with 11 aims) identified in the Communication on the EU strategy to support Member States in reducing alcohol related harm are:

- 1) Protect young people, children and the unborn child;
- 2) Reduce injuries and death from alcohol-related road accidents;
- 3) Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;
- 4) Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns;
- 5) Develop and maintain a common evidence base at EU level.

On the basis of the brief discussion during the first meeting of the Committee the Commission had circulated a proposal for indicators before the meeting and received written comments from Committee members, which were also addressed during discussions.

1) Protect young people, children and the unborn child

Aim 1: To curb under-age drinking, reduce hazardous and harmful drinking among young people, in cooperation with all stakeholders

The three previously suggested indicators were agreed:

- Accessibility of alcohol to adolescents, alcohol purchase for off-premise consumption,
- Accessibility of alcohol to adolescents, on-premise consumption,
- Binge drinking among adolescents.

In addition a fourth indicator was agreed:

- Adolescent alcohol consumers (%) in the last 12 months.

² Definition of the indicator harmful drinking was further discussed following questions raised by the Committee on National Alcohol Policy and Action in January 2010 regarding gender differences. Conclusion: indicator remains as originally proposed.

Aim 2: To reduce the harm suffered by children in families with alcohol problems

No indicator is currently available. No consensus has been reached among experts as to which approach is to be taken but different approaches are being piloted. The Committee could therefore not make a recommendation for an indicator to cover this aim.

Aim 3: To reduce exposure to alcohol during pregnancy, thereby reducing the number of children born with Foetal Alcohol Disorders

The Committee agreed on the following indicator:

- Harm resulting from alcohol during pregnancy.

The Committee also suggested to the European Commission to work on additional data sources and to consider developing additional indicator(s).

2) Reduce injuries and death from alcohol-related road accidents

Aim 4: To contribute to reducing alcohol-related road fatalities and injuries

The proposed indicator is:

- Alcohol-related road traffic accidents.

However, the Committee concluded that as regards source of data the reliability of presently available data is poor. It has suggested to the European Commission to explore further if the data source can be developed.

3) Prevent alcohol-related harm among adults and reduce the negative impact on the workplace;

Aim 5: To decrease alcohol-related chronic physical and mental disorders

Hospital discharge data regarding mental disorders is not comparable because of differences in the organisation of treatment in Member States. The committee decided therefore not to include an indicator on alcohol-attributable chronic mental disorders.

Hospital discharge data can, on the other hand, be used for physical disorders. The committee agreed to keep the indicator "prevalence of alcohol-attributable chronic physical disorders", using 4 character ICD-10 codes for two diseases: alcoholic cirrhosis of the liver (K70.3), and alcohol-induced pancreatitis (acute and chronic) (K85.2 and K86.0).³

Aim 6: To decrease the number of alcohol-related deaths

The Committee agreed on using the mortality output from the calculations of 'Years of Life Lost' which would be done for the key indicator on alcohol-attributable health harm. There should be four categories:

- Infectious diseases,
- Chronic diseases,
- Unintentional external causes,
- Intentional external causes.

Aim 7: To provide information to consumers to make informed choices

The Committee discussed that the Eurobarometers can be used for assessing awareness of consumers. The following areas to be explored were identified: a) awareness of effect of alcohol on ability to drive, and b) awareness of the impact of alcohol consumption on health.

³ This decision was amended in light of lack of data at the 4 character level. The two diseases are therefore at 3 character level, a) Alcoholic liver disease (ICD-10 code K70) and b) Pancreatitis, acute and chronic (ICD-10 codes K85-K87).

The Committee also held a discussion on the proposed questions for the Eurobarometers.

Aim 8: To contribute to the reduction of alcohol-related harm at the workplace, and promote workplace related actions

The Committee could not identify an existing indicator for this aim but recommends to the European Commission that further work be carried out in this area.

4) Inform, educate and raise awareness on the impact of harmful and hazardous alcohol consumption, and on appropriate consumption patterns

Aim 9: To increase EU citizens' awareness of the impact of harmful and hazardous alcohol consumption on health, especially the impact of alcohol on the foetus, on under-age drinkers, on working and on driving performance

The Committee could not identify an existing indicator for this aim. Further exploration is needed.

5) Develop, support and maintain a common evidence base

Aim 10: To obtain comparable information on alcohol consumption, especially on young people; definitions on harmful and hazardous consumption, on drinking patterns, on the social and health effects of alcohol; and information on the impact of alcohol policy measures and of alcohol consumption on productivity and economic development

Aim 11: To evaluate the impact of initiatives taken on the basis of this Communication

The Committee agreed that no specific indicators are needed for aims 10 and 11 since other indicators contribute to fulfil them.

IV. Any other business

Other possible participants and/or contributions to the work of the Committee

The Committee discussed whether any additional experts would be needed on the Committee and concluded that currently this is not the case. However, it would welcome additional information from industry on any additional data on underage drinking that is not already available, divided according to different categories (wine, beer, spirits, etc.).

V. Next steps

The Committee has decided that currently there is no need for further meetings. But it will reconvene when and if it becomes necessary. The results of the work shall be presented at the next meetings of the European Alcohol and Health Forum and the Committee on National Alcohol Policy and Action.

Annex 1 – List of participants

Experts

Björn Hibell, ESPAD

Patrik Nylander, Swedish Ministry of Health and Social Affairs

Jürgen Rehm, Head, Epidemiological Research Unit, Technische Universität Dresden,
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