Australian Government

Australian Institute of Health and Welfare

Australia's health 2018

# 4.5 Tobacco smoking

## The decline in daily smoking has slowed

Successful public health strategies over several decades have seen daily smoking rates in Australia decline. The National Drug Strategy Household Survey showed that the daily smoking rates halved between 1991 and 2016 (from 24% to 12%). However, there was no decline between 2013 and 2016 (AIHW 2017).

## The majority of daily smokers are aged 40 and over

People aged 40–49 continued to be the age group most likely to smoke daily (16.9%) and no improvement in the smoking rate was seen for this group in 2016 (16.2% in 2013 and 16.9% in 2016).

The population of smokers is ageing and the majority (57%) of daily smokers in 2016 were aged 40 and over—different from the trend 15 years ago when the majority were aged 14–39. Long-term reductions in smoking have been largely driven by fewer people ever taking up smoking. Between 2001 and 2016, the proportion of people who reported never smoking rose from 51% to 62% (AIHW 2017).

## Some groups are making positive changes

Considerable progress towards reducing smoking continued to be made among teenagers—the proportion of teenagers who were current smokers (people who reported smoking daily, weekly or less than weekly) declined from 5.0% in 2013 to 2.1% in 2016. Young people also continued to delay the uptake of smoking, with the average age at which people aged 14–24 smoked their first full cigarette increasing from 14.3 years in 2001 to 16.3 years in 2016 (a significant increase from 15.9 years in 2013).

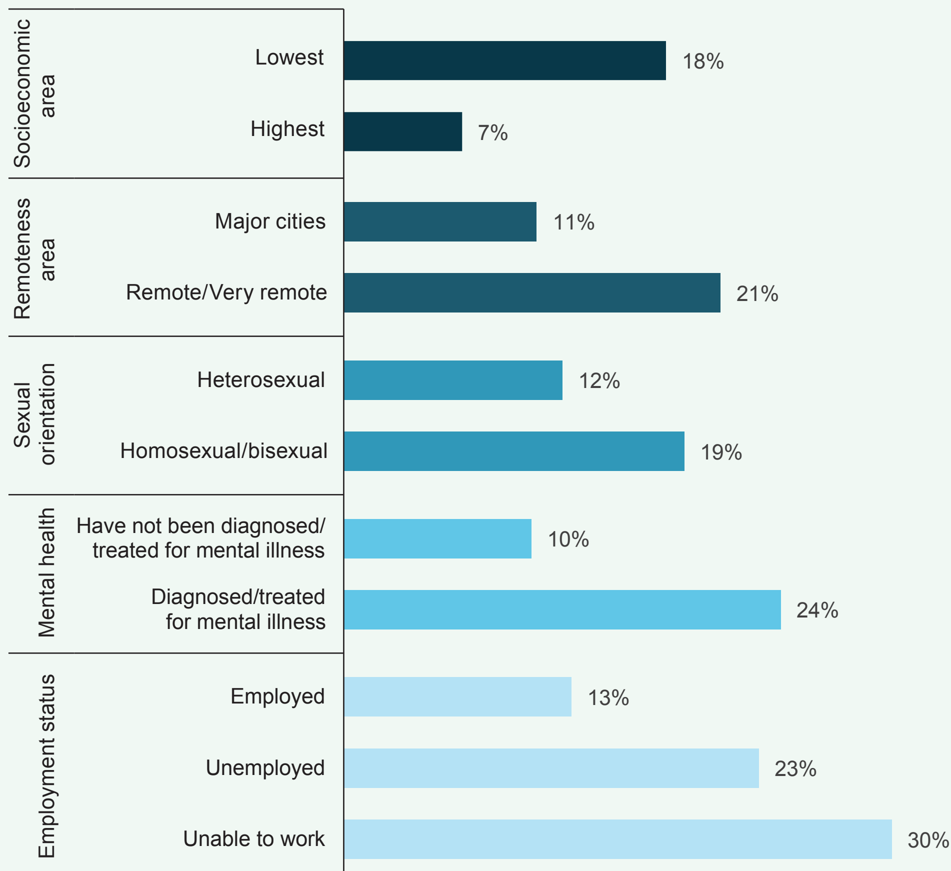
There were also fewer people being exposed to tobacco smoke: the proportion of dependent children exposed to tobacco smoke inside the home continued to decline, from 3.7% in 2013 to 2.8% in 2016 (a dramatic fall from 31% in 1995), and the proportion of pregnant women smoking during their pregnancy declined from 15% in 2009 to 10% in 2015.

People living in the lowest socioeconomic area were one of the few groups to report a decline in daily smoking between 2013 and 2016—from 20% to 18%—but they still have a much higher smoking rate than people living in the highest socioeconomic area (6.5%) (AIHW 2017).

