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# Global alcohol policy implementation in Thailand: A narrative review

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**Abstract**

Alcohol consumption is growing in emerging economies. Thailand is an upper-middle-income emerging economy in Southeast Asia where the alcohol market has been under an oligopoly, which political groups are attempting to amend. The Thai Ministry of Public Health works in close partnership with the non-profit sector in alcohol control, and has recently adapted the World Health Organization's (WHO) SAFER initiatives as part of the national alcohol agenda. In light of these ongoing changes, we conducted a narrative review with the following objectives: (1) to describe the development of alcohol control policy strategies in Thailand; and (2) to describe the current situation on alcohol policy implementation. We performed a search of the published and grey literature in both Thai and English languages using keywords related to topics of interest, and reviewed data on SAFER's effectiveness using a group of indicators (policy-attributable health outcomes). We found that Thailand has laws and regulations covering various domains of SAFER. However, gaps do exist with regard to regulation of alcohol outlet density, relatively low alcohol sales permit fees, control of online and surrogate marketing of alcoholic products, and enforcement of drinking-and-driving deterrence measures, among others. A review of the indicators showed that annual per capita alcohol consumption (APC) and prevalence of drinkers have remained constant since 2008, whereas the prevalence of binge-drinking has been on a decline since 2014. However, deaths attributable to alcohol have increased in both men and women. The findings of this narrative review may have implications for policymakers and stakeholders in behavioral health.

## Introduction

The latest global status report on alcohol and health estimated that in 2016 approximately 43% of the global population aged 15 years and over were current drinkers (had at least one drink within the past 12 months; World Health Organization [WHO], 2018a). Per-capita consumption of pure alcohol tends to be higher in high-income countries, of which 17 of the 20 countries with the highest level are located in WHO Europe Region (WHO, 2018a). However, alcohol consumption is also growing in emerging economies. For example, India, Mexico and Brazil were identified as key volume growth markets for the global alcohol industry during 2022-2027 (International Wine & Spirit Research [IWSR], 2022).

Thailand is an upper-middle-income emerging economy in Southeast Asia. Among the population aged 15 years and older, 47% of men and 11% of women are current drinkers (Nontarak & McNeil, 2022; Wichaidit et al., 2019). The alcohol-attributable fraction is also higher among Thai men than Thai women, with regard to liver cirrhosis, road traffic injuries, and cancer (WHO, 2023). Alcohol consumption became common in Thai society in the late 18th century, when Chinese communities established alcohol distilleries (Thamarangsi, 2006). The state quickly monopolized the production of alcohol and issued excise tax collection measures, making alcohol one of the main sources of state revenue (Thamarangsi, 2006). The monopoly then shifted to an oligopoly, with legislations that enabled production licenses to be issued only to mass producers (The Nation, 2023). In 1985, the state licenses to produce alcohol became open to bids, and one single business magnate won 100 percent of the concession (Forbes Staff Writers, 2005). Currently, Thailand's alcohol market is dominated by two business conglomerates. This oligopoly has been the subject of political debate for quite some time, and a center-left political party aims to propose amendment to ministerial

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regulations on liquor production as one of their first actions in the new parliamentary session (Connor, 2023; The Nation, 2023).

Alcohol control instruments in Thailand consist of three primary legislations: (1) The Alcohol Beverage Control Act of 2008 ("the ABC Act") for restriction of access to alcohol, alcohol advertisement and marketing, and treatment and rehabilitation of alcohol dependence patients (Alcoholic Beverage Control Act, B.E. 2551, 2008 [ABC Act 2008]); (2) The Excise Tax Act of 2017 for taxation and pricing of alcohol beverages, and regulating production and licensing for alcohol trade (Excise Act, B.E. 2560, 2017); and (3) The Road Traffic Act of 1979, Amendment 2022, for control of drink driving (Road Traffic Act, B.E. 2565, 2022). The Ministry of Public Health is the primary national-level organization for alcohol control, currently working under the National Alcohol Action Plan Phase II (NAAP-II) for the years 2021 through 2027 (Office of the National Alcoholic Beverage Control Committee, 2022) structured under the framework of the World Health Organization's SAFER strategies (WHO, 2018b). The non-profit sector is also heavily involved in alcohol control in Thailand, and works in close partnership with the Ministry of Public Health. The Thai Health Promotion Foundation (ThaiHealth) was established in 2001 as a public organization under the directive of the Prime Minister to engage in health promotion and reduce the burden of disease in the Thai population. ThaiHealth is funded by surcharging 2% of the Excise Tax on alcohol and tobacco. This measure enables ThaiHealth to receive approximately 120 million USD per year in revenue (Pongutta et al., 2019). This revenue is used in part to fund alcohol control activities of non-governmental organizations (Ministry of Public Health, 2020), including the StopDrink Network, to engage in media and grassroots-level campaigns nationwide. These campaigns and activities resulted in considerable public awareness (Pongutta et al., 2019), and alcohol-per-capita consumption in Thailand remained stable despite an increase in per capita income during 2001 to 2019 (WHO, 2018a). Nonetheless, a number of challenges to alcohol control in Thailand remain, including: (1) the need to strengthen mechanisms for enforcement of existing policy instruments; (2) the extraordinary ease in obtaining alcohol retail sales license and proliferation thereof; (3) a lack of human resources and capital to deter drink-driving; and (4) legal ambiguities, particularly with regard to emerging issues such as online advertising and alcohol sales (Waleewong, 2020).

