TARGET 2

Reduce harmful use of alcohol

A PREAMBLE

Alcohol use is a component cause of more than 200 disease and injury conditions, including heart diseases, cancers, liver diseases, a range of mental and behavioural disorders, and other non-communicable diseases (NCD). Alcohol use accounts for considerable healthcare resource use, personal suffering, morbidity, death and social consequences. Reducing alcohol-attributable disease burden is a global public health priority as affirmed by the World Health Organization (WHO)'s *"Global Strategy to Reduce the Harmful Use of Alcohol"* [50]. Globally, alcohol is estimated to be the seventh-leading risk factor in 2016 in both DALYs (disability-adjusted life years) (4.2%) and deaths (5.2%)[51]. Both total consumption of alcohol and drinking patterns such as heavy episodic drinking contribute to alcohol-related harm. The risk of most alcohol-attributable health conditions is correlated with the overall levels of alcohol consumption with no evidence of a threshold effect for cancers and hypertension[51, 52]. There is simply no safe drinking level.

B LOCAL SITUATION

Below provides a snapshot of local situation regarding Indicators (3), (4a), (4b) and (5) derived from the WHO's global monitoring framework (GMF) and Indicators (S2) to (S3) of local relevance on alcohol consumption. Detailed definitions, specifications and data sources of these key/ supplementary indicators are provided in **Section E**.

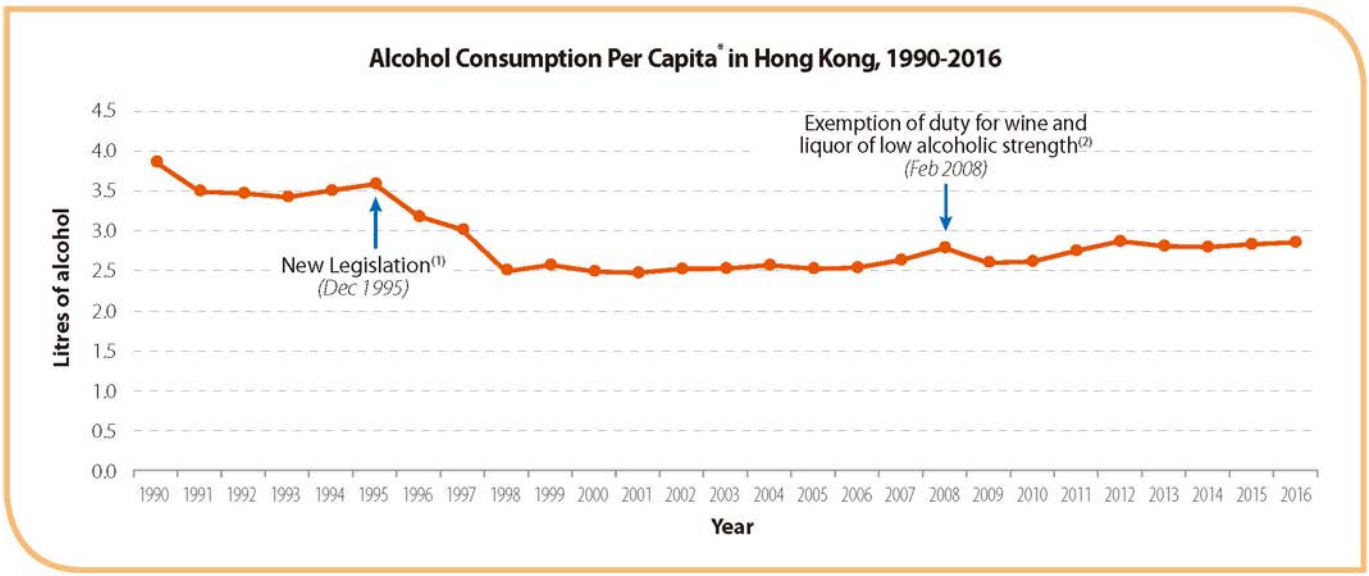
[50] Global strategy to reduce harmful use of alcohol. Geneva: World Health Organization, 2010. Available at: http://www.who.int/substance_abuse/activities/gsrhua/en/

[51] Global, regional, and national comparative risk assessment of 84 behavioural, environmental and occupational, and metabolic risks or clusters of risks, 1990-2016: a systematic analysis for the Global Burden of Disease Study 2016. Lancet 2017; 390: 1345-422.