# Some groups are more likely to smoke daily than others

Good health is not shared equally among people in Australia and smoking is one example of a key risk factor for disease that contributes to these inequalities. Although some improvements are being made among these groups, daily smoking continues to be more commonly reported among Aboriginal and Torres Strait Islander people (see Chapter 6.5 'Health behaviours of Indigenous Australians'), people living in the lowest socioeconomic area, people identifying as homosexual/bisexual, and people who were unable to work or were unemployed (Figure 4.5.1).

**Figure 4.5.1: Proportion of people who are daily smokers, by selected demographic characteristics, 2016**




*Source:* AIHW 2017; Table S4.5.1.

# Most smokers want to quit

According to the National Drug Strategy Housing Survey 2016, 7 in 10 (69%) current smokers planned to quit smoking and 3 in 10 (29%) tried to quit in the previous 12 months but did not succeed. The main reason smokers tried to quit or change their smoking behaviour was because it was costing too much money (52%).

# Smoking is the leading risk factor for disease

Tobacco smoking is the leading preventable cause of death and disease in Australia and a leading risk factor for many chronic conditions.

The Australian Burden of Disease Study estimated that tobacco use contributed to almost 18,800 deaths in 2011—more than 1 in every 8 (13%) deaths. Taking into account illness as well as deaths, tobacco use caused more disease and injury burden in Australia than any other single risk factor and was responsible for 9.0% of the total burden of disease. The largest impact from tobacco use is on cancer, respiratory diseases and cardiovascular disease.

The total burden attributable to tobacco use was only slightly lower (0.2%) in 2011 than in 2003 (equivalent to an 18% decline in the age-standardised rate), despite reductions in tobacco use and exposure over this period. This may be because health improvements from reductions in tobacco use take longer to become evident in cancer and chronic respiratory diseases (for which burden rates are still increasing) than in cardiovascular disease (for which there has been a large decrease in burden) (AIHW 2016).

# Smokers have poorer health than non-smokers

In 2016, smokers were less likely to rate their health as 'excellent' than people who had never smoked (8.3% compared with 22%) and were more likely than people who had never smoked to self-report being diagnosed with, or treated for, a mental illness in the previous 12 months (28% compared with 12% for people who had never smoked). The proportion of smokers self-reporting a mental illness also increased—both in recent years (from 21% in 2013), and over the last decade (17% in 2007).

The mechanisms linking tobacco smoking with mental health problems are complex; however, it is understood that people may perceive that smoking helps to relieve or manage psychiatric symptoms of their disorder (Minichino et al. 2013). It has also been shown that people with mental health conditions may find it difficult to stop smoking; however, on quitting, they are likely to experience improvements in their mood, general wellbeing, mental health and quality of life (Greenhalgh et al. 2016).

A high proportion of smokers also drink alcohol in risky quantities (49% exceeded the lifetime or single-occasion risk guidelines in 2016) and use illicit drugs (36% had used at least one illicit drug in the previous 12 months). Risky alcohol consumption and illicit drug use are both risk factors that increase the likelihood of a person's developing a disease or health disorder.

## What is missing from the picture?

There are limited national data available on how and why people quit smoking, and how they successfully maintained quitting. Most survey questions related to changes in behaviour or stopping smoking are targeted at smokers not ex-smokers.

There are currently no regular data collections on smoking prevalence among homeless people or on the relationship status of household smokers (for example, parent or sibling).

## Where do I go for more information?

More information on tobacco smoking is available at <www.aihw.gov.au/reports-statistics/behaviours-risk-factors/smoking/overview>. The reports *National Drug Strategy Household Survey 2016: detailed findings* and *Tobacco indicators: measuring midpoint progress—reporting under the National Tobacco Strategy 2012–2018* and other recent releases are available for free download.

More information on the Australian Burden of Disease Study is available at <www.aihw.gov.au/reports-statistics/health-conditions-disability-deaths/burden-of-disease/overview>. The report *Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011* and other recent releases are available for free download.

### References

AIHW (Australian Institute of Health and Welfare) 2016. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2011. Australian Burden of Disease Study series no. 3. Cat. no. BOD 4. Canberra: AIHW.

AIHW 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.

Greenhalgh EM, Stillman S & Ford C 2016. Smoking and mental health. In: Scollo MM & Winstanley MH (eds). Tobacco in Australia: facts and issues. Melbourne: Cancer Council Victoria. Viewed 12 January 2018, <http://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health>.

Minichino A, Bersani FS, Calo WK, Spagnoli F, Francesconi M, Vicinanza R et al. 2013. Smoking behaviour and mental health disorders—mutual influences and implications for therapy. International Journal of Environmental Research and Public Health 10(10):4790–811.