In consideration of the recent adaptation of SAFER initiatives as part of the national alcohol control agenda, ongoing changes in the national government, and existing challenges in alcohol policy implementation, a narrative review on the effectiveness of adopting global alcohol policy in Thailand will be of interest to relevant stakeholders and inform future actions. The objectives of this narrative review are: (1) to describe the development of alcohol control policy strategies in Thailand; and (2) to describe the current situation on alcohol policy implementation.

## Methods

The authors performed a search of the published and grey literature in Thai and English languages using keywords related to each topic of interest. The authors made the searches in mid-2023, with Google as the search engine. The search terms were organic and in Thai language. For example, measures on excise tax would be "Paasii Sura Sappasamit". When each author found an issue of interest, the author would perform further iterations at their own discretion. In particular, MT performed searches on legislations that are relevant for the SAFER strategies in Thailand, whereas PV summarized key indicators of the output and outcomes of implementation and/or monitoring mechanisms of alcohol control policy in Thailand. PV also reviewed data on alcohol consumption in Thailand using a selected group of indicators (Table 1). All authors have Thai as their native language.

**Table 1**

***Alcohol Consumption Indicators in Thailand and Data Sources***

| No. | Measurement | Definition | Data source |
|---|---|---|---|
| 1 | **Annual per capita consumption (APC)**<br>• Total alcohol production in Thailand<br>• Excluding unrecorded alcohol production (unlicensed or unregulated alcohol)<br>• Unit: litres of pure alcohol per capita | $\frac{\text{Total alcohol production}}{\text{Number of population aged 15 years or older}}$ | Excise Department |
| 2 | **Prevalence of current drinkers aged 15 years or older** | $\frac{\text{Number of past-year current drinkers aged 15 years or older}}{\text{Number of population aged 15 years or older}}$ | National Statistical Office |
| 3 | **Prevalence of current drinkers aged 15 to 19 years** | $\frac{\text{Number of past-year current drinkers aged 15 to 19 years}}{\text{Number. of population aged 15 to 19 years}}$ | National Statistical Office |
| 4 | **Prevalence of binge drinkers**<br>• Binge drinking = having 4-5 standard drinks or more per session | $\frac{\text{Number of binge drinkers}}{\text{Total number of drinkers}}$ | National Statistical Office |
| 5 | **Number of alcohol-related morbidities & mortalities** | N/A | National Health Security Office (NHSO) and hospital records |

# Results

**Part 1: Scope and Evolution of Thai Alcoholic Beverage Control Measures**

Throughout history, Thai alcoholic beverage control laws evolved with the attitudes toward alcohol and priorities of the state (Thamarangsi, 2006; The Nation, 2023). Attitudes toward alcohol in Thailand varied over time from being regarded as a type of food and beverage, to recreational products that could generate state revenue via taxation, and as a tool to promote tourism that also created health hazards (Suriyawongpaisal et al., 2021; Thamarangsi, 2006).

