



Deposited via The University of York.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/id/eprint/161361/>

Version: Accepted Version

---

**Article:**

Yang, Fan, Angus, Colin, Duarte, Ana Isabel et al. (2020) Impact of socioeconomic differences on distributional cost-effectiveness analysis. *Medical Decision Making*. ISSN: 1552-681X

<https://doi.org/10.1177/0272989X20935883>

---

**Reuse**

Items deposited in White Rose Research Online are protected by copyright, with all rights reserved unless indicated otherwise. They may be downloaded and/or printed for private study, or other acts as permitted by national copyright laws. The publisher or other rights holders may allow further reproduction and re-use of the full text version. This is indicated by the licence information on the White Rose Research Online record for the item.

**Takedown**

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing [eprints@whiterose.ac.uk](mailto:eprints@whiterose.ac.uk) including the URL of the record and the reason for the withdrawal request.

## **Impact of socioeconomic differences on distributional cost-effectiveness analysis**

**Running head:** how socioeconomic differences affect DCEA

Fan Yang, PhD<sup>1</sup> [fan.bella.yang@york.ac.uk](mailto:fan.bella.yang@york.ac.uk)

Colin Angus, Msc<sup>2</sup> [c.r.angus@sheffield.ac.uk](mailto:c.r.angus@sheffield.ac.uk)

Ana Duarte, Msc<sup>1</sup> [ana.duarte@york.ac.uk](mailto:ana.duarte@york.ac.uk)

Duncan Gillespie, PhD<sup>2</sup> [duncan.gillespie@sheffield.ac.uk](mailto:duncan.gillespie@sheffield.ac.uk)

Simon Walker, Msc<sup>1</sup> [simon.walker@york.ac.uk](mailto:simon.walker@york.ac.uk)

Susan Griffin, PhD<sup>1</sup> [susan.griffin@york.ac.uk](mailto:susan.griffin@york.ac.uk)

<sup>1</sup>Centre for Health Economics, University of York, UK

<sup>2</sup>Sheffield Alcohol Research Group, Health Economics and Decision Science, ScHARR,  
University of Sheffield, UK

### **Corresponding author:**

Fan Yang, Centre for Health Economics, University of York

Alcuin A Block, York, YO10 5DD, UK ([fan.bella.yang@york.ac.uk](mailto:fan.bella.yang@york.ac.uk))

The work was undertaken at the Centre for Health Economics, University of York, and the Sheffield Alcohol Research Group, Health Economics and Decision Science, ScHARR, University of Sheffield; the work was presented at Society for Social Medicine & Population Health Annual Scientific Meeting 2019.

Financial support for this study was provided entirely by a grant from Public Health Research Consortium (PHRC). The funding agreement ensured the authors' independence in designing the study, interpreting the data, writing, and publishing the report.

## **Abstract**

Public health decision makers value interventions for their impacts on overall health and health inequality. Distributional cost-effectiveness analysis (DCEA) incorporates health inequality concerns into economic evaluation by accounting for how parameters, such as effectiveness, differ across population groups. Good understanding of how and when accounting for socioeconomic differences between groups affects the assessment of intervention impacts on overall health and health inequality could inform decision makers where DCEA would add most value.

We interrogated two DCEA models of smoking and alcohol policies, using first national level and then Local Authority level information on various socioeconomic differences in health and intervention use. Through a series of scenario analyses, we explored the impact of altering these differences on the DCEA results.

When all available evidence on socioeconomic differences was incorporated, provision of a smoking cessation service was estimated to increase overall health and increase health inequality, while the screening and brief intervention for alcohol misuse was estimated to increase overall health and reduce inequality. Ignoring all or some socioeconomic differences resulted in minimal change to the estimated impact on overall health in both models, however, there were larger effects on the estimated impact on health inequality. Across the models there were no clear patterns in how the extent and direction of socioeconomic differences in the inputs translated into the estimated impact on health inequality. Modifying use or coverage of either intervention so that each population group matched the highest level improved the impacts to a greater degree than modifying intervention effectiveness. When local level socioeconomic differences were considered, the magnitude of impacts was altered; in some cases, the direction of impact on inequality was also altered.

## **Keywords**

Distributional cost-effectiveness analysis, economic evaluation, health inequality, public health

1 **Introduction**

2 Cost-effectiveness analysis (CEA) is routinely employed to inform health care resource  
3 allocation decisions [1]. When allocating resources in public health, decision makers often  
4 consider how potential policies would improve population health and reduce unfair health  
5 inequalities (i.e., reduce the perceived unfairness of the distribution of health across the  
6 population) [2, 3]. The decision about whether to fund a public health intervention is  
7 therefore informed by its impact on the distribution of health across the population: both in  
8 terms of its sum total and the extent of inequality between relevant population groups. The  
9 distributional cost-effectiveness analysis (DCEA) framework considers how interventions  
10 impact the distribution of health [4, 5]. It is used to estimate the net impact of an intervention  
11 on overall health and in each population group of interest, and to examine the trade-offs  
12 between improving overall health and reducing health inequality.

13  
14 To perform DCEA, the evaluation of costs and consequences of alternative interventions  
15 must account for differences between equity relevant groups [6]. This requires evidence on  
16 how the parameters of the evaluation, e.g., the value of inputs to a decision analytic model,  
17 vary between groups. Lack of evidence on between-group differences can make it  
18 challenging to conduct a formal evaluation. Even when the evidence is available, a DCEA is  
19 more complex than a standard CEA and policy makers may lack the resources to undertake  
20 DCEA in all circumstances. Developing greater understanding of how and when accounting  
21 for socioeconomic differences in model inputs affects the final estimate of the intervention  
22 impact on the distribution of health could enable us to identify a subset of parameters that are  
23 sufficient to inform the intervention impact, which may make it possible to simplify the  
24 DCEA process, and help decision makers and analysts to know where DCEA would add most  
25 and when to gather further evidence on socioeconomic differences.

26  
27 When appraising how an intervention impacts on health inequality, a common question is  
28 whether anything can be done to modify either the intervention itself or the way in which it is  
29 delivered in order to make it benefit population groups more fairly [7]. For example, if uptake  
30 of the intervention is socially patterned, policy makers may ask whether it is worthwhile  
31 investing in actions that increase uptake in lower socioeconomic groups. A breakdown  
32 showing how eliminating socioeconomic differences in each model input could alter the final  
33 distribution of health could help direct efforts to answer such questions.

34

1 In the UK, Local Authorities have the responsibility of making decisions about which public  
2 health interventions to fund for their local population. However, many appraisals of the  
3 potential interventions are performed and reported at a national level [8]. The extent of  
4 socioeconomic differences in model inputs can vary between settings, e.g., the smoking  
5 prevalence by socioeconomic status within Local Authorities differs from the overall national  
6 figure [9]. The population distribution between socioeconomic groups may also differ  
7 between settings. Consequently, evaluating the intervention impact based on national level  
8 estimates may not be informative for the impact that would be expected at a local level.  
9 Therefore, it may be relevant to local decision makers to understand how local level variation  
10 will alter estimated policy impacts compared to the national level estimates.

11

12 In this study, we adapted two existing DCEA models of public health interventions to address  
13 four broad questions:

14 (a) how influential is failing to consider specific socioeconomic differences on the estimated  
15 intervention impacts on overall health and health inequality?;

16 (b) which modifiable intervention characteristics represent the most valuable targets to  
17 mitigate socioeconomic differences in intervention impact?;

18 (c) how generalisable are conclusions about the intervention impacts on overall health and  
19 health inequality between areas with different characteristics?;

20 (d) what conclusions can we draw about the generalisability of the results of the two studies  
21 to other interventions or disease areas?

22

## 23 **Methods**

### 24 *Overview*

25 DCEA of smoking and alcohol policies were conducted using two existing models [10, 11].  
26 Health benefits were expressed as quality-adjusted life years (QALYs) and costs in pounds  
27 sterling (£, 2018 price year) under a National Health Service (NHS) and personal social  
28 services perspective. An annual discount rate of 3.5% was applied to both benefits and costs  
29 in accordance with National Institute for Health and Care Excellence (NICE) guidance [12].  
30 The NICE cost-effectiveness threshold of £20,000 per QALY was used [13].

31

32 In both models, we considered inequality between population groups defined according to the  
33 level of socioeconomic deprivation in individuals' area of residence, i.e., Index of Multiple  
34 Deprivation (IMD) [14]. IMD is an area-level weighted composite index combining

1 information on income, employment, health, education, housing, crime and living  
2 environment for a geographical area of approximately 1,500 residents [14]. As IMD is not an  
3 individual-level measure, there will be variation in the socioeconomic status of residents  
4 within each area and even highly deprived areas will have some high socioeconomic status  
5 inhabitants. The population was divided into five groups defined by quintile of IMD, and  
6 differences in model inputs across IMD quintiles were characterised. Both models estimate  
7 the amount by which policies change health within each population group. Summing over the  
8 change in health across all five groups gives the total change in population health, expressed  
9 as population incremental net health benefit (NHB) [1].

10

11 Considering the general population's preference for reducing health inequality between rich  
12 and poor groups, we can present the total population health as the 'equally distributed  
13 equivalent (EDE) health'. To calculate this EDE health, the strength of preference for  
14 reducing inequality is used as a weight to provide a weighted total population health. EDE  
15 health can be interpreted as the amount of health distributed equally to all population groups  
16 that would be considered equally valuable to the distribution being evaluated [4]. Given the  
17 preference for reducing existing health inequalities, the EDE is lower than the population  
18 health, and the difference describes the amount of overall health that people would be willing  
19 to sacrifice to achieve an equal distribution. Alternatively, the difference between the EDE  
20 and the total population health can be interpreted as the welfare cost of health inequality, as it  
21 represents the social value that could be gained if health were redistributed equally. A policy  
22 that leaves the total population health unchanged but reduces the difference in health between  
23 population groups will increase the EDE health. We expressed the policy impact on health  
24 inequality using the difference between how policies alter the EDE health (which increases  
25 with total health and with reduction of inequality in health) and how policies alter total health  
26 (incremental NHB).

27

28 Scenario analyses were performed to explore how altering socioeconomic differences in  
29 model inputs affects the estimated impacts.

30

### 31 ***Models***

32 The smoking model is a cohort Markov model that assesses the cost-effectiveness of nicotine  
33 replacement therapies in adult smokers (18-75 years) over a lifetime horizon [10]. These  
34 therapies are accessed through primary care [10]. The Markov model includes three mutually

1 exclusive health states: smokers, former smokers and death. Smokers and former smokers  
2 differ in mortality risk, health-related quality of life (HRQoL) and risk of developing six  
3 smoking-related diseases, modelled as events with impact on costs and HRQoL. The  
4 Sheffield Alcohol Policy Model is a hybrid simulation consisting of two linked models that  
5 evaluates the cost-effectiveness of screening and brief interventions (SBIs) to reduce alcohol  
6 misuse [11]. The first part of the model takes a baseline population of individual drinkers and  
7 simulates receipt of SBIs and the resulting age-adjusted trends in alcohol consumption over a  
8 20-year time horizon. The second part of the model aggregates these individuals into cohorts  
9 based on age, gender, IMD quintile and baseline drinking level. The model simulates 45  
10 alcohol-related health conditions, which are linked to associated mortality rates and hospital  
11 admissions.

12

13 In this study, we focus on the provision of e-cigarette in the smoking model and the strategy  
14 of delivering SBIs to all patients when registering with a new primary care practice ('Next  
15 Registration') in the alcohol model, both compared to 'no intervention'.