[52] Rehm J et al. The relation between different dimensions of alcohol consumption and burden of disease - an overview. Addiction, 2010, 105(5).817-843.

Indicator (3): Harmful use of alcohol: adult per capita consumption

The estimated total alcohol consumption per capita (aged 15+ years) fell from 3.87 litres in 1990 to 2.62 litres in 2010 but gradually increased to 2.86 litres in 2016. The chart below shows the estimated alcohol consumption per capita (aged 15+ years) over the period 1990-2016.



Notes: * Alcohol consumption per capita is used for monitoring the trend and for international comparison of alcohol consumption at the population level, but may not be able to fully reflect the actual drinking amount in local population because the accuracy of the figure may be affected by many factors, such as stockpiling and tourist consumption, etc

(1) Legislation to combat drink driving in Hong Kong was first introduced in December 1995

(2) The exemption of duty for wine and liquor with an alcoholic strength of not more than 30% has been implemented since February 2008

Sources: Census and Statistics Department, Customs and Excise Department and company reports of local beer manufacturers

Indicator (4a): Harmful use of alcohol: heavy episodic drinking among adolescents

During the 2015/16 school year, the proportion of students who had binge drinking at least monthly was 1.0%. The corresponding figures for primary and secondary school students were 0.8% and 1.2% respectively.

Indicator (4b): Harmful use of alcohol: heavy episodic drinking among adults

According to the Population Health Survey (PHS) 2014/15, the age-standardised prevalence of binge drinking on at least one occasion monthly among persons aged 18+ years was 2.4% (Crude rate: 2.3%).

Indicator (5): Harmful use of alcohol: alcohol-related morbidity and mortality

Results of the PHS 2014/15 showed that the proportion of persons aged 15+ years who had an Alcohol Use Disorders Identification Test (AUDIT) score of 16 or above, indicating harmful drinking or probable alcohol dependence, was 0.4%.

Indicator (S1): Prevalence of ever drinking, 12-month drinking and 30-day drinking among young people

The prevalence of ever drinking, 12-month drinking and 30-day drinking among primary 4-6, secondary 1-6 and post-secondary students decreased from 61.4%, 43.4% and 23.2% in 2008/09 to 56.2%, 41.3% and 20.2% in 2014/15 respectively. The table below shows the prevalence of alcohol use by education level. It is worth noting that while ever drinking, 12-month drinking and 30-day drinking rates for primary 4-6 and secondary 1-6 students showed a downward trend between 2008/09 and 2014/15, corresponding rates for post-secondary students either did not fall or showed a rising trend.

Prevalence of alcohol use among primary 4-6, secondary 1-6 and post-secondary students in 2008/09, 2011/12 and 2014/15

School year	2008/09	2011/12	2014/15
Ever drinking (%)			
Primary 4-6	40.1	28.3	26.0
Secondary	64.9	59.0	56.8
Post-secondary	78.6	77.7	78.7
Overall	61.4	56.0	56.2
12-month drinking (%)			
Primary 4-6	20.9	14.5	13.4
Secondary	46.1	42.6	39.2
Post-secondary	64.6	65.7	67.1
Overall	43.4	41.0	41.3
30-day drinking (%)			
Primary 4-6	10.1	4.6	3.9
Secondary	24.2	18.7	17.7
Post-secondary	37.5	33.1	37.6
Overall	23.2	18.4	20.2

Source: Survey of Drug Use among Students, Narcotics Division of Security Bureau

Indicator (S2) and (S3): Proportion of adolescents reported having the first sip (S2) or starting a monthly drinking habit (S3) at age below 16 years

Findings on the proportions of adolescents reported having the first sip at age below 16 years and starting a monthly drinking habit at age below 16 years will be available from the School-based Tobacco Survey among Students conducted from 2018/19 onwards.

C LOCAL TARGET

At least 10% relative reduction in the prevalence of binge drinking and harmful use of alcohol (harmful drinking/alcohol dependence) among adults and in the prevalence of drinking among youth by 2025[53].

[53] The WHO sets a voluntary global target of 'at least 10% relative reduction in the harmful use of alcohol by 2025, as appropriate, within the national context'.