The current legislations reflect the legacy of ideas and goals from the previous eras. Historically, consumption of alcoholic beverage among the people of Siam (now Thailand) was only allowed among the peasants on special religious and social events (Wisalo, 1993). Alcohol taxation began during the reigns of King Prasat Thong (early 17th century) and King Narai (later 17th century), which eventually included both alcohol production and sales (Wisalo, 1993). In the 18th century, alcohol became more common in Siam with a large influx of Chinese immigrants who brought the knowledge of alcohol distillation and distribution. The Siamese government banned home production and created a monopoly on alcohol production in combination with excise tax collection, and created the office of the Excise Master, although irregularities occurred (Thamarangsi 2006; Wisalo 1993). The Thai state viewed alcohol as a recreational product that was a lucrative source of state revenue, and put measures in place to ensure alcohol availability while maintaining control over consumption and revenue generation. The signing of the 1855 Bowring Treaty with Britain lifted restrictions against foreign alcohol, which then flooded the Siamese market. The Alcohol Stamp Act of 1886 then curbed consumption of foreign alcohol, but alcohol tax became an important source of state revenue, particularly when the state was cash-strapped (Wisalo, 1993). In 1909, the government abolished the post of Excise Master, created a state-run decentralized system for alcohol tax collection, and incentivized alcohol sales through a reward system for provincial governors (Thamarangsi, 2006) without measures to control alcohol consumption or its consequences (Wisalo, 1993). During the interwar periods, alcohol production became a state-run monopoly (Thamarangsi, 2006). During the postwar years, alcohol consumption further increased due to foreign influences, proliferation of supply, and socio-economic changes (Wisalo, 1993). The Thai government started granting brewing licenses, albeit with requirements for mass production capacities, eventually creating an oligopoly of two corporations.

Alcohol production in Thailand is currently regulated by the Finance Ministerial Order on Alcohol Production 2022, issued on 1st November 2022 (Ministerial Order on Alcoholic Beverage Production B.E. 2565 (2022), 2022), under the Excise Act of 2017. It allows non-commercial homebrew to be legal and relaxes requirements on authorized capital and production capacity regulated in the Finance Ministerial Order on Permission for Alcohol Production 2017 (Ministerial Order on Permission for Alcoholic Beverage Production B.E. 2560 (2017), 2017), while still maintaining safety and environmental impact assessment requirements. Currently, Thailand faces a major challenge in controlling alcohol production through the movements of a popular political party and business interest groups to reduce alcohol control (Connor, 2023; The Nation, 2023), including lifting advertising restrictions and hours of sales (Wipatayotin, 2024). Debates and polemics are ongoing (Connor, 2023; The Nation, 2023). In this first part, we present the scope and evolution of alcohol control measures related to seven policy areas outlined in the NAPP-II. A summary of the comparison between WHO's SAFER and Thailand's NAPP-II, and ongoing challenges, are outlined in Table 2.

***Policy Area 1: Taxation and Price Regulation***

Thailand first unified laws related to the production, transportation, sale and taxation of alcoholic beverages as the Spirits Act B.E. 2493 in 1950. Later, the Emergency Decree Amending the Spirits Act B.E. 2493, (No.4) B.E. 2521 (1978) made the alcohol excise taxation system a *Two-Chosen-One (2C1)* approach, with a combination of: (1) ad valorem taxation (levied on price); and (2) specific taxation (levied on volume of pure alcohol content; Sornpaisarn et al., 2012). The 2C1 system also created large gaps in the tax rates of various alcoholic beverages (Sornpaisarn et al., 2012) which favored four categories of beverage (white spirits, mixed spirits, special blend spirits, and cheap whisky) over the other main categories (expensive whisky, brandy, community-fermented beverages, beer, and wine), leading to changes in alcohol consumption and reducing the effect of alcohol taxation on drinking behaviors (Sornpaisarn & Kaewmungkun, 2014). In 2013 a combined system was introduced which would involve using the higher of the specific rate options (levied on volume of pure alcohol content or on volume of beverage) and summing the rate with the ad valorem tax (Excise Department, 2013). Another modification of the taxation system was made in 2017 with a combination of both specific and ad valorem tax rates to reduce the complexity of the calculation, with the aim of eventually reducing consumption of beverages with high alcohol content (Excise Act, B.E. 2560, 2017). In addition to excise tax, the government also imposes value-added tax (7%), customs duty (on imported beverages), and has earmarked 17.5% of alcohol excise taxes for community development (10%), social activities (Thai Public Broadcast Service 1.5%, National Sports Development Fund 2%, and Older Persons Fund 2%) and public health (ThaiHealth, 2%). However, changes in 2013 were followed by a 2.5% increase in alcohol price, and a 2.6% reduction in heavy drinking among beer drinkers, whereas changes in 2017 only raised prices by 0.2% (Thavitsri, 2019).

