
GBD 2016 Alcohol Collaborators*

Summary

Background Alcohol use is a leading risk factor for death and disability, but its overall association with health remains complex given the possible protective effects of moderate alcohol consumption on some conditions. With our comprehensive approach to health accounting within the Global Burden of Diseases, Injuries, and Risk Factors Study 2016, we generated improved estimates of alcohol use and alcohol-attributable deaths and disability-adjusted life-years (DALYs) for 195 locations from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older.

Methods Using 694 data sources of individual and population-level alcohol consumption, along with 592 prospective and retrospective studies on the risk of alcohol use, we produced estimates of the prevalence of current drinking, abstention, the distribution of alcohol consumption among current drinkers in standard drinks daily (defined as 10 g of pure ethyl alcohol), and alcohol-attributable deaths and DALYs. We made several methodological improvements compared with previous estimates: first, we adjusted alcohol sales estimates to take into account tourist and unrecorded consumption; second, we did a new meta-analysis of relative risks for 23 health outcomes associated with alcohol use; and third, we developed a new method to quantify the level of alcohol consumption that minimises the overall risk to individual health.

Findings Globally, alcohol use was the seventh leading risk factor for both deaths and DALYs in 2016, accounting for 2.2% (95% uncertainty interval [UI] 1.5–3.0) of age-standardised female deaths and 6.8% (5.8–8.0) of age-standardised male deaths. Among the population aged 15–49 years, alcohol use was the leading risk factor globally in 2016, with 3.8% (95% UI 3.2–4.3) of female deaths and 12.2% (10.8–13.6) of male deaths attributable to alcohol use. For the population aged 15–49 years, female attributable DALYs were 2.3% (95% UI 2.0–2.6) and male attributable DALYs were 8.9% (7.8–9.9). The three leading causes of attributable deaths in this age group were tuberculosis (1.4% [95% UI 1.0–1.7] of total deaths), road injuries (1.2% [0.7–1.9]), and self-harm (1.1% [0.6–1.5]). For populations aged 50 years and older, cancers accounted for a large proportion of total alcohol-attributable deaths in 2016, constituting 27.1% (95% UI 21.2–33.3) of total alcohol-attributable female deaths and 18.9% (15.3–22.6) of male deaths. The level of alcohol consumption that minimised harm across health outcomes was zero (95% UI 0–0.8) standard drinks per week.

Interpretation Alcohol use is a leading risk factor for global disease burden and causes substantial health loss. We found that the risk of all-cause mortality, and of cancers specifically, rises with increasing levels of consumption, and the level of consumption that minimises health loss is zero. These results suggest that alcohol control policies might need to be revised worldwide, refocusing on efforts to lower overall population-level consumption.

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Introduction

Alcohol use has a complex association with health. Researchers have recognised alcohol use as a leading risk factor for disease burden, and studies link its consumption to 60 acute and chronic diseases.1,2 Additionally, some research suggests that low levels of alcohol consumption can have a protective effect on ischaemic heart disease, diabetes, and several other outcomes.3,4 This finding remains an open question, and recent studies have challenged this view by use of mendelian randomisation and meta-analyses.5–10 Determination of harm due to alcohol use is complicated further by the multiple mechanisms through which alcohol use affects health: through cumulative consumption leading to adverse effects on organs and tissues; by acute intoxication leading to injuries or poisoning; and by dependent drinking leading to impairments and potentially self-harm or violence. These effects are also influenced by an individual’s consumption pattern and volume of drinking.11 Measuring the health effects of alcohol use requires careful consideration of all these factors.
Several studies have attempted to address these factors to provide global estimates of alcohol consumption and its associated health effects. The most comprehensive among these studies have been WHO’s Global Status Report on Alcohol and Health, as well as previous iterations of the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD). The present study aims to build upon pre-existing work and to address several limitations found in earlier research.

First, the available studies have assessed the risk of alcohol use by relying on external meta-analyses, which do not control for confounding in the selection of the reference category within constituent studies. This approach is problematic because of the so-called sick quitter hypothesis, which emphasises the importance of reference category selection in correctly assessing risk among drinkers, along with other confounding study characteristics such as survival bias. Until recently, most meta-analyses of alcohol consumption have not controlled for the composition of the reference category. Subsequently, assessments of harm relying on these studies have been biased. We sought to resolve this issue within our meta-analyses by including controls for different reference categories and the average age of participants.

Second, previous studies have used sales data to estimate population-level alcohol stock. Researchers have noted the benefit of using sales data instead of survey data for quantifying alcohol stock available within a location. However, sales data still have bias because of consumption by tourists and unrecorded consumption from illicit sales, home brewing, and local beverages. Without correction for these factors, estimates relying on sales data can be biased and lead to inaccurate cross-national comparisons. In the current study, we adjusted the estimates of population-level alcohol stock to account for the effects of tourism and unrecorded consumption.

Third, previous studies have assumed zero as the counterfactual exposure level that minimises harm. Within a comparative risk assessment approach, a counterfactual level of consumption that minimises health loss due to alcohol use is zero. These findings strongly suggest that alcohol control policies should aim to reduce total population-level consumption. To potentially reduce the effects of alcohol use on future health loss, there is a need for countries to revisit their alcohol control policies and assess how they can be modified to further lower population-level consumption.

**Implications of all the available evidence**

The total attributable burden of alcohol use was larger than previous evidence has indicated and increases monotonically with consumption. Based on weighted relative risk curves for each health outcome associated with alcohol use, the level of consumption that minimises health loss due to alcohol use is zero. These findings strongly suggest that alcohol control policies should aim to reduce total population-level consumption. To potentially reduce the effects of alcohol use on future health loss, there is a need for countries to revisit their alcohol control policies and assess how they can be modified to further lower population-level consumption.

**Added value of this study**

In this analysis we improved available estimates of alcohol use and its associated health in five ways. First, we consolidated 694 individual and population-level data sources to estimate alcohol consumption levels among current drinkers. Second, we developed a method to adjust population-level consumption for alcohol consumed by tourists. Third, we improved pre-existing methods that account for unrecorded population-level consumption. Fourth, we did a new systematic review and meta-analysis of alcohol use and 23 associated health outcomes, which we used to estimate new dose–response curves of relative risk. Fifth, using the new relative risk curves and a new analytical method, we estimated the exposure of alcohol consumption that minimises an individual’s total attributable risk.
A Females

Population average of standard drinks daily

- <1.00
- 1.01–2.00
- 2.01–3.00
- 3.01–4.00
- 4.01–5.00
- >5.00

The Caribbean

B Males

Population average of standard drinks daily

- <1.00
- 1.01–2.00
- 2.01–3.00
- 3.01–4.00
- 4.01–5.00
- >5.00

The Caribbean
prevalence of current drinking (having one or more drinks in the past year); abstention from alcohol (having no alcohol in the past year); the distribution of alcohol consumption among current drinkers in standard drinks daily; and the disease burden attributable to alcohol use, in terms of deaths and disability-adjusted life-years (DALYs). We produced these estimates for 195 locations from 1990 to 2016, for both sexes and for 5-year age groups between the ages of 15 years and 95 years and older. We also did a new meta-analysis to assess the dose–response risk of alcohol consumption for 23 outcomes. Lastly, we estimated the level of alcohol consumption that minimises an individual’s total attributable risk of any health loss.

