National Institute for Health and Clinical Excellence

PUBLIC HEALTH PROGRAMME
ALCOHOL USE DISORDERS (PREVENTION)

Consultation on Additional Evidence from 4th August – 1st September 2009
Comments to be submitted by 5pm at the very latest on Tuesday 1st September 2009

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Name:	**Rachel Seabrook**		
Organisation:	**Institute of Alcohol Studies**		
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Modelling to assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributabel harm in England using the Sheffield Alcohol Policy Model version 2.0	General		We would like to commend the authors on the scope and thoroughness this report. In addition, the authors have been careful to note the limitations of available evidence and have clearly pointed out areas where it has been necessary to make assumptions. We would urge those using the report to take note of these limitations and assumptions.

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	1.2	26	As the authors note, an across-the-board increase in price is not a policy in itself. The current taxation structure does not allow for this as duty is applied by volume of product, not by price and VAT is not specific to alcohol. However, it would in principle be possible to introduce an additional ad-valorum duty, as is currently applied to cigarettes. If it is assumed that taxes are uniformly passed on to the consumer, this would have the effect of increasing the price by a uniform percentage. Unfortunately, that assumption is somewhat problematic in the light of practices such as below-cost selling of alcohol.

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	2.3.1.2	37	There is no justification given for the use of a threshold in the risk functions. It is now well established that the risk functions for most partially attributable chronic conditions are linear through zero. Notable exceptions are heart disease and stroke. The authors introduced a threshold for wholly attributable harms only for consistency with partially attributable harms, so this has no justification either. We argue that if a single form is to be chosen for all risk functions in this analysis, it should be linear through zero.
	2.3.1.2	39	Figure 2.6 does not identify the units for the absolute risk scale (vertical axis).

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	2.4	62-65	Section 2.4.1 sets out the framework for assessing cost effectiveness of screening and brief interventions, which fit comfortably into the standard NICE framework: "The costs of the intervention incurred by the NHS and social services are examined and balanced against the health benefits gained in terms of quality adjusted life years, with account also taken of any financial savings to health and social care due to reduced illness." This should be taken as the model for such assessments and the goal should be to map the assessment of different types of interventions onto this framework as closely as possible. Key features are: The COSTS are to the NHS and social services, taking account of savings to these institutions. The BENEFITS are to individuals, in terms of QALYs. The authors note that the range of costs and benefits can be difficult to determine, and comment that the public sector costs are likely to be negligible.

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	cont'd	62-65	Certainly regulatory changes do not incur costs directly to the NHS and social services. This raises the question of which costs are most closely analogous and therefore appropriate to include. We endorse the statements made on p. 63, that, "From a public sector perspective the costs [of workplace harms] to be included would be the lost productivity from public sector employees and … the sickness and unemployment benefit payments across the remaining population," and "Costs to individuals are outwith the scope of NICE economic assessments." However, we feel that the decisions taken by the authors do not reflect these statements. *Tax* On p 65, the authors argue that decreases and increases in tax and duty revenues should not be considered as costs and benefits as these return to the wider economy. This may be true when considering the economy as a whole, but that is not the case here. NICE considers costs/savings to the NHS and social services, not the economy as a whole.

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	cont'd	62-65	Broadening the focus slightly, these are paid for out of the 'public purse', which clearly includes tax revenue. *Lost productivity* Firstly, only lost productivity by public sector employees is a cost to the public purse and therefore relevant to this analsyis. Lost productivity in the private sector should be excluded. Secondly, unemployment of an individual only results in lost productivity in a situation where there is otherwise full employment. In an environment in which a percentage of the workforce is unemployed, it seems reasonable to assume that a job left vacant will be filled in due course, so the lost productivity is only experienced for the time taken to fill the post. *Benefits* We dispute the statement (p 63) that benefits should be excluded from the analsysis on the basis that they are transfer payments. As health and social care costs are paid for out of the 'public purse', so are benefits, therefore costs and savings in benefits

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	cont'd	62-65	should be included in the analysis. However, on the assumption that alcohol does not lead to a net increase in unemployment (assuming that vacancies are filled), there would be only a minimal net increase in unemployment benefit, though there might be an increase in sickness and related benefits. On the basis of these considerations, we recommend that the following costs/savings be included in the analysis: Changes in tax and duty revenue Net changes in benefit payments Lost productivity in the public sector due to absences and for the duration that posts remain vacant following unemployment The last of these may be too small in magnitude to justify the effort of modelling the cost.

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	2.6.2.2	77	When modelling the effects of price promotions, no distinction is made between bulk discounts and discounts that apply to single items. For example, pricing one bottle of wine at £5 and two for £9 is a bulk discount whereas reducing the price of each bottle from £5 to £4.50 is discount that applies to single items. This distinction is important because bulk discounts contain within them an incentive to buy larger quantities beyond that implicit in price elasticity: It is necessary to buy more in order to get the discount. This implies a greater price elasticity for bulk discounts than for other changes in price, including discounts applied to single items. It is therefore likely that the model underestimates the effect of banning bulk discounts. We do not know of any existing dataset that would allow this distinction to be examined.
	2.6.3	87	No rationale is given for choosing 25% as the threshold for higher and lower priced drinks. In the absence of such a rationale, it would be more natural to use a median split.

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	3.1.1.2	104	We note that there is a very small difference in net cost between AUDIT-C 3 and FAST 3 when delivered by a practice nurse (SBI2 vs. SBI3) but a substantial difference between these when delivered by a GP (SBI5 vs. SBI6). Please could we have an explanation of this difference.
	3.1.2.1	107	The possibility that a five-minute brief intervention might be less effective than one of 25 minutes is considered only as a sensitivity analysis. According to evidence presented in this report, the best available evidence is consistent with lower effectiveness for a five-minute intervention. Therefore this should be the baseline scenario, not the sensitivity analysis. A further sensitivity analysis could be conducted considering even lower effectiveness.
	3.2.1.2	116	We note that conclusions relating to sales and tax/duty are based on the assumption that price increases are achieved without corresponding increases in tax and duty. This may be realistic for minimum price policies, but not for general price increases.