ALCOHOL

The health burden related to harmful alcohol consumption, both in terms of morbidity and mortality, is considerable in most parts of the world (Rehm et al., 2009; WHO, 2018d). Alcohol use is associated with numerous harmful health and social consequences, including an increased risk of a range of cancers, stroke, and liver cirrhosis, among others. Foetal exposure to alcohol increases the risk of birth defects and intellectual impairment. Alcohol misuse is also associated with a range of mental health problems, including depressive and anxiety disorders, obesity and unintentional injury (Currie et al., 2012). In 2016, the harmful use of alcohol resulted in some 3 million deaths (5.3% of all deaths) worldwide and 132.6 million DALY – 5.1% of all DALY in that year (WHO, 2018d). While many countries set age limits for purchasing or drinking alcohol, lack of enforcement and no age limits in some countries allow young people to access alcohol easily, increasing their consumption and risk of harmful consequences.

UN SDGs targets strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol.

WHO estimates that 5.1% of the global burden of disease is attributable to alcohol (WHO, *www.who.int/news-room/fact-sheets/detail/alcohol/*), which accounts for about as much mortality and disability as tobacco and hypertension (Rehm et al., 2009). In the South East Asian region, 4.6% of all deaths in 2012 were attributed to alcohol consumption, and in the Western Pacific region, 5.9%. The direct and indirect economic costs of alcohol (which include lost productivity, health care costs, and road traffic crashes and crime-related costs) are substantial – in Thailand and the Republic of Korea these are about 2% of GDP (Rehm et al., 2009; Thavorncharoensap et al., 2010).

In Asia-Pacific, alcohol consumption is highest among more developed countries (Figure 4.23, left panel). Adults aged 15 years and over in Australia, the Republic of Korea, New Zealand and Japan consumed over seven litres of alcohol per capita in 2015. In Thailand; Mongolia; China and the Lao PDR, alcohol consumption was between five and seven litres. Because cultural and religious traditions in a number of the remaining countries prohibit drinking alcohol, consumption figures in these are minimal. In some countries, only certain groups of people consume alcohol; in Thailand, for example, around one-third of the population drinks.

Average consumption increased by 0.9 and 0.8 litres per capita in upper-middle and lower-middle low income Asia-Pacific countries between 2000-15 (Figure 4.23, right panel), although variations exist across countries. Among countries with significant intake, alcohol consumption declined in Australia, the Republic of Korea; New Zealand and Japan. In Viet Nam, China, India and Mongolia, the increase in alcohol consumption per capita between 2000-15 was very large at more than two litres per capita.

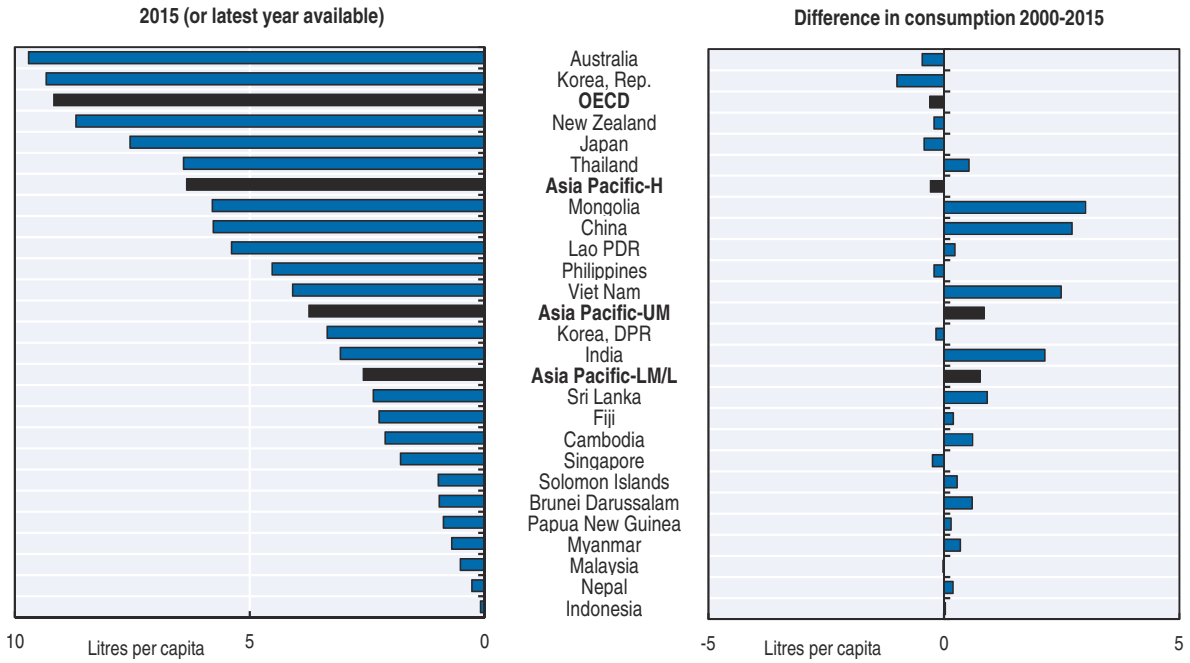
Changing patterns of drinking lead to more potential for harm through binging and heavy drinking occasions. In Asian countries, 16.8% of men and 4.5% of women reported weekly heavy episodic drinking during the last 30 days in 2010. In Mongolia, more than 70% of males and 40% of women reported heavy episodic drinking for the past 30 days (Figure 4.24). In Australia in 2010, two in five people aged 15 and over were at risk of harm from a single drinking occasion in the past 12 months; about 13% of recent drinkers admitted to driving under the influence of alcohol (AIHW, 2016).

