Response to NHMRC 'Draft Guidelines to Reduce Health Risks from Drinking Alcohol'

[NHMRC has removed personal information]
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The NHMRC draft Guidelines are problematic in a number of respects. We focus here on only three key issues: the individual framing of both alcohol-consumption and the Guidelines themselves; the quality and use of 'evidence' in creating the Guidelines; and the Guidelines' treatment of the issue of equity.

1. Individual Framing of the Alcohol Consumption & Guidelines

The declared primary aim of these draft Guidelines is to provide *individuals* with recommendations about alcohol consumption so that they can change their behaviour (p.5). Other kinds of intervention (legal or other regulatory processes; standards of conduct associated with buying, selling and serving, p.4). are explicitly ruled out of consideration. This makes no sense for three reasons.

First, the model of human agency that is assumed in these draft Guidelines is just false. The Guidelines are framed in terms of individuals and their alcohol consumption is seen to result from individual-level decision-making. However, we know from over thirty years of work in psychology, that human beings are not purely rational deliberators, and that there are many non-rational influences upon our choices (see the work of Kahneman, Tversky, Slovic, Gigerenzer, etc). We do not simply maximise our individual utility based upon a detached consideration of information. In addition, we know that the consumption of alcohol is often a *social* activity. Many of us like to consume alcohol in different social situations, as a group in a pub or as an important contribution to key social events such as birthdays, marriage, success at work, etc. Indeed, there is evidence that in turn our preferences, often enacted in choices, are themselves to a large extent the result of past social and cultural influence. If we are serious about tackling health risks from alcohol, we should have a social and cultural focus within our health promotion work, not just look towards individual-level change.

Second, it is striking that there is no discussion in the draft Guidelines of one of the most influential policy initiatives of the last fifteen years, so-called 'nudging' – changes to the decision-making environment that go largely unnoticed by people operating in that environment – but still allow for individual choice. Nudging allows for a default to be set to what is in the best interests of people, based on the best possible evidence, but still leaves room for individuals to deviate from that default if they so choose. We are not advocating for such a model of policy making, just pointing out the surprising absence of nudging given its apparent current popularity in Australian policy making. One important reason for nudging's popularity, is the widespread acceptance that the individual-level rational deliberator model of agency that is assumed in these Guidelines is simplistic and inaccurate.

Third, the draft Guidelines are supposedly evidence-based, something we examine in more detail below. However, no evidence is provided in the Guidelines that information alone changes population-level behaviour and the evidence that exists that legal and regulatory changes may reduce alcohol consumption and thereby health risks is never considered. The Guidelines claim that they seek to address the

health risks of alcohol consumption, and whilst they note that 75% of Australians support action on alcohol-related harms (p.24), there is no consideration of the possible interventions that are best supported by the evidence in terms of impact upon alcohol consumption such as minimum alcohol unit pricing, restrictions on advertising, restrictions on hours of sale in bars, pubs and supermarkets etc. (See for example, Purshouse et al (2010), Brennan et al (2008) et al.; and research groups such as:
https://www.uvic.ca/research/centres/cisur/projects/active/projects/canadian-alcohol-policy-evaluation.php).

2. The Quality and Use of Evidence

Throughout the report, it is claimed that the Guidelines are based firmly on the best evidence available. As seen above, this is not true, and the only fair view is that the draft Guidelines (and presumably the terms of reference for the relevant committee) were shaped by a prior ideological commitment to neoliberal ideas, rather than a fair review of all of the relevant evidence. We can also see a curious approach to the available evidence in Guideline #3, on consuming alcohol while pregnant or breastfeeding. The report acknowledges that there is not enough evidence to demonstrate harmful effects to a foetus resulting from low levels of alcohol consumption (p. 3, 47), but the Guidelines then firmly recommend that women who may become pregnant or are pregnant abstain from alcohol completely (p. 47-51), using precaution as the justification. By contrast, although there is good evidence of harms from high consumption of alcohol to everyone, the report does not suggest that everyone should abstain (or that alcohol should be illegal, on a precautionary basis). It is, the draft Guidelines suggest, only females who may be or may become pregnant who need to abstain.

