# IAS response to Public Health England consultation on proposed changes to the calculation of alcohol-related mortality and hospital admissions

March 2021

## 1. Do you agree with the proposal to update the AAFs in this way?

We are routine users of Local Alcohol Profiles for England (LAPE) figures but are non-expert in alcohol attributable fraction (AAF) methodology. We agree with the proposal to update the AAFs, as it is important to use recent and high-quality evidence to understand alcohol harm. We welcome this comprehensive review of the evidence resulting in updated indicators.

## 2. The change will improve the accuracy of published statistics but will result in a break in the data series at the date the correction is implemented. Is this an acceptable scenario for you?

Yes, a break in the data series is acceptable in our view. We think there is a risk that this change could get misunderstood or misrepresented, so clear communication this is a methodological update is essential (see our answer to Q4).

## 3. Is the proposed date of introduction (2016) to align with the alcohol consumption prevalence data used appropriate?

Yes. We note there have not been any major alcohol policy developments in England at this time, for which an unbroken data series would have been helpful in evaluating the impact of this policy.

## 4. Do you think your stakeholders and partners will readily understand and accept that the reduction is a result of a change in methodology and not necessarily a real reduction in the harm alcohol causes to individuals?

We are supportive of using higher quality and more up-to-date data, as are many of our stakeholders and partners.

We do believe there is a risk that the revised figures may be misunderstood or misquoted, so it is very important efforts are made to communicate clearly that this is a methodological change. It is also important to emphasise this methodological change was not done to 'correct' the AAFs, but to reflect new evidence on harms and up-to-date data on consumption.

The presentation of charts can help to address this (presentation of e.g. Fig 4 in the consultation document is very clear), as well as presenting AAFs using the old and new methods separately, and adding explanatory notes to figures and tables. Perhaps there are learnings from past methodological changes during the Health Survey for England or General Lifestyle Survey that can be applied also.

Clarity about the new methodology may be required in multiple areas. For example, we notice the impact of the new AAFs is experienced differently across age groups (Fig 1 in consultation doc – the number of deaths is impacted the most among the oldest age groups). Has it been explored whether there are other distributional impacts of this change, for instance by region or deprivation? These impacts would need to be communicated clearly too, along with the headline changes in mortality and admission episodes.

## 5. Based on the latest evidence, the new AAFs changed the upshift (the extent to which people in surveys may underestimate their drinking) down to 40% from the 59% used previously. Is this your preferred approach?

We support the use of up-to-date data, so in principle revising the upshifting approach is a good idea.

Relative risks of health conditions in published literature are often based on associations with self-reported alcohol consumption. This means these studies have the same under-reporting issues as surveys like the Health Survey for England. If this is the case for the relative risks used to calculate the AAFs, then upshifting alcohol consumption might not be necessary at all.

We are happy to discuss this topic in more detail. We read that the ScHARR model does not upshift consumption. In any case we note in the Health Lumen report this change is said to only have a small impact.

## 6. Do you have any other comments or points that you would like us to consider?

The change in AAFs is largely due to changes in consumption patterns. It isn't clear if there is a plan to update these at regular intervals in the future – this would be useful background information to know.

Two comments on Appendix 1:

1) Regarding chronic conditions - we support former drinkers and never drinkers being in separate categories, where relevant, in line with the evidence that health selection influences drinking throughout life.[1] It would be good to have a rationale for which diseases it was important to distinguish former and never drinkers from each other, or whether this was led by the evidence available.

2) Regarding acute conditions - it is mentioned that the ScHARR work takes into account BMI and liver metabolism, but not the Jones & Bellis or Health Lumen work. It is unclear why one is favoured over another, it would be nice to have a rationale presented.

[1] Ng Fat, L., Cable, N. and Shelton, N. (2015), Worsening of Health and a Cessation or Reduction in Alcohol Consumption to Special Occasion Drinking Across Three Decades of the Life Course. Alcohol Clin Exp Res, 39: 166-174. https://doi.org/10.1111/acer.12596