Tobacco consumption among adults

Tobacco kills nearly 6 million people each year, of whom more than 5 million are from direct tobacco use and more than 600 000 are non-smokers exposed to second-hand smoke (WHO, 2015). Tobacco is a major risk factor for at least two of the leading causes of premature mortality – cardiovascular diseases and cancer, increasing the risk of heart attack, stroke, lung cancer, cancers of the larynx and mouth, and pancreatic cancer, among others. In addition, it is a dominant contributing factor for respiratory diseases such as chronic obstructive pulmonary disease (US DHHS, 2014). Smoking in pregnancy can lead to low birth weight and illness among infants. Smoking remains the largest avoidable risk factor for health in OECD countries and worldwide.

The proportion of daily smokers in the adult population varies greatly, even between neighboring countries (Figure 4.1). Nineteen of 34 OECD countries had less than 20% of the adult population smoking daily in 2013. Rates were lowest in Sweden, Iceland, Mexico and Australia (less than 13%). Rates were also less than 13% in Brazil, Colombia, and India, although the proportion of smokers among men is high, up to 23% in India. On the other hand, smoking rates remain high in Greece in both men and women, and in Latvia and Indonesia where more than one in two men smoke daily. Smoking prevalence is higher among men than among women in all OECD countries except in Sweden and Iceland. The gender gap in smoking rates is particularly large in Korea, Japan, and Turkey, as well as in the Russian Federation, India, Indonesia, Latvia, Lithuania, South Africa and China (Figure 4.1).

Smoking rates across most OECD countries have shown a marked decline, although other forms of smokeless tobacco use, such as snuff in Sweden, are not taken into account. On average, smoking rates have decreased by about one fourth since 2000, from 26% in 2000 to 20% in 2013. Large reductions occurred in Norway, Iceland, Sweden, Denmark and Ireland, as well as in India.

In the period that followed World War II, smoking rates were very high among men (50% or more) in most OECD countries through to the 1960s and 1970s, while the 1980s and the 1990s were characterised by a marked downturn in tobacco consumption. Non-OECD countries and emerging economies stand at an earlier phase of the evolution of smoking, with high rates and a wide gender gap. In OECD countries, much of the decline in tobacco use can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans, increased taxation, and restriction of smoking in public spaces and restaurants, in response to rising rates of tobacco-related diseases. More stringent policies and higher level of taxes have led to bigger reductions in smoking rates between 1996 and 2011 in OECD countries (OECD, 2015). As governments continue to reinforce their anti-tobacco policies, new strategies such as plain packaging for tobacco products aimed to restrict branding have been implemented (e.g. in Australia) and are being adopted by an increasing number of countries.

Several studies provide strong evidence of socio-economic differences in smoking and mortality (Mackenbach et al., 2008). People in less affluent social groups have a greater prevalence and intensity of smoking, a higher all-cause mortality rate and lower rates of cancer survival (Woods et al., 2006). The influence of smoking as a determinant of overall health inequalities is such that, if the entire population was non-smoking, mortality differences between social groups would be halved (Jha et al., 2006).

Definition and comparability

The proportion of daily smokers is defined as the percentage of the population aged 15 years and over who report smoking every day. International comparability is limited due to the lack of standardisation in the measurement of smoking habits in health interview surveys across OECD countries. Variations remain in the age groups surveyed, the wording of questions, response categories and survey methodologies (e.g. in a number of countries, respondents are asked if they smoke regularly, rather than daily). Self-reports of behaviours may also suffer from social desirability bias that may potentially limit cross-country comparisons.