Methods
Study design
This study follows the comparative risk assessment framework developed in previous iterations of GBD. In the following sections, we summarise our methods and briefly present innovations. A full explanation is available in appendix 1. This study fully adheres to the Guidelines for Accurate and Transparent Health Estimates Reporting (GATHER) statement.21

We estimated alcohol use exposure as grams of pure ethanol consumed daily by current drinkers (which we present here in terms of standard drinks daily, defined as 10 g of pure ethyl alcohol). We estimated relative risks by dose in grams of pure ethanol alcohol, for each included risk–outcome pair. We ascertained which cause and injury outcomes to include by reviewing prospective and observational studies of alcohol use, and then assessing the causal association using Bradford-Hill’s criteria for causation.22 We included 23 outcomes, and the full list of risk–outcome pairs, as well as the corresponding data sources, are provided in appendix 1 (pp 52–140).

Data sources
We found sources that included indicators of current drinking prevalence and alcohol consumed in grams per day using the Global Health Data Exchange (GHDx) and PubMed.23 For the meta-analysis, we searched PubMed, the GHDx, and references of previously published meta-analyses. For our exposure estimates, we extracted 121029 data points from 694 sources across all exposure indicators. For our relative risk estimates, we extracted 3992 relative risk estimates across 592 studies. These relative risk estimates corresponded to a combined study population of 28 million individuals and 649 000 registered cases of respective outcomes. We list all the included data sources in appendix 1 (pp 52–140).

To estimate standard drinks consumed daily by current drinkers, we followed the general approach used by Rehm and colleagues.8 We briefly explain this method here, along with two methodological innovations to account for bias in the sales model: an adjustment to account for tourist consumption and an updated adjustment for unrecorded consumption. A full explanation of this approach is available in appendix 1 (pp 18–49).

To estimate exposure, we combined estimates of population-level alcohol stock and individual-level alcohol consumption to produce standard drinks consumed daily among current drinkers and current drinker prevalence, within a specific location, year, age group, and sex. We started by estimating population-level alcohol stock in litres per capita from sales data, individual-level estimates of the prevalence of current drinkers and abstainers from survey data, and individual-level estimates of the amount of alcohol consumed in grams per day from survey data. Then, for a given location and year, we rescaled age-specific and sex-specific estimates of individual-level consumption so that they aggregated to the estimates of population-level consumption. When surveys reported amount consumed in terms of beverage types, we converted these data into grams of pure ethanol using density equations and assumptions of the average alcohol content by drink type (appendix 1, p 50). Finally, we rescaled estimates of current drinking and abstention so that, within a given location, year, age group, and sex, the two estimates summed to one.

After we derived our model of population-level alcohol stock from sales data, we controlled for sources of bias that could arise from tourism and unrecorded consumption not recorded in formal sales. To account for tourist consumption, we computed an additive measure for alcohol consumed abroad by domestic citizens and subtractive measures for alcohol consumed domestically by tourists. We extracted data on the number of tourists by country of origin and destination from the World Tourism Organization and used these data to obtain estimates of total tourists, percentage of tourists by location, and average duration of stay using a spatio-temporal Gaussian process regression.24 We combined these estimates with measures of alcohol in litres per capita by location, to calculate net amounts of total population-level alcohol stock consumed by tourists or domestic citizens travelling abroad. To account for alcohol stock not captured within formal alcohol sales data (ie, unrecorded consumption from illicit production, home brewing, local beverages, or alcohol sold as a non-alcohol product), we collated estimates across published studies of the percentage of total alcohol stock due to unrecorded consumption. We sampled 1000 times from a uniform distribution with a range between zero and the average of these collated studies by location (sampling from the uncertainty interval from each study, then averaging the draws) to

Figure 2: Average standard drinks (10 g of pure ethanol per serving) consumed per day, age-standardised, for females (A) and males (B) in 2016, in 195 locations
ATG=Antigua and Barbuda. VCT=Saint Vincent and the Grenadines. Isl=Islands. FSM=Federated States of Micronesia. LCA=Saint Lucia. TTO=Trinidad and Tobago. TLS=Timor-Leste.
generate a conservative estimate of the total stock likely to be unrecorded. We used a conservative approach because of the wide heterogeneity in both the methods and estimates within included data sources. We provide estimates of these percentages in appendix 1 (pp 46–49).

**Systematic review and meta-analysis**

We did a new systematic review for each associated outcome to incorporate new findings on risk and to improve upon existing approaches. This strategy allowed us to systematically control for reference category confounding in constituent studies across associated outcomes. We provide the search strategy, search diagrams, dose–response curves for each included outcome, and references for each outcome in appendix 1 (pp 57–146).

Drawing from our systematic review, we did a meta-analysis of risk outcomes for alcohol use. For each outcome, we estimated the dose–response relative risk curve using mixed-effects logistic regression with non-linear splines for doses between 0 and 12·5 standard drinks daily. We selected 12·5 standard drinks daily as a cutoff point given the absence of available data beyond this range. We present additional details of the model in appendix 1 (pp 51–138). We tested the significance of including a study-level confounding variable on the composition of the reference category (eg, whether former drinkers were included in the abstainer category or not). When found to be significant, this variable was included as a predictor within the model, which was the case for ischaemic heart disease, ischaemic stroke, and diabetes.

Using our dose–response curves, we estimated the consumption level that minimises harm, which is defined in the comparative risk assessment approach as the theoretical minimum risk exposure level (TMREL). We chose a theoretical minimum on the basis of a weighted average relative risk curve across all attributable outcomes. We constructed weights for each risk outcome based on the respective global, age-standardised DALY rate per 100 000 in 2016 for both sexes. Our TMREL was the minimum of this weighted all-attributable outcome dose–response curve.

**Attributable burden due to alcohol use**

We calculated PAFs using our estimates of exposure, relative risks, and TMREL, following the same approach taken within the GBD studies. For alcohol-use disorders, which are by definition fully attributable, we assumed a PAF of 1. Following this calculation, we multiplied PAFs by outcome-specific estimates of deaths and DALYs and summed these across outcomes to calculate the total attributable burden in specific locations. We aggregated both exposure and burden results at the global level and have presented them by quintile of the Socio-demographic Index (SDI). SDI is a summary measure of overall development, based on educational attainment, fertility, and income per capita within a location. Locations categorised by SDI quintile are found in appendix 1 (pp 8–12). We also constructed age-standardised values of all estimates, using the same age weights as those used in the GBD standard population.