With the current taxation system, Thailand's alcohol taxes are already considered high relative to other countries (Excise Department, 2016; Wall et al., 2018). However, there has been no tax rate adjustment since 2017, making alcoholic beverage prices based on the consumer price index (CPI) for tobacco and alcohol stable after 2017 (from June 2017 to 2023, CPI = 94.47, 100.01, 100.02, 100.02, 100.03, 102.28, and 102.94, respectively; base year = 2019; Trade Policy and Strategy Office, 2023). In 2022, the NAAP-II set

the goal to increase alcohol tax rate in a manner coherent with inflation and is also considering other measures, e.g., minimum unit pricing.

**Table 2**

***Comparison of WHO's SAFER to Thailand's NAAP-II and Ongoing Challenges in Thailand***

| WHO's SAFER Policy | Thailand's NAAP-II Policy Area | Ongoing Challenges in Thailand |
|---|---|---|
| **S**: Strengthen restrictions on alcohol availability | Policy Area 2: Regulating availability | No law regarding alcohol outlet density; Need to reduce number of alcohol sales permit per 1,000 persons |
| **A**: Advance and enforce drink driving counter measures | Policy Area 5: Preventing drink-driving | Need to increase random and mandatory breath tests |
| **F**: Facilitate access to screening, brief interventions and treatment | Policy Area 4: Providing screening and treatments | Need to earmark budget for alcohol use disorder treatment and put Section 33 of the Alcoholic Beverage Control Act into effect |
| **E**: Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion | Policy Area 3: Regulating marketing | Legal gaps exist with regard to online and surrogate marketing of alcoholic beverages |
| **R**: Raise prices on alcohol through excise taxes and pricing policies | Policy Area 1: Taxation and price regulation | Need to increase alcohol tax rate in a manner coherent with inflation; Need to consider additional measures, e.g., minimum unit pricing |
| Not in SAFER | Policy Area 6: Managing the drinking environment<br><br>Policy Area 7: Providing information and education | Need to support workplaces and public spaces in promoting alcohol abstinence; Need to further improve health literacy regarding alcohol |

***Policy Area 2: Regulating Availability***

Control of alcohol availability in Thailand started in 1972, when the government of Field Marshal Thanom Kittikachorn enacted the Announcement of the Revolutionary Council No. 253, which prohibited the sale of alcohol during 11:00 to 14:00 and 17:00 to 24:00 (Office of the Council of State, 2011). The Announcement also prohibited intoxicated persons from purchasing alcohol or entering an alcohol sales venue. The regulations remained in place until 2008, when they were transferred to and reinforced by the ABC Act of 2008 (Alcoholic Beverage Control Act, B.E. 2551, 2008). The 2008 Act further prohibited the sale and consumption of alcohol at public facilities, educational and health facilities, and gas stations. The Act also prohibited sales to individuals under 20 years of age, and sales of alcohol during dates designated by the Committee, which now includes five major Buddhist holidays (Amarin TV, 2023). The vast majority of Thailand's population are Buddhists, and abstaining from alcohol is one of the Five Precepts of Buddhism. Prohibition of alcohol sales on major religious holidays can be regarded as a way to use religion as a tool to promote reduction of alcohol use.

However, despite the relatively strict legal codes, Thailand has no law regarding outlet density. Furthermore, the current licensing system is rather permissive, with an expedited alcohol sales permit application system (Excise Department, 2009) and the permit fee of approximately 2200 Thai Bahts or 60 USD per year (Excise Department, 2023), i.e., the equivalent of just under seven days at minimum wage. In that regard, alcohol stakeholders in Thailand set the number of population per alcohol sale permit ratio as an indicator in the NAAP-II to increase the ratio from the baseline of 144 persons per permit (or 6.94 permits per 1,000 persons) in 2019, to 152 persons per permit (or 6.58 permits per 1,000 persons) in 2023, 167 persons per permit (or 5.98 permits per 1,000 persons) in 2024, 184 persons per permit (or 5.43 permits per 1,000 persons) in 2025, 202 persons per permit (or 4.95 permits per 1,000 persons) in 2026, and 245 persons per permit (or 4.08 permits per 1,000 persons) in 2027. The NAAP-II also emphasizes the need to develop the legal enforcement system and mechanism to restrict access to alcohol (Office of the National Alcoholic Beverage Control Committee, 2022).