Almost two in five road traffic deaths were attributable to alcohol in the Asia-Pacific region in 2013. In Lao PDR and Papua New Guinea, more than 50% of road traffic deaths are associated with alcohol (Figure 4.25). Based on the blood alcohol concentration (BAC) at which crash risk begins to increase exponentially, WHO recommends drink-driving prevention legislation set maximum legal thresholds at 0.05g/dl. WHO recommendations go further to specify no higher than 0.02 for novice and probationary drivers due to the interaction of alcohol and inexperience. Both aspects are required for WHO to consider a country with good legislation for drink driving. Setting and enforcing legislation on BAC limits of 0.05 g/dl can lead to significant reductions in alcohol-related crashes. For example Japan reduced BAC from 0.05 to 0.03 and recorded a 38% reduction in alcohol associated crashes. Some countries – such as Fiji, Australia and New Zealand – have limited BAC level to 0 g/dl for novice drivers.

Definition and comparability

Alcohol intake is measured in terms of annual consumption of litres of pure alcohol per person aged 15 years and over. Sources are based mostly on FAO (Food and Agriculture Organization of the United Nations) data, which consist of annual estimates of beverage production and trade supplied by national Ministries of Agriculture and Trade. The methodology to convert alcoholic drinks to pure alcohol may differ across countries. Data are for recorded alcohol, and exclude homemade sources, cross-border shopping and other unrecorded sources. Information on drinking patterns is derived from surveys and academic studies (WHO, 2018d).

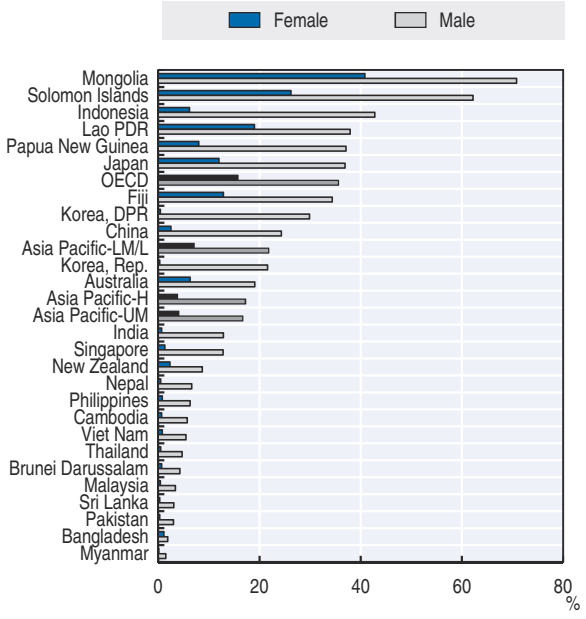
4.23. Recorded alcohol consumption, population aged 15 years and over



Source: WHO GHO, 2018.

StatLink http://dx.doi.org/10.1787/888933868025

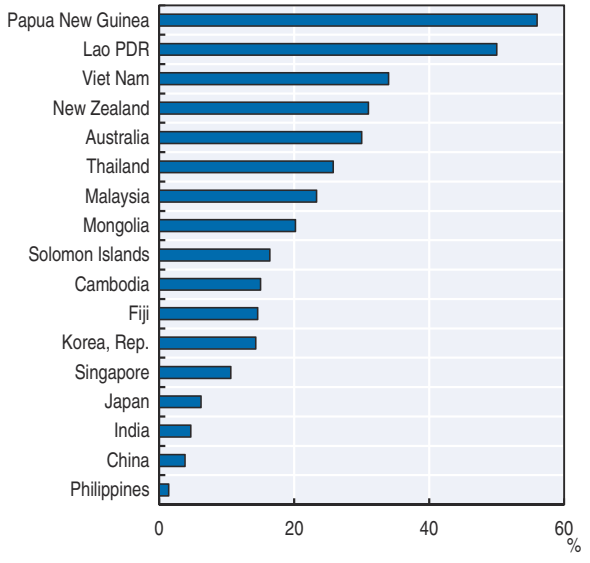
4.24. Heavy episodic drinking (drinkers only), past 30 days (%), 2010 (or nearest available year)



Source: WHO GHO 2018.

StatLink http://dx.doi.org/10.1787/888933868044

4.25. Proportion of road traffic deaths that are attributable to alcohol, 2013



Source: WHO GHO 2018.

StatLink http://dx.doi.org/10.1787/888933868063