

Changing Demographics of Tobacco Users: Implications for Public Health

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Commentary

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DESCRIPTION

Each year over 70 million people die world-wide due to tobacco use. Smoking is responsible for about 22% of all cancer deaths globally. It accounts for over two-third of all lung cancer mortalities and contributes significantly to mortality rates for oral cancer, as well as bladder, stomach, liver, pancreas, kidney, cervical and colorectal cancer. In addition to cancer, smoking contributes to coronary heart diseases, chronic obstructive pulmonary diseases, cardiovascular diseases, stroke, and peptic ulcers. Indeed, about 20% of all deaths in the United States can be attributed to smoking. From the individual perspective, a given smoker has about a 50% chance of dying from smoking, with the average smoker living 10 years less than a non-smoker. Although there are risks associated with non-combustible tobacco use, this chapter focuses on combustible tobacco use because of its much higher prevalence and relative risk. Nevertheless, patient should be advised to cease all forms of tobacco use.

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Smoking cessation is associated with decreased mortality and morbidity from cancer and other diseases. When compared to continuing to smoke, quitting smoking at age 30 results in a nine-year increase in life expectancy, while quitting at age 60 only results in a three-year increase. Thus, great potential for cancer prevention lies with long-term cessation of smoking. In this chapter, we are beginning by noting the changing demographic profile of current smokers. We then review the evidence-based treatment for tobacco use and dependence, emphasizing primarily qualitative and meta-analytic reviews. We refer to *Treating Tobacco Use and Dependence*, a 2008 update of the clinical practice guidelines for U.S. public health services, which is based on an analysis of 8700 research articles and includes treatment recommendations drawn from meta-analyses of the majority of treatment modalities. We then discuss special issues of relevance for treating cancer patients. New to this update is a discussion of electronic cigarettes, the use of which has grown exponentially over the past decade, including among cancer patients.

Evolving landscape of tobacco and nicotine use

Several countries have implemented strategies toward reducing tobacco burden, such as monitoring tobacco use, offering access to smoking cessation interventions, increasing tobacco taxes, or introducing public warning about the danger of tobacco use. Although these actions have led to global reduction in tobacco use in most developed countries, these nations still account for half of all female daily smokers and roughly 75% of male daily smokers. In wealthy nations, efforts to minimize tobacco use have been successful; in developing nations, these efforts should be strengthened. Developing countries have shown moderate smoking prevalence across time, but many of these nations are showing increase in the prevalence of smoking and smoking-related mortality that are commensurate with increase in income, decreases in the cost of tobacco, heavier marketing from the tobacco industry, and limited tobacco-related public health policies. As such, developing countries are vulnerable to assuming the burden of the tobacco epidemic. Additionally, certain demographic groups in the world are disproportionately affected by the burden of cigarette use. For instance, regardless of per capita gross national income, tobacco smoking is particularly widespread among those with low income and is rising quickly among youth, especially females, in developing countries.

Since the landmark 1964 U.S. Surgeon General's Report, less than one in five adults in the U.S. smoke, a remarkable decrease in adult smoking prevalence. Due to the fact that the decrease in smoking frequency has not been uniform across demographic groups, the demographic profile of smokers now differs significantly from that of smokers' decades ago. Different loads of tobacco-related illness and mortality are linked to these variations in tobacco use prevalence. In particular, a substantial body of evidence demonstrates that lower educational attainment, being below the poverty level, identifying as American Indian/Alaska Native, living in the Midwest or South, working in a blue-collar or service industry, having active military or veteran status, having a disability, having a severe mental illness, and not having health insurance are associated with higher prevalence of smoking in the U.S.

There are also more recent changes in the demographic of tobacco users that coincide with shifts in the racial/ethnic composition of the U.S. and/or more inclusive data collection. That is, subgroups who identify as more than one race/ethnicity, as sexually or gender minorities, or as immigrants report greater tobacco use. Regarding race/ethnicity, although Hispanics and non-Hispanic Asians have among the lowest smoking prevalence by race/ethnicity, there is wide variation in smoking behaviour within the subgroups and across gender. Among foreign-born men living in the U.S. 24.8% of Mexicans, 47.7% of Filipinos, and 52.7% of Chinese people reported being current smokers, which is of particular relevance to healthcare in the United States given that Mexico, the Philippines, and Chinese represented three of the top five countries with the largest population of foreign-born

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individuals in the U.S. In 2010 alone 29.3% of all immigrants living in the U.S. were from Mexico. Thus, the distribution of tobacco use and its consequent health and economics burdens are unequal and shifting, requires attention by both researchers and clinicians.