How is this justified? It seems as though there is a commitment to the classic liberal distinction between harm to oneself and harm to others. The relevant risk is framed at one point in the report as 'increased risk to women' (p. 2), but it appears that the real concern is "harms beyond the drinker" (p. 21). (As an aside, it is worth noting that the report says both Guidelines 2 and 3 are about such third-party harms, but guideline 2 is about the (underaged) drinker themselves. Only guideline 3 is actually about harms beyond the drinking person.) Can this harm-to-others view in Guideline 3 be justified? If harms beyond the drinker are going to be considered at all, focusing on foetuses as the only relevant group that might experience harms resulting from a drinking person's behaviour is arbitrary at best. In fact, it makes no sense as it prioritises a sub-set of *possible*-people, who are not legal persons, where there is no clear evidence of harm from another's drinking, over other relevant groups of *actual* people, where there is evidence of third-party harm (e.g. domestic violence and sexual assault). Indeed, surprisingly there is no discussion in the Guidelines of such harms, despite the clear evidence that alcohol consumption is a major risk-factor. Nor is there any discussion of harms from excessive alcohol consumption on the family and friends of the drinker.

It is striking, once again, that the focus is on individuals, in this case individual women, and the resultant responsibilisation of females as individuals dislocated from their cultural context. It treats all females of child-bearing age as ever-possibly-pregnant, suggesting that they should exclude themselves from a key part of (settler) Australian culture. The culture of high rates of alcohol use is itself left unexamined and blameless. Culture is an important factor that is given little attention in this report and no attention is given to the place of Australia's wine and beer *production* industries.

3. Impacts on Equity

There is much to say about the overall framing of the draft Guidelines. It is striking how there is no real engagement with issues or the literature to do with harm reduction, and the assumptions about individual liberty that motivate the whole approach are naïve. A significant value that does appear is that of equity, as alongside each guideline is a small section on how the Guidelines's recommendations will supposedly impact upon equity. While it is likely true that these Guidelines will not create new inequities, it is *not* true that the report, and the provision of information as a health promotion tactic, will *not* deepen existing inequalities (as claimed on pp. 25, 41 & 50).

The report states that the burden of disease from alcohol consumption is skewed toward the lowest income groups (p. 25). This makes these particular groups relevant potential target audiences for health promotion intervention regarding alcohol.

However, when health promotion focuses on the provision of information as a means to change individual behaviour, as in these Guidelines, it, ironically, often increases inequity. This is because lower-income audiences are far less likely to have access to such information and they are less likely to be able to act on its basis (even if they have access to it). It is well established that those best-placed to take up health advice from information campaigns are those who are least in need of it: the 'concerned White middle-class' who are already health conscious, literate, and have access to a broader range of options regarding food and recreation. If a target of this report is the lowest-income groups, then giving information is an ineffective way to reach them, and insofar as other better-off groups do take up this information, inequities may actually grow.

This deepening of inequities is especially relevant regarding First Nations Australians, who are barely mentioned in the report (see a small section on p. 11). Particular consideration about the kinds of inequities faced by such groups (access, trauma, education, etc.) that could be deepened by a settler-focussed and individualistic approach to alcohol consumption should be central to a coherent and genuinely equity-focus alcohol reduction policy.

Conclusions

These draft Guidelines aim to reduce health risks from drinking alcohol. There are a number of factors that we outline above that suggest to us that the implementation of these Guidelines will have little impact on alcohol consumption. Indeed, assuming that policy remains fixated on old-fashioned views of individual agency, and there are no regulatory changes, we predict that in ten years there will have been little if any reduction in alcohol across the Australian population. It is a significant failure of government responsibility not to act to protect us all from our favourite drug.