Although most people enjoy drinking alcohol responsibly, the health burden related to hazardous and harmful alcohol consumption, both in terms of morbidity and mortality, is considerable in many parts of the world. High alcohol intake increases the risk for chronic diseases such as liver cirrhosis, cancers, cardiovascular diseases and injury, and impacts foetal and child development. Drunkenness and alcohol dependence also leads to harmful social consequences, such as drink-driving and violence (WHO, 2011i).

In the Southeast Asian region, 2.3% of all deaths in 2004 were attributed to alcohol consumption, and in the Western Pacific region, over 5%. The direct and indirect economic costs of alcohol (which include lost productivity, health care costs, and road accident- 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).

Alcohol consumption across Asia/Pacific populations is highest among more developed countries (Figure 2.8.1). Adults aged 15 years and over in the Republic of Korea, Australia, New Zealand and Japan consumed over seven litres of alcohol per capita in 2008. In Thailand; Macao, China, the Lao PDR; China and the Philippines, consumption was between four and seven litres. Because cultural and religious traditions in a number of the remaining countries prohibit drinking alcohol, consumption figures in these are minimal (Figure 2.8.3). In some countries, only certain people groups consume alcohol; in Thailand, for example, around one third of the population drink. The average consumption across 20 Asia/Pacific countries and economies in 2008 was a modest 2.4 litres per capita, compared to 10.0 in OECD countries.

Average consumption across the whole region exhibited an increase between 1990 and 2008 (Figures 2.8.1 and 2.8.2), although variations exist among countries. Among countries with significant intake, alcohol consumption declined in DPR Korea; Hong Kong, China; Japan; New Zealand and Australia. Consumption increased in Macao, China; Cambodia; Mongolia; China; the Lao PDR and Thailand. For China, alcohol consumption increased from 3.4 litres per capita in 1990 to 4.7 in 2007, in conjunction with rapid economic development.

Changing patterns of drinking lead to more potential for harm through binging and heavy drinking occasions, especially among young people (Figure 2.8.3). In the Southeast Asian region in 2005, 22% of drinkers reported weekly heavy episodic drinking during the last 12 months (WHO, 2011i). In Japan and the Lao PDR around 20% of all males surveyed in 2005 reported regular heavy drinking. In Australia in 2010, one in five people aged 14 and over were at risk of alcohol-related harm over their lifetime, and two in five 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, 2012). In India and Pakistan, two low alcohol-consuming countries, a high proportion of drinkers drink heavily on single occasions.

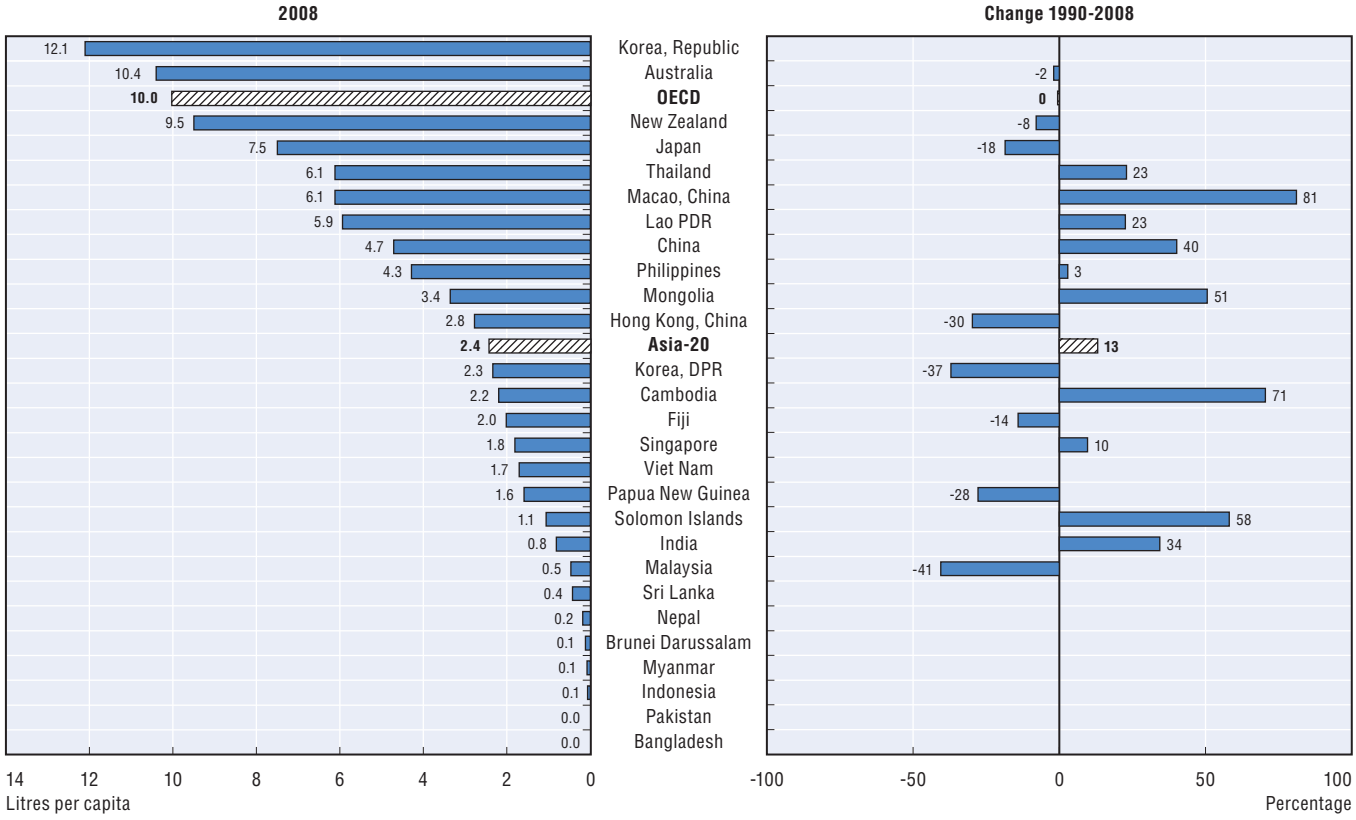
The World Health Organization endorsed a Global Strategy to Reduce the Harmful Use of Alcohol in 2010, through direct measures such as medical services for alcohol-related health problems, and indirect measures, such as the dissemination of information on alcohol-related harm. The strategy contains a set of principles to guide the development and implementation of policies at all levels, sets priority areas for global action, and recommends target areas for national action.

