

# Ignoring our elders: tobacco control's forgotten health equity issue

Tim McAfee <sup>1</sup>, Ruth E Malone <sup>1</sup>, Janine Cataldo<sup>2</sup>

Over the past decades, demand-side tobacco control efforts in many countries have focused primarily on younger populations, including prevention of initiation in youth and young adults, and encouraging quitting among those in their 20s, 30s and 40s.<sup>1</sup> This focus has been explained primarily based on limited resources and long-term efficiency: it is more cost-effective over many decades to prevent initiation or get someone to quit young than it is to get older people who have smoked a long time to quit.<sup>2</sup> But there has been almost no examination of this paradigm and its effects from a health equity perspective.

In the US private health insurance sector, smoking status is among few factors besides age that health insurers are legally allowed to use to charge a higher premium amount.<sup>3</sup> Because premiums for older people are already as much as three times higher than those for younger individuals, the discriminatory effect of this policy is a greater burden for older smokers. Clinicians are also less likely to refer older individuals for cessation support or to prescribe cessation medications.<sup>4</sup>

Public health agencies likewise expend little effort specifically to motivate and help older tobacco users, compared with outreach and specially designed programmes for younger people who are members of priority populations suffering from health disparities. Yet older smokers as a group have grave intersectional disadvantages: they are poorer, less educated, have higher rates of mental illness, are more likely to be non-White, disabled and have multiple chronic conditions than younger smokers.<sup>5 6</sup> The lack of attention has consequences: in the USA, smoking prevalence in those 65 and older did not decrease from 2000 to 2015.<sup>7</sup> This lack of progress is likely due to an actual decrease in quit attempts and successes in older smokers, while among those under

45 years prevalence decreased and quit attempts increased.<sup>8</sup> Although smoking prevalence is lower in those over 65 than in younger groups, this is not due to targeted public health or clinical efforts,<sup>9</sup> but rather to differential attrition due to markedly increased absolute mortality rates among older tobacco users.

In public health, perhaps the most visible efforts to encourage smokers to quit are large mass media campaigns at the state and national levels. In general, however, older adults have not been a target of these campaigns. Although the rationale for this exclusion is not well documented, the ad development processes for public health antitobacco campaigns have not tested resonance of themes in those over 65, as has been done frequently for priority/target populations. Elders are rarely featured and are not a media buy focus. This omission is intentional because campaigns prioritise reaching younger smokers. Some focus group evidence suggests that the more negatively framed messages that appeal to youth and middle-aged smokers may not resonate as much with older people, who may respond to positive framing.<sup>10</sup>

In addition, the US Centers for Disease Control and Prevention and most states have not developed community collaborations with or provided funding to senior advocacy groups to work on tobacco, as has been done for eight other identified priority populations.<sup>11 12</sup> This situation persists even though over two-thirds of the burden of smoking-related morbidity and mortality is concentrated in those over 65,<sup>13</sup> and demographic shifts in the USA suggest that 16% of the population (63 million people) will be over the age of 70 by 2050.<sup>14</sup>

Notably, the tobacco industry has not adopted a similar hands-off stance. Tobacco industry document research shows that they systematically targeted older adults. Older smokers' fears of the dangers of smoking (and industry's concern that they would quit as a result) led to development of the 'light' and 'low tar' campaigns, falsely conveying to older people the notion that these products were safer. Couponing initiatives and giveaways at nursing homes were targeted to older smokers.<sup>15</sup>

What rationales allow continued discriminatory policies towards older people, despite increased awareness of health equity as a fundamental public health principle? The principal rationale is that by getting young people to not start smoking or quit early, they will eventually avoid all or most smoking-attributable risk. Quitting before age 40 adds around 10 years of life expectancy, while someone aged 55–64 who quits 'only' gains on average 4 years.<sup>2</sup> Thus, if the cost to prevent initiation in a young adult, or to generate a quit in a 30-year-old, is similar to the cost to generate a quit in a 55-year-old, then putting limited resources on younger smokers makes a certain economic sense. A pragmatic political consideration has been that the general public and politicians are more inclined to support measures focusing on the young than measures to help older tobacco users to quit.