We made one adjustment to road injury PAFs to estimate how much burden occurred to others because of alcohol use by another individual. We based this adjustment on data from the US Fatality Analysis Reporting System (FARS), which includes the average number of deaths in automobile accidents involving alcohol and the percentage of those deaths distributed by age and sex. We multiplied age-specific and sex-specific alcohol-attributable and road-injury-attributable DALYs by the average number of fatalities, given the driver’s age and sex. We then redistributed these attributable DALYs according to the FARS-derived probabilities that a population by age and sex would be involved in a road injury, given the exposed driver’s age and sex. Because of data availability, we assumed that locations outside the USA would follow a similar pattern to what we estimated with FARS. After redistributing the attributable DALYs, we derived PAFs again by dividing the redistributed attributable DALYs by total DALYs within specific demographics.

**Uncertainty analysis**

For all steps, we calculated uncertainty for estimation of exposure, attributable deaths, and DALYs by taking 1000 draws from the data’s uncertainty due to sampling error and modelling uncertainty arising from hyper-parameter selection and parameter estimation. We then used these draws throughout the entire modelling process. When reporting uncertainty intervals, we present the 2·5th and 97·5th percentiles of the draws.

**Role of the funding source**

The funders of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report. The corresponding author had full access to all the data in the study and had final responsibility for the decision to submit for publication.

**Results**

**Global, regional, and national trends in alcohol consumption**

In 2016, 32.5% (95% uncertainty interval [UI] 30.0–35.2) of people globally were current drinkers. 25% (95% UI 23–27) of females were current drinkers, as were 39% (36–43) of males (appendix 2). These percentages corresponded to 2·4 billion (95% UI 2·2–2·6) people globally who were current drinkers, with 1·5 billion (1·4–1·6) male current drinkers and 0·9 billion (0·8–1·0) female current drinkers (appendix 2, pp 2–1994). Globally, the mean amount of alcohol consumed was 0·73 (95% UI 0·68–0·78) standard drinks daily for females and 1·7 (1·5–1·9) standard drinks daily for males.

The prevalence of current drinking varied considerably by location (figure 1). Prevalence was highest for high SDI locations, where 72% (95% UI 69–75) of females and
Figure 3 continues on next page
Articles

B Males

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Age group (years)

Cause
- Tuberculosis
- Lower respiratory infections
- Oesophageal cancer
- Colon and rectum cancer
- Lip and oral cavity cancer
- Liver cancer
- Pharynx and nasopharynx cancer
- Larynx cancer
- Breast cancer
- Ischaemic stroke
- Haemorrhagic stroke
- Hypertensive heart disease
- Atrial fibrillation and flutter
- Cirrhosis and other chronic liver diseases
- Pancreatitis
- Epilepsy
- Alcohol use disorders
- Diabetes
- Transport injuries
- Unintentional injuries
- Self harm
- Interpersonal violence

Attributable DALY rate (per 100 000)

Age group (years)
83% (80–85) of males were current drinkers (locations comprising each SDI quintile are provided in appendix 2, pp 8–12). Drinking prevalence was lowest in low-to-middle SDI locations, where 8.9% (95% UI 6.6–9.7) of females and 20% (17–22) of males were current drinkers. Across SDI quintiles, females consumed less alcohol than males, with the size of this disparity decreasing with higher levels of SDI. For example, we found large differences between females and males in Nepal, with only 1.5% (95% UI 1.2–1.9) of females being current drinkers in 2016, compared with 21% (17–25) of males. Conversely, many high SDI locations had similar prevalence between sexes. For example, we found minimal differences in Sweden, where 86% (95% UI 84–88) of females and 87% (85–89) of males were current drinkers.

The population average of standard drinks consumed daily among current drinkers in 2016 also differed widely by location and sex (figure 2). High SDI locations had the highest average of standard drinks consumed daily, with 1.9 (95% UI 1.3–2.7) standard drinks consumed daily among females and 2.9 (2.0–4.1) among males. Low SDI locations had the smallest average for males, with 0.6 (0.2–2.4) standard drinks consumed daily, while low-to-middle SDI locations had the lowest average for females, with 0.3 (0.1–0.6) standard drinks consumed daily.

Global patterns in alcohol-attributable deaths and disease burden

In 2016, 2.8 million deaths (95% UI 2.4–3.3) were attributed to alcohol use. This corresponds to 2.2% (95% UI 1.5–3.0) of total age-standardised deaths among females and 6.8% (5.8–8.0) among males. In terms of overall disease burden, alcohol use led to 1.6% (95% UI 1.4–2.0) of total DALYs globally in 2016 among females and 6.0% (5.4–6.7) among males. Globally, alcohol use was ranked as the seventh leading risk factor for premature death and disability in 2016, compared with other risk factors in the GBD studies. Among the population aged 15–49 years, alcohol use was the leading global risk factor for risk-attributable disease burden, causing 8.9% (95% UI 7.8–9.9) of attributable DALYs for men and 2.3% (2.0–2.6) for women. Among the population aged 15–49 years, 3.8% (95% UI 3.2–4.4) of female deaths and 12.2% (10.8–13.6) of male deaths were attributable to alcohol use.

Both total burden attributable to alcohol use and the proportion of causes associated with alcohol use varied by sex, age, and SDI quintile (figure 3; appendix 2, pp 1997–2186). In absolute terms, the alcohol-attributable burden by age was smaller for females than for males (figure 3). For females, the alcohol-attributable burden increased with age, while for males the burden increased until between 55–65 years of age, after which attributable burden decreased. Females, particularly in high SDI locations, experienced some protective effects for ischaemic heart disease and diabetes beyond 60 years of age. For males, only high SDI and low SDI locations had noticeable protective effects for ischaemic heart disease, but the effect was small compared with the total attributable burden in those locations.

For both males and females, health outcomes comprising the attributable burden changed across the lifespan (figure 3). The three leading causes of attributable deaths in this age group were tuberculosis (1.4% [95% UI 1.0–1.7] of total deaths), road injuries (1.2% [0.7–1.9]), and self-harm (1.1% [0.6–1.5]). For females aged 15–49 years, alcohol use disorders constituted the largest proportion of the attributable burden across SDI quintiles; the primary exception was tuberculosis, which accounted for the largest proportion of attributable burden in low SDI settings. In this age range, transport injuries and alcohol use disorders were the predominant causes of attributable burden for males in high-to-middle SDI quintiles; for low-to-middle SDI and low SDI quintiles, tuberculosis was the primary cause of the attributable burden for both sexes.

Beyond 50 years of age, the causes of total attributable burden became more complex by SDI quintile. For populations aged 50 years and older, cancers accounted for a large proportion of total alcohol-attributable deaths in 2016, constituting 27.1% (95% UI 21.2–33.3) of total alcohol-attributable female deaths and 18.9% (15.3–22.6) of alcohol-attributable male deaths. In high SDI countries, cancers were the predominant source of attributable burden among both sexes. In low SDI countries, tuberculosis was the primary cause of burden for both sexes, followed by cirrhosis and other chronic liver diseases. The profile of attributable burden in high-to-middle SDI and middle SDI countries for females and males was largely composed of ischaemic stroke and haemorrhagic stroke, followed by liver cancer for females. In all SDI quintiles, haemorrhagic stroke and hypertensive heart disease were the largest sources of burden for females aged 80 years and older. For men in this age group, the composition of the burden was similar to that of males aged 50 years or older.

