PHE Consultation on proposed changes to the calculation of smoking-attributable mortality and hospital admissions
Action on Smoking and Health (ASH) response

21 September 2020 to 3 November 2020

About ASH

Action on Smoking and Health (ASH) is a public health charity set up by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health and Social Care to support delivery of the Tobacco Control Plan for England. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry or any other commercial interest.

We own a small number of shares in Imperial Brands and BAT to enable us to attend AGMs and interrogate the company about its activities. The shares are not held for financial gain or benefit and dividends are not claimed.

Questions raised

1. Do you agree with the proposal to update the relative risks in this way?

The RCP report was an important piece of work, particularly because it identified significant diseases which had not previously been included. However, it is not the only work in this area, and while we do think that it is appropriate to review the relative risks, we think more work is needed before the RR are updated, looking at other sources and not just the RCP report.

One comparator is the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) published in the Lancet, which provides a systematic scientific assessment of published, publicly available, and contributed data on incidence, prevalence, and mortality for a mutually exclusive and collectively exhaustive list of diseases and injuries. It has just been updated and we would encourage PHE to contact the authors to compare the attributable risk fractions being used with those in the RCP report, and what sources the GBD is using. While we are not arguing that the AF used should necessarily be exactly the same as in the GBD, it would be helpful if any differences could be identified and explained.

https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30819-X/fulltext
https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)30819-X/fulltext#supplementaryMaterial
http://ghdx.healthdata.org/gbd-results-tool

2. Do you agree with the rationale for inclusion and exclusion of particular conditions within our analysis aligned to the Royal College of Physicians report?

See above.

3. Which of the 3 options for mental health would you prefer:

- include Mental Health conditions as per the calculations in this document with clear caveats
- exclude mental health conditions from the calculations
- explore further data sources for mental health conditions to be included in the calculations, increasing the complexity of the calculations.

ASH supports the response submitted by colleagues from the National Addiction Centre at King's College London, which we copy below for ease of access.

We are pleased to see the inclusion of mental health. We would strongly recommend **option 3** to ensure parity of esteem between mental and physical health conditions. Searching for alternative relative risk data sources is justifiable. If such data do not exist, it provides incentive to conduct new primary research to calculate the relative risks. However, *only* following option three may considerably delay the inclusion of mental health in any new calculation, therefore **option 1** appears to be the most preferable in the short term. However, a caveat should be made very explicit in the data. The caveats are that these figures in this consultation document will be underestimates due to some mental health conditions not being included in the RCP report, and thus no relative risk is available for them. Such an underestimate may minimise the scale of the problem, and lead to lack of smoking cessation interventions being prioritized for people with mental health conditions, for whom research may be limited (and therefore not included in the RCP report).

Option 2 should *absolutely not* be followed. It will lead to lack of parity in national statistics between physical and mental health conditions, disincentive recording of them, and vastly underestimate the number of smoking attributable hospital admissions/deaths.

We also wish to comment on the consultation document's premise that "*we are aware that the Hospital Episode Statistics data will not fully capture all hospital admissions related to mental health illness*" (page 18). The HES Admitted Patient Care (APC) database covers all NHS inpatient admissions, including any admission to private or third sector hospitals subsequently reimbursed by the NHS. As such, HES APC is estimated to contain >99% of all inpatient hospital activity in England, with an inpatient hospital admission including any secondary care-based activity requiring a hospital bed, (i.e. this includes day cases, births and deliveries, and both elective and emergency admissions, in physical and mental health hospitals). Further clarity about this statement would be helpful. If this refers to a lack of identification or recording of mental health disorders by hospital professionals, thus the diagnoses not getting coded into HES data, whilst this may be an issue it is not one that should mean we exclude smoking attributable fractions from the coded mental health conditions, and would likely perpetuate the problem of coding mental health conditions if there is no incentive from the hospital to lower their smoking related admissions. If it refers to the fact that only a few mental health conditions are mentioned within the RCP report and thus the relative risks are not comprehensive for all mental health conditions (we know for example a significant proportion of

people with alcohol dependence smoke and their hospital admissions will have a smoking attributable fraction, which is not included in these calculations as no relative risk is presented in the RCP report), that is justification for looking to other data sources than the RCP report.

What also may need to be taken into account is that people with a mental health condition often have more than one condition (e.g. schizophrenia and depression) and they also have co-occurring smoking related physical health conditions. There is also emerging research that tobacco smoking is implicated in the onset of psychosis and recognition of this should be taken into account.

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

On hospital admissions it appears that a different methodology is used for estimating obesity and alcohol related admissions compared to that for tobacco.
For smoking the Population Attributable Fraction approach is used, but obesity and alcohol include any admissions where obesity/alcohol are down as a primary or secondary diagnosis in Hospital Episode Statistics. It would be useful to understand why the same method is not used for tobacco as for alcohol and obesity, and what impact this has on the comparative results?

Also there are significant differences in the new RR compared to the old. If PHE is going to make such significant changes it needs to explain why they've changed so significantly, or at the very least put forward some hypotheses for why this is the case.