16

### 17 ***Impact on overall health***

18 The models estimate the incremental direct health benefits and incremental healthcare costs  
19 of the interventions, compared to 'no intervention', specific to smokers and alcohol users in  
20 each IMD quintile. Zero health benefit accrues to people who are not eligible for the  
21 interventions (i.e. non-smokers and those who do not misuse alcohol). The incremental costs  
22 are converted into health opportunity costs, i.e., the health that would have been achieved if  
23 those resources had been used for other purposes, using the NICE cost-effectiveness  
24 threshold. The health benefits of making resources available for other purposes will not fall  
25 equally to all socioeconomic groups. Research has shown that a greater proportion of the  
26 benefit from changes in NHS spending goes to more deprived groups. Deprived groups  
27 therefore lose out most when resources are appropriated for specific policies, or conversely  
28 stand to gain the most when policies are cost saving and release resources [15]. For each IMD  
29 quintile, the health opportunity costs are subtracted from the direct health benefits to provide  
30 the distribution of the incremental net health benefit (iNHB), i.e. the change in health by  
31 population group. The impact on overall health is the population iNHB, i.e., the sum of iNHB  
32 across all quintiles.

33

34

1 ***Impact on health inequality***

2 The baseline distribution of health is the distribution of quality-adjusted life expectancy  
3 (QALE) [16], which combines differences in life expectancy between groups with differences  
4 in quality of life between groups. The iNHB in each IMD quintile estimated for each  
5 intervention is added to the baseline QALE in each IMD quintile to estimate the predicted  
6 distribution of QALE following the implementation of the intervention. The QALE  
7 distribution is summarised as EDE health by using the Atkinson index, with an inequality  
8 aversion parameter derived from a UK population survey [17]. The Atkinson inequality  
9 aversion parameter describes the strength of preference for reducing relative inequality in  
10 health. When applied to calculate the EDE, it assigns higher weight to health improvements  
11 in more deprived groups that have lower baseline QALE, and a lower weight to health  
12 improvements in less deprived groups with greater baseline QALE [18]. The change from the  
13 EDE in the baseline health to the EDE of the health with the intervention, i.e., incremental  
14 EDE (iEDE), encompasses the impact of the intervention on both overall health and health  
15 inequality. To isolate the impact on health inequality, we look at the difference between iEDE  
16 and iNHB, with positive value showing that the intervention reduces the cost of health  
17 inequality. We illustrate these calculations for the smoking model in **Box 1**.

### Box 1. Smoking cessation model

1. Extract the incremental direct health benefits (*a*) and the incremental healthcare costs (*b*) of e-cigarette vs ‘no intervention’ from the smoking DCEA model for each IMD quintile in England.
2. Sum the incremental costs (*c*) and then convert to health opportunity costs at a rate of £20,000 per QALY (*d*), i.e., £ (-156,391,946)/£20,000 = -7,820 QALYs.
3. Use the proportion of the health opportunity costs borne by each IMD quintile (*e*) to calculate the size of the health opportunity costs in each IMD quintile (*f*), e.g., health opportunity costs for IMD1 is -7,820\*0.26 = -2,033 QALYs.
4. Calculate the incremental NHB for each IMD quintile (*g*) by subtracting health opportunity costs from the incremental direct health benefits, e.g., incremental NHB for IMD1 is 6,560 - (-2,033) = 8,593 QALYs.
5. Calculate the incremental NHB per capita by IMD quintile (*i*) using the distribution of the adult population of England (*h*), e.g., IMD1, the individual incremental NHB is 8,593/8,307,456 = 0.0010 QALYs.
6. Add the individual incremental NHB to the baseline QALE (*j*) to calculate the QALE with the intervention by IMD quintile (*k*).
7. Calculate EDE for the baseline QALE distribution (*l*) and the QALE distribution with the intervention (*m*) using the Atkinson social welfare function with an inequality aversion parameter,  $\epsilon$ , of 10.95.

$$EDE = \left( \frac{1}{N} \sum h_i^{1-\epsilon} \right)^{\frac{1}{1-\epsilon}}$$

$h_i$ = individual QALE for a person in IMD quintile *i*  
 $N$ = total population size  
 $\epsilon$ = Atkinson inequality aversion parameter

8. Calculate the population incremental EDE with the intervention (*n*), i.e., the difference of population EDE with the intervention and the population baseline EDE, where the population EDE is multiplying EDE by total population size.
9. Calculate the population incremental NHB with the intervention (*o*), i.e., sum incremental NHB across all quintiles.
10. Calculate how the intervention changes health inequality (iEDE-iNHB) (*p*), i.e., 70,002 - 80,782 = -10,780 QALYs.

|  | IMD1<br>(most deprived) | IMD2        | IMD3         | IMD4        | IMD5<br>(least deprived) |
|--|-------------------------|-------------|--------------|-------------|--------------------------|
| 1. (a) Incremental direct health benefits <sup>1</sup> , QALYs | 6,560                   | 15,619      | 13,201       | 19,350      | 18,233                   |
| (b) Incremental costs <sup>1</sup> , £                         | -12,544,948             | -32,507,825 | -29,016,052  | -42,924,171 | -39,398,949              |
| 2. (c) Total incremental costs (sum of b), £                   |                         |             | -156,391,946 |             |                          |
| (d) Total health opportunity costs (c/20,000), QALYs           |                         |             | -7,820       |             |                          |
| 3. (e) Proportion of health opportunity costs <sup>2</sup>     | 0.26                    | 0.22        | 0.22         | 0.16        | 0.14                     |
| (f) Health opportunity costs (d*e), QALYs                      | -2,033                  | -1,720      | -1,720       | -1,251      | -1,095                   |
| 4. (g) Incremental NHB (a-f), QALYs                            | 8,593                   | 17,339      | 14,921       | 20,601      | 19,328                   |
| 5. (h) Population size <sup>3</sup>                            | 8,307,456               | 8,863,275   | 8,790,681    | 8,657,257   | 8,376,275                |
| (i) Individual incremental NHB (g/h), QALYs                    | 0.0010                  | 0.0020      | 0.0017       | 0.0024      | 0.0023                   |
| 6. (j) Baseline QALE (no intervention) <sup>4</sup>            | 64.7                    | 68.5        | 70.6         | 73.6        | 75.6                     |
| (k) QALE with e-cigarette (i+j)                                | 64.7010                 | 68.5020     | 70.6018      | 73.6024     | 75.6023                  |
| 7. (l) Baseline EDE, QALYs                                     |                         |             | 69.465       |             |                          |
| 8. (m) EDE with the intervention, QALYs                        |                         |             | 69.467       |             |                          |
| (n) Population incremental EDE (m*sum of h-l*sum of h), QALYs  |                         |             | 70,002       |             |                          |
| 9. (o) Impact on overall health (sum of g)                     |                         |             | 80,782       |             |                          |
| 10. (p) Impact on health inequality (n-o)                      |                         |             | -10,780      |             |                          |

<sup>1</sup>calculated using results from the model.

<sup>2</sup>Love-Koh J et al. Estimating Social Variation in the Health Effects of Changes in Healthcare Expenditure. *Medical Decision Making* 2020.

<sup>3</sup>Office for National Statistics (ONS) mid-year population estimates 2017.

<sup>4</sup>Love-Koh J et al. The Social Distribution of Health: Estimating Quality-Adjusted Life Expectancy in England. *Value in Health* 2015.

1 ***Inequality in model inputs***

2 Model inputs in which we reflect socioeconomic differences were categorised into four  
3 groups: background parameters, behaviours, health consequences of behaviour, and  
4 intervention characteristics. The level and direction of inequality in these model inputs  
5 between population groups are summarised using the concentration index [19] (**Table 1**). It  
6 ranges from -1 to 1, with negative values demonstrating higher values of the input in more  
7 deprived groups, while positive values demonstrate higher values in less deprived groups.  
8 The following sections give an overview of each category of input, and more detailed  
9 information is available in the **Appendix**.

10

11 ***Background parameters***

12 Background parameters reflect the level of health that would be observed without  
13 interventions, including the baseline QALE [16] and health opportunity costs [15]. Baseline  
14 QALE is higher in less deprived areas and more health opportunity costs fall on residents in  
15 more deprived areas (**Table 1**).

16

17 ***Behaviours***

18 Behaviours including the smoking prevalence and the abstention from drinking by IMD  
19 quintile were based on survey data. The smoking model incorporated the proportion of  
20 smokers in each IMD quintile [9]. The alcohol model incorporated socioeconomic differences  
21 in abstention from drinking, average weekly consumption and peak day drinking. People in  
22 more deprived groups are more likely to smoke but less likely to drink, drink less on average  
23 and ‘binge’ drink at lower levels (**Table 1**).

24

25 ***Health consequences of behaviour***

26 Health consequences of behaviour include mortality, related diseases and HRQoL. In the  
27 smoking model, the annual mortality rates for smokers (**Figure S1**) were based on general  
28 population all-cause mortality [20], proportion of smokers, former smokers and non-smokers  
29 [21], and the increased relative risk of death for smokers [22]. Mortality in the alcohol model  
30 was modelled separately by health condition, including alcohol-related mortality and all other  
31 causes combined (**Figure S2**). In both models, there is a higher death rate in more deprived  
32 areas (**Table 1**).

33

1 The socioeconomic difference in the smoking-related diseases was estimated using the  
2 average population incidence [21] and the relative risk between IMD quintiles of developing  
3 smoking-related disease [23]. We assumed that the middle IMD quintile, i.e., IMD3, was  
4 represented by the average incidence of smoking-related disease, and then applied relative  
5 risks to estimate incidence in other IMD quintiles. Data on alcohol-related diseases were  
6 obtained from individual hospital records. People living in more deprived areas are more  
7 likely to develop smoking- and alcohol-related diseases (**Table 1**).

8  
9 The smoking model included HRQoL for smokers and former smokers by IMD quintile,  
10 estimated from survey data by linear regression (details available in **Table S6**). People living  
11 in less deprived areas tend to have higher HRQoL (**Table 1**). The same decrement in HRQoL  
12 for each smoking-related disease was applied across all IMD quintiles as no evidence was  
13 identified to inform differential effects. In the alcohol model, separate HRQoL values were  
14 applied for each alcohol-related health condition for each age-sex subgroup [24], with no  
15 evidence available for differences by IMD quintile.

16  
17 In both models, the healthcare costs associated with disease-related events are not  
18 differentiated by IMD, as we did not identify evidence that would let us impose a different  
19 healthcare costs per health event by deprivation.

#### 20 *Intervention characteristics*

21 Socioeconomic differences in intervention impact were incorporated in both models. In the  
22 smoking model, the socioeconomic difference in effectiveness (**Table S7**) was incorporated  
23 assuming that the middle quintile was represented by the average quit rate for the intervention  
24 [25], and then applying the relative risk of quitting between IMD quintiles [26]. The  
25 socioeconomic difference in intervention uptake was based on the proportion of smokers  
26 supplied with an NHS Stop Smoking Service [21]. In the alcohol model, we did not consider  
27 socioeconomic difference in the intervention effect because of the lack of clear evidence, but  
28 incorporated the difference in the access to the intervention. It consists of an initial step  
29 where individuals attending primary care are selected to be screened, informed by the rates at  
30 which individuals register with new GP practices [27] (**Table S8**) and a second step where  
31 those identified as drinking at potentially risky levels (screen positive) receive an  
32 intervention, estimated using the Alcohol Toolkit Study [28] (**Table S9**). The concentration  
33 indices show higher effectiveness and uptake of smoking cessation in less deprived areas,  
34

1 while those for alcohol interventions show higher screening coverage and screening positive  
2 in more deprived areas (**Table 1**).