Health risks associated with alcohol consumption

Figure 4 shows the relative risk curves for selected health outcomes, separately for females and males. Estimated relative risk curves for each health outcome are presented in appendix 2 (pp 52–140). With this analysis, we only found statistically significant evidence for the J-shaped curve for ischaemic heart disease; non-significant J-shaped curves were observed for diabetes and ischaemic stroke. For ischaemic heart disease, we found a
minimum relative risk of 0·86 (0·80–0·96) for men and 0·82 (0·72–0·95) for women, occurring at 0·83 standard drinks daily for men and 0·92 standard drinks daily for women. We found no significant difference in relative risk curves for ischaemic heart disease or diabetes when estimating the curves by age. For all other outcomes, including all cancers, we found that relative risk monotonically increased with alcohol consumption (appendix 2, pp 57–146).

In estimating the weighted relative risk curve, we found that consuming zero (95% UI 0·0–0·8) standard drinks daily minimised the overall risk of all health loss (figure 5). The risk rose monotonically with increasing amounts of daily drinking. This weighted relative risk curve took into account the protective effects of alcohol use associated with ischaemic heart disease and diabetes in females. However, these protective effects were offset by the risks associated with cancers, which increased monotonically with consumption. In a sensitivity analysis, where we explored how the weighted relative risk curve changed on the basis of the choice of weights for various health outcomes, the curve changed significantly only in settings where diabetes and ischaemic heart disease comprised more than 60% of total deaths in a population.

Discussion
In 2016, alcohol use led to 2·8 million deaths and was the leading risk factor for premature death and disability among people aged 15–49 years, with nearly 9% of all attributable DALYs for men and more than 2% for women. Our findings indicate that alcohol use was associated with far more health loss for males than for females, with the attributable burden for men around three times higher than that for women in 2016. By evaluating all associated relative risks for alcohol use, we found that consuming zero standard drinks daily minimises the overall risk to health.

Previous research has analysed all-cause risk due to alcohol use by either investigating all-cause risk in particular cohorts and survey series, or through meta-analyses of those studies.26,27 Past findings subsequently suggested a persistent protective effect for some low or moderate levels of alcohol consumption on all-cause mortality. However, these studies were limited by small sample sizes, inadequate control for confounders, and non-optimal choices of a reference category for calculating relative risks. More recent research, which has used methodologies such as mendelian randomisation, pooling cohort studies, and multivariable adjusted meta-analyses, increasingly shows either a non-significant or no protective effect of drinking on all-cause mortality or cardiovascular outcomes.7,14,28 Our results on the weighted attributable risk are consistent with this body of work. Taken together, these findings emphasise that alcohol use, regardless of amount, leads to health loss across populations. Although we found some protective effects for ischaemic heart disease and diabetes among women, these effects were offset when overall health risks were considered—especially because of the strong association between alcohol consumption and the risk of cancer, injuries, and communicable disease. These findings stress the importance of assessing how alcohol use affects population health across the lifespan.

Evaluating attributable burden across SDI quintiles revealed the magnitude by which outcomes of alcohol use differ and how total attributable burden relates to increasing SDI. Our results indicate that alcohol use and its harmful effects on health could become an increasing challenge amid gains in SDI. Given that most low and low-to-middle SDI settings currently have lower average alcohol consumption than high-to-middle SDI settings, it is crucial for decision makers and government agencies to enact or maintain strong alcohol control policies today to prevent the potential for rising alcohol use in the future. Effective policies now could yield substantial population health benefits for years to come.
Our results point to a need to revisit alcohol control policies and health programmes, and to consider recommendations for abstinence. In terms of reducing population-level alcohol use, WHO provides a set of best buys—policies that provide an individual year of healthy life at less than the cost of the average individual income.\(^9\) Governments should consider how these recommendations can be implemented within their local contexts and broader policy platforms, including excise taxes on alcohol, controlling the physical availability of alcohol and the hours of sale, and controlling alcohol advertising. Any of these policy actions would contribute to reductions in population-level consumption—an important step toward decreasing the health loss associated with alcohol use.

Failing to address harms from alcohol use, particularly at high levels of consumption, can have dire effects on population health. The mortality crisis in Russia is a striking example, where alcohol use was the primary culprit of increases in mortality starting in the 1980s and led to 75% of deaths among men aged 15–55 years.\(^9\) Current global trends—namely, population ageing—portend a growing toll of the alcohol-attributable burden in the absence of policies, particularly since many cancers disproportionately affect older individuals. Consequently, low-to-middle SDI countries could benefit from policy action today to keep alcohol consumption low and prevent greater health loss in the future. High and high-to-middle SDI locations need to consider stronger alcohol reduction policies, such as those recommend by WHO, in an effort to reduce population-level consumption.

Our results should be interpreted within the context of the study’s limitations. First, our consumption estimates might not fully capture illicit production or unrecorded consumption given our use of sales data in estimation. We have sought to adjust for consumption beyond sales data, but given the heterogeneity of these estimates it is likely that additional methodological refinements are necessary to improve the quantification of unrecorded consumption. Second, drinking patterns within a year are assumed to be consistent; however, past work shows that drinking patterns, rather than average levels of consumption such as standard daily drinks, might be related to different levels of risk and harm. Unfortunately, the data requirements for assessment of such drinking patterns by age, sex, and location far exceed what is currently available. For instance, few prospective studies quantify the effects of drinking patterns and average levels of consumption in tandem, a requirement for correctly assessing the risk of alcohol-attributable outcomes. Third, the data used to estimate motor vehicle harm caused to others from alcohol use were only available for the USA (ie, FARS data). Although it is unlikely that the patterns observed in FARS are drastically different from those of other locations (appendix I, pp 141–144), this assumption needs to be tested with more location-specific estimates. Fourth, we were unable to find robust data about the harm caused to others from alcohol-attributable interpersonal violence, a major potential source of health loss. More retrospective studies are needed to assess the harm to others caused through an individual’s alcohol use.\(^9\) Fifth, consumption for populations younger than 15 years was not assessed because of data sparseness on alcohol use for these age groups. In the absence of such data, potential approaches to address this limitation, such as assuming consumption patterns of older age groups or trying to extrapolate past levels of alcohol consumption, are likely to introduce additional bias or error. More research on youth drinking and the associated risk is required to estimate alcohol-attributable burden for this age group. Last, we sought to quantify the risk of alcohol use only for outcomes with evidence meeting the criteria for the comparative risk assessment approach of GBD studies. However, there are additional outcomes, such as dementia and psoriasis, for which accumulating evidence suggests that alcohol use might be a risk factor.\(^9\) In combination, these limitations suggest that our results are likely to underestimate both the health risks and overall attributable burden of alcohol use.

