

**Institute of Alcohol Studies' response to North West Public Health Observatory consultation on the methods used to estimate alcohol-related hospital admissions for England**

The Institute of Alcohol Studies (IAS), as an independent research organization, takes a keen interest in the methods used to calculate the impact of alcohol on society, both in the UK and overseas. IAS sees accurate and comprehensive data collection as essential in creating an evidence base to support the implementation and evaluation of effective policies to reduce alcohol harm. We recognize the importance awarded to data on alcohol-related hospital admissions, which is one of the major indicators in the Public Health Outcomes Framework for England.

IAS welcomes the opportunity to participate in this consultation, with the aim of strengthening the data used to represent the impact of alcohol on hospital admissions, and thus to better understand the burden caused by alcohol on the health service.

A summary of IAS responses to the questions outlined in the consultation document is as follows:

<b>Question</b>	<b>IAS response</b>
A. Do you think we should stick with publishing information based on <u>just</u> the current measure?	NO
B. If not, what other information should be provided?	Estimates using primary and secondary diagnoses, based on a sub-set of conditions which are wholly attributable to alcohol or have a high AAF based on age and sex.
C. Do you agree with the proposal to publish figures based only on primary diagnoses alongside current estimates?	NO
D. Should the conditions and relative risks be updated and, if so, how often?	YES, every 3 years but more frequently if important data become available during interim periods
E. Do you support the proposal to apply revisions retrospectively only if the scale of the revisions is sufficiently large?	YES
F. Do you agree with the proposals to update consumption estimates annually, using GHS/GLF data up to 2011 and HSE data from 2011?	YES – however IAS is concerned that the transition from GHS to HSE data will impact upon the precision of the estimates
G. Do you agree with the proposal to use three years' worth of HSE data to produce consumption estimates?	YES - but only if adjustments can be made to accommodate the discontinuity which might

	be caused by the change in data source
H. Do you agree with the proposal to continue to use the consumption estimates that were available when the alcohol-related admission estimates for a particular period were first produced?	YES
I. Do you agree with the proposal to retain the current practice of using national consumption estimates to generate AAFs?	YES

The key issues IAS has identified within this consultation are as follows:

### **Purpose of data**

It is essential that the data collected on hospital admissions serve its intended purpose, be that to feed into local needs assessments and commissioning of services and/or national alcohol policy decisions and evaluation. Before the outcome of this consultation can be decided, there is a need to establish what the key functions of the data are and attempt to prioritise them – for example, whether or not the data need to show only admissions numbers or provide an indicator of the burden caused by alcohol on the health and/or economy of a given population. Consideration for the methods used to collect data for comparable health risks, such as smoking and obesity, may also be useful when establishing the purpose for alcohol-related hospital admissions figures.

### **Primary versus secondary diagnoses**

The consultation draws attention to the debate surrounding coding for primary versus combined primary and secondary alcohol-related diagnoses and highlights potential weaknesses in current measurement of both of these variables.

It is undeniable that changes in coding practices have altered the data collected on alcohol-related hospital admissions considerably in recent years, making both year on year trending difficult and comparisons between regions a challenge. Furthermore, the discontinuation of the General Lifestyle Survey (GLS) will diminish the precision of future estimates of alcohol consumption, forcing reliance on pooled data from the much smaller Health Survey for England (HSE).

Estimates based only on primary diagnoses could be considered more ‘robust’ for the purpose of comparisons over time and between regions, as these data are largely unaffected by changes in coding practice or regional variations in quality of coding data. However, **it is of crucial importance to note that reliance on data based solely on primary diagnoses will not allow a full picture of hospital admissions resulting from or affected by alcohol consumption to be determined.**

Alcohol is associated with more than 60 adverse health consequences and is ranked by the World Health Organisation as the third leading cause of death and disability in the developed world<sup>1</sup>. Data based on primary diagnoses alone, might obviate capture of much of the data currently associated with medium to low alcohol-attributable fractions (AAF) and externalities such as drink driving accidents, violent assaults and injuries. **These alcohol-related health harms can only be captured by recording data on**

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<sup>1</sup> WHO (2010) Global strategy to reduce the harmful use of alcohol, World Health Organisation, Geneva

## **secondary diagnoses.**

It is therefore essential that a robust measure that reflects the true impact of alcohol on hospital admissions is developed, taking into account both primary and secondary diagnoses resulting from or affected by alcohol.

### **IAS recommendations**

Given the challenges presented by changes to coding practices and the transition from GLS to HSE survey data, IAS recommends that the methodology used to record data on alcohol-related hospital admissions be amended in order to produce a more robust estimate of the burden caused by alcohol that is comparable between regions and over time.

Option D in the consultation document, to: **'Produce estimates of alcohol-related admissions using both primary and secondary diagnoses, but based on a subset of conditions that can be caused by alcohol (e.g. wholly attributable to alcohol or those with a high attributable fraction.)'** is the method favoured by IAS. The only difficulty perceived with this option is that the AAFs vary significantly in relation to both age and gender and this must be taken into account. Thus, the AAF for road traffic accident (RTA) deaths is high in young men but negligible in older men and women, while the AAF for oesophageal cancer is high in older individuals but low in young adults. In consequence neither condition if selected would be useful for application across the board. Varying the conditions with high AAF by age and sex will allow for greater precision in the estimates and better attribution of the overall health care burden caused by alcohol.

Institute of Alcohol Studies  
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