

## Cost of alcohol studies: A policy tool, not a research programme

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Policies concerning health and welfare are based on comparisons, whether or not this is explicit. An important element in the policymaking is, How does the size of problem X compare with the size of problem Y? Mäkelä (2012) quotes Reuter on the "armaments race" between government agencies in developing estimates of the economic costs of their respective problems. In my experience from working for substantial periods in four countries, the initiative for cost of alcohol studies comes always from the policy side, not from researchers. Cost-of-illness studies do not have high standing among economists, and are not generally funded through competitive scientific grants systems. The demand for them from the policy arena is the driving force. Cost of alcohol studies have thus never to my knowledge been a research programme; they are commissioned as a policy tool. However, as an element in the "evidence base" for policy they should be done with integrity and in accordance with best scientific practices.

Part of Mäkelä's critique is concerned with "inconsistent methods and contentious assumptions". On this front, there is much we agree on. From my perspective, one caveat is that the critique tends to take for granted and argue from a basis of "basic tenets of mainstream welfare economics", without acknowledging that some of these are subject to dispute.

At a more general level, Mäkelä has three main complaints: that it would be preferable to stick to measures of health and other problems, rather than an aggregative approach; that a government-budget perspective on costs is defensible, but not a societal perspective; and that reducing harms to the common metric of money "conceals important issues and value judgements".

Taking Mäkelä's advice on the first two points might well lead to more defensible estimates, but each path still has its own problems, as well as not providing policymakers with what they want. Health measures based on hospital or other registers are influenced by the nature and operations of the health system; those based on population surveys, as Mäkelä illustrates for harm to others from drinking, are influenced by attitudes and response biases. Further, there is still the problem of how to make comparisons at an aggregate level: should it be on years of life lost (building in an assumption about the proper length of life, and ignoring disablement)? Or should it be on DALYs, with all their underlying assumptions and measurement difficulties built into a single dimension of degree of disability? And a government-budget perspective on costs exacerbates a problem which Mäkelä notes, that comparisons between societies will reflect general societal decisions about the extent to which costs

are paid by governments or are left private.

Any analysis which reduces disparate dimensions to a common metric can be criticised as concealing important issues and value judgements. This is true whether or not the metric is money. Thus an effort to reduce the harmfulness of drugs to a single metric was recently critiqued by a team of economists as mixing apples and oranges (Caulkins et al. 2011). But, at the policy level, this is exactly what national and international drug control regimes insist on doing (Room 2011). Similarly, those deciding on policy priorities, if the decisions are to be "evidence-based", want to see concrete evidence, which at some point is usually reduced to a single common metric, whether in terms of money, DALYs, or something else.

So what is to be done, given that there will be a continuing policy demand for societal cost studies? One possibility is for researchers to refuse to do the studies, or to try to deflect the political demands to other kinds of studies. Economists generally tend to try to push their policy clients towards cost-effectiveness or cost-benefit studies, though, as Mäkelä indicates, such studies have their own problems. And the result of such efforts at deflection seems often to be that both kinds of studies are then commissioned (thus the Australian cost study referenced by Mäkelä was followed up with a cost-effectiveness study; Collins & Lapsley 2008).

The other set of options, accepting that social cost studies will continue to be commissioned, is to try to improve their quality and their comparability. This was the path taken by the efforts under WHO auspices which Mäkelä references (Single et al. 2003). Though there are still prob-

lems with recent studies, as Mäkelä makes clear, the quality and comparability of these studies has considerably improved under the impetus of such efforts.

An important way of moving forward, in my view, is by providing confidence intervals and sensitivity analyses which indicate the range within which particular components of overall estimates are likely to fall. There is of course a likelihood that political actors will try to override the inherent indeterminacy of the estimates, usually by picking the largest figure ("up to \$X"), but the ranges will be there in the report for all to see. Alternative ways in which the components can be added into an overall figure should also be clearly indicated (for example, tangible costs only, vs. tangible plus intangible), with an indication of the issues at stake in whether a figure is added in.

As Mäkelä indicates, one of the general claims concerning the utility of cost of alcohol studies is that they identify information gaps. While he is sceptical about this, I think they often have served this purpose. Due to the peculiarities of welfare economics accounting, the cost studies tradition leaves some of these gaps unprobed – for example, alcohol-related social welfare expenditures, which are defined as transfer costs. But often the studies do stimulate the collection or extraction of new data, and sometimes they have been part of the impetus for new studies. For instance, one impulse towards the recent spate of studies of alcohol's harm to others has been analyses like the cost of alcohol study for England and Wales, which identified four areas of social costs, indicating starkly for one of them, family and social networks, "costs not identified"

in the absence of relevant data (Prime Minister's Strategy Unit 2004, 14). Cost of alcohol studies have also had an influence at the conceptual level. In the era of the first modern cost-of-illness study of alcohol (Berry et al 1975), the whole U.S. policy attention had been on the alcoholic and what he or she was doing to his or her own life. Berry et al's reframing of alcohol issues into a holistic societal perspective, as is inherent in a cost-of-illness study, played a part in opening up the perspective and discourse at the commissioning

agency, the National Institute on Alcohol Abuse and Alcoholism, to a broader view of alcohol problems in society.

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## REFERENCES

- Berry, R.E. & Boland, J.P. & Smart, C. & Kanak, J. (1977): The economic cost of alcohol abuse: 1975. Brookline, MA: Policy Analysis, Inc.
- Caulkins, J.P. & Reuter, P. & Coulson, C. (2011): Basing scheduling decisions on scientific ranking of drugs' harmfulness: False promise from false premises. *Addiction* 106 (11): 1886–1890
- Collins, D.J. & Lapsley, H.M. (2008): The avoidable costs of alcohol abuse in Australia and the potential benefits of effective policies to reduce the social costs of alcohol. National Drug Strategy Monograph No. 70. Canberra: Department of Health and Ageing (Ref. 10.08.2012. Online: [http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/OA14D387E42AA201CA2574B3000028A8/\\$File/mono70.pdf](http://www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/OA14D387E42AA201CA2574B3000028A8/$File/mono70.pdf))
- Mäkelä, K. (2012): Cost-of-alcohol studies as a research programme. *Nordic Studies on Alcohol & Drugs* 29 (4): 321–344.
- Prime Minister's Strategy Unit (2004): Alcohol harm reduction strategy for England. London: Cabinet Office (Ref. 10.08.2012. Online: <http://www.newcastle-staffs.gov.uk/documents/community%20and%20living/community%20safety/caboffice%20alcoholhar%20pdf.pdf>)
- Room, R. (2011): Scales and blinkers, motes and beams: Whose view is obstructed on drug scheduling? *Addiction* 106 (11): 1895–1896
- Single, E. & Collins, D. & Easton, B. & Harwood, H. & Lapsley, H. & Kopp, P. & Wilson, E. (2003): International guidelines for estimating the costs of substance abuse. 2<sup>nd</sup> ed. Geneva: World Health Organization.