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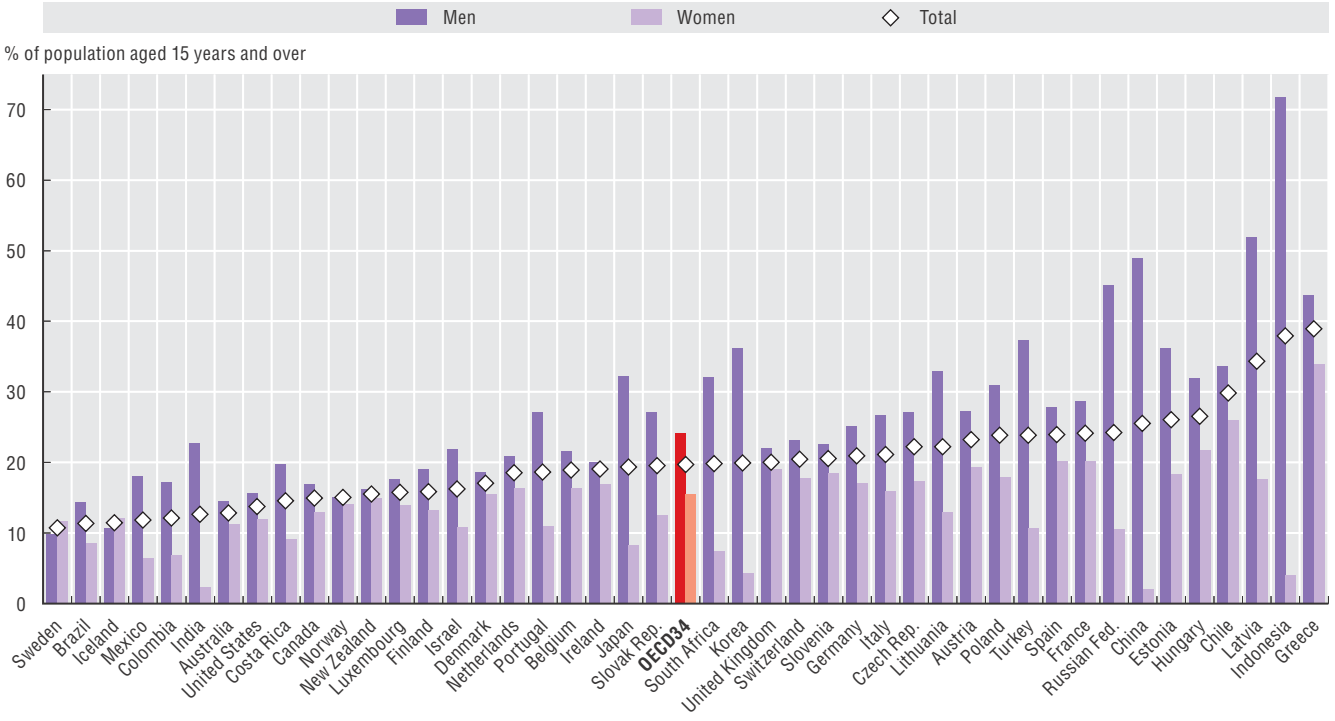
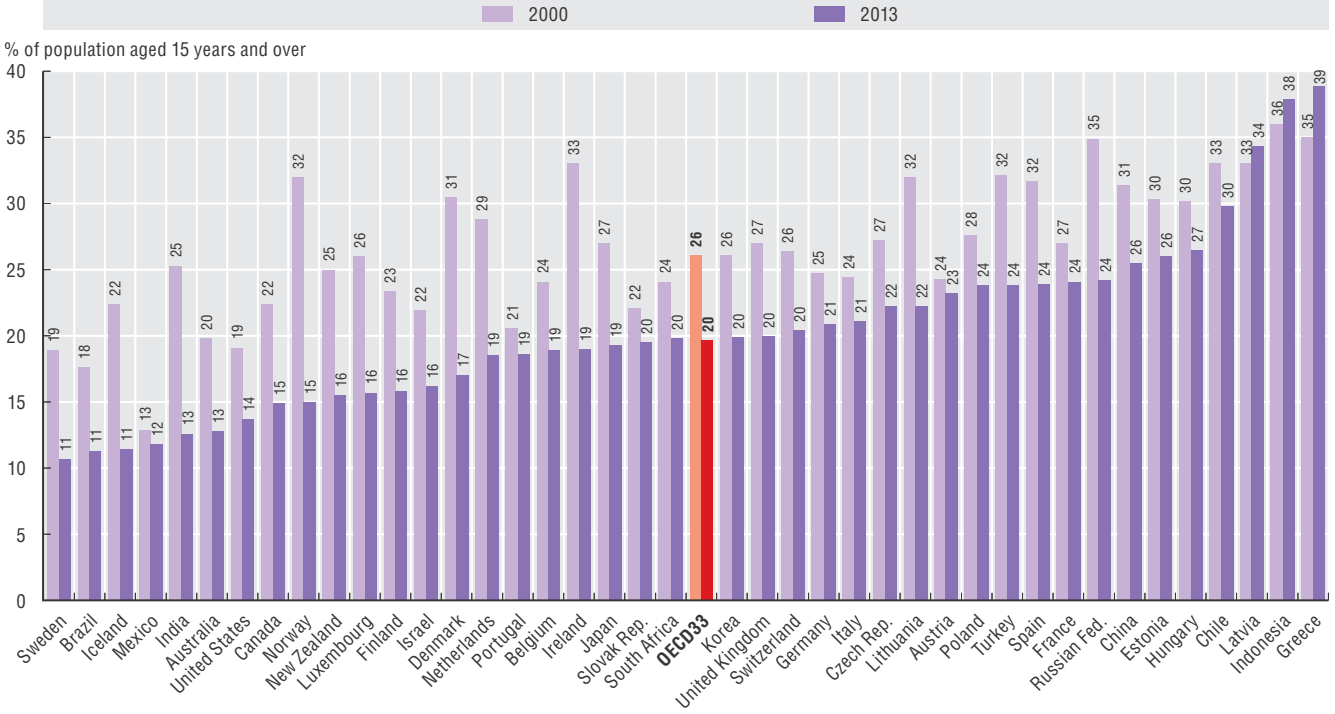
4.1. Daily smoking in adults, 2013 (or nearest year)



Note: Countries are ranked in ascending order of smoking rates for the whole population.
Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888933280827

4.2. Change in daily smoking in adults, 2000 and 2013 (or nearest years)



Source: OECD Health Statistics 2015, *http://dx.doi.org/10.1787/health-data-en.*
Information on data for Israel: *http://oe.cd/israel-disclaimer*

StatLink http://dx.doi.org/10.1787/888933280827