Alcohol use is a leading risk factor for disease burden, both in terms of mortality and morbidity, and has been linked to numerous negative health and social outcomes, including more than 200 disease and injury conditions such as cancer, stroke, 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 depression and anxiety disorders, obesity and unintentional injury (WHO, 2018[26]). In 2016, 2.8 million deaths were attributed to alcohol use globally, corresponding to 2.2% of total age-standardised deaths among females and 6.8% among males. In terms of overall disease burden, alcohol use led to 1.6% of total DALYs globally among females and 6% among males, ranking alcohol use as the seventh leading risk factor for premature death and disability in 2016, compared with other risk factors in the Global Burden of Disease studies (Griswold et al., 2018[27]).

Average alcohol consumption in the LAC region was more than 6 litres per capita in 2016, lower than the 9.3 litres per capita in the OECD. The lowest consumption is observed in Guatemala, Costa Rica and El Salvador, while the highest intake is in Uruguay, Saint Lucia, Argentina and Barbados (Figure 4.23, left panel). Consumption is in general higher among more developed countries, consistent with trends in other world regions. The evolution of alcohol consumption in the period 2010-16 has been very heterogeneous across countries, but the regional average has increased by almost 3%. Countries like Guatemala and Venezuela experienced decreases of over 25%, while Dominica and Trinidad and Tobago increased their per capita intake by the same percentage (Figure 4.23, right panel).

Heavy and binge drinking are drinking patterns with more associated health risks. In average in the LAC region, 43% of the drinking population in 2016 had a heavy episodic drinking in the past 30 days (Figure 4.24). In Peru, Saint Lucia, Grenada, Saint Kitts and Nevis, and Trinidad and Tobago, around half of all drinkers report heavy drinking behaviour. Rates of heavy drinking are below 35% in countries such as Chile, Guatemala, El Salvador, Argentina and Uruguay, suggesting a different drinking culture in some of the countries with higher population intakes. Regarding gender patterns, in average men have more than 2.5 times heavy episodic drinking than women, with Peru, Saint Lucia, Grenada, Saint Kitts and Nevis, and Trinidad and Tobago leading for both genders.

Regarding road accidents in the LAC region, between one out of three for men and more than one out of every five for woman can be attributed to alcohol consumption (Figure 4.25). The rates are over 40% for male drivers in Argentina, Uruguay, Barbados, Grenada, Saint Lucia, Trinidad and Tobago, while among women rates are over 40% in Saint Lucia and over 30% in Barbados and Trinidad and Tobago.

Reduction of health, safety and socio-economic problems attributable to alcohol requires broad-based strategies (e.g. addressing the wider social determinants of health) and ones that target alcohol drinkers. Policies raising awareness of public health problems caused by harmful use of alcohol and ensuring support for effective alcohol policies, regulating the marketing of alcoholic beverages and restricting the availability of alcohol, in particular to younger people, can be further developed in the region. Drink-driving policies have proven to be effective; for instance in Chile a "zero tolerance" policy was enacted in 2012 with positive results. Demand can be reduced through taxation and pricing mechanisms, which in LAC countries has been less utilised as a policy tool. Finally, in relation to alcohol-use disorders, implementing screening and brief interventions programmes along with providing accessible and affordable treatment is an effective strategy (WHO, 2018[26]; Sassi, 2015[28]).

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.