**Conclusion**

Alcohol use is a leading risk factor for disease burden worldwide, accounting for nearly 10% of global deaths among populations aged 15–49 years, and poses dire ramifications for future population health in the absence of policy action today. The widely held view of the health benefits of alcohol needs revising, particularly as improved methods and analyses continue to show how much alcohol use contributes to global death and disability. Our results show that the safest level of drinking is none. This level is in conflict with most health guidelines, which espouse health benefits associated with consuming up to two drinks per day. Alcohol use contributes to health loss from many causes and exacts its toll across the lifespan, particularly among men. Policies that focus on reducing population-level consumption will be most effective in reducing the health loss from alcohol use.

**GBD 2016 Alcohol Collaborators**

Dentistry, University of Costa Rica, San Pedro, Costa Rica (Prof J Castillo Rivas MSc); Department of Health Planning and Economics, National School of Public Health, Institute of Health Carlos III, Madrid, Spain (F Catá-López PhD); College of Medicine, National Taiwan University, Taipei, Taiwan (Prof J Chang PhD); Department of Development Studies (Prof A Chattopadhyay PhD); Department of Public Health & Mortality Studies (Prof U Ram PhD). International Institute for Population Sciences, Mumbai, India (Prof Kumar PhD; A Path MPH); Tata Memorial Hospital, Mumbai, India (Prof P Chaturvedi MD); Department of Public Health and Primary Care, University of Cambridge, UK (Prof R Chowdhury PhD); Department of Endocrinology (Prof N Thomas PhD), Christian Medical College and Hospital (CMC), Vellore, India; Health Data Research UK, London, UK (S Chung PhD); School of Medicine (L G Cioabu PhD), University of Adelaide, Adelaide, SA, Australia (A O Olajumun JD); Department of Nutrition (Prof R M Claro MD); Department of Maternal and Child Nursing and Public Health (Prof M Rohbo MPh). Department of Community Medicine and Surgery, University of Milan-Bicocca, Monza, Italy (S Conti PhD; A Lafranconi MD, F Madotto PhD); Postgraduate Program in Epidemiology, Federal University of Rio Grande do Sul, Porto Alegre, Brazil (E Cousin MSc; B B Duncan MD, Prof M I Schmidt PhD). Department of Family Medicine and Public Health, University of California San Diego, La Jolla, CA, USA (Prof M H Criqui MD); Clinical Toxicology Service, Guy’s and St. Thomas’ NHS Foundation Trust, London, UK (Prof P J Dargan MB); National Medical University of Almaty, Kazakhstan (Prof K Davletov PhD). Monash Centre for Health Research and Implementation (Prof B de Courten PhD), School of Public Health and Preventive Medicine (Prof Y Guo PhD). Centre of Cardiovascular Research and Education in Therapeutics (B Olofi-Asenso MSc), Monash University, Melbourne, VIC, Australia; Monash Health, Melbourne, VIC, Australia (Prof B de Courten PhD); Institute of Public Health (Prof J De Neve MD, B Moazen MSc, S Mohammad PhD); Department of Ophthalmology, Medical Faculty Mannheim (Prof J B Jonas MD). Heidelberg University, Heidelberg, Germany; Department of Clinical Pharmacy, Aksum University, Aksum, Ethiopia (G T Derzom MSc); Department of Psychiatry, Icahn School of Medicine at Mount Sinai, New York, NY, USA (Prof D C Des Jarsali PhD); Dishs Foundation, Gurgaon, India (S Dey PhD); Indian Council of Medical Research, New Delhi, India (R S Dhullwal MD); Department of Community Medicine, University of Peradeniya, Peradeniya, Sri Lanka (S D Dharmaratne MD); Health Research Section, Nepal Health Research Council, Kathmandu, Nepal (M Dhamal PhD); Department of Population and Health, University of Cape Coast, Cape Coast, Ghana (D T Doku PhD); School of Health Sciences, University of Tampere, Tampere, Finland (G Grosso PhD); Department of Clinical Pathology, Medical Faculty Copenhagen, Copenhagen, Denmark (Prof S Rawaf PhD). Integrated Tumor Registry, University-Hospital Polyclinic Vittorio Emanuele, Catania, Italy (G Grosso PhD), Commission of Public Health, West Virginia Bureau for Public Health, Charleston, WV, USA (Prof R Gupta MD); Department of Health Policy, Management & Leadership, West Virginia University, Morgantown, WV, USA (Prof R Gupta MD); National Institute for Health and Care Excellence, London, UK (Prof R Gupta MD); Department of Preventive Cardiology, Eternal Heart Care Centre & Research Institute, Jaipur, India (Prof R Gupta MD); Department of Anthropology, University of Delhi, Delhi, India (V Gupta PhD); Indian Institute of Public Health, Public Health Foundation of India, Hyderabad, India (Prof M GVS MD); Department of Radiology, Johns Hopkins University, Baltimore, MD, USA (N Hafezi-Nejad MD); Department of Family and Community Medicine, Arabian Gulf University, Manama, Bahrain (Prof R R Hamadeh DPhil); School of Health and Environmental Studies, Hamdan Bin Mohammed Smart University, Dubai, United Arab Emirates (Prof S Hamidi DrPH); Neurology Department, Sir Charles Gardiner Hospital, Perth, WA, Australia (Prof G J Hankey MD); Department of Vital and Health Statistics (H L Harb MPH), Department of Disease, Epidemioms and Pandemics Control (J Nansseu MD), Ministry of Public Health, Beirut, Lebanon; Cardiology Department (Prof S Harikrishnan MD). See Chitra Tirunal Institute for Medical Sciences and Technology, Trivandrum, India (G Mini PhD); Research and Development Unit, Parc Sanitari Sant Joan de Déu (CIBERSAM), Sant Boi de Llobregat, Spain (Prof J M Haro MD, A Koyanagi MD, S Tyrovolas PhD); Department of Medicine (Prof J M Haro MD), University of Barcelona, Barcelona, Spain (S Tyrovolas PhD); Public Health Department (H Y Hassen MPH), Pharmacy Department (A T Kefale MSc), Mizan-Tepi University, Mizan Tepi, Ethiopia (Prof A Henok MPH); Unit of Epidemiology and Social Medicine, University Hospital Antwerp, Wilrijk, Belgium (H Y Hassen MPH); Karolinska University Hospital, Stockholm, Sweden (R Nauvoeller PhD); Subdirector of Regulations, Guidelines and Technical Procedures, Secretary of Health, National Commission Against Addiction, Mexico City, Mexico (Prof N F Hernández-Llanes MPH); Department of Statistics and Econometrics (Prof C Hertel PhD, Prof A Mirica PhD, A Pana MD); Bucharest University of Economic Studies, Bucharest, Romania (B V Lleana PhD); Department of Reproductive Health, Hawassa University, Hawassa Ethiopia (D T T Hbistu MPH); Transdisciplinary Centre for Qualitative Methods, Manipal University, Manipal, India (P Hoogar PhD); Department of Pulmonology, Yokohama City University, Yokohama, Japan (N Hotta MD); National Human Genome
