

5 Smoking

5.1 Background

The smoking of tobacco is the risk factor associated with the greatest burden of disease in Australia, accounting for 9.7% of all Disability Adjusted Life Years (DALYs) (Mathers et al. 1999). It is estimated that 27% of Australian men and 23% of Australian women are smokers (Hill et al. 1998). Tobacco smoking increases the risk of cancers, coronary heart disease, peripheral vascular disease and stroke. It was estimated in 1995 that 3.2 million (23.5%) adult Australians were at risk of heart disease and other chronic conditions due to smoking (Australian Institute of Health and Welfare 1999). Smoking was responsible for 21% of all male deaths, 9% of all female deaths and 100,000 hospital episodes for an estimated 800,000 bed days per year (Australian Institute of Health and Welfare 1996).

Australians are more aware of the health risks of smoking than ever before, with significant public health gains in tobacco control in recent years achieving worldwide recognition. Average per capita consumption of tobacco fell by 49% between 1965 and 1993, with marked decreases after national bans on radio and TV advertising and mass media quit smoking campaigns (National Health and Medical Research Council 1995). Nonetheless, *National Goals and Targets for Australia's Health* (Nutbeam et al. 1993) recognised smoking as the 'single most important modifiable cause of premature death and disability in Australia'. *National Health Priority Areas* also recognises smoking as an important modifiable cause of premature death and disability in Australia (Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare 1999a). The national objective is to reduce the prevalence of regular smoking among adults and secondary school students. The population indicator for smoking will rely on self-reported smoking through:

- ABS National Health Surveys;
- ABS Population Survey Monitor;
- NHF Risk Factor Prevalence Surveys;
- Anti-Cancer Council of Victoria Patterns of Tobacco Smoking;
- National Campaign Against Drug Abuse; and
- National Household Survey.

Comparable data on regular smoking can also be obtained through the SAND program which allows investigation into the relationship between each category of smoking status and morbidity under management.

5.2 Research questions

1. What is the smoking status of general practice patients?
2. Is smoking status in general practice patients associated with particular patient profiles?

5.3 SAND questions

Box 5.1: Smoking status

GPs asked the patients (18+ years):

What best describes your smoking status?

Smoke daily
Occasional smoker
Previous smoker
Never smoked

Note: The term 'smoking' is used here to mean