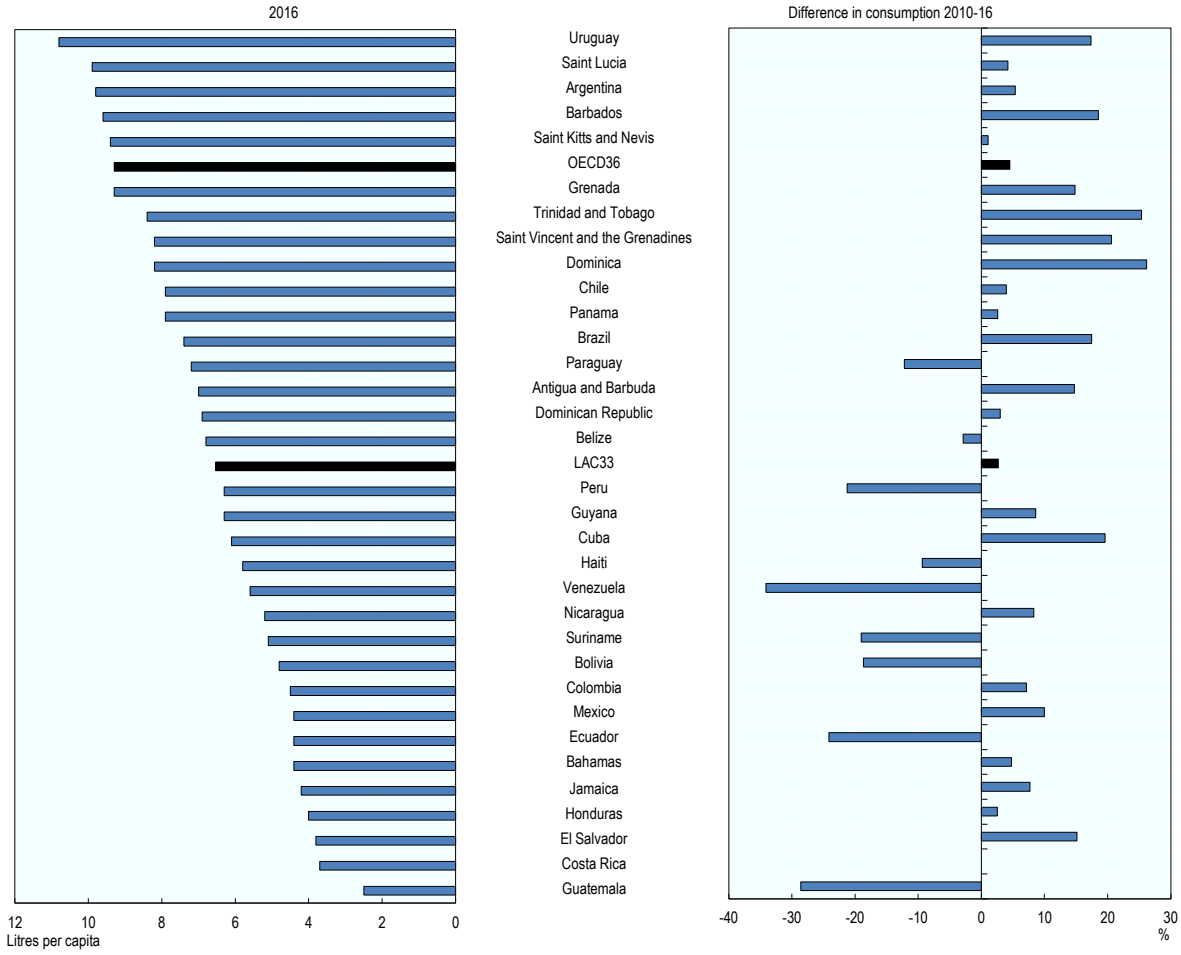
References

[27] Griswold, M. et al. (2018), "Alcohol use and burden for 195 countries and territories, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016", *The Lancet*, Vol. 392/10152, pp. 1015-1035, *http://dx.doi.org/10.1016/s0140-6736(18)31310-2*.

[28] Sassi, F. (ed.) (2015), *Tackling Harmful Alcohol Use: Economics and Public Health Policy*, OECD Publishing, Paris, *https://dx.doi.org/10.1787/9789264181069-en*.

[26] WHO (2018), *Alcohol*, World Health Organization, *https://www.who.int/news-room/fact-sheets/detail/alcohol*.

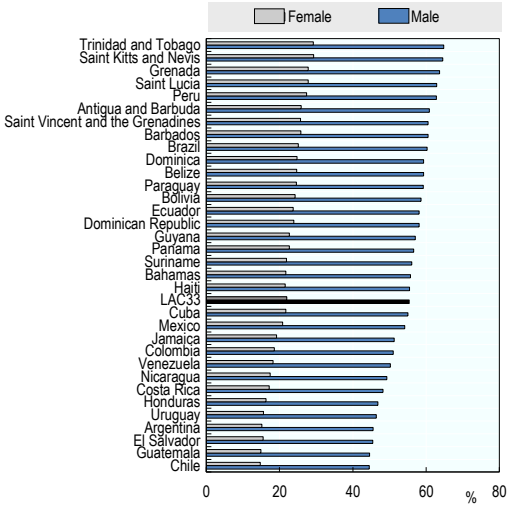
Figure 4.23. **Recorded alcohol consumption, population aged 15 years and older, 2016**



Source: WHO GHO 2018. OECD Health Statistics 2019 for Mexico, Chile, Colombia, Costa Rica and Brazil.

StatLink https://stat.link/kr2nxp

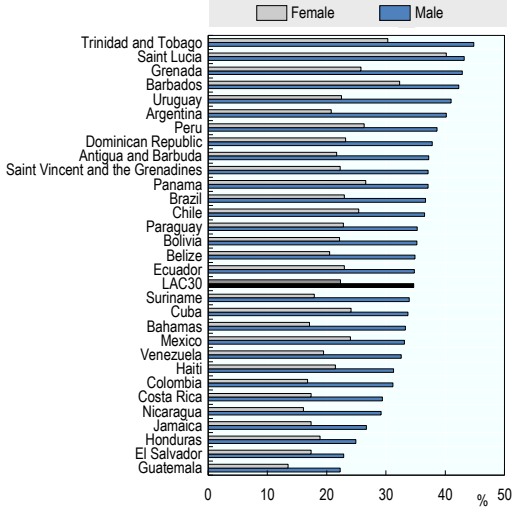
Figure 4.24. **Heavy episodic drinking (drinkers only), past 30 days (%), 2016**



Source: WHO GHO 2018.

StatLink https://stat.link/794qad

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



Source: WHO GHO 2018.

StatLink https://stat.link/q9hjx8