

The health burden related to harmful alcohol consumption, both in terms of morbidity and mortality, is considerable in most parts of the world (WHO, 2018[37]; Sassi, 2015[38]). Alcohol use is associated with numerous harmful health and social consequences, including an increased risk of mouth and throat, larynx, esophagus, colon and rectal, liver and breast 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 injuries (WHO, 2018[37]). In 2016, the harmful use of alcohol – including road traffic deaths attributable to alcohol – resulted in some 3 million deaths worldwide (5.3% of all deaths), and 132.6 million DALYs lost (– 5.1% of all DALYs in that year) (WHO, 2018_[39]; see indicator “Road safety” in Chapter 4). 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.

Alcohol accounts for more deaths than TB, HIV/AIDS, hypertension, diabetes, digestive diseases, road injuries and violence (WHO, 2018[37]). 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 (WHO, 2018[37]; Rhem et al., 2009[39]; Thavorncharoensap et al., 2010[40]).

In Asia-Pacific, alcohol consumption is highest among more developed countries and territories (Figure 4.23, left panel). Adults aged 15 years and over in Australia, New Zealand and the Republic of Korea consumed over nine litres of alcohol per capita in 2016. In China, Japan, Lao PDR, Mongolia and Thailand, alcohol consumption was between five and seven litres. Because cultural and religious traditions in a number of the remaining countries and territories prohibit drinking alcohol, consumption figures in these are minimal. In some countries and territories, only certain groups of people consume alcohol. In Thailand, for example, only about one-third of adults drinks alcohol, but still they have the highest per capita alcohol consumption in South-East Asia. (WHO, 2018[37]).

Average consumption increased by 1 litre per capita in middle and low income Asia-Pacific countries and territories since 2010 (Figure 4.23, right panel), although variations exist across countries and territories. Alcohol consumption declined in Australia, Japan, Korea DPR, the Philippines, the Republic of Korea and Singapore. In Cambodia, China, India and Mongolia, the increase in alcohol consumption per capita was very large at more than two litres per capita.

In many Asia-Pacific countries and territories, the proportion of people with bingeing and heavy drinking has increased in recent years, and on average across countries and territories in the region, one man in two and one woman in five reported heavy episodic drinking during the last 30 days in 2016 (Figure 4.24; OECD/WHO, 2018_[12]). In Fiji, Papua New Guinea and Solomon Islands, around 70% of males and over 30% of women reported heavy episodic drinking during the past 30 days.

More than two in five road traffic deaths were attributable to alcohol in Asia-Pacific in 2016. Australia has the highest proportion of road traffic deaths associated with alcohol in the region, followed by New Zealand, Singapore and the Republic of Korea. In all countries and territories in Asia-Pacific, the proportion of road traffic deaths attributable to alcohol was higher, for males than for females. The difference is particularly large in Thailand where the proportion for male (34%) is more than twice the proportion for female (15%) (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. For novice and probationary drivers, WHO recommendations go further to specify no higher than 0.02 g/dl due to the interaction of alcohol and inexperience. Setting and enforcing legislation on BAC limits of 0.05 g/dl can lead to significant reductions in alcohol-related crashes. Japan sets the limit of to 0.015g/d; and some countries and territories – such as Australia, Fiji and New Zealand – have limited BAC level to 0g/dl for novice drivers.