D ACTIONS TO ACHIEVE TARGET

1) Background of the Government initiatives to reduce alcohol-related harm

- Reducing alcohol-related harm has been accorded primary importance in the prevention and control of NCD in Hong Kong. To this end, a Working Group on Alcohol and Health (WGAH) was formed in June 2009 under the Steering Committee on Prevention and Control of NCD chaired by the Secretary for Food and Health. The WGAH published the *"Action Plan to Reduce Alcohol-related Harm in Hong Kong"* in October 2011, which set out 5 priority areas, 10 recommendations and 17 specific actions to reduce alcohol-related harm[54], including some of the "best buys"[55] and other recommended interventions identified by the WHO in the *"Global Strategy to Reduce the Harmful Use of Alcohol"*. The action plan has been fully implemented. Many of the action items have become regular features of the Government's NCD response or have inspired further initiatives tailored to the changing social and environmental circumstances.

2) Existing actions/interventions/ programmes/policies

- The Department of Health (DH) has carried out public education regarding alcohol-related harm, in particular among young people. To step up educational efforts to combat underage drinking, DH launched a territory-wide health campaign entitled "Young and Alcohol Free" campaign in late 2016, with young people as the primary target, together with their parents, teachers and caregivers, working through parent groups, schools, healthcare professionals and relevant government bureaux/departments using a variety of means and channels. Examples are printed materials, telephone education hotline, website, electronic publications, announcements in the public interest, game booths, school-based curriculum teaching, competitions and workshops, public health talks, community events, media interviews and social media promotion.

- In late 2017, DH launched a public educational drive entitled "Alcohol Fails" campaign, targeting at the general public and working with healthcare professionals. The campaign aims to provide up-to-date evidence on alcohol-related harm; raise public awareness of the importance of making informed choices about drinking; dissociate alcohol drinking from healthy ways of living, namely exercising and socialising; personal skills to recognise and slash at-risk drinking patterns; and foster partnerships with healthcare professionals, community groups, media, etc., to build environments that are supportive of an alcohol-free lifestyle.

- At present, resources allocated for provision of services catering to the need of at-risk drinkers and people with alcohol dependence are considered not adequate. For example, a few

[54] More details about the action plan is available at: https://www.change4health.gov.hk/en/strategic_framework/structure/working_group_on_ah/index.html

[55] According to the updated Appendix 3 of the WHO Global NCD Action Plan 2013-2020, "best buys" are interventions that are considered to be the most cost-effective and feasible for implementation, for which the WHO-CHOICE analysis found an average cost-effectiveness ratio of ≤ I$100/DALY averted in low- and lower middle-income countries. (Source: http://apps.who.int/iris/bitstream/10665/259232/1/WHO-NMH-NVI-17.9-eng.pdf)

psychiatric departments in Hospital Authority provide alcohol problem clinics at a level similar to the Tuen Mun Alcoholic Problem Clinic. Outside the public sector, one non-governmental organisation (NGO), the Tung Wah Group of Hospitals Integrated Center for Addition Prevention and Treatment and "Stay Sober Stay Free" Alcohol Abuse Prevention and Treatment Service, makes up most of the limited clinical and social support services for people with alcohol-related problems.

3) Specific actions/interventions/ programmes/polices to be introduced, enhanced or explored to achieve target by 2025

- Impose a statutory regulatory regime to prohibit commercial sale and supply of intoxicating liquor to minors, in addition to the prohibition of minors from drinking alcohol on licensed premises as laid down in the Dutiable Commodities (Liquor) Regulations (Cap. 109B). The enacted regulation to cover all forms of commercial sale and supply of alcohol, including internet sale will commence in the second half of 2018. (Food and Health Bureau (FHB)/DH)

- Encourage primary care professionals to carry out alcohol screening and brief interventions (A-SBI) to identify and manage at-risk drinkers as an integral part of practice, by promulgating the A-SBI guidelines and related health education materials developed under Actions 14 and 15 of the *"Action Plan to Reduce Alcohol-related Harm in Hong Kong"* to primary care professionals. (DH)

- Engage advocates and community partners in anti-alcohol education targeting general public to strengthen public literacy about harmful effects of drinking especially on youth, making alcohol-free choices part of healthy living. (DH)

- Strengthen treatment services for people with alcohol problems or supporting people who want to cut down or stop drinking, e.g. the Government to make reference to the model of smoking cessation services to allocate resources to fund local NGOs to provide free or heavily subsidised alcohol treatment services for persons with harmful drinking. (FHB/DH)

- Keep in view and explore the feasibility and timely implementation of "best buys"[56] or other recommended interventions/policies to reduce alcohol-related harm based on WHO guidance. (All government bureaux/departments)

