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Editorials

Reducing tobacco harms among older adults: a critical agenda for tobacco control

Tobacco Control is to be commended for selecting older adults for special focus in this issue. Publication of this special issue coincides with the coordinated release of theme issues on aging by nearly 100 journals in more than 30 countries throughout the world.[1a]

Now is a critical time for new strategies aimed at protecting our oldest citizens from the harm caused by tobacco. A number of trends and developments intensify the need and opportunity to strengthen tobacco control initiatives aimed at older adults, rounding out an increasingly youth-focused prevention agenda.[1b]

The age boom

As most of the papers in this special series point out, America's age boom is the primary impetus for renewed efforts in the United States to help older smokers quit, and to expand smoke-free policies to the environments where older adults live, work, and recreate. Americans aged 65 and older represent the fastest growing segment of the American population. One "baby-boomer" turns 50 every 7.6 seconds.[2] According to Husten *et al* in this issue,[3] these trends ensure that the sheer number of older smokers will continue to increase into the next century—despite the lower prevalence of smoking among older Americans. And, sadly, they also ensure that tobacco is likely to remain the leading cause of chronic disease and premature death among older adults, and a major contributor to escalating healthcare costs.[4 5] Thus, as the nation focuses increasingly on improving health outcomes and containing the costs of medical care for chronic disease,[6] efforts to protect current and future cohorts of older adults from the harms of tobacco use and environmental tobacco smoke (ETS) exposure must be expanded.

New knowledge about smoking and older adults

Before the Surgeon General's report in 1990[7] declared that "it is never too late to quit smoking", little was known about the dramatic and often immediate benefits of smoking cessation for older adults. Data compiled in the past decade (much of which is summarised in the papers published in this special issue and referenced in Citations on pages 262–266) have expanded our knowledge about the health harms of smoking and the benefits of quitting among older adults, and about the dangers of ETS exposure and the long-term consequences for older adults.[7–9]

In addition, new evidence concerning patterns of smoking and quitting in older adults, and the factors that impede or facilitate their efforts to quit—has provided important guidance for targeting and tailoring programmes to meet their needs. For instance, the paper by Husten *et al*[3] exploring ethnic/racial and gender differences in smoking prevalence and quit ratios among older Americans, suggests the need for targeted efforts to assist older women and black, male smokers. Related cross-sectional and cohort studies have helped to clarify factors contributing to these and other subgroup differences, and to identify the individual characteristics associated with quitting success.[10–12] For example, in a large community survey of older adults, King and her colleagues[10] found that disparities between older men and women in educational level and marital status accounted for their higher rates of continued smoking, versus quitting. And a recent re-analysis of the 1986 Adult Use of Tobacco Survey (AUTS) found several interesting differences between older men and women smokers in quitting barriers and motives that could be harnessed in interventions aimed at older women smokers: older women were more concerned than their male counterparts about the effects of smoking on their health, the possible harms to others, and the costs of smoking; in addition, they were more concerned about weight gain as a quitting barrier, more likely to view smoking as a helpful weight control and coping tactic, and less likely to report having received advice about smoking cessation and assistance from their personal physician.[11]

There are now a handful of treatment outcome studies, strengthened by the Dale *et al*[13] and Ossip-Klein *et al*[14] papers in this issue, that have specifically examined predictors of quitting success among older smokers, confirming that the same factors are important for the nation's most senior smokers as for their younger adult counterparts. In aggregate, these studies have shown the following factors to be beneficial: lower nicotine dependence,[13 15 16] higher quitting self-efficacy,[14–16] prior quitting success,[13 16] stronger quitting motivation,[13 15 16] greater perceived health benefits,[15 16] lower perceived quitting barriers,[16] using a greater number of quitting strategies,[15 16] having few or no acquaintances who smoke[14] and/or a non-smoking spouse,[13] and for older smokers quitting with the patch, more frequent contact with physicians, pharmacists, or both, and less concomitant smoking.[17] These findings already have been used, with promising results, to design individually tailored treatments for older smokers. For instance, in a controlled pilot study with older nicotine patch users, three-month quit rates were almost twice as high for quitters who received the age-targeted *Clear horizons* guide described by Ossip-Klein *et al*[14] with a series of individually tailored letters containing personalised advice to help them capitalise on their unique quitting assets and

overcome their quitting barriers, as for quitters receiving usual care.[18] A full evaluation is now underway.

Recent industry disclosures and tobacco liability lawsuits

Born roughly between 1910 and 1935, the older populations represented in the four original articles in this issue[3 13 14 19] began smoking long before tobacco was recognised as dangerous or addictive. They were introduced to cigarettes by celebrity role models such as Humphrey Bogart, Edward R Murrow, and Ava Gardner, and were subjected to the cigarette advertising campaigns of the 1930s, '40s, and '50s that touted the safety and health benefits of smoking—for example, "Luckies are nice to your throat", "Reach for a Lucky instead of a sweet". (As Falit[20] points out in this issue, the remnants of these trends can be found in present-day cigar advertising aimed at baby-boomers and older Americans.) One consequence has been a striking "age gap" in awareness of the health risks of smoking and the benefits of quitting: the 1986 AUTS showed that older smokers were much less likely to see smoking as a risk for heart disease, lung cancer, emphysema, and bronchitis, and much less concerned about their personal smoking risks.[11]

Broad media coverage of confidential tobacco company documents disclosing that the industry knew long ago that cigarettes are both dangerous and addictive,[21 22] unprecedented public characterisation of past advertising campaigns as "misleading and fraudulent",[23] and inescapable publicity surrounding the growing number of personal liability and class action lawsuits (brought almost entirely on behalf of *older* adults and their families) and the suits filed by most state Attorneys General to recover state Medicaid funds spent on the treatment of smoking-related disease,[21-24] may prove a powerful force in penetrating the cultural smokescreen that has for decades shielded older smokers from awareness and acceptance of their personal health risks from smoking.[11] This, in turn, may raise their quitting motivation and enrolment in cessation programmes—as long as there is a simultaneous effort to communicate that it is indeed "never too late to quit".

