2.5. Tobacco consumption among adults

Tobacco is the second major cause of death in the world, after cardiovascular disease, and is directly responsible for about one in ten adult deaths worldwide, equating to about 6 million deaths each year (Shafey *et al.*, 2009). It is a major risk factor for at least two of the leading causes of premature mortality – circulatory diseases and a range of cancers. In addition, it is an important contributory factor for respiratory diseases, while smoking among pregnant women can lead to low birth weight and illnesses among infants. It remains the largest avoidable risk to health in OECD countries.

The proportion of daily smokers among the adult population varies greatly across countries, even between neighboring countries (Figure 2.5.1). In 2007, rates were lowest in Sweden, the United States, Australia, New Zealand, Canada, Iceland and Portugal, all at less than 20% of the adult population smoking daily. On average, smoking rates have decreased by about 5 percentage points in OECD countries since 1995, with a higher decline in men than in women. Large declines occurred in Turkey (47% to 33%), Luxembourg (33% to 21%), Norway (33% to 22%), Japan (37% to 26%) and Denmark (36% to 25%). Greece maintains the highest level of smoking, along with Turkey and Hungary, with 30% or more of the adult population smoking daily. Greece and Mexico are the only OECD countries where smoking appears to be increasing in both men and women.

In the post-war period, most OECD countries tended to follow a general 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 (World Bank, 1999). 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).

Although large disparities remain, smoking rates across most OECD countries have shown a marked decline over recent decades (Figure 2.5.3). Smoking prevalence among men continues to be higher than among women in all OECD countries except Sweden and Norway. Female smoking rates continue to decline in most OECD countries, and in a number of cases (Turkey, New Zealand, Iceland, Canada, United States, United Kingdom and Ireland) at an even faster pace than male rates. Only in five countries do female smoking rates appear to have been increasing over the last 12 years (Austria, Germany, Greece, Mexico and Portugal), but in these countries women are still less likely to smoke than men. In 2007, the gender gap in smoking rates was particularly large in Korea, Japan and Turkey and, to a lesser extent, in Mexico, Portugal, Greece and Poland (Figure 2.5.2).

Several studies provide strong evidence of socio-economic differences in smoking and mortality (Mackenbach *et al.*, 2008). People in lower 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, in a non-smoking population, mortality differences between social groups would be halved (Jha *et al.*, 2006).

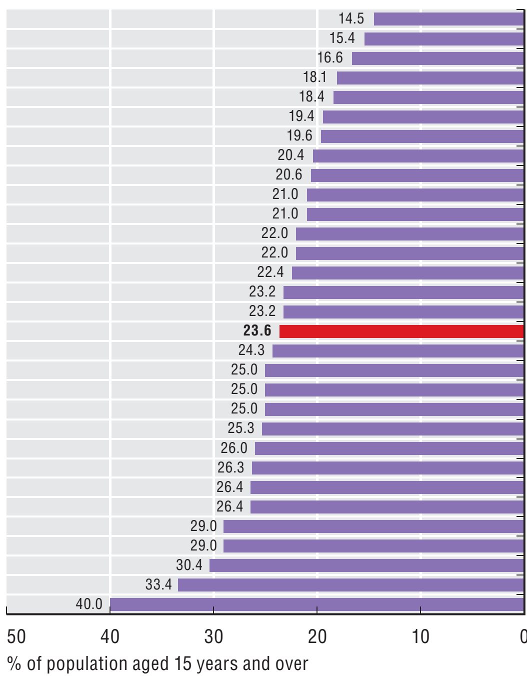
Figure 2.5.4 shows the correlation between tobacco consumption (as measured by grams per capita) and incidence of lung cancer across OECD countries, with a time lag of two decades. Higher tobacco consumption at the national level is also generally associated with higher mortality rates from lung cancer one or two decades later across OECD countries.