***Policy Area 3: Regulating marketing***

Prior to the ABC Act of 2008, control of alcohol advertisement had been gradually tightening. In 2003, a regulation was issued where alcohol advertisements on television and radio were allowed only from 22:00 to 05:00 of the next day. Section 32 of the Act further restricted alcohol advertisement (ABC Act, B.E. 2551, 2008) as follows:

> *No person shall advertise or display, directly or indirectly, the name or trademark of any alcoholic beverage in a manner showing the properties thereof or inducing another person to drink.*
>
> *Advertisements or public relations provided by the manufacturer of any kind of alcoholic beverage shall only be made for giving information thereof or giving social creative knowledge without displaying any illustration of such alcoholic beverage or its package, except for the display of a symbol of such alcoholic beverage or that of its manufacturer as prescribed by the Ministerial Regulation.*

*The provisions of paragraph one and paragraph two shall not apply to any advertisement broadcast from outside of the Kingdom.*

At present, on Thai television advertisements for alcohol are broadcast only after 22:00, with no images of alcoholic beverages, the container, or mention of alcohol. Displayed images typically include either corporate social responsibility activities or images of traditional Thai dance with the logo of the beverage or the company displayed very briefly near the end of the commercial segment. However, legal gaps currently exist with regard to online and surrogate marketing of alcoholic beverages, and the NAAP-II focuses on changing attitudes and reducing support for alcohol consumption, and increasing refusal of funding support from the alcohol industry among state agencies (Office of the National Alcoholic Beverage Control Committee, 2022).

***Policy Area 4: Providing Screening and Treatments***

Section 16 of the ABC Act authorized the National Alcoholic Beverage Control Committee to issues policies and guidelines regarding treatment of alcohol use disorder, and Section 33 enabled individuals with alcohol use disorders (AUD), groups, or public or private organizations that aim to treat or rehabilitate AUD to request support for treatment or rehabilitation from the Royal Thai Government (ABC Act, B.E. 2551, 2008). However, actions under Section 33 have not been systematically implemented despite calls for updates to the ABC Act (Thai Rath Online, 2021). Less than 10% of people with AUD could access care for their condition. The lack of implementation could be partly attributed to the lack of earmarked funding mechanisms combined with an unfavorable sociopolitical environment, and unmet needs for capacity building among healthcare personnel (International Health Policy Program, 2009). Thus, the NAAP-II includes both behavioral screening and treatment among those with medium to high levels of AUD. The aim is to increase treatment coverage among those with medium to high levels of AUD, from 10% to 40%, of all eligible persons by 2027 (Office of the National Alcoholic Beverage Control Committee, 2022).

***Policy Area 5: Preventing Drink-Driving***

The first law in Thailand to govern drinking and driving was the Road Traffic Act of B.E. 2522 (1979), now in its 13th Revision (Road Traffic Act, B.E. 2565, 2022). The latest version of the Act stated that in four vulnerable groups (drivers under 20 years of age, drivers with temporary driving licenses, drivers with the incorrect type of driving license, and drivers whose licenses were revoked or suspended) having blood alcohol above 20mg/% is considered as driving while intoxicated. The limit for the general population is 50mg/%. No provision exists regarding drinking and driving in the ABC ACT of 2008 (ABC Act, B.E. 2551, 2008). Current gaps in drinking and driving laws include having no law ruling commercial and social host liability, and having no systematic approach to provide compensation for damages incurred from driving while intoxicated. There is also a need to increase the number of random breathalyser tests among all drivers, and to conduct alcohol tests among all drivers who were involved in road traffic accidents (Office of the National Alcoholic Beverage Control Committee, 2022).

***Policy Area 6: Managing the Drinking Environment***

The drinking environment includes the physical environment, as well as the social environment. In Thailand, alcohol is predominantly consumed in a social context (Wichaidit et al., 2019). One key organization working on altering the social context of drinking is ThaiHealth, an autonomous government agency legally mandated to work on health promotion for reduction of alcohol consumption (Ministry of Public Health of Thailand, 2017), funded by earmarking 2% of alcohol excise tax (Excise Act, B.E. 2560, 2017). Since 2001, ThaiHealth has partnered with civil society organizations, notably the StopDrink Network, to encourage alcohol temperance. The most prolific ThaiHealth-StopDrink collaboration has been the "Stop Drink during Buddhist Lent" campaign, which included both nation-wide media campaigns and community led activities, and experienced considerable public health impact (Health Intervention and Technology Assessment Program [HITAP], 2018). However, despite progress made in media and community spaces, efforts to manage the social environment to control alcohol are still needed in the workplace and in other public spaces. Thus, the NAAP-II aims to encourage development of alcohol policy in public, private, and other organizations, with the target for 90% of public, private, and other organizations in Thailand to have a policy against alcohol consumption at events related to the organization (Office of the National Alcoholic Beverage Control Committee, 2022).