3

#### 4 *Local Authority level inputs*

5 To contrast national level results to local area results, we selected two Local Authorities with  
6 distinct socioeconomic profiles (smoking: **York** and **Sheffield**; alcohol: **Liverpool** and  
7 **Trafford**). More residents in York and Trafford live in the least deprived quintile compared  
8 to England as a whole, while in Sheffield and Liverpool more residents living in the most  
9 deprived quintile (**Figures S3 & S4**) [29]. The smoking model used local information on  
10 smoking prevalence only (**Figure S5**), while the alcohol model included local information on  
11 mortality and morbidity rates from alcohol-related diseases, the abstention of drinking and  
12 mean weekly alcohol consumption (**Figure S6**). The remaining differences for other  
13 parameters were based on national level figures in the absence of relevant data.

14

#### 15 *Analysis*

16 A series of scenario analyses were performed to explore the impact of altering the  
17 socioeconomic differences in model inputs on DCEA results, corresponding to the four  
18 questions raised in introduction. The intervention impacts estimated in each scenario analysis  
19 were compared to the ‘base case’ estimates, which constitute the results when all the  
20 socioeconomic differences in the model inputs mentioned previously are incorporated. We  
21 assume that the ‘base case’ represent the ‘best’ estimate of the intervention impacts. The  
22 ‘base case’ results and the results of each scenario analysis are presented as scatter plots on  
23 the health equity impact plane [3]. The differences from the ‘base case’ reflect in which  
24 direction and to what extent each scenario affects how well the each model estimates  
25 intervention impact on the distribution of health.

26

27 Question (a): all model inputs were set to the population average value in all IMD quintiles.  
28 This is equivalent to a standard CEA in which only the average population impact on overall  
29 health is calculated. It was expected that ignoring all socioeconomic differences would have  
30 minimal effect on the estimated impact on overall health but a larger effect on the impact on  
31 health inequality. We then excluded socioeconomic difference in one model input at a time  
32 and compared the model outputs with the ‘base case’ estimates. This illustrates to what  
33 degree ignoring socioeconomic difference in each model input would affect the estimates of  
34 impacts on overall health and health inequality.

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28  
29  
30  
31

Question (b): the model inputs we identified as potentially modifiable intervention characteristics were set to the highest level achieved in any of the groups to explore the value of ‘levelling up’ to eliminate the differences. In the smoking model, all groups were assumed to have the highest probability of quitting smoking and highest intervention uptake rate. In the alcohol model, the alcohol misuse screening coverage was assumed to go up to the highest level across all quintiles within the same age-sex group (‘age-sex max’) and also the highest across all age-sex-deprivation groups (‘global max’).

Question (c): the model inputs reflecting socioeconomic differences at local level were incorporated to estimate the ‘base case’ results for two Local Authorities in each model. To enable comparisons across areas that differ in population size, the intervention impacts for 100,000 adults were presented. The ‘base case’ results at local level were compared between Local Authorities and to the results for the nation as a whole.

Question (d): as the two models evaluated different interventions in different disease areas, we compared the results of abovementioned analyses in the two models to assess how the conclusions might vary between models. Additionally, for analyses in addressing question (a), we rearranged the results by plotting the changes in the estimated impacts against the concentration index of the model input which was ignored and then compared these across both models to explore the possible patterns between the extent of inequality of model inputs and the variations in estimated impacts on overall health and health inequality.

**Results**

The results of base case and scenario analyses are summarised in **Table 2** and plotted in **Figure 1** and **Figure 2**. These base case estimates indicate that compared to ‘no intervention’, e-cigarette was estimated to increase overall health (iNHB=80,782 QALYs), but increase health inequality (iEDE-iNHB=-10,780 QALYs), while the alcohol ‘Next Registration’ strategy was estimated to increase overall health (iNHB=4,336 QALYs) and reduce inequality (iEDE-iNHB=444 QALYs) (**Table 2**).

1 ***(a) How influential is failing to consider socioeconomic differences?***

2 *Ignoring socioeconomic differences in all model inputs*

3 Compared to the base case, ignoring socioeconomic differences in all model inputs reduced  
4 the amount by which the interventions were predicted to increase overall health (smoking  
5 model: -272 QALYs, -0.34%; alcohol model: -253 QALYs, -5.83%) (**Table 2**); e-cigarette  
6 was predicted to have no effect on inequality and the alcohol 'Next Registration' strategy was  
7 predicted to increase inequality (**Table 2 & Figure 1**).

8  
9 *Ignoring the socioeconomic difference in one model input at a time*

10 Compared to the base case, in the smoking model, ignoring the socioeconomic difference in  
11 smoking prevalence resulted in the greatest increase in the estimated overall health impact  
12 (4,902 QALYs, 6.07% greater than the total in base case), while ignoring the difference in  
13 intervention effectiveness resulted in the greatest reduction (-3,564 QALYs, -4.39%) (**Table**  
14 **2**). In the alcohol model, ignoring the socioeconomic difference in mean alcohol consumption  
15 resulted in the greatest increase in the estimated overall health impact (756 QALYs, 17.44%),  
16 while ignoring the difference in drinking prevalence resulted in the greatest reduction (-389  
17 QALYs, -8.97%) (**Table 2**).

18  
19 In the smoking model, ignoring the socioeconomic differences in health opportunity costs,  
20 smoking prevalence and risk of smoking-related diseases increased the extent by which the  
21 intervention was estimated to increase inequality, while ignoring socioeconomic differences  
22 in baseline QALE, mortality risks, HRQoL, effectiveness and uptake reduced this extent  
23 (with removal of the socioeconomic difference in uptake making e-cigarette inequality-  
24 reducing), compared to the base case (**Figure 1a**). In the alcohol model, ignoring the  
25 socioeconomic differences in average weekly consumption, peak day consumption, screening  
26 coverage, likelihood of screening positive and the health opportunity costs increased the  
27 extent by which the intervention was estimated to reduce inequality, while ignoring the  
28 socioeconomic differences in abstinence from drinking, alcohol-related diseases and mortality  
29 rates reduced it (with removal of the socioeconomic difference in morbidity making the  
30 strategy inequality-increasing) (**Figure 1b**).

31  
32 ***(b) Which modifiable intervention characteristics represent the most value?***

33 Levelling up effectiveness and uptake of smoking cessation intervention increased the  
34 estimated overall health impact by 7,448 QALYs (9.22%) and 28,875 QALYs (35.74%),

1 respectively, and reduced the extent by which it was predicted to increase inequality, with  
2 levelling up uptake making e-cigarette inequality-reducing, compared to the base case (**Table**  
3 **2 & Figure 2a**).

4  
5 In the alcohol model, increasing coverage of the ‘Next Registration’ strategy to the age-sex  
6 specific maximum level increased the estimated improvement in overall health by 480  
7 QALYs (11.07%) and increased the extent by which it was estimated to reduce inequality,  
8 and increasing the coverage to population maximum level increased the estimated  
9 improvement in overall health by 13,556 QALYs (312.64%) and reduced health inequality to  
10 a much greater extent (**Table 2 & Figure 2b**).

11  
12 *(c) How generalisable are conclusions between settings?*

13 Results per 100,000 adults for each setting are presented in **Figure 3**. In the smoking model,  
14 using local level evidence, e-cigarette was estimated to improve overall health in England,  
15 York and Sheffield with different magnitudes of impacts (**Figure 3a**); it was estimated to  
16 increase inequality in Sheffield and England but reduce inequality in York (**Figure 3a**). The  
17 alcohol ‘Next Registration’ strategy was estimated to increase overall health and reduce  
18 inequality in England and both Local Authorities, but the greatest increase in overall health  
19 was in Liverpool and the greatest reduction in health inequality was in Trafford (**Figure 3b**).

20  
21 *(d) How generalisable are the results between models and disease areas?*

22 The concentration index of each model input and the amount by which ignoring it alters the  
23 estimated intervention impacts on overall health and health inequality is plotted in **Figure S7**  
24 and **Figure 4**, respectively. In both models, there was no clear pattern relating inequality of  
25 the model input to how it alters the estimated impact on overall health (**Figure S7**). In the  
26 smoking model, there was a positive correlation between the concentration index and the  
27 impact of ignoring socioeconomic differences in that input on the estimated health inequality  
28 impact, compared to the base case (**Figure 4a**). Ignoring the socioeconomic differences in  
29 model inputs that are more concentrated on the less deprived (positive concentration index  
30 values) increases the amount by which the intervention is estimated to reduce inequality  
31 while ignoring the socioeconomic differences in model inputs concentrated on the more  
32 deprived results (negative concentration index values) decreases it. However, this pattern was  
33 not clearly observed in the alcohol model (**Figure 4b**).

34

## 1 **Discussion**

2 Evidence on how the impacts of policies vary across population groups is vital to inform  
3 decisions that rest on consideration of impacts on overall health and health inequality. By  
4 interrogating two different DCEA models that feature opposite effects on inequality, we  
5 demonstrated how the evidence for socioeconomic differences in policy impact could be  
6 evaluated within a DCEA framework, which represents a form of stratified cost-effectiveness  
7 analysis. Good understanding of how and when accounting for socioeconomic differences  
8 between groups affects the assessment of intervention impacts on overall health and health  
9 inequality could advice researchers whether it is possible to simplify the DCEA process and  
10 inform decision makers where DCEA would add most value.

11  
12 First, we found that failing to consider socioeconomic differences would affect the estimated  
13 policy impacts to a different degree between the two models. It has a more minor influence  
14 on the estimated overall health impact in the smoking model, and a greater influence in the  
15 non-linear alcohol model (smoking model: -0.21% alcohol model: -5.83%). As anticipated, it  
16 greatly affected the estimated impact on health inequality, influencing not only the magnitude  
17 but also the direction of effect (smoking: increase inequality to no effect; alcohol: reduce  
18 inequality to increase inequality). Ignoring socioeconomic differences in just one input can  
19 have a substantial effect on the results, but we found no clear relationship that might predict  
20 which model inputs are most influential.

21  
22 Second, levelling up modifiable intervention characteristics to the highest level achieved in  
23 any subgroup would improve estimated health inequality impact to the direction that favours  
24 the interventions. It also increases the estimated overall health impact, so it would not impose  
25 a trade-off between improvement in overall health and reduction in inequality.

26 Socioeconomic variation in smoking cessation uptake appears a more valuable target for  
27 modification than socioeconomic variation in effectiveness. This could inform decision  
28 makers where to focus efforts to make policies benefit population groups more fairly. It  
29 should be noted that such efforts usually attract additional costs, and further analysis would  
30 be needed to explore whether the benefits are worthwhile.

31  
32 Third, the magnitude of impacts on overall health and health inequality at one Local  
33 Authority was different compared to that at another Local Authority or the nation as a whole.  
34 In the smoking model, the direction of the impact was also different (e-cigarette was

1 estimated to reduce inequality in York, but to increase inequality measured across England  
2 and Sheffield). The inconsistency in the policy impacts between settings is likely to be driven  
3 by the different deprivation structures of the populations and the local level socioeconomic  
4 differences. This suggests that caution should be taken when generalising recommendation of  
5 interventions from national level to Local Authorities, and between Local Authorities  
6 differing in deprivation structure of the population and other model inputs. Prioritisation and  
7 local level decision making could be better supported by conducting and reporting analyses  
8 that reflects differences relevant to the local context.