Advances in cessation treatment and prospects for improved treatment access related to health system change

In general, cessation-oriented research published since 1990 has shown that older smokers are highly responsive to targeted smoking cessation programmes,[16] and that they are at least as likely as younger smokers, if not more, to succeed in quitting—either on their own or with the aid of formal clinic, self-help, and pharmacological treatments.[14 15 17 25] This includes brief interventions, through primary care, combining provider quitting advice with nicotine replacement therapy[15-17]—the strategy emphasised in the new smoking cessation clinical practice guideline issued by the Agency for Health Care Policy and Research (AHCPR).[26] Unfortunately, despite the fact that older smokers see their doctors more often each year,[3 11 15] it is still the case that most of them fail to receive regular smoking cessation advice and assistance,[11 27 28] that most insurers fail to reimburse for smoking cessation treatments,[29] and that most health plans [companies providing or paying for health services] fail to incorporate them as core preventive benefits.[30]

Four recent developments hold promise to alter this state of affairs.

- The shift from fee-for-service medicine to managed care will bring unprecedented opportunities and incentives for incorporating tobacco cessation advice and assistance into routine care—in large part because the financial justification for managed care is mainly based on its ability to control costs by preventing disease.[31]
- The 1996 AHCPR clinical practice guideline will provide an authoritative standard for acceptable treatment that can be met in everyday care.[26]
- The 1996 addition of smoking cessation advice by a healthcare provider as a standard quality measure in the United States' leading health plan "report card" will give health plans new motivation to expand their tobacco intervention activity[32]; and
- Managed care's emphasis on "demand management" to curb unnecessary use,[33] and "chronic disease management" to prevent chronic disease and its costly complications and flare ups,[34 35] will fortify efforts to curb tobacco use and ETS exposure among older patients—especially for the millions of older Americans who suffer from asthma, chronic obstructive pulmonary disease, coronary heart disease, diabetes, ulcers, and many other conditions exacerbated by smoking or ETS exposure, or who take medications that are compromised by nicotine.[36]

Evidence for reduced use of healthcare services among Health Maintenance Organisation (HMO) enrollees who do quit smoking,[37] and the potential for more rapid health-related and economic "returns on investment" from smoking cessation with older than younger adults[38 39] may especially encourage tobacco control efforts among older smokers.

Advances in tobacco control policy

The 1990s witnessed pervasive changes in public and private clean indoor air policies throughout the United States, and state increases in tobacco excise taxes.[21 40] These advances, rules by the US Food and Drug Administration on tobacco marketing and advertising, and the wide number of public health policy changes under discussion as part of the Liggett settlement.[21] and as part of a comprehensive tobacco industry settlement agreement[24 41 42] are likely to prove beneficial for older smokers as well as for the nation's youth—for example, changes in packaging, warning labels, and product design. Likewise, possibilities for expanded funding for counteradvertising, education programmes, and smoking cessation treatments—drawing on revenues from state or federal tobacco excise taxes earmarked for tobacco control activities, or from new industry funds[21 41 42]—stand to greatly benefit older smokers. Given the dearth of educational and treatment programmemes in facilities used by older smokers,[19] one recommendation is to mandate some of this funding specifically for educational and cessation programmes in facilities catering to older adults. In this issue Bergman and Falit[19] supply new data on smoke-free policies in environments where older smokers live, work, and recreate—policies with potential to reduce tobacco consumption among older smokers, as well as to curb or eliminate ETS exposure among older non-smokers. This paper also offers interesting new perspectives on the benefits of smoke-free policies. The field needs more studies like this one, as well as studies that monitor the impact of clean indoor air regulation and other tobacco control policies, on older adults.

In sum, trends and gains over the past decade provide a strong foundation for the next generation of efforts to reduce tobacco-related threats to the health and wellbeing of older adults and their families. As we move to protect our youth from the scourge of tobacco-caused death and disease in the 21st century, we cannot and should not neglect the needs of older smokers and older adults at risk for ETS-caused disease.

Indeed, society owes a special debt to older smokers. Because the human and economic tolls of tobacco use and

addiction have been greatest (and clearest) in later life, much of what has been learned in the past century about the dangers of smoking and ETS exposure has been learned from studying older adults—hundreds of millions who lost their lives prematurely to nicotine addiction. Viewed in this light, older adults have made a uniquely compelling contribution to the current tobacco control agenda. One measure of their power can be found in the force of the accumulating individual, class action, and state Attorneys General lawsuits filed almost exclusively on behalf of the older victims of death and disease caused by smoking and ETS—a force powerful enough to bring the tobacco industry to the public health negotiating table. Any new tobacco control agenda forged through these negotiations which does not vigorously protect future generations of older adults from continued tobacco harms simply would not be right.

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