***Policy Area 7: Providing Information and Education***

Although national-level campaigns for health education regarding alcohol are systematic and actively implemented, gaps remain. ThaiHealth is mandated to provide health education and health promotion for reduction of alcohol consumption to the general public (Ministry of Public Health of Thailand, 2017). However, in the general population of Thailand, drinking persisted even during the COVID-19 pandemic (Wichaidit et al., 2021), particularly among men (Wichaidit et al., 2019). Similarly, although drinking has declined in recent years among adolescents and youths (Assanangkornchai et al., 2020), the prevalence has remained very high in population sub-groups (Wichaidit et al., 2023) and nearly half of the participants in a recent study had inadequate levels of health literacy with regard to alcohol (Yangyuen et al., 2021). Strategies of the NAAP-II to address these gaps include providing continued support for health education, health promotion, and initiating projects to install values in abstaining from alcohol and creating opportunities to abstain from drinking (Chinanonvej, 2020; Office of the National Alcoholic Beverage Control Committee, 2022).

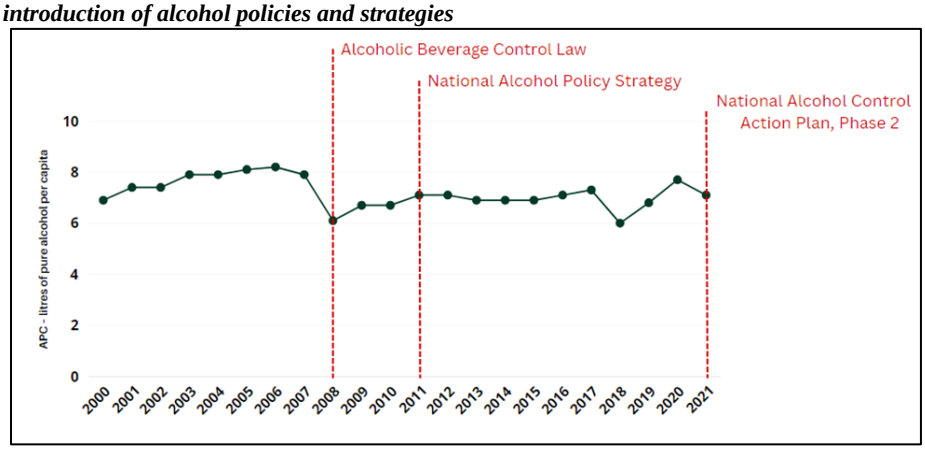
**Part 2: Policy-Attributable Health Outcomes**

The NAAP-II is designed to mitigate the extent and severity of harm arising from alcohol consumption in Thailand (Office of the National Alcoholic Beverage Control Committee, 2022). The Plan includes four central objectives: (1) to manage and decrease overall consumption; (2) to prevent initiation among new drinkers and regulate the total number of drinkers; (3) to mitigate risks associated with drinking through addressing consumption levels, patterns, and post-drinking behaviors; and (4) to confine and alleviate the severity of harm stemming from alcohol consumption. These outcomes are guided by global policies, notably the WHO's SAFER initiative, underscoring our efforts to align with international standards. The SAFER framework emphasizes the importance of regulating alcohol availability, pricing, marketing, and driving under the influence laws, which mirrors our approach. By adopting these global strategies, we not only aim to curb alcohol-related issues domestically but also contribute to the worldwide agenda of improving public health outcomes related to alcohol use. The indicators (policy-attributable health outcomes) in the past, present, and future are as follows:

***Annual per capita consumption (APC):*** Following the introduction of the ABC Act in 2008, the APC exhibited a notable decrease (Figure 1). Subsequently, the APC maintained a consistent level, approximately ranging from six to eight liters. This sustained stability may be linked to the strategic interventions introduced through the National Alcohol Policy strategy in 2011, further reinforced by the subsequent NAAP-II in 2021.