9  
10 The conclusions that can be drawn from this study are limited as it is based on only two  
11 models. Although both decision models have been used to support real resource allocation  
12 decisions in the UK, the base case results may omit potential socioeconomic differences in  
13 inputs where evidence was not available. For example, if disease-related events require more  
14 resource use for treatment, or impose a greater quality of life decrement, in more deprived  
15 groups, the socioeconomic differences in healthcare costs and health-related quality of life  
16 would be underestimated. In view of this, sensitivity analyses of more DCEA models can be  
17 combined with the results from our analysis to further our understanding of how influential  
18 considering socioeconomic differences in different types of model input is on the estimated  
19 policy impacts. We have not considered alternative interventions or designs of the  
20 interventions (e.g. extra efforts on targeting disadvantaged groups), which would be expected  
21 to have alternative impacts on inequalities, but there is scope for the use of DCEA and other  
22 methods to help inform how best to design interventions to impact on inequalities.

23 Additionally, the evidence on socioeconomic differences in model inputs is associated with  
24 uncertainty. The smoking model incorporated this uncertainty, which could be analysed with  
25 a probabilistic sensitivity analysis, to provide credible intervals around estimated policy  
26 impacts. However, the computing time for the individual simulation alcohol model was  
27 already high and did not allow for probabilistic sensitivity analysis. Consequently, we did not  
28 compare the influence of uncertainty across the two models.

29  
30 The results presented in this study indicate that between-group differences in patterns of  
31 disease, intervention efficacy and intervention use can combine and interact in a complex  
32 manner and produce results that are difficult to predict. Thus, a formal analysis of inequality  
33 impacts, such as that provided by a full DCEA, can be beneficial in guiding resource  
34 allocation decisions. In practice, the decision on whether to conduct a DCEA or some other

1 form of stratified analysis may be informed by qualitative approaches, similar to those used  
2 in the integrated health technology assessment (HTA) process [30]. A number of other  
3 methods have been proposed in the literature for including health inequality concerns in  
4 economic evaluation, for example the extended CEA [31], but these methods would rely on  
5 the same evidence on socioeconomic differences utilised here [5] and do not use inequality  
6 indices to explicitly analyse trade-offs between improving health and reducing health  
7 inequality. Although we have seen in this study that additional work is needed to conduct the  
8 DCEA and the approach would increase complexity and introduce uncertainty, the  
9 applications of DCEA have shown that it is feasible to implement within a typical HTA  
10 process and the skills required lie within the capabilities of analysts currently conducting  
11 CEA [4]. The trade-offs between health improvement and inequality reduction, informed by a  
12 full DCEA, would assist decision makers to clarify and quantify the nature of their inequality  
13 concerns and provide better ways of communicating findings to wider audiences [4].  
14

## 15 **Conclusions**

16 By conducting two case studies, one assessing smoking cessation intervention and the other  
17 assessing alcohol screening and brief intervention, we found that conclusions about their  
18 impact on health inequality are strongly influenced by socioeconomic differences in model  
19 inputs, but not in an easy way to predict. This affirms the potential value for increasing the  
20 extent of formal and quantitative analysis of health inequality impacts to inform resource  
21 allocation decisions. Our study also suggests the need for better consideration of the diversity  
22 in deprivation structure, epidemiology and access to services across settings.  
23

## 24 **References**

- 25 [1] Drummond MF, Sculpher MJ, Torrance GW, O'Brien BJ, Stoddart GL. Methods for the  
26 economic evaluation of health care programmes. 3rd ed. Oxford, UK: Oxford University Press 2005.  
27 [2] Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P, Consortium for the European Review of  
28 Social Determinants of H, et al. WHO European review of social determinants of health and the  
29 health divide. *Lancet*. 2012; 380(9846):1011-29.  
30 [3] Cookson R, Drummond M, Weatherly H. Explicit incorporation of equity considerations into  
31 economic evaluation of public health interventions. *Health Econ Policy Law*. 2009; 4(Pt 2):231-45.  
32 [4] Asaria M, Griffin S, Cookson R. Distributional Cost-Effectiveness Analysis: A Tutorial. *Med*  
33 *Decis Making*. 2016; 36(1):8-19.  
34 [5] Asaria M, Griffin S, Cookson R, Whyte S, Tappenden P. Distributional cost-effectiveness  
35 analysis of health care programmes--a methodological case study of the UK Bowel Cancer Screening  
36 Programme. *Health Econ*. 2015; 24(6):742-54.  
37 [6] Love-Koh J, Cookson R, Gutacker N, Patton T, Griffin S. Aggregate Distributional Cost-  
38 Effectiveness Analysis of Health Technologies. *Value Health*. 2019; 22(5):518-26.

- 1 [7] White M, Adams J, Heywood PJSi, health p. How and why do interventions that increase  
2 health overall widen inequalities within populations. 2009; 65:82.
- 3 [8] NICE. NICE - Public Health Guidance. 2019 Available from:  
4 <https://www.nice.org.uk/guidance/published?type=ph>
- 5 [9] Public Health England. Local Tobacco Control Profiles. 2019 Available from:  
6 <https://fingertips.phe.org.uk/profile/tobacco-control>
- 7 [10] York Health Economics Consortium. Smoking Cessation Interventions and Services2018.
- 8 [11] Purshouse RC, Brennan A, Rafia R, Latimer NR, Archer RJ, Angus CR, et al. Modelling the  
9 cost-effectiveness of alcohol screening and brief interventions in primary care in England. *Alcohol*  
10 *Alcohol*. 2013; 48(2):180-8.
- 11 [12] National Institute for Health and Care Excellence. Guide to the methods of technology  
12 appraisal 20132013 4 April 2013.
- 13 [13] Earnshaw J, Lewis G. NICE guide to the methods of technology appraisal. Springer 2008.
- 14 [14] Government DfCaL. The English Indices of Deprivation 2015 Statistical Release 72015.
- 15 [15] Love-Koh J, Cookson R, Claxton K, Griffin S. Estimating Social Variation in the Health  
16 Effects of Changes in Health Care Expenditure. *Med Decis Making*. 2020:272989X20904360.
- 17 [16] Love-Koh J, Asaria M, Cookson R, Griffin S. The Social Distribution of Health: Estimating  
18 Quality-Adjusted Life Expectancy in England. *Value Health*. 2015; 18(5):655-62.
- 19 [17] Atkinson ABJJoet. On the measurement of inequality. 1970; 2(3):244-63.
- 20 [18] Robson M, Asaria M, Cookson R, Tsuchiya A, Ali S. Eliciting the Level of Health Inequality  
21 Aversion in England. *Health Econ*. 2017; 26(10):1328-34.
- 22 [19] O'donnell O, Van Doorslaer E, Wagstaff A, Lindelow M. Analyzing health equity using  
23 household survey data: a guide to techniques and their implementation: The World Bank 2007.
- 24 [20] Statistics OfN. Number of deaths by sex, single year of age and IMD decile, England, deaths  
25 registered 2001-2015. 2017.
- 26 [21] Love-Koh J, Pennington R, Owen L, S. G. Frameworks for considering health inequalities  
27 and their suitability for use within NICE public health guidelines. 2018.
- 28 [22] Doll R, Peto R. Mortality in relation to smoking: 20 years' observations on male British  
29 doctors. *Br Med J*. 1976; 2(6051):1525-36.
- 30 [23] Eberth B, Olajide D, Craig P, Ludbrook A. Smoking-related disease risk, area deprivation and  
31 health behaviours. *J Public Health (Oxf)*. 2014; 36(1):72-80.
- 32 [24] Purshouse R, Brennan A, Latimer N, Meng Y, Rafia R, Jackson R, et al. Modelling to assess  
33 the effectiveness and cost-effectiveness of public health related strategies and intervention to reduce  
34 alcohol attributable harm in England using the Sheffield Alcohol Policy Model version 2.02009.
- 35 [25] Caponnetto P, Campagna D, Cibella F, Morjaria JB, Caruso M, Russo C, et al. EffiCiency  
36 and Safety of an eLectronic cigAreTte (ECLAT) as tobacco cigarettes substitute: a prospective 12-  
37 month randomized control design study. *PLoS ONE*. 2013; 8(6):e66317.
- 38 [26] Dobbie F, Hiscock R, Leonardi-Bee J, Murray S, Shahab L, Aveyard P, et al. Evaluating  
39 Long-term Outcomes of NHS Stop Smoking Services (ELONS): a prospective cohort study. *Health*  
40 *Technol Assess*. 2015; 19(95):1-156.
- 41 [27] Weir S, Juhasz A, Puellas J, Tierney TS. Relationship between initial therapy and blood  
42 pressure control for high-risk hypertension patients in the UK: a retrospective cohort study from the  
43 THIN general practice database. *BMJ Open*. 2017; 7(7):e015527.
- 44 [28] Beard E, Brown J, West R, Acton C, Brennan A, Drummond C, et al. Protocol for a national  
45 monthly survey of alcohol use in England with 6-month follow-up: 'the Alcohol Toolkit Study'. *BMC*  
46 *Public Health*. 2015; 15:230.
- 47 [29] England PH. Local Authority Health Profiles. Available from:  
48 <https://fingertips.phe.org.uk/profile/health-profiles>
- 49 [30] Wahlster P, Brereton L, Burns J, Hofmann B, Mozygamba K, Oortwijn W, et al. An  
50 Integrated Perspective on the Assessment of Technologies: Integrate-Hta. *Int J Technol Assess Health*  
51 *Care*. 2017; 33(5):544-51.
- 52 [31] Verguet S, Laxminarayan R, Jamison DT. Universal public finance of tuberculosis treatment  
53 in India: an extended cost-effectiveness analysis. *Health Econ*. 2015; 24(3):318-32.

## Tables

**Table 1.** Category and concentration index of model inputs incorporating socioeconomic variation

| <b>Category:</b>                       | <b>Gradient in:</b>                                | <b>Concentration index</b> |
|--|--|----------------------------|
| Background parameters<br>(both models) | Baseline quality-adjusted life expectancy          | 0.03                       |
|  | Health opportunity costs                           | -0.12                      |
| Behaviours                             | Smoking: prevalence                                | -0.08                      |
|  | Alcohol: abstention from drinking                  | 0.06                       |
|  | Alcohol: average weekly consumption                | 0.03                       |
|  | Alcohol: peak day consumption                      | 0.06                       |
| Health consequences of<br>behaviour    | Smoking: mortality                                 | -0.08                      |
|  | Alcohol: mortality                                 | -0.07                      |
|  | Smoking-related diseases                           | -0.02                      |
|  | Alcohol-related diseases                           | -0.05                      |
|  | Smoking: health-related quality of life            | 0.01                       |
| Intervention<br>characteristics        | Smoking: intervention effectiveness (quit smoking) | 0.04                       |
|  | Smoking: intervention uptake                       | 0.17                       |
|  | Alcohol: individuals screened for alcohol misuse   | -0.01                      |
|  | Alcohol: probability of screening positive         | -0.01                      |

