## 2.5. 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, 2013). It is a major risk factor for at least two of the leading causes of premature mortality – circulatory disease and cancer, increasing the risk of heart attack, stroke, lung cancer, cancers of the larynx and mouth, and pancreatic cancer. Smoking also causes peripheral vascular disease and hypertension. In addition, it is an important contributing factor for respiratory diseases such as chronic obstructive pulmonary disease (COPD). Smoking in pregnancy can lead to low birth weight and illness among infants. It remains the largest avoidable risk factor for health in OECD countries.

The proportion of daily smokers in the adult population varies greatly, even between neighboring countries (Figure 2.5.1). Fifteen of 34 OECD countries had less than 20% of the adult population smoking daily in 2011. Rates were lowest in Sweden, Iceland and the United States (less than 15%). Rates were also less than 15% in India, South Africa, and Brazil. Although large disparities remain, smoking rates across most OECD countries have shown a marked decline. On average, smoking rates have decreased by about one fifth over the past ten years, with a steeper decline in men than in women. Large reductions occurred since 2000 in Norway (32% to 17%), Iceland (22% to 14%), Netherlands (32% to 21%), Denmark (31% to 20%) and New Zealand (25% to 17%). Greece maintains the highest level of daily smoking among OECD countries, at around 32% of the adult population, along with Chile and Ireland, with around 30%, although the latest figure for Ireland dates from 2007. Smoking rates were even higher in the Russian Federation.

In the post-war period, most OECD countries tended to follow a pattern marked by very high smoking rates among men (50% or more) through to the 1960s and 1970s, while the 1980s and the 1990s were characterised by a marked downturn in tobacco consumption. Much of this decline can be attributed to policies aimed at reducing tobacco consumption through public awareness campaigns, advertising bans and increased taxation, in response to rising rates of tobacco-related diseases. In addition to government policies, actions by anti-smoking interest groups were very effective in reducing smoking rates by changing beliefs about the health effects of smoking, particularly in North America (Cutler and Glaeser, 2006).

Smoking prevalence is higher among men compared to women in all OECD countries except Norway, although male and female rates in Denmark, Iceland and the United Kingdom are similar (Figure 2.5.2). Female smoking rates continue to decline in most OECD countries, and in a number of cases (Ireland, Turkey, and New Zealand) at an even faster pace than male rates. However, in three countries, female smoking rates have been increasing over the last ten years (Czech Republic, Portugal and Korea), but even in these countries women are still less likely to smoke than men. In 2011, the gender gap in smoking rates was particularly large in Korea, Japan, Mexico, and Turkey, as well as in the Russian Federation, India, Indonesia and China (Figure 2.5.2).

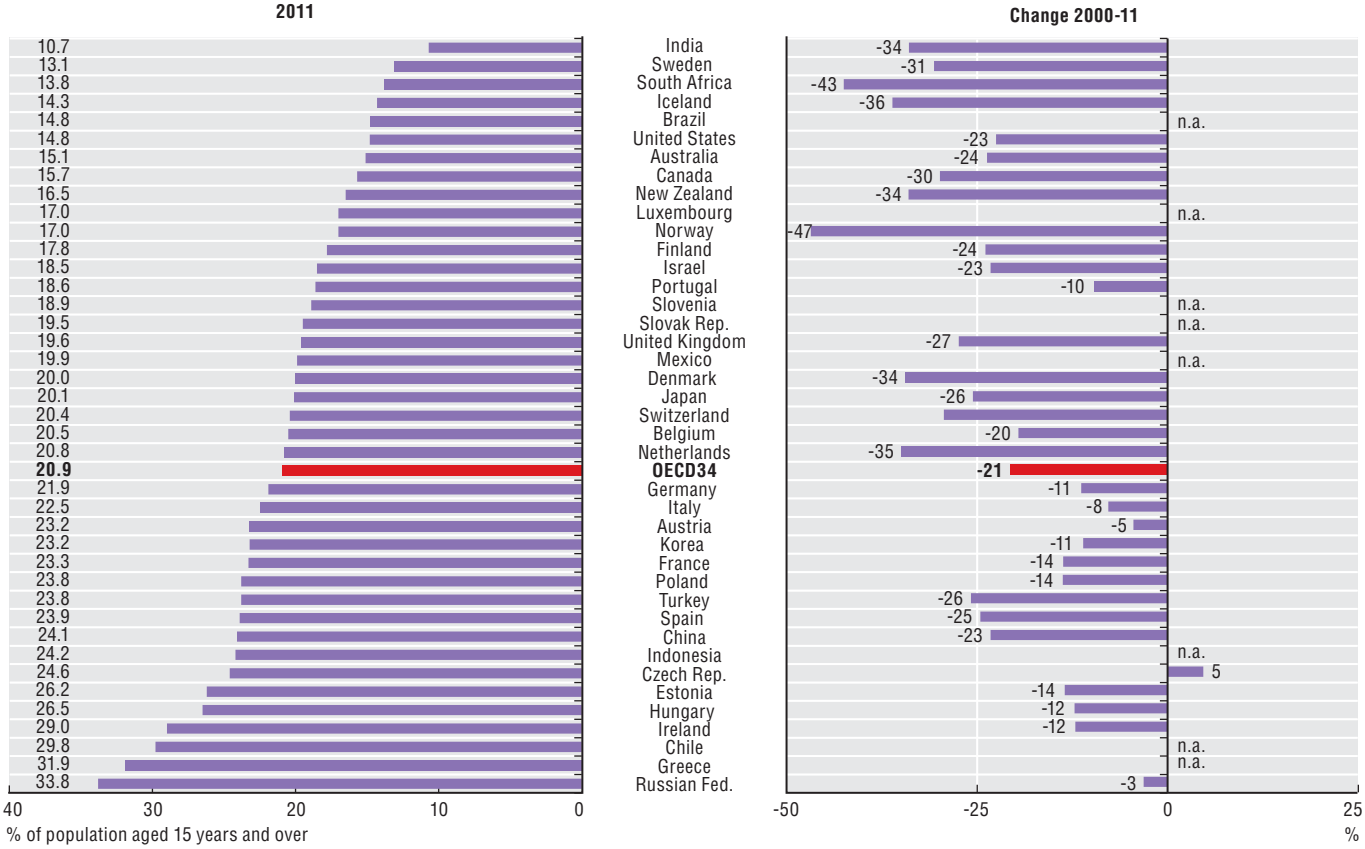
Several studies provide strong evidence of socio-economic differences in smoking and mortality (Mackenbach et al., 2008). People in less affluent social groups have a greater prevalence and intensity of smoking, a higher all-cause mortality rate and lower rates of cancer survival (Woods et al., 2006). 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).

