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Modelling Alcohol-Attributable Mortality Risks and Hospital Admission Rates in Ireland

Plain language summary

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Research has shown that drinking alcohol increases the risk of health problems, including injuries, cancers, digestive diseases, heart disease, and other serious conditions that can lead to death or hospital admission. At the request of the Department of Health, HIQA carried out this work to help inform an update of the national low-risk alcohol guidelines, which were last revised in 2015.

In Ireland, there are 10 grams of pure alcohol in approximately half a pint of normal-strength beer, stout or cider, or in a small glass of wine of around 100ml.

We combined information on alcohol consumption, deaths, hospital admissions, and how alcohol affects the risk of particular health conditions. We got this data from the Healthy Ireland Survey, alcohol sales data from the Office of the Revenue Commissioners, death records from the Central Statistics Office, and hospital admission data from the Hospital In-Patient Enquiry system.

In this study, we estimated the lifetime risk of dying because of alcohol, including premature death (that is, dying before age 75). We also estimated how hospital admission rates change with different levels of drinking.

Between 2022 and 2024, alcohol was estimated to account for an average of 1,420 deaths every year in Ireland. This represented 4% of all deaths, including 6% of deaths in males and 1.9% of deaths in females. Alcohol was also estimated to account for 27,066 hospital admissions every year.

Most deaths caused by alcohol were due to long-term conditions. Among men, the leading causes of death were cancers, injuries, digestive diseases, and heart disease. Among women, the leading causes of death were cancers, digestive diseases, injuries, and heart disease. Short-term conditions, including injuries, made up a large share of alcohol-related hospital admissions.

Overall, alcohol-related risk generally increased as people drank more. The lifetime risk of death before age 75, death at any age, years of life lost, and the rate of hospital admissions all increased when people drank more alcohol per day.

We also examined alcohol consumption levels linked to lifetime risk levels of 1 in 1,000 and 1 in 100. A lifetime risk of 1 in 1,000 means that if 1,000 people drank at that average level throughout their lives, about one extra person would be expected to die before age 75 because of alcohol. A lifetime risk of 1 in 100 means that if 100 people drank at that average level throughout their lives, about one extra person would be expected to die before age 75 because of alcohol. These lifetime risk levels have been used in similar international studies.

For death before age 75, the 1 in 1,000 risk level was reached at about five grams of alcohol per day for men and four grams per day for women. The 1 in 100 risk level was reached at about 18 grams of alcohol per day for men and 16 grams per day for women.

A small reduction in the risk of death before age 75 was seen for men with the lowest levels of alcohol consumption. However, this reduction in the risk of death was not seen across all outcomes or in women. Overall, we did not find a level of drinking where there was no consistent risk of death because of alcohol.

A large share of deaths caused by alcohol happened among people drinking at lower individual levels, because this is a much larger group. This means that it is not only people who drink heavily or who are dependent on alcohol that are harmed by alcohol.

How alcohol is consumed also matters. People who drink the same amount each week may have different risks depending on whether they spread drinking across the week or whether they drink a lot in short amounts of time. In additional analyses, drinking the same weekly amount over fewer days increased the estimated risk of dying from injuries.

The results are estimates, not exact cut-offs. The estimates for men and women were close enough that small differences between them should be interpreted cautiously.

The estimates are likely to underestimate the full impact of alcohol on health and society. The analysis only included health conditions where there is strong evidence that alcohol can be a cause and where enough information was available to estimate the risk. It did not include all alcohol-related conditions, harms to others, or wider harms to families, communities, and society.

Despite these limitations, the findings provide important evidence to inform an update of the low-risk alcohol guidelines. This report is one part of the wider evidence base that will be considered as part of that process. It provides evidence to help the Department of Health decide how alcohol-related risk should be described and communicated. Decisions about guideline limits involve policy judgement, including how much risk is considered acceptable and how this should be explained to the public.

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