**Figure 1**

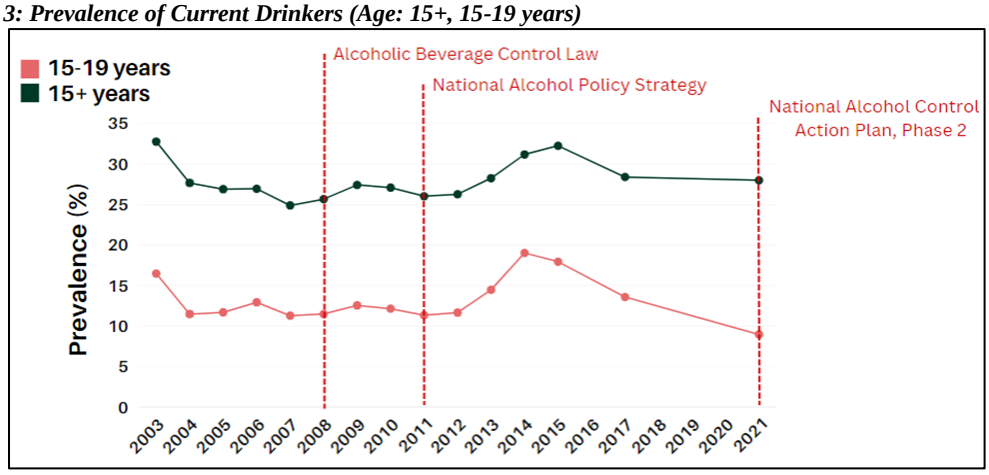
***Indicator 1: Annual per capita consumption (APC) – litres of pure alcohol per capita by year. The dash lines and remarks in red texts denote introduction of alcohol policies and strategies***




***Prevalence of drinking in adults (aged 15 years and older) and adolescents (aged 15 to 19 years)****:* Spanning nearly two decades, the prevalence of alcohol consumption remained relatively steady within both adult and teenage populations (Figure 2). The convergence of three policy initiatives (i.e., Alcohol Beverage Control Law, National Alcohol Policy Strategy, and National Alcohol Control Action Plan, Phase 2) could potentially contribute to the sustained stability observed in these prevalence rates.

**Figure 2**

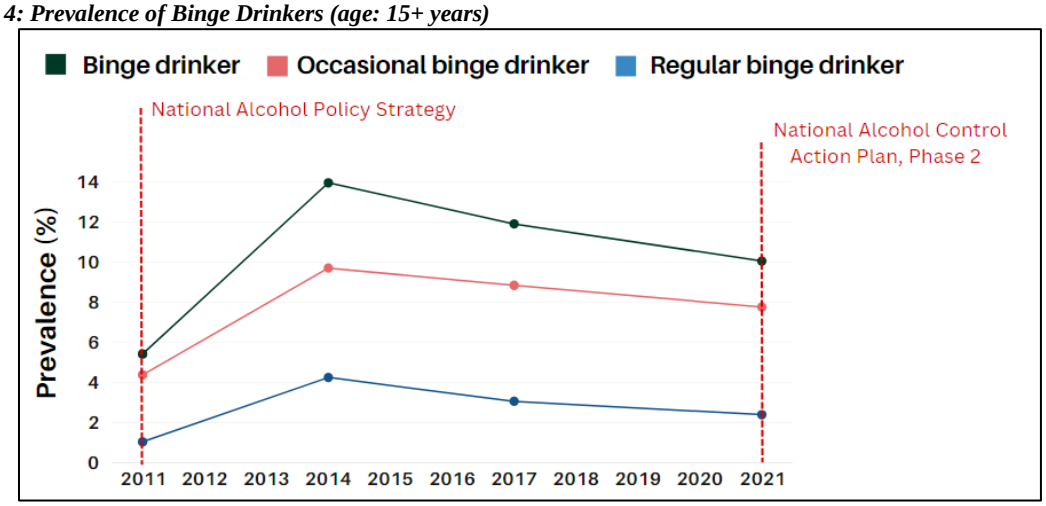
***Indicators 2, 3: Prevalence of Current Drinkers (Age: 15+, 15-19 years)***



***Prevalence of heavy drinkers in the adult population*:** A promising trend emerged as the prevalence of binge drinking displayed a decline starting from 2014 (Figure 3). The observed improvement in behavioral patterns may have coincided with the introduction of the National Alcohol Policy Strategy in 2011, suggesting a potential influence. However, establishing a direct causal link requires further investigation. This observation invites additional research to explore the relationship between policy initiatives and public health outcomes.