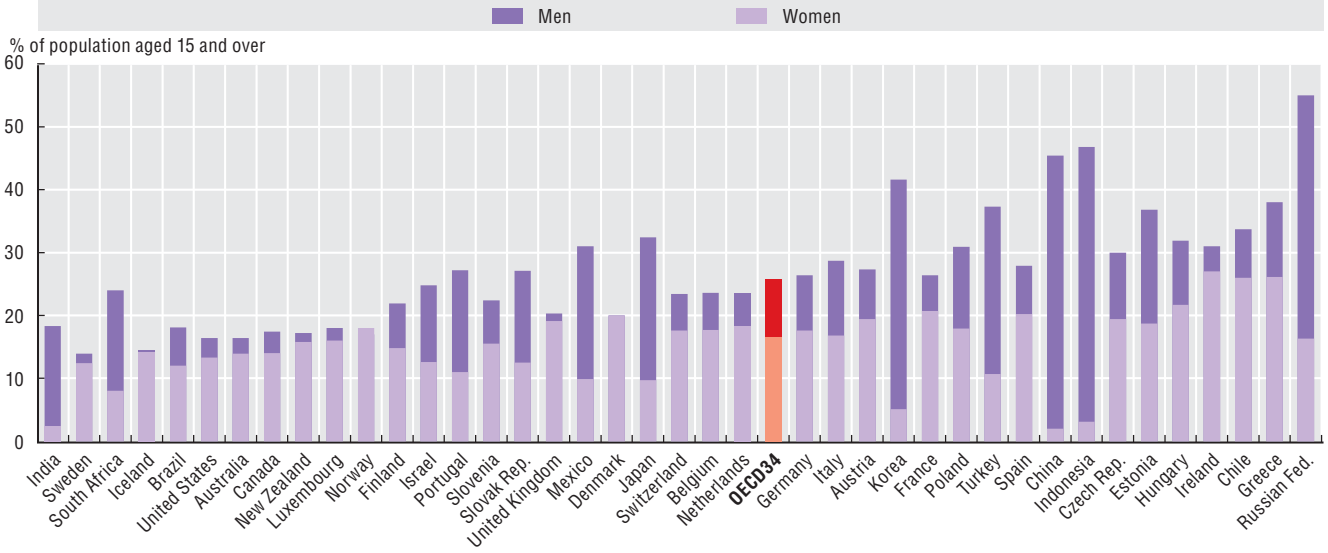
### 2.5.1. Adult population smoking daily, 2011 and change between 2000 and 2011 (or nearest year)




*Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en*; national sources for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916610

### 2.5.2. Gender gap in adults smoking daily, 2011 (or nearest year)




*Note:* Countries are ranked in increasing order of smoking rates for the whole population.

*Source: OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en*; national sources for non-OECD countries.

StatLink http://dx.doi.org/10.1787/888932916629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