[56] According to the updated Appendix 3 of the WHO Global NCD Action Plan 2013-2020, "best buys" are interventions that are considered to be the most cost-effective and feasible for implementation, for which the WHO-CHOICE analysis found an average cost-effectiveness ratio of ≤ I$100/DALY averted in low- and lower middle-income countries. (Source: http://apps.who.int/iris/bitstream/10665/259232/1/WHO-NMH-NVI-17.9-eng.pdf)

E DEFINITIONS AND SPECIFICATIONS OF LOCAL INDICATORS

Key indicators *(derived from the WHO's GMF[57])*

Indicator (3): Estimated total alcohol consumption per capita (aged 15+ years) within a calendar year in litres of pure alcohol

- Monitoring frequency: annual
- Sources: deduction from recorded data of (i) Census and Statistics Department; (ii) Customs and Excise Department; and (iii) company reports of local beer manufacturers

Indicator (4a): Prevalence of binge drinking at least monthly among adolescents

- Monitoring frequency: every 1 or 2 years depending on source
- Sources:
  (1) Health Assessment Questionnaire (HAQ) self-administered by students (Primary 4 and 6, Secondary 2, 4 and 6) attending Student Health Service Centres, Department of Health every year
  (2) School-based Tobacco Survey among Students, Food and Health Bureau every 2 years
- Definitions: (i) "binge drinking" is defined as having 5 or more cans/glasses of alcoholic drinks in total (approximately 60 grams of pure alcohol) within a few hours; (ii) "adolescents" refer to those aged between 10-19 years, roughly corresponding to the primary 4-6 and secondary 1-6 students

Indicator (4b): Age-standardised prevalence of binge drinking at least monthly among adults (aged 18+ years)

- Monitoring frequency: every 2 years
- Source: Population Health Survey / Health Behaviour Survey, Department of Health
- Definition: "binge drinking" is defined as drinking at least 5 cans of beers, 5 glasses of table wine or 5 pegs of spirits (approximately 60 grams of pure alcohol) on a single occasion

[57] The WHO recommends 3 indicators for monitoring, namely:
- Indicator (3): Total (recorded and unrecorded) alcohol per capita (aged 15+ years) consumption within a calendar year in litres of pure alcohol (Expected frequency: annual)
- Indicator (4): Age-standardised prevalence of heavy episodic drinking (defined as those who report drinking 6 (60 g) or more standard drinks on a single occasion) among adolescents and adults (Expected frequency: every 5 years)
- Indicator (5): Alcohol-related morbidity and mortality among adolescents and adults (aged 15+ years) (Expected frequency: every 5 years)

Indicator (5): Proportion of persons (aged 15+ years) who had an Alcohol Use Disorders Identification Test (AUDIT) score of 16 or above, which indicates harmful drinking or probable alcohol dependence

- Monitoring frequency: every 2 years
- Source: Population Health Survey / Health Behaviour Survey, Department of Health

Supplementary indicators related to youth drinking *(of local relevance)*

Indicator (S1): Prevalence of ever drinking, 12-month drinking and 30-day drinking among young people

- Monitoring frequency: every 2 or 4 years depending on source
- Sources:
  (1) Survey of Drug Use among Students, Narcotics Division of Security Bureau every 4 years
  (2) School-based Tobacco Survey among Students, Food and Health Bureau every 2 years
- Definition: "young people" refers to those aged between 10-24 years[58], roughly corresponding to primary 4-6, secondary 1-6 and post-secondary students

Indicator (S2): Proportion of adolescents reported having the first sip at age below 16 years

- Monitoring frequency: every 2 years
- Source: School-based Tobacco Survey among Students, Food and Health Bureau
- Definition: "adolescents" refers to those aged between 10-19 years, roughly corresponding to primary 4-6 and secondary 1-6 students

Indicator (S3): Proportion of adolescents reported starting a monthly drinking habit at age below 16 years

- Monitoring frequency: every 2 years
- Source: School-based Tobacco Survey among Students, Food and Health Bureau
- Definition: "adolescents" refers to those aged between 10-19 years, roughly corresponding to primary 4-6 and secondary 1-6 students

[58] The WHO defines 'adolescents' as those people between 10 and 19 years of age, while the United Nations defines 'youth' as 15–24 years. 'Young people' (10–24 years) is a term used by the WHO to combine adolescents and youth. (Source: http://apps.who.int/adolescent/second-decade/section2/page1/recognizing-adolescence.html)