Health Services Research & Policy (Prof M McKee DSc), Department of Non-communicable Disease Epidemiology (Prof D Prabhakaran DM), London School of Hygiene & Tropical Medicine, London, UK; Department of Internal Medicine, Sevenhills Hospital, Mumbai, India (V Mehta MD); Institute for Agricultural and Nutritional Sciences (T Meier PhD), Institute of Epidemiology, Biostatistics and Informatics (I Shiue PhD), Martin Luther University Halle-Wittenberg, Halle, Germany; Innovation Office Nutricard, Competence Cluster for Nutrition and Cardiovascular Health (NUTRICARD), Halle, Germany (T Meier PhD); College of Health Sciences, Debre Tabor University, Debre Tabor, Ethiopia (A Melese MSc); Department of Public Health, University of West Florida, Pensacola, FL, USA (Prof P T N Memiah DrPH); Peru Country Office of the UNFPA, United Nations Population Fund (UNFPA), Lima, Peru (W Mendoza MD); Center for Translation Research and Implementation Science, National Heart, Lung, and Blood Institute, Bethesda, MD, USA (G A Mensah MD); Comprehensive Cancer Center, Breast Surgery Unit, Helsinki University Hospital, Helsinki, Finland (T J Meretoja MD); Ethiopian Academy of Medical Science, Mekelle, Ethiopia (Prof H B Mezgebe MSc); Department of Hypertension & Internal Medicine (Prof T Mazgiowski MD), Zdroje Hospital | Wiedeka Foundation; Pomeranian Medical University, Szczecin, Poland; Pacific Institute for Research & Evaluation, Calverton, MD, USA (T R Miller PhD); School of Public Health, Curtin University, Perth, WA, Australia (T R Miller PhD); Department of Public Health, Amritra Institute of Medical Sciences, Kochi, India (G M Min PhD); President’s Office, National Institute of Statistics Romania, Bucharest, Romania (Prof A Mirica PhD); Kyrgyz State Medical Academy, Bishkek, Kyrgyzstan (Prof E M Mirrakhimov MD); Department of Atherosclerosis and Coronary Heart Disease, National Center of Cardiology and Internal Disease, Bishkek, Kyrgyzstan (Prof E M Mirrakhimov MD); Department of Health and Social Work, Institute of Addiction Research (ISFF), Frankfurt University of Applied Sciences, Frankfurt Am Main, Germany (B Mouzen MSc); Department of Biology, Salaluddin University, Erbil, Iraq (K A Mohammad PhD); ISHK University, Erbil, Iraq (K A Mohammad PhD); Nutrition and Cohort Studies Department, Ihsafan Cardiovascular Research Institute (N Mohammadifar PhD); Cardiovascular Research Institute (Prof N Sarrajzaegadeh MD), Isfahan University of Medical Sciences, Isfahan, Iran; Health Systems and Policy Research Unit (S Mohammed PhD), Department of Community Medicine (M B Suffyan MD), Ahmadu Bello University, Zaria, Nigeria; Clinical Epidemiology and Public Health Research Unit, Institute for Maternal and Child Health, IRCCS Burlo Garofolo, Trieste, Italy (L Monasta DSc, L Ronfani PhD); Lancaster University, UK (P Moroga PhD); International Laboratory for Air Quality and Health, Science and Engineering Faculty, Queensland University of Technology, Brisbane, QLD, Australia (Prof L Morawska PhD); St. Paul’s Hospital Millennium Medical College, Addis Ababa, Ethiopia (T Jalu MPH); Department of Endocrinology & Metabolism, Institute of Postgraduate Medical Education and Research, Kolkata, Kolkata, India (Prof S Mukhopadhyay MD); School of Medical Sciences, University Sains Malaysia, Kulang Kerian, Malaysia (Prof K Musa PhD); Initiative for Non Communicable Diseases, International Centre for Diarrhoeal Disease Research, Bangladesh, Dhaka, Bangladesh (A Nahred PhD); Department of Epidemiology, University of Alabama at Birmingham, Birmingham, AL, USA (G Naik MPH); Epidemiology Department (Prof F Najafi PhD), Research Center for Environmental Determinants of Health (M Soofi PhD), Kermanshah University of Medical Sciences, Kermanshah, Iran; Suraj Eye Institute, Nagpur, India (V Nanga MD); Department of Public Health, Faculty of Medicine and Biomedical Sciences, University of Yavoude, Yaoundé, Cameroon (J Nansseu MD); Department of Epidemiology and Public Health, University Sidi Mohamed Ben Abdellah, Fez, Morocco (Prof C Nejjar PhD); International School of Public Health, Mohammed VI University of Health Science, Casablanca, Morocco (Prof C Nejjar PhD); Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Inlandet Hospital Trust, Brumunddáll, Norway (S P Neupane PhD); Department of Biological Sciences, University of Embu, Embu, Kenya (J W Ngunjiri DrPH); Institute for Global Health Innovations, Duy Tan University, Hanoi, Vietnam (C T Nguyen MPH, L H Nguyen MPH, T H Nguyen BMedSc); Public Health Department, Semarang State University, Kota Semarang, Indonesia (D A Ningrum MPH); Graduate Institute of Biomedical Informatics, Taipei Medical University, Taipei City, Taiwan (D A Ningrum MPH); Research Unit, Health Policy Consult, Accra, Ghana (R Ofori-Assenso MSc); School of Social Sciences and Psychology Department (Prof A M N Renzaho PhD), Western Sydney University, Penrith, NSW, Australia (F A Ogho PhD); Dept of Preventive Medicine, School of Medicine, Kyung Hee University, Gyeonggi-do, South Korea (Prof T Oh PhD); HIV/AIDS, STIs & TB (HAST) Programme, Human Sciences Research Council (HSRC), Durban, South Africa (O Oladimeji MD); School of Public Health, Faculty of Health Sciences, University of Namibia, Oshakati, Namibia (O Oladimeji MD); Department of Psychiatry, University of Lagos, Lagos, Nigeria (A T Olagunju MD); Autonomous University of Chile, Chile (Prof P R Oliveses PhD); Executive Director (B O Olusanya PhD), Centre for Health Start Initiative, Ikoyi, Nigeria (J O Olusanya MBA); Graduate School of Public Health, San Diego State University, San Diego, CA, USA (Prof E Oren PhD); School of Psychology, University of Ottawa, Ottawa, ON, Canada (H M Oropo PhD); Center for Vaccine Development, University of Maryland, Baltimore, MD, USA (Prof J R Ortiz MD); Global Health Nursing, St. Luke’s International University, Chuo-Ku, Japan (Prof E Ota PhD); College of Medicine, University of Ibadan, Ibadan, Nigeria (Prof M O Owolabi DrM); Agricultural Economics and Development, University of Alberta, Edmonton, AB, Canada (Prof S A Sibbald PhD); Institute of Public Health, Faculty of Medicine and Biomedical Sciences, University of Yaoundé, Yaoundé, Cameroon (J