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.

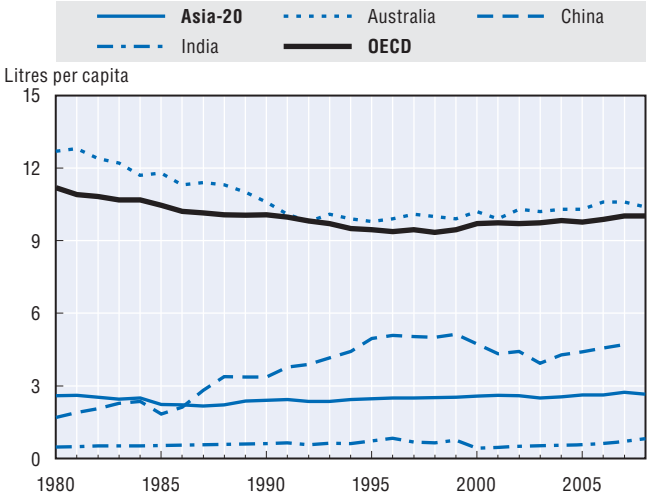
The methodology to convert alcoholic drinks to pure alcohol may differ across countries. Data are for recorded alcohol, and exclude homemade sources, cross-border shopping and other unrecorded sources. Information on drinking patterns are derived from surveys and academic studies (WHO, 2011i).

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



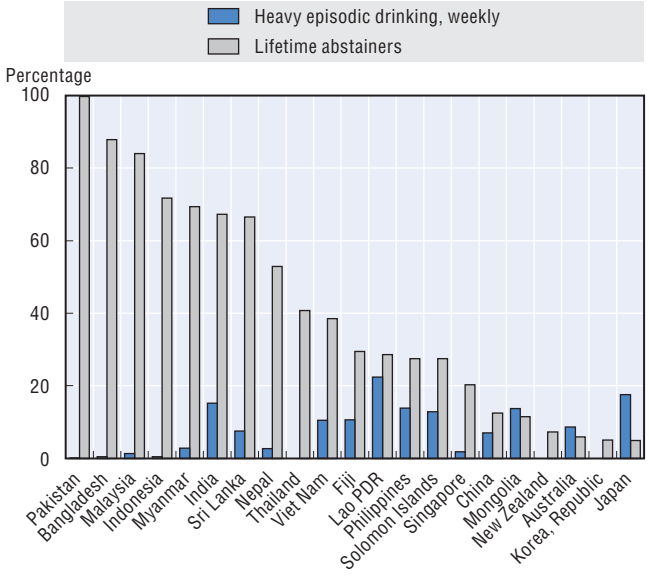
Source: WHO Global Information System on Alcohol and Health (GISAH); *OECD Health Data 2012*.

2.8.2. Trends in alcohol consumption, selected countries, 1980-2008



Source: WHO Global Information System on Alcohol and Health (GISAH); *OECD Health Data 2012*.

2.8.3. Patterns of consumption among males, 2005 (or nearest available year)



Source: WHO Global Information System on Alcohol and Health (GISAH).

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Chapter 3

Health care resources and utilisation