But what sort of ethical company are we keeping by deprioritising millions of older smokers in the name of efficiency, many of whom will develop diseases and die from the consequences of their continued smoking? This zero-sum game mindset pits the young against the old, focusing on potential benefits to younger people who do not start smoking or quit, even though those benefits will mainly accrue many decades in their future. This efficiency model perhaps reached its zenith (or nadir) in a 2001 study sponsored by Philip Morris and provided to the Czech Republic when it was considering a cigarette excise tax. Examining tobacco's overall economic impact, the study concluded that the early deaths of people who smoked helped the government's finances by decreasing its pension and healthcare obligations.<sup>16</sup> This argument that maintaining smoking in the elderly is cost-efficient was not generally well-received. Most people did not agree that it was reasonable to let older smokers die in order to preserve either government coffers or tobacco industry profits. But has public health made a similar calculus?

Additional rationales for not systematically addressing smoking among older people include mistaken assumptions that they are not interested in quitting; that they are unlikely to be successful; and that even if they do quit, the damage is already done. However, older smokers are as likely to succeed if they do try to quit, and no more likely to relapse.<sup>17</sup> Although they may be less likely to make quit attempts, this may not mean they are not interested in quitting, but rather that they are less hopeful regarding success, believe quitting is futile, or have less exposure to

<sup>1</sup>Social and Behavioral Sciences, University of California, San Francisco, California, USA

<sup>2</sup>Department of Physiological Nursing, School of Nursing, University of California, San Francisco, San Francisco, California, USA

**Correspondence to** Dr Tim McAfee, Department of Social and Behavioral Sciences, University of California, San Francisco, CA 94143, USA; tim.mcafee@ucsf.edu

age-appropriate encouragement and help to quit.<sup>18 19</sup> A similar likelihood of success coupled with lower likelihood of trying calls for targeted interventions designed to increase older people's quit attempts, such as mass media campaigns, increased clinical cessation support and community-level collaborations.

For older individuals, the urgency of quitting is greater and the harm from continued smoking is more imminent. 'The damage is already done' argument is not supported by the major conclusion of the 2020 US Surgeon General's Report that 'smoking cessation is beneficial at any age',<sup>20</sup> which has been reinforced by recent prospective studies of hundreds of thousands of older people.<sup>21 22</sup>

More people died from smoking-attributable causes in the USA in 2020 alone (~480 000)<sup>23</sup> than from COVID-19 (~375 000).<sup>24</sup> What if, during the COVID-19 pandemic, we had applied the same dominant paradigm regarding age that is currently present in tobacco control? Public health would have concentrated on strategies to protect the young and middle aged, viewing those over 65 as essentially a lost cause, of less critical interest because their life expectancy is dramatically shorter. There would have been no full-court press to first vaccinate those over 65, or to develop strategies to treat those with multiple comorbid conditions (predominately seniors). We would have witnessed far more deaths among the elderly, wiping out whole generations.

Seem far fetched? There were vocal minority arguments made as the pandemic progressed that, essentially, the elderly and the infirm *should* be sacrificed because they had already lived a long life, and the economic repercussions of COVID-19 restrictions on business and education of the young were too draconian in their effects on the non-elderly. Thankfully, for those who believe in the inherent value of every person's life and in the wisdom and experience of older people, this was not the course of action taken.

Those who suffer multiple forms of stigmatisation and feel devalued in society find it harder than higher status, socially valued individuals to change health behaviours, lacking resources and social encouragement to do so. The deprioritisation of older smokers is a symptom of institutionalised ageism, which must be addressed systematically

to apply the tenets of health equity and inclusion in our work. Across all areas of tobacco control, we must do better by our elders.

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**Twitter** Ruth E Malone @MaloneRuth

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**ORCID iDs**

Tim McAfee <http://orcid.org/0000-0001-80087-9817>  
Ruth E Malone <http://orcid.org/0000-0002-3324-2183>

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