**Table 2.** Estimates of impacts on overall health and health inequality in base case and scenario analysis

|   | iNHB                             | Change in iNHB<br>from base case | iEDE    | Change in iEDE<br>from base case | Inequality<br>(iEDE-iNHB) | Change in the impact on inequality<br>compared to base case |
|---|----------------------------------|----------------------------------|---------|----------------------------------|---------------------------|---|
| <b>Smoking model (e-cigarette vs ‘no intervention’)</b>         |                                  |                                  |         |                                  |                           |   |
| Base case   | 80,782                           | -                                | 70,002  | -                                | -10,780                   | <b>Increase inequality</b>                                  |
| (a) Ignoring all gradients                                      | 80,510                           | -272 (-0.34%)                    | 80,510  | 10,508 (15.01%)                  | 0                         | Smaller increase  |
|   | Baseline QALE                    | 0 (0%)                           | 80,781  | 10,779 (15.40%)                  | -1                        | Smaller increase  |
|   | Health opportunity costs         | 0 (0%)                           | 69,019  | -983 (-1.40%)                    | -11,763                   | Larger increase   |
|   | Smoking prevalence               | 4,902 (6.07%)                    | 69,454  | -548 (-0.78%)                    | -16,229                   | Larger increase   |
| (b) Ignoring gradient in:                                       | Mortality                        | -1,239 (-1.53%)                  | 70,261  | 259 (0.37%)                      | -9,282                    | Smaller increase  |
|   | Smoking-related diseases         | 1,636 (2.03%)                    | 70,853  | 851 (1.22%)                      | -11,564                   | Larger increase   |
|   | HRQoL                            | -153 (-0.19%)                    | 70,053  | 51 (0.07%)                       | -10,575                   | Smaller increase  |
|   | Effectiveness                    | -3,546 (-4.39%)                  | 69,942  | -60 (-0.09%)                     | -7,294                    | Smaller increase  |
|   | Uptake                           | -345 (-0.43%)                    | 81,463  | 11,461 (16.37%)                  | 1,027                     | Inequality-reducing   |
| (c) Levelling up to the best in:                                | Effectiveness                    | 7,448 (9.22%)                    | 79,929  | 9,927 (14.18%)                   | -8,300                    | Reduce  |
|   | Uptake                           | 28,875 (35.74%)                  | 111,057 | 41,055 (58.65%)                  | 1,400                     | Inequality-reducing   |
| <b>Alcohol model (‘Next Registration’ vs ‘no intervention’)</b> |                                  |                                  |         |                                  |                           |   |
| Base case   | 4,336                            | -                                | 4,780   | -                                | 444                       | <b>Reduce inequality</b>                                    |
| (a) Ignoring all gradients                                      | 4,083                            | -253 (-5.83%)                    | 3,580   | -1,199 (-25.08%)                 | -503                      | Increases inequality  |
|   | Baseline QALE                    | 0 (0%)                           | 4,336   | -444 (-9.29%)                    | 0                         | Smaller reduction   |
|   | Health opportunity costs         | 0 (0%)                           | 4,989   | 209 (+4.37%)                     | 652                       | Larger reduction  |
|   | Abstinence                       | -389 (-8.97%)                    | 4,125   | -655 (-13.7%)                    | 178                       | Smaller reduction   |
|   | Mortality                        | 194 (+4.47%)                     | 4,565   | -215 (-4.5%)                     | 35                        | Smaller reduction   |
| (b) Ignoring gradient in:                                       | Alcohol-related diseases         | 519 (+11.97%)                    | 4,645   | -135 (-2.82%)                    | -211                      | Increases inequality  |
|   | Average weekly consumption       | 756 (+17.44%)                    | 6,253   | 1,474 (+30.84%)                  | 1,162                     | Larger reduction  |
|   | Peak day consumption             | 388 (+8.95%)                     | 5,421   | 642 (+13.43%)                    | 698                       | Larger reduction  |
|   | Screening coverage               | 157 (+3.62%)                     | 5,492   | 713 (+14.92%)                    | 999                       | Larger reduction  |
|   | Screening positive (risky level) | 466 (+10.75%)                    | 5,512   | 732 (+15.31%)                    | 709                       | Larger reduction  |
| (c) Levelling up to the best in:                                | Screening rates (age-sex max)    | 480 (+11.07%)                    | 6,213   | 1433 (+29.98%)                   | 1,397                     | Larger reduction  |
|   | Screening rates (global max)     | 13,556 (+312.64%)                | 22,141  | 17361 (+363.2%)                  | 4,248                     | Larger reduction  |

QALE: quality-adjusted life expectancy

HRQoL: health-related quality of life

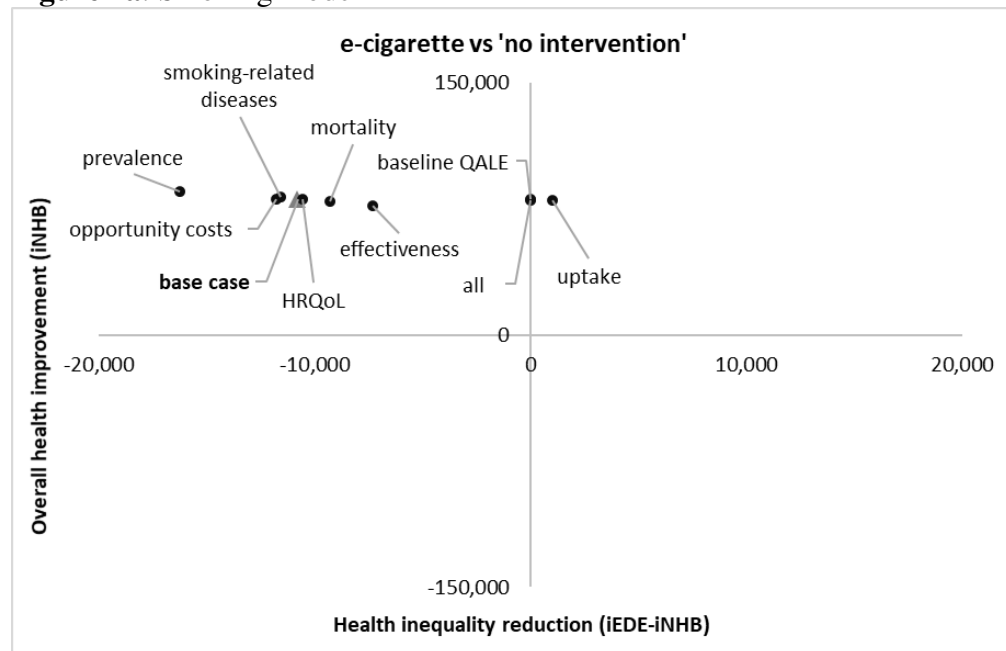
iNHB: incremental net health benefit

iEDE: incremental equally distributed equivalent health

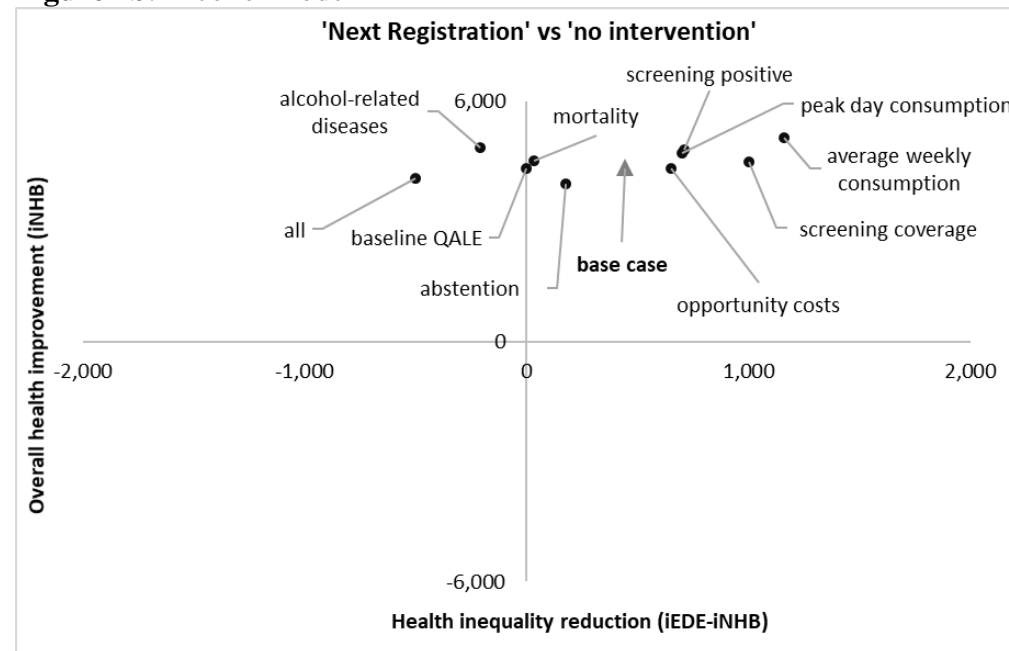
## Figures

**Figure 1.** Health equity impact plane\* showing scenario analysis results where socioeconomic differences are ignored

**Figure 1a.** Smoking model



**Figure 1b.** Alcohol model

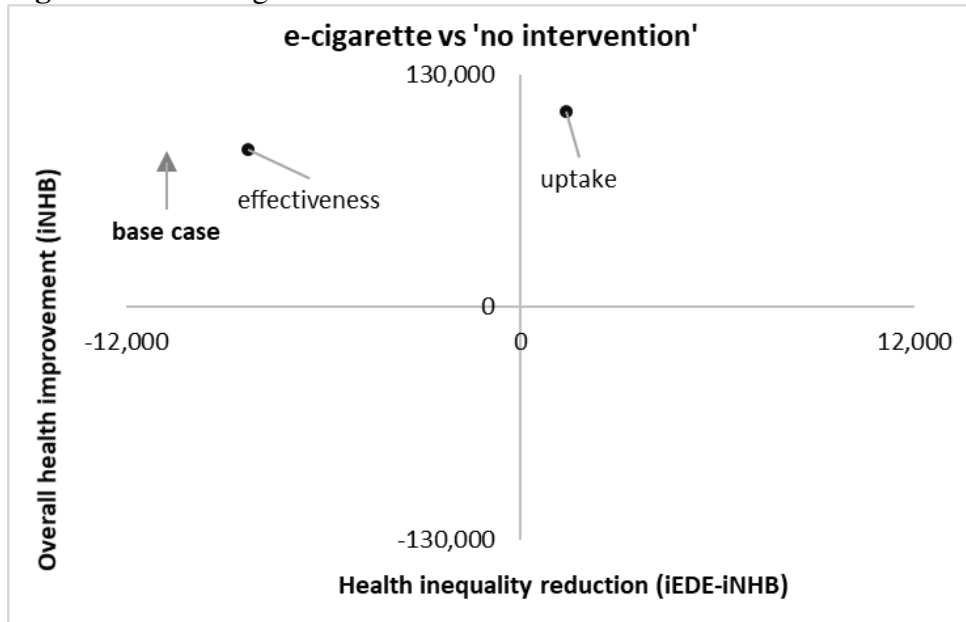


\*In the health equity plane, the y axis is the increase in population health and the x axis is the reduction in health inequality. Interventions that improve overall health fall in the north of the plane. Interventions that reduce inequality fall in the east of the plane. E-cigarette was estimated to increase overall health and increase inequality, so it locates in the north-west quadrant. 'Next Registration' was estimated to increase overall health and reduce inequality, so it locates in the north-east quadrant.