**Figure 3**

***Indicator 4: Prevalence of Binge Drinkers (age: 15+ years)***




***Deaths attributable to alcohol:*** Data from the Thai population death database from the Strategy and Planning Division, Ministry of Public Health, and the database for inpatients and outpatients in Thailand, from the 43-file data of the Ministry of Public Health for the years 2015 to 2019 (B.E. 2558-2562). The variables detailed are the causes of death and illnesses (ICD-10 codes) related to the consumption of alcoholic beverages, the year of death, age at death, and gender. Analyzing the age-adjusted rates of alcohol-attributable deaths per 100,000 individuals between 2015 and 2019, a discernible upward trend was evident (Table 3). The overall rates escalated from 30.92 to 36.89 cases per 100,000, with this pattern being consistently observed among both male and female populations.

**Table 3**

***Indicator 5: Number of Alcohol-Related Morbidities and Mortalities***

| Year | Morbidity rate adjusted for age per 100,000 population | | | Number of deaths | | |
|---|---|---|---|---|---|---|
| | Total | Male | Female | Total deaths | Alcohol-related deaths | Alcohol-attributable deaths |
| 2015 | 30.92 | 56.83 | 6.86 | 445,964 | 166,190 | 17,302 |
| 2016 | 33.09 | 60.82 | 7.34 | 469,085 | 175,764 | 18,708 |
| 2017 | 33.05 | 61.15 | 6.97 | 458,010 | 175,252 | 18,860 |
| 2018 | 31.30 | 57.96 | 6.55 | 461,818 | 176,561 | 18,000 |
| 2019 | 36.89 | 68.84 | 7.23 | 494,339 | 194,503 | 21,362 |

*Source*: National Health Security Office (NHSO) and hospital records

## Discussion and Conclusion

In this narrative review, we summarized the history and current scope of Thailand's alcoholic beverage control and compared the existing alcohol control policy implementation with those recommended in the Global Strategy to reduce the harmful use of alcohol, Global Action Plan for the prevention and control of NCDs and the SAFER initiatives. We presented the results of our search of the grey literature and policy and program documents in Thai, and presented our findings accordingly. As a narrative review, the work in this paper did not require approval from a Research Ethics Board or similar governing body.

In a comparison among 11 middle-income countries in South-East Asia, Thailand has the most varied forms of alcohol control, with the exception of the Maldives where there was a total ban on alcohol (Sornpaisarn et al., 2020). Thailand has a long history of alcohol taxation, whereas control of production varied from free-market production before the Second World War, to state monopoly during the 1950s, to state-facilitated oligopoly by business conglomerates in the 1980s, to current attempts to break the oligopoly. However, in order for alcohol control to be effective in the modern-day context, the existing legal and policy gaps need to be considered and addressed. The outlet density in Thailand (number of permits per 1,000

population) is at present higher than in certain states of the USA by magnitude (Milam et al., 2020). Thus, it is unclear how the extent of outlet density in Thailand differs from others. However, considering that alcohol availability is directly associated with alcohol consumption, prevalence, and intensity (Azar et al., 2016; Dimova et al., 2023), addressing this legal gap can significantly contribute to alcohol control efforts.

Annual per capita alcohol consumption (APC) in Thailand showed an overall decreasing trend but with considerable fluctuations, similar to the prevalence of drinking. Alcohol-related morbidities fluctuated, whereas mortalities showed an overall rise. The rise in the absolute number of alcohol-attributable deaths could have been influenced by the aging population and shifting demographic structure (Wang et al., 2020). Thus, age-standardized measures might have been a better measurement of such burden of disease.

In conclusion, we reviewed the evolution of alcoholic beverage laws in Thailand as well as some indicators (policy-attributable health outcomes). We found gaps within the existing laws that provide opportunities for additional policy considerations. We also found issues with the current indicators (policy-attributable health outcomes) that should receive further attention. The findings of this narrative review may have implications for policymakers and stakeholders in behavioral health. However, a number of limitations should be considered in the interpretation of the findings. Firstly, the search strategy for this manuscript was based on the subjective discretion of each author, making the process haphazard, subjective, and difficult to replicate. Secondly, the body of knowledge regarding each policy area covered in this review was not exhaustive. We recommend interested readers to engage in a systematic review of the evidence for domain-specific policy analyses.

## Authors' Contributions

Conceptualization, S.A.; methodology, S.A., M.T., P.V.; data extraction, M.T., P.V., W.W.; writing-original draft preparation, W.W.; writing-review and editing, all authors; supervision, S.A. and W.W.; project administration, S.A.; funding acquisition: N/A. All authors have read and agreed to the published version of the manuscript. Each author certifies that their contribution to this work meets the standards of the International Committee of Medical Journal Editors.

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