Definition and deviations

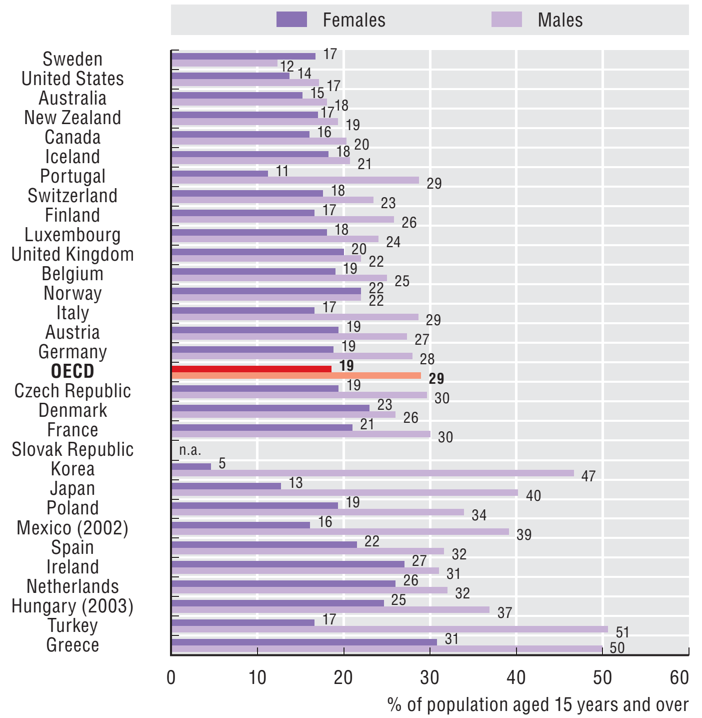
The proportion of daily smokers is defined as the percentage of the population aged 15 years and over reporting smoking every day.

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 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.

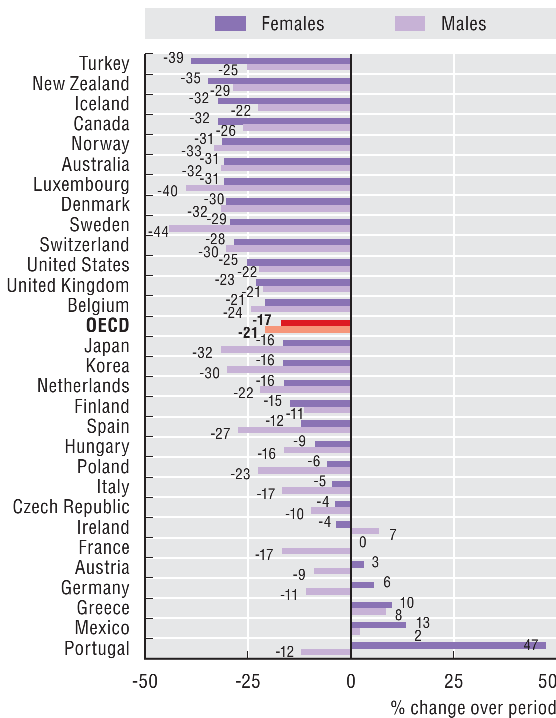
2.5.1 Percentage of adult population smoking daily, 2007 (or latest year available)



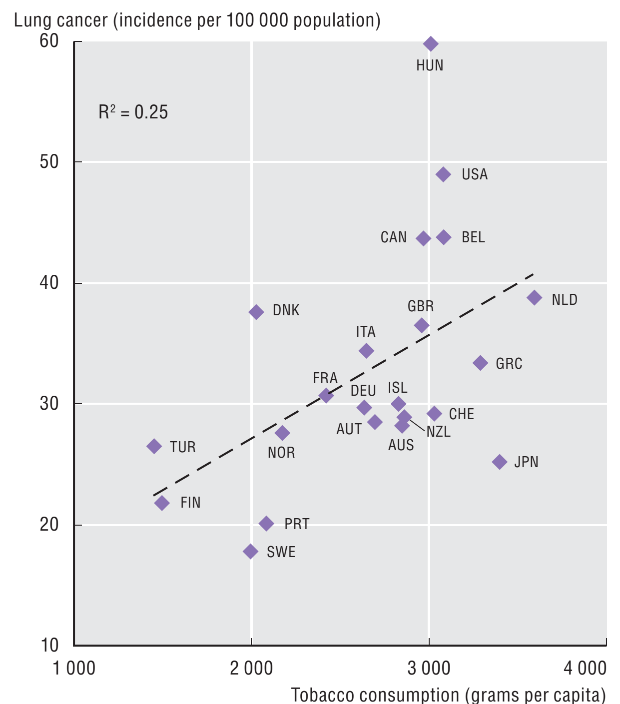
2.5.2 Percentage of females and males smoking daily, 2007 (or latest year available)



2.5.3 Change in smoking rates by gender, 1995-2007 (or nearest year)



2.5.4 Tobacco consumption, 1980 and incidence of lung cancer, 2002



Source: OECD Health Data 2009.

StatLink http://dx.doi.org/10.1787/717778312610

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