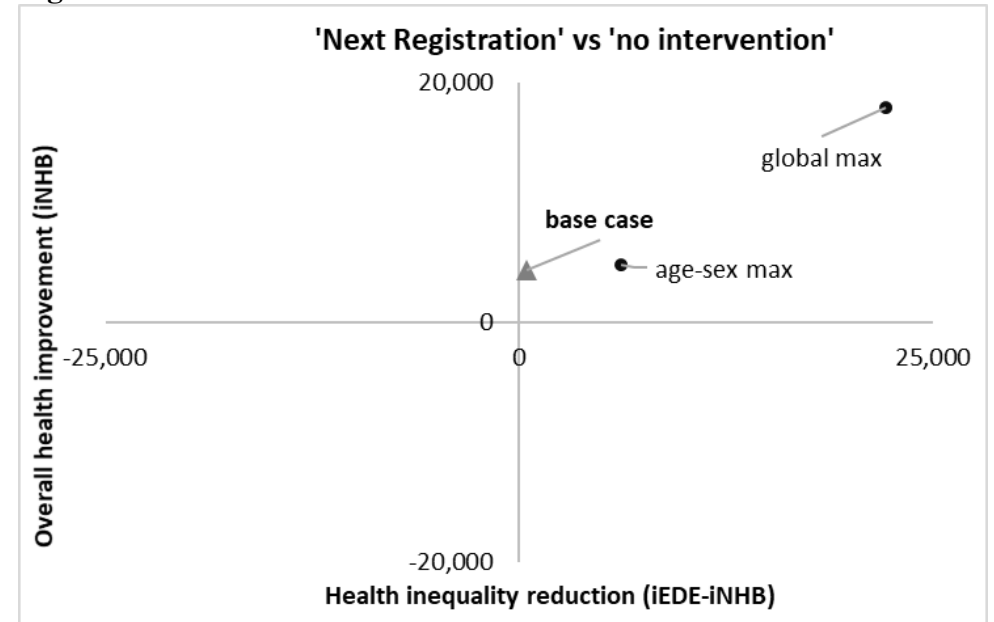
Compared to the base case, if the location of the result in scenario analysis moves upward on the y axis, the model estimates more health improvement; if the location moves towards the right side on the x axis, the model estimates less inequality. For example, in the smoking model, the result of ignoring the socioeconomic difference in effectiveness moves downward and to the right, which indicates less health improvement and less inequality, compared to the base case.

**Figure 2.** Health equity impact plane\* showing scenario analysis results where levelling up to the best

**Figure 2a.** Smoking model



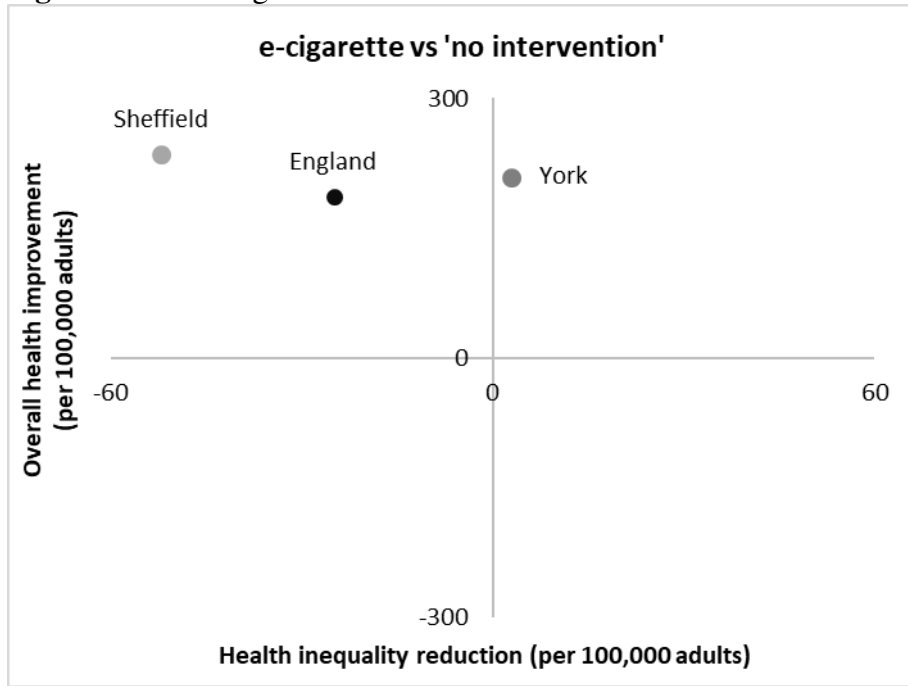
**Figure 2b.** Alcohol model



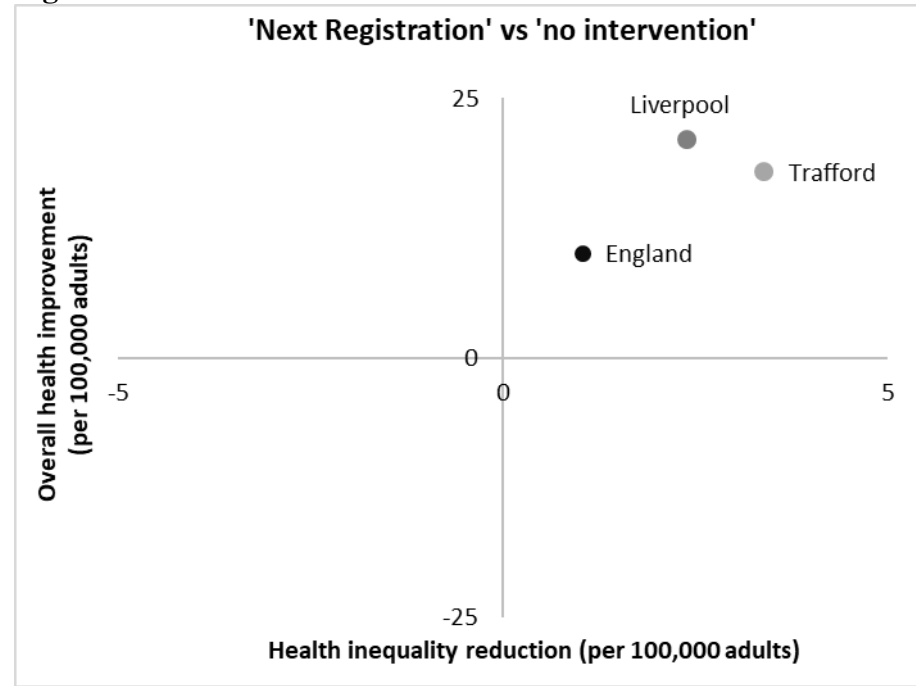
\*Compared to the base case, if the location of the result in scenario analysis moves upward on the y axis, the model estimates more health improvement; if the location moves towards the right side on the x axis, the model estimates less inequality. For example, in the smoking model, the result of levelling up uptake moves upward and to the right, which indicates more health improvement and less inequality, compared to the base case. The location of 'uptake' is in the north-east quadrant, indicating the intervention is estimated to reduce inequality.

**Figure 3.** Equity impact plane\* showing the overall health and health inequality for Local Authority analysis

**Figure 3a.** Smoking model



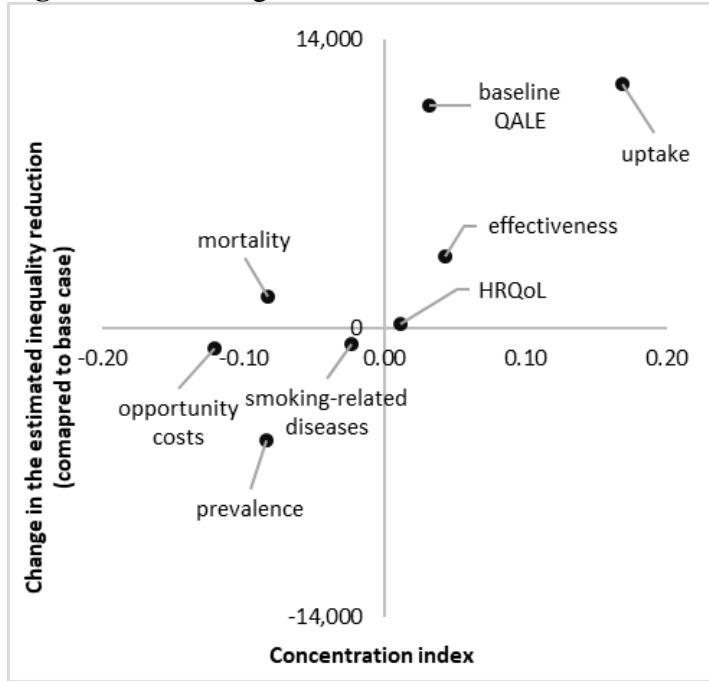
**Figure 3b.** Alcohol model



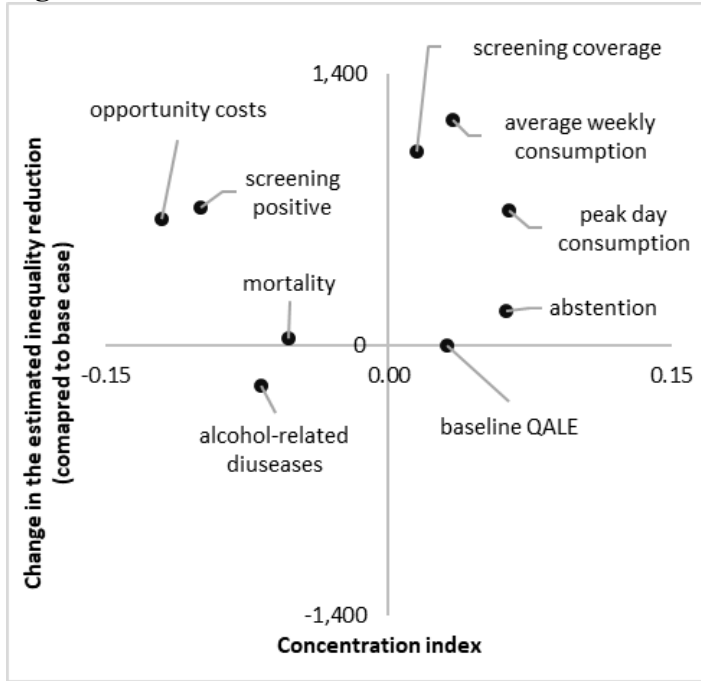
\*Compared to the base case, if the location of the result in scenario analysis moves upward on the y axis, the model estimates more health improvement; if the location moves towards the right side on the x axis, the model estimates less inequality. For example, in the smoking model, the result for 'Sheffield' moves upward and to the left, which indicates more health improvement and more inequality, compared to the result for 'England'.

**Figure 4.** Impact on health inequality vs. concentration index where socioeconomic differences are ignored

**Figure 4a.** Smoking model



**Figure 4b.** Alcohol model



## Appendices

**Table S1.** Distribution of health opportunity costs by IMD quintile groups

| Parameter             | Value | Source                     |
|-----------------------|-------|----------------------------|
| IMD1 (most deprived)  | 0.26  | Love-Koh et al. (2016) (1) |
| IMD2                  | 0.22  |                            |
| IMD3                  | 0.22  |                            |
| IMD4                  | 0.16  |                            |
| IMD5 (least deprived) | 0.14  |                            |

IMD: Index of Multiple Deprivation

**Table S2.** Distribution of the adult population of England

|                       | Adult population |
|-----------------------|------------------|
| IMD1 (most deprived)  | 8,307,456        |
| IMD2                  | 8,863,275        |
| IMD3                  | 8,790,681        |
| IMD4                  | 8,657,257        |
| IMD5 (least deprived) | 8,376,275        |

IMD: Index of Multiple Deprivation

**Table S3.** The social distribution of baseline QALE in England

|                       | QALE at birth (years) | Source                     |
|-----------------------|-----------------------|----------------------------|
| IMD1 (most deprived)  | 64.7                  | Love-Koh et al. (2015) (2) |
| IMD2                  | 68.5                  |                            |
| IMD3                  | 70.6                  |                            |
| IMD4                  | 73.6                  |                            |
| IMD5 (least deprived) | 75.6                  |                            |

IMD: Index of Multiple Deprivation

QALE: quality-adjusted life expectancy

**Table S4.** Smoking prevalence by IMD in England (2017)

| Smoking prevalence    | Mean   | 95% confidence interval |
|-----------------------|--------|-------------------------|
| IMD1 (most deprived)  | 17.17% | 16.55%, 17.79%          |
| IMD2                  | 15.96% | 15.22%, 16.70%          |
| IMD3                  | 14.09% | 13.24%, 14.95%          |
| IMD4                  | 12.68% | 11.80%, 13.57%          |
| IMD5 (least deprived) | 11.38% | 10.53%, 12.24%          |

