Australian Government
National Health and Medical Research Council

Public consultation: draft *Australian guidelines to reduce health risks from drinking alcohol*

Personal details

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[NHMRC has removed personal information]

Submission reflects

Organisation / Individual An individual

Individual Background Researcher – Other

Questions

1. **Please indicate which format you read the guideline in.**
   PDF report
2. **The draft guidelines are presented in a new IT platform, MAGICapp. Please indicate how strongly you agree with the following statement: *The draft Australian Guidelines to Reduce Health Risks from Drinking Alcohol are easy to navigate in MAGICapp.***
   No comment
3. **Please indicate how strongly you agree with the following statement: *The Plain English summary is clear, simple and easy to understand*.**
   No comment
4. **Do you have any comments on how the *Plain English summary* could be improved?**
   N/A
5. **Do you have any comments on how the *Introduction* could be improved?**
   N/A
6. **Do you have any comments on how the *Background* could be improved?**
   N/A
7. **Please indicate how strongly you agree with the following statement: *The Understanding risk section is clear, simple and easy to understand*.**
   No comment
8. **Do you have any comments on how the *Understanding risk* section could be improved?**
   N/A
9. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline One?**

I have significant concerns about the modelling by the Sheffield Alcohol Research Group (SARG). SARG were commissioned by Public Health England (PHE) to carry out similar modelling for the UK's alcohol guidelines review (2014-16). They produced a model with implied guidelines of 18 units for women and 21 units for men, lower than epidemiological literature suggests but close to the guidelines at the time. PHE then asked SARG to remove threshold effects from the risk curves for several serious alcohol-related diseases. There was no scientific justification for doing so and SARG initially resisted on the basis that 'it does not seem right to assign people drinking at very low levels a risk of acquiring alcoholic liver disease and similar conditions'. In effect, it meant assuming that light and moderate drinkers were at increased risk of developing diseases such as cirrhosis, for which there is no evidence. PHE insisted, however, and SARG removed the threshold effects for a payment of over £7,000. In the text of their final report SARG stressed that the threshold effect was removed '[a]t the request of the commissioners (Public Health England)'. Removing the threshold produced new and very different risk curves of 12.5 units for men and 14 units for women, thereby giving support to a lowering of the guidelines to 14 units for men and women, which was duly announced in 2016. (https://life.spectator.co.uk/articles/the-new-drinking-guidelines-are-based-on-massaged-evidence/) By changing their methodology at the insistence of their funder, SARG have shown that their research is not truly independent. Why has the Australian government commissioned modelling from a group that has been shown to produce findings that its commissioner wants to see?

In its work for the Australian government, SARG drops the threshold effects from the base case despite having previously said this 'does not seem right'. Interestingly, when they show how the curves look like with thresholds included, there is almost no difference in the implied guidelines, in stark contrast to their work for PHE. There is a suspicion that SARG are making it up as they go.

NHMRC also lean heavily on the opinion of SARG employees who are sceptical of the protective effects of moderate drinking. They, in turn, rely on the work of the anti-alcohol campaigner *[NHMRC has removed personal information]* who has devoted much of his career to casting doubt on these protective effects. In fact, the evidence for these effects has grown stronger, not weaker, as confirmatory evidence continues to be published. Mendelian Randomisation work in this area is in its infancy and has focused on subsamples of the Chinese population where a gene linked to alcohol is relatively common. The gene is rare in western populations, however, and so the tentative findings have little or no relevance to Australia or the UK.

10. **Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).**

    It is not clear why mathematical modelling is required at all when the mortality curves from the epidemiological literature can be used to identify a 'safe level' of drinking. NHMRC accepts the logic of setting the guidelines at the point at which mortality risk is no higher than that of a nondrinker. This seems sensible and we can estimate this level by looking at the epidemiology. A meta-analysis of 34 studies suggests that it is between 40g and 60g per day, ie. 24 to 42 standard drinks per week.

    (https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/769554)

    There are justified concerns about the presence of unhealthy former drinkers in these studies, but the J Curve remains when they are excluded, albeit less strongly. A meta-analysis of 83 studies found that the optimal amount to drink (from a health perspective) is 100g per week, but that drinkers' mortality risk does not exceed that of a nondrinker until they are consuming 300g per week. The implied 'safe drinking' limit is around 280g per week, ie. 28 standard drinks. (https://www.thelancet.com/cms/10.1016/S0140-6736(18)30134X/attachment/5b9e9977-5741-4caf-9ab1-ab873eef63fc/mmc1.pdf - see page 31).

11. **Do you have any editorial or readability comments on the sections that make up Guideline One?**

    N/A

12. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline Two?**

N/A

13. **Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).**
    N/A
14. **Do you have any editorial or readability comments on the sections that make up Guideline Two?**
    N/A
15. **Do you have any comments on how the evidence has been used to develop the recommendation for Guideline Three?**
    N/A
16. **Is there any evidence relevant for this guideline that has been missed? If so, please provide the citation(s).**
    N/A
17. **Do you have any editorial or readability comments on the sections that make up Guideline Three?**
    N/A
18. **Do you have any comments on how the *Drinking frequency* section could be improved?**
    N/A
19. **Do you have any comments on how the *Administrative report* could be improved?**
    N/A
20. **Are there any additional terms that should be added to the *glossary*?**
    N/A
21. **Are there any additional abbreviations or acronyms that should be added to this section?**
    N/A
22. **Do you have any comments on how the *Australian standard drinks* section could be improved?**
    N/A

Disclaimer I have read the security warning/disclaimer below and accept the risks and conditions outlined.

Permission to publish yes