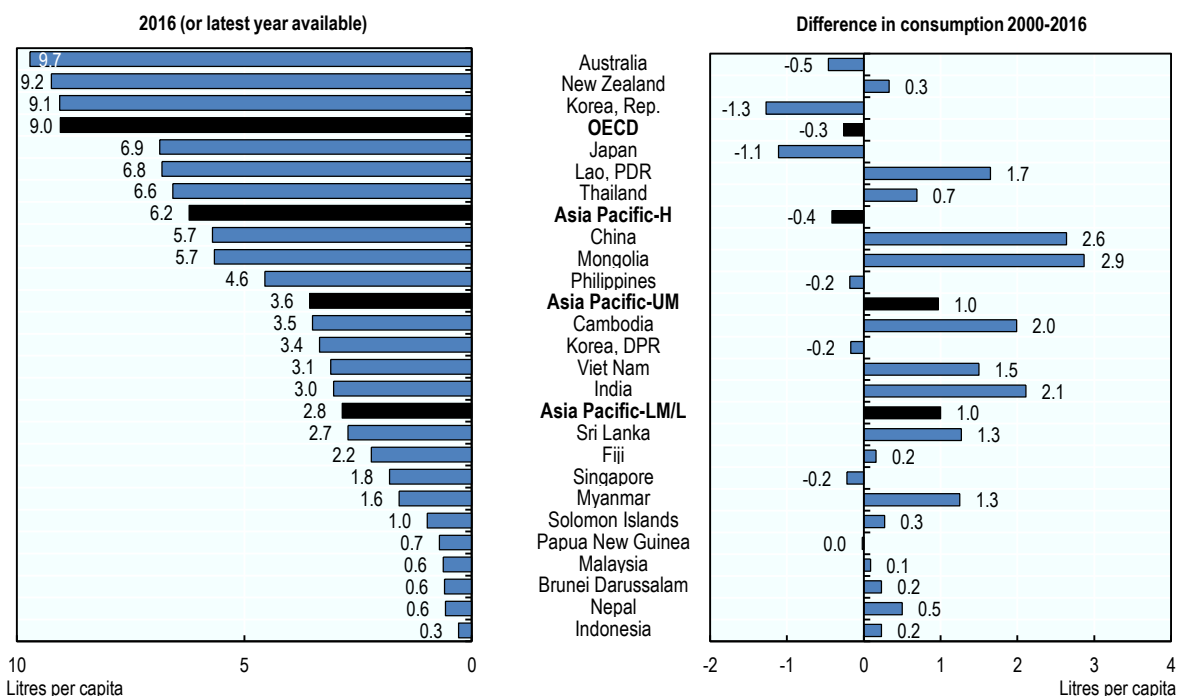
Definition and comparability

Alcohol intake is measured in terms of annual consumption of litres of pure alcohol per person aged 15 years and over.

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, 2018[37]).

Heavy episodic drinking refers to the proportion of adult drinkers aged 15 and over who had at least 60 grams of pure alcohol at least once in the past 30 days. Sixty grams of pure alcohol is contained in approximately six standard alcoholic drinks (WHO, 2020[41]).

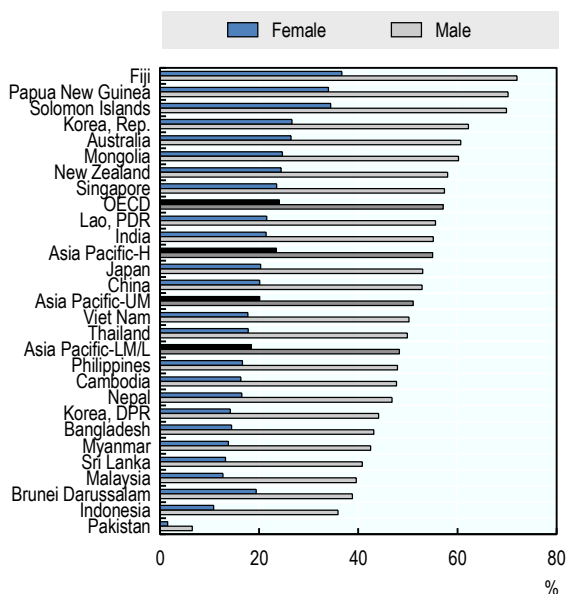
Figure 4.23. Recorded alcohol consumption, population aged 15 years and over, 2016 or latest year available



Source: WHO GISAH 2018.

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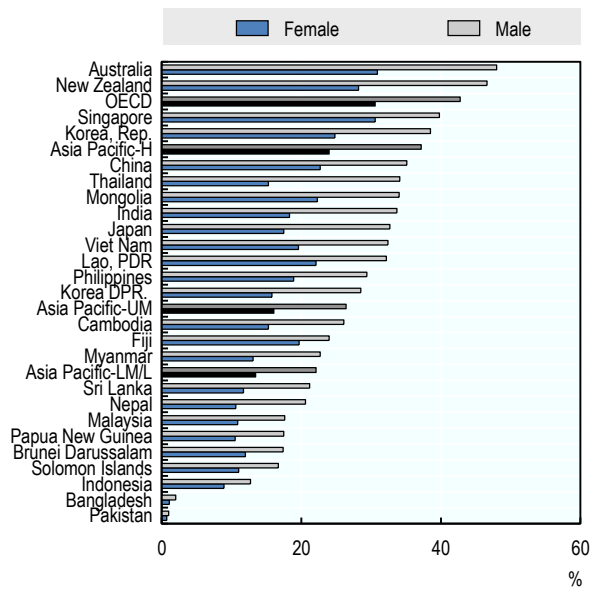
Figure 4.24. Heavy episodic drinking (drinkers only), past 30 days (percent), 2016 (or latest year available)



Source: WHO GISAH 2018.

StatLink <https://stat.link/gwt763>

Figure 4.25. Proportion of road traffic deaths that are attributable to alcohol, 2016



Source: WHO GISAH 2018.

StatLink <https://stat.link/dovqm4>



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