IMD: Index of Multiple Deprivation

**Table S5.** Socioeconomic differences in drinking

| Deprivation quintile  | Abstention rate | Average weekly consumption (units/drinker) | Peak day consumption (units/drinker) |
|-----------------------|-----------------|--|--------------------------------------|
| IMD1 (most deprived)  | 28.2%           | 13.00                                      | 4.44                                 |
| IMD2                  | 32.0%           | 12.01                                      | 3.96                                 |
| IMD3                  | 14.1%           | 12.54                                      | 4.33                                 |
| IMD4                  | 12.3%           | 13.63                                      | 5.11                                 |
| IMD5 (least deprived) | 7.1%            | 14.95                                      | 5.71                                 |

IMD: Index of Multiple Deprivation

**Table S6.** Output from HRQoL regression model using EQ-5D data from the Health Survey for England 2012 and 2014

| Variable                  |                       | Coefficient   | Standard error |
|---------------------------|-----------------------|---------------|----------------|
| <b>Constant</b>           |                       | 0.903***      | 0.0139         |
| <b>Age group</b>          | 16-24                 | Ref           |                |
|                           | 25-34                 | -0.0124***    | 0.0137         |
|                           | 35-44                 | -0.0544***    | 0.0133         |
|                           | 45-54                 | -0.0681***    | 0.0135         |
|                           | 55-64                 | -0.0986***    | 0.0138         |
|                           | 65-74                 | -0.107***     | 0.0145         |
|                           | 75+                   | -0.1630***    | 0.0165         |
| <b>Smoking status</b>     | Former smoker         | Ref           |                |
|                           | Smoker                | -0.0340***    | 0.0069         |
| <b>IMD</b>                | IMD1 (most deprived)  | Ref           |                |
|                           | IMD2                  | 0.0320**      | 0.0099         |
|                           | IMD3                  | 0.0281**      | 0.0101         |
|                           | IMD4                  | 0.0545***     | 0.0102         |
|                           | IMD5 (least deprived) | 0.0736***     | 0.0101         |
| <b>Adjusted R-squared</b> |                       | <b>0.0414</b> |                |

\* p<0.05, \*\* p<0.01, \*\*\* p<0.001

IMD: Index of Multiple Deprivation

HRQoL: health-related quality of life

**Table S7.** Relative risk of quitting smoking

| Parameter             | Value | 95% confidence interval | Distribution | Source                 |
|-----------------------|-------|-------------------------|--------------|------------------------|
| IMD1 (most deprived)  | 1     | -                       |              | Dobbie et al. 2015 (3) |
| IMD2                  | 1.35  | 0.94, 1.81              | Lognormal*   | Grant 2014 (4)         |
| IMD3                  | 1.22  | 0.79, 1.73              | Lognormal*   |                        |
| IMD4                  | 1.27  | 0.91, 1.67              | Lognormal*   |                        |
| IMD5 (least deprived) | 1.36  | 0.94, 1.82              | Lognormal*   |                        |

\*Estimates transformed to the log scale

IMD: Index of Multiple Deprivation

**Table S8.** Socioeconomic difference in screening rates in the alcohol model

| Deprivation quintile  | 'Next Registration' strategy | Source               |
|-----------------------|------------------------------|----------------------|
| IMD1 (most deprived)  | 9.4%                         | Weir et al. 2017 (5) |
| IMD2                  | 12.6%                        |                      |
| IMD3                  | 12.8%                        |                      |
| IMD4                  | 11.2%                        |                      |
| IMD5 (least deprived) | 11.1%                        |                      |

IMD: Index of Multiple Deprivation

**Table S9.** Output from screening outcome regression model in the alcohol model from Alcohol Toolkit Study

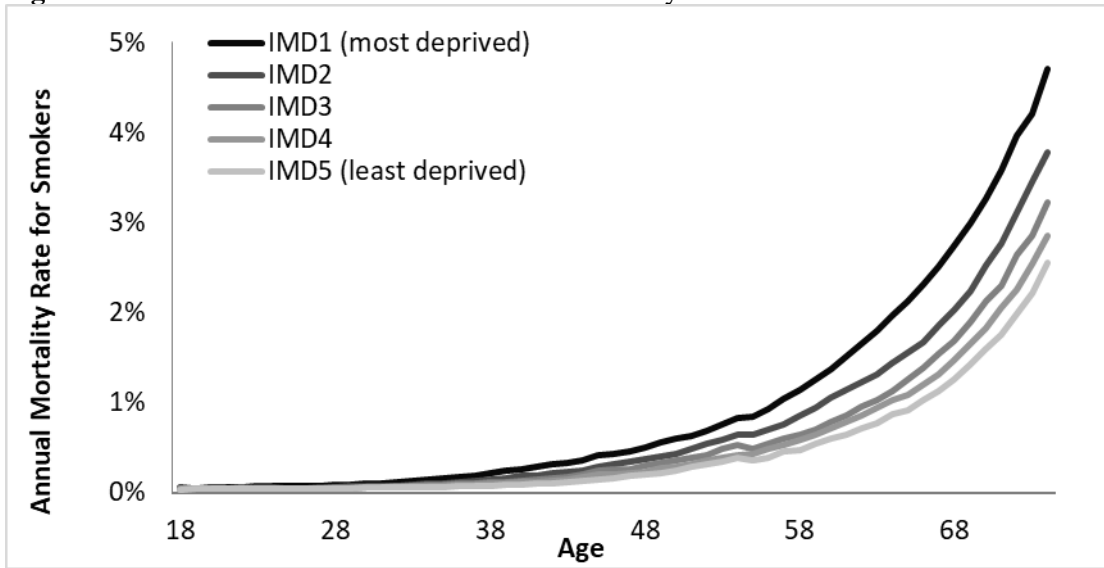
| Variable                             |                       | Odds Ratio | Standard Error |
|--------------------------------------|-----------------------|------------|----------------|
| <b>Constant</b>                      |                       | 0.1226***  | 0.0055         |
| <b>Age group</b>                     | 16-24                 | Ref        |                |
|                                      | 25-34                 | 0.4944***  | 0.0216         |
|                                      | 35-54                 | 0.2655***  | 0.0105         |
|                                      | 55+                   | 0.0750***  | 0.0035         |
| <b>Sex</b>                           | Male                  | Ref        |                |
|                                      | Female                | 0.7267***  | 0.0215         |
| <b>Mean consumption (units/week)</b> |                       | 1.2463***  | 0.0029         |
| <b>IMD</b>                           | IMD5 (least deprived) | Ref        |                |
|                                      | IMD4                  | 1.1851***  | 0.0436         |
|                                      | IMD3                  | 1.2540***  | 0.0556         |
|                                      | IMD2                  | 1.2730***  | 0.0668         |
|                                      | IMD1 (most deprived)  | 1.7310***  | 0.1120         |

\*p<0.05, \*\* p<0.01, \*\*\* p<0.001

Source: Beard et al. 2015 (6)

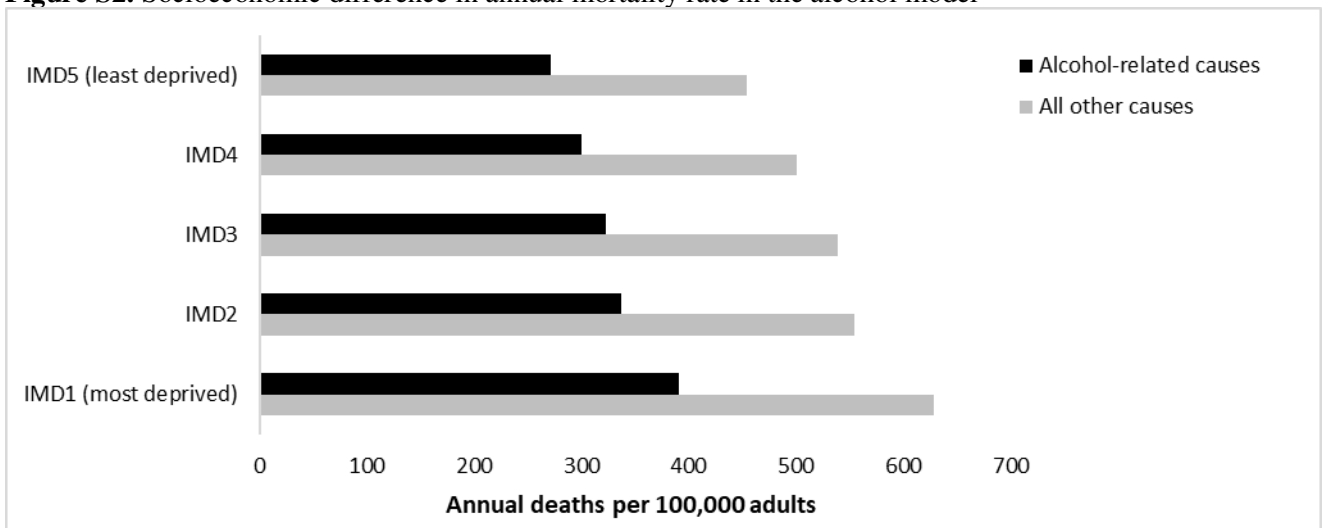
IMD: Index of Multiple Deprivation

**Figure S1.** Socioeconomic difference in annual mortality risk for smokers



IMD: Index of Multiple Deprivation

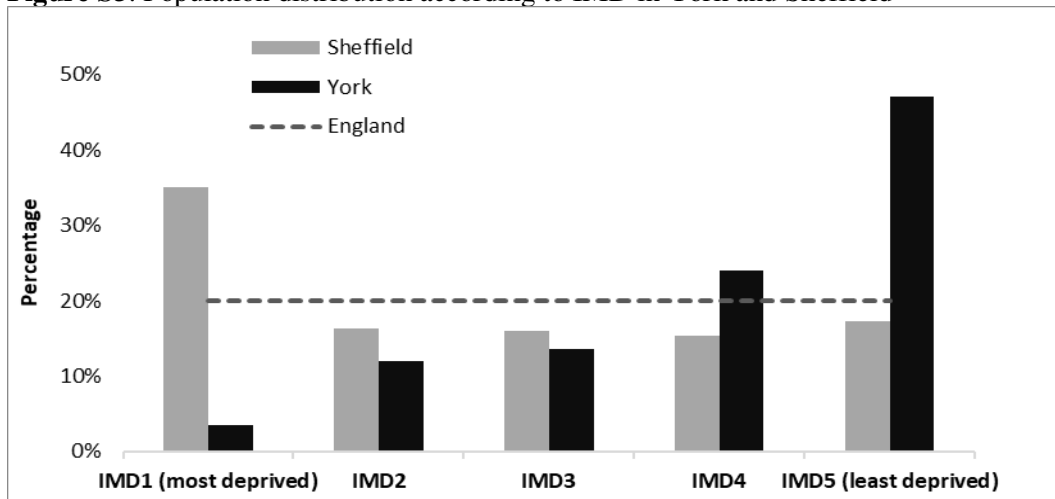
**Figure S2.** Socioeconomic difference in annual mortality rate in the alcohol model\*



\* extracted from Office for National Statistics (ONS) data 2012-2016

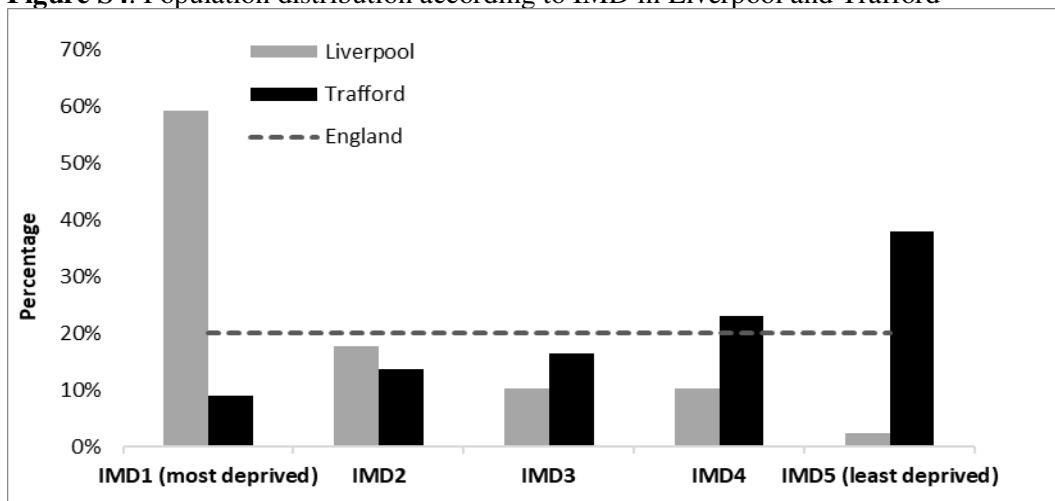
IMD: Index of Multiple Deprivation

**Figure S3.** Population distribution according to IMD in York and Sheffield



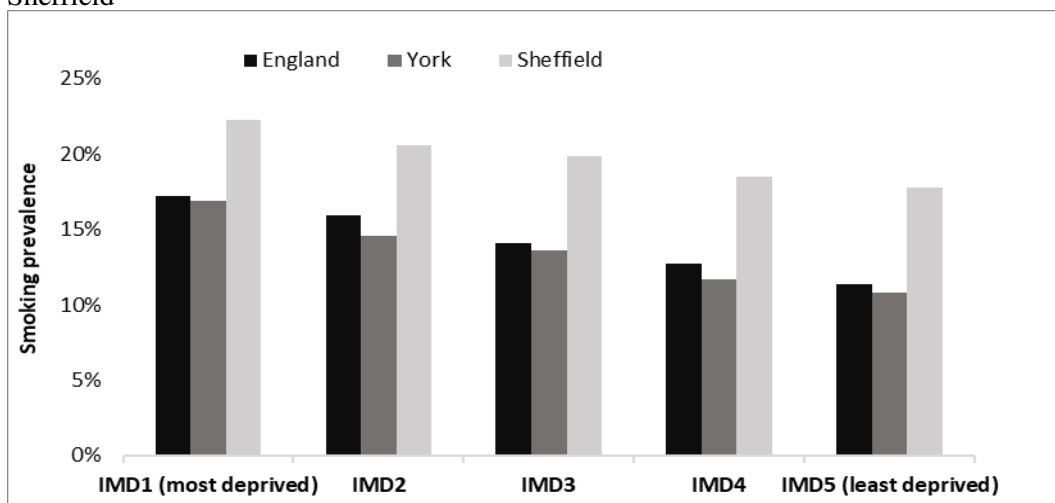
IMD: Index of Multiple Deprivation

**Figure S4.** Population distribution according to IMD in Liverpool and Trafford



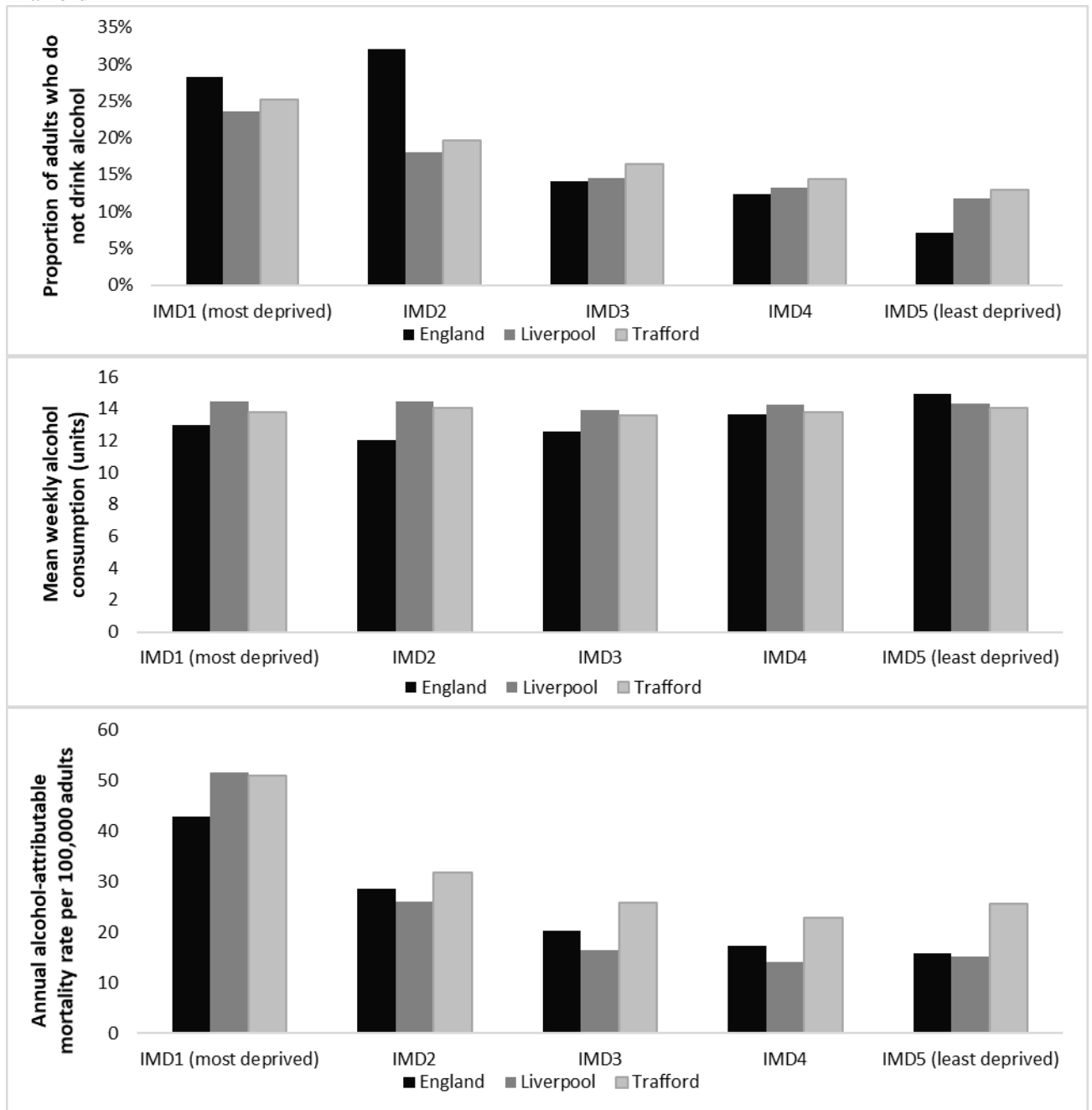
IMD: Index of Multiple Deprivation

**Figure S5.** Variation in socioeconomic difference in smoking prevalence for England, York and Sheffield



IMD: Index of Multiple Deprivation

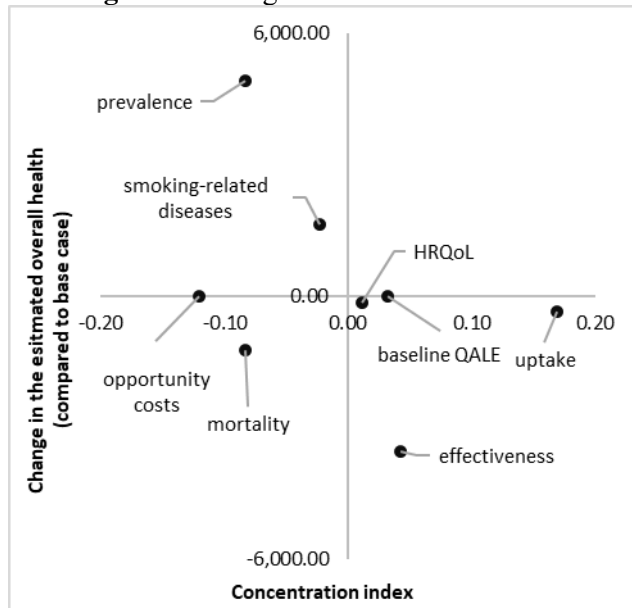
**Figure S6.** Variation in socioeconomic differences in model inputs for England, Liverpool and Trafford



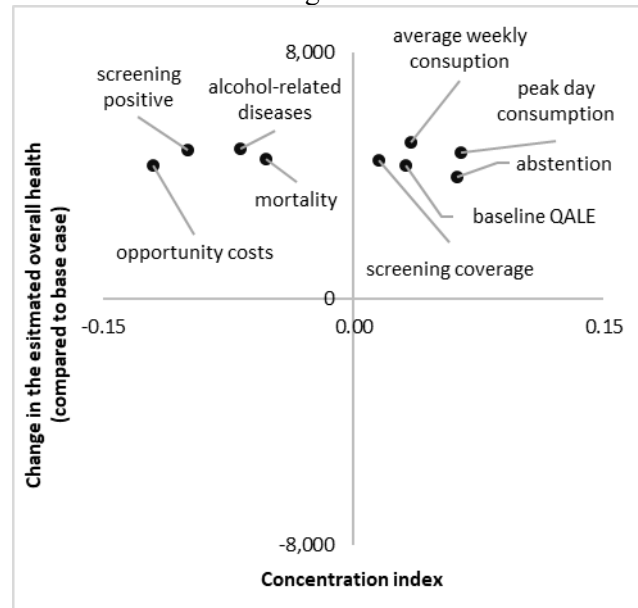
IMD: Index of Multiple Deprivation

**Figure S7.** Impact on overall health vs. concentration index where socioeconomic differences are ignored

**Smoking model:** e-cigarette vs ‘no intervention’



**Alcohol model:** Next Registration vs ‘no intervention’



1. Love-Koh J, Cookson R, Claxton K, Griffin S. Estimating Social Variation in the Health Effects of Changes in Health Care Expenditure. *Medical Decision Making*. 2020 [Epub ahead of print].
2. Love-Koh J, Asaria M, Cookson R, et al. The Social Distribution of Health: Estimating Quality-Adjusted Life Expectancy in England. *Value Health*. 2015; 18: 655-62.
3. Dobbie F, Hiscock R, Leonardi-Bee J, et al. Evaluating Long-term Outcomes of NHS Stop Smoking Services (ELONS): a prospective cohort study. *Health Technol Assess*. 2015; 19: 1-156.
4. Grant RL. Converting an odds ratio to a range of plausible relative risks for better communication of research findings. *BMJ*. 2014; 348: f7450.
5. Weir S, Juhasz A, Puelles J, Tierney TS. Relationship between initial therapy and blood pressure control for high-risk hypertension patients in the UK: a retrospective cohort study from the THIN general practice database. *BMJ Open*. 2017; 7(7):e015527.
6. Beard E, Brown J, West R, Acton C, Brennan A, Drummond C, et al. Protocol for a national monthly survey of alcohol use in England with 6-month follow-up: 'the Alcohol Toolkit Study'. *BMC Public Health*. 2015; 15:230.