Nansseu MD); Department of Medical Humanities and Social Medicine, Kostin University, Busan, South Korea (Prof E Park PhD); Population Health Group, Murdoch Children’s Research Institute, Melbourne, VIC, Australia (Prof G C Patton MD); Health, Nutrition and HIV AIDS Program, Save the Children, Kalimandu, Nepal (D Paudel PhD); School of Public Health, University of Witswatersrand, Johannesburg, South Africa (Prof M Paus PhD); Institute of Medicine, University of Gothenburg, Gothenburg, Sweden (Prof M Paus PhD); School of Public Health, University of Witwatersrand, Johannesburg, South Africa (Prof M Petzold PhD); Institute of Medicine, University of Gothenburg, Gothenburg, Sweden (Prof M Petzold PhD); Shanghai Mental Health Center, Shanghai, China (Prof M R Phillips MD); Basic Medical Sciences Department, Bruker University Technology, Durban, South Africa (Prof J D Pillay PhD); Department of Economics & Business (Prof M J Postma PhD), University Medical Center Groningen (Prof J M Van Boven PhD, Prof M J Postma PhD) University of Groningen, Groningen, Groningen, Netherlands; Non-Communicable Diseases Research Center, Alborz University of Medical Sciences, Karaj, Iran (M Qorbani PhD); Medicem, Spain (A Radfar MD); Centre School of Public Health, Lahore, Pakistan (A Rafay MS, Prof S M Rana PhD); Research and Evaluation Division, BRAC, Dhaka, Bangladesh (M Rahman PhD); Austin Clinical School of Nursing (M Rahman PhD), Centre for Alcohol Policy Research (Prof R Room PhD), Department of Psychology and Counselling (Prof T Wijeratne MD), La Trobe University, Heidelberg, VIC, Australia; Society for Health and Demographic Surveillance, Suri, India (R Rai MPH); Department of Economics, University of Göttingen, Göttingen, Germany (R Rai MPH); Medical University Innsbruck, Austria (S Rajic MD); Department of Nephrology, Nizami's Institute of Medical Sciences, Hyderabad, India (Prof S Raju MD); Public Health Department, University of Health Sciences, Lahore, Pakistan (Prof S S Rana PhD); Institute for Poverty Alleviation and International Development (L C Ranaahut PhD), Yonsei University, South Korea (Prof S S Rana PhD); Department of Preventive Medicine and Occupational Medicine, Loma Linda University Medical Center, Loma Linda, CA, USA (C Resi MD); Department of Clinical Research, University of Umeå, Umeå, Sweden; University of São Paulo, Brazil (C Amorim PhD); Centre for Social Research on Alcohol and Drug Use, Centre for Public Health Science, Stockholm University, Stockholm, Sweden (Prof R Room PhD); Golestan Research Center of Gastroenterology and Hepatology, Golestan University of Medical Sciences, Gorgan, Iran (G Roshandel PhD); Department of Cardiology, All India Institute of Medical Sciences (AIIMS), New Delhi, India (Prof A Roy MD); National Institute for Research in Environmental Health, North Carolina, USA (Prof T R Miller PhD); College of Public Health, University of Alabama at Birmingham, Birmingham, AL, USA (G Naik MPH); Epidemiology Department (Prof F Najafi PhD), Research Center for Environmental Determinants of Health (M Soofi PhD), Kermanshah University of Medical Sciences, Kermanshah, Iran; Suraj Eye Institute, Nagpur, India (V Nanga MD); Department of Public Health, Faculty of Medicine and Biomedical Sciences, University of Yavoude, Yaoundé, Cameroon (J Nansseu MD); Department of Epidemiology and Public Health, University Sidi Mohamed Ben Abdellah, Fez, Morocco (Prof C Nejjar PhD); International School of Public Health, Mohammed VI University of Health Science, Casablanca, Morocco (Prof C Nejjar PhD); Norwegian National Advisory Unit on Concurrent Substance Abuse and Mental Health Disorders, Inlandet Hospital Trust, Brumunddáll, Norway (S P Neupane PhD); Department of Biological Sciences, University of Embu, Embu, Kenya (J W Ngunjiri DrPH); Institute for Global Health Innovations, Duy Tan University, Hanoi, Vietnam (C T Nguyen MPH, L H Nguyen MPH, T H Nguyen BMEdSc); Public Health Department,
Health, Indian Council of Medical Research, Bhopal, India (T D Sabde MD); College of Medicine, University of Sharjah, Sharjah, United Arab Emirates (Prof S Siddiqui PhD); College of Pharmacy, Pakistan (Z Saleem PharmD); Center for Health Policy & Center for Primary Care and Outcomes Research, Stanford University, Stanford, CA, USA (Prof J A Salomon PhD); Clinical Research Division, Chest Research Foundation, Pune, India (Prof S S Salvi MD); Department of Surgery, Marshall University, Huntington, WV, USA (Prof J Sanabria MD); Department of Nutrition and Preventive Medicine, Case Western Reserve University, Cleveland, OH, USA (Prof J Sanabria MD); Nephrology Group, LFS-Fundación Jimenez Diaz, Madrid, Spain (M Sanchez-Nito PhD); Faculty of Medicine, Institute of Social Medicine, Center School of Public Health and Health Management, University of Belgrade, Belgrade, Serbia (Prof M M M Santric Milicevic PhD); Health Economics and Financing Research Group, International Centre for Diarrhoeal Disease Research, Bangladesh, Dhaka, Bangladesh (A R Sarkar MSc); Department of Health and Society, Faculty of Medicine, University of Applied and Environmental Sciences, Bogotá, Colombia (Prof R Sarmiento-Suárez MPH); Department of Public Health Medicine, Howard College Campus, University of KwaZulu-Natal, Durban, South Africa (Prof B Sartorius PhD); UGC Centre of Advanced Study in Psychology, Utkal University, Bhubaneswar, India (Prof M Satpathy PhD); Department of Public Health Sciences, University of North Carolina at Charlotte, Charlotte, NC, USA (M Sawhney PhD); Market Access, Bayer, Istanbul, Turkey (M Saylan MD); Swiss Research Institute for Public Health and Addiction in the University of Zurich, Zurich, Switzerland (M F Schaub PhD); Health Sciences Departments, Federal University of Santa Catarina, Florianópolis, Brazil (Prof J C Schneider PhD, Prof D A S Silva PhD); Department of Operative and Preventive Dentistry, Charity University Medical Center - Berlin, Berlin, Germany (Prof F Schwendicke MPH); Independent Consultant, Karachi, Pakistan (M A Shaikh MSc); Department of Laboratory Sciences (Prof M Sharif PhD), Department of Basic Sciences (Prof M Sharif PhD), Islamic Azad University, Sari, Iran; Department of Pulmonary Medicine, Fudan University, Shanghai, China (J Shie MD); Usher Institute of Population Health Sciences and Informatics, University of Edinburgh, Edinburgh, UK (Prof A Sheikh MSc); The Research Institute at Nationwide Children's Hospital, Columbus, OH, USA (J Shen PhD); National Institute of Infectious Diseases, Tokyo, Japan (M Shigematsu PhD); Washington State University, Pullman, WA, USA (Prof K Shishani PhD); Symbiosis Institute of Health Sciences, Symbiosis International University, Pune, India (Prof S R Shukla PhD); Department of Psychology, Reykjavik University, Reykjaviq, Iceland (Prof I D Sigfusdottir PhD); Department of Health and Behavior Studies, Columbia University, New York, New York, USA (Prof I D Sigfusdottir PhD); Portuguese Institute of Sport and Youth, Lisbon, Portugal (N T da Silva MPH); Brasilia University, Brasilia, Brazil (Prof D A Silva MSc); School of Preventive Oncology, Patna, India (D N Sinha PhD); Department of Epidemiology, Healis Sekhsaria Institute for Public Health, Mumbai, India (D N Sinha PhD); Pneumology Service, Research Institute of the University Hospital of the Princess (IISP), Madrid, Spain (Prof J B Soriano MD); Pneumology Service, Autonomous University of Madrid, Madrid, Spain (Prof J B Soriano MD); Division of Community Medicine, International Medical University, Kuala Lumpur, Malaysia (Prof C T Sreeramareddy MD); Institute and Outpatient Clinic for Occupational, Social and Environmental Medicine, University Hospital Munich, Munich, Germany (N Steckling DrPH); Department of Public Health, Health Services Research and Health Technology Assessment, University for Health Sciences, Medical Informatics and Technology, Hall LT., Austria (N Steckling DrPH); Department of Criminology, Law and Society, University of California Irvine, Irvine, CA, USA (Prof B L Sykes PhD); Carlos III Health Institute, CIBERSAM, Madrid, Spain (Prof R Talavera-Seijas PhD); Cardiovascular Research Center, Osaka International Cancer Institute, Osaka, Japan (T Tabuchi MD); Department of Psychiatry and Behavioral Sciences, New York Medical College, Valhalla, NY, USA (M Takakoki MD); Institute of Public Health, Jagiellonian University Medical College, Krakow, Poland (R Topor-Mudy PhD); Department of Ophthalmology, Medical School, Aristotle University of Thessaloniki, Thessaloniki, Greece (Prof F Topouzis PhD); Department of Health Economics, Hanoi Medical University, Hanoi, Vietnam (Prof B Siddhant PhD, Prof B Tran PhD); Department of Neurology, University of Copenhagen, Copenhagen, Denmark (T C Truelsen PhD); Department of Vascular Medicine, University Heart Center of Hamburg, Hamburg, Germany (Prof N Tsilimparis PhD); Department of Internal Medicine, Federal Teaching Hospital, Abakaliki, Nigeria (K N Ukwa MSc); Gomal Centre of Biochemistry and Biotechnology, Gomal University, Dera Ismail Khan, Pakistan (I Ullah PhD); Programmatic Management of Drug Resistant TB Unit, TB Culture Laboratory, Mufti Mehmoon Memorial Teaching Hospital, Dera Ismail Khan, Pakistan (I Ullah PhD); Argentine Society of Medicine, Buenos Aires, Argentina (Prof P R Valdez ME); Intensive Care Unit, Hospital Velez Sarsfield, Buenos Aires, Argentina (Prof P R Valdez ME); UKK Institute, Tampere, Finland (Prof T J Vasankari MD); Raffles Neuroscience Centre, Raffles Hospital, Singapore, Singapore (Prof N Venketasubramanian FRCP); Department of Information and Internet Technologies, I.M. Sechenov First Moscow State Medical University, Moscow, Russia (K R Vladimirov PhD); Department of Health Care Administration and Economy, National Research University Higher School of Economics, Moscow, Russia (Prof V Vlassov MD); Center for Disease Burden, Norwegian Institute of Public Health, Bergen, Norway (Prof S Vollset DrPH); Department of Nursing, Debre Markos University, Debremarks, Ethiopia (F W S Wagne W MSc); Foundation University Medical College, Foundation University, Rawalpindi, Pakistan (Prof Y Waheed PhD); Demographic Change and Ageing Research Area (A Werdecker PhD), Competence Center of Mortality-Follow-Up, German National Cohort (R Westerman DSc), Federal Institute for Population Research, Wiesbaden, Germany, Independent Consultant, Satuﬁenberg, Germany (A Werdecker PhD); Information Services Division, NHS Scotland, Edinburgh, Scotland (G M A Wyper MSc); University of Strathclyde, Glasgow, Scotland (G M A Wyper MSc); School of Medicine, Nanjing University, Nanjing, China (Prof G Xu MD); Department of Preventive Medicine, University of Mississippi Medical Center, Jackson, MS, USA (Prof Y Yano MD); Division of Injury Prevention and Mental Health Improvement, Chinese Center for Disease Control and Prevention, Beijing, China (P Ye MPH); Centre for Suicide Research and Prevention, University of Hong Kong, Hong Kong, China (Prof P Yip PhD); University of South Australia, Adelaide, Australia (B D Yirsw PhD); Department of Biostatistics, School of Public Health, Kyoto University, Kyoto, Japan (Prof Yonemoto MPH); Department of Preventive Medicine, Korea University, Seoul, South Korea (Prof S Yoon PhD); College of Public Health, Ohio State University, Columbus, OH, USA (Prof Y Yotivebig PhD); School of Public Health, University of Kinshasa, Kinshasa, Democratic Republic of the Congo (Prof M Yotivebig PhD); Department of Health Policy and Management, Jackson State University, Jackson, MS, USA (Prof M Z Younis DrPH); Tsinghua University, Beijing, China (Prof M Z Younis DrPH); Department of Cardiology, Mother Hospital, Thrissur, India (G Zachariah MD); University of Texas, Houston, TX, USA (X Zhang PhD).

Contributors
Max G Griswold, Nancy Fullman, and Emmanuela Gakidou prepared the manuscript. Max G Griswold, Nancy Fullman, and Stephanie R M Zimsen extracted data. Max G Griswold developed the models, methods, conducted all analysis and produced the results. Emmanuela Gakidou, Mohammad H Forouzanfar, and Christopher J L Murray conceived of the study. Emmanuela Gakidou provided overall guidance. Caitlin Hawley and Joseph S Salama managed the project. All other authors contributed at least to one of the following: provided data, reviewed results, developed modelling infrastructure, and/or reviewed and contributed to the final manuscript.

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www.thelancet.com Vol 392 September 22, 2018

1033
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Data sharing
Raw data underlying figures and relative risk curves have been made publicly available on Mendeley Data, a secure online repository for research data, as of September 19, 2018 (DOI:10.17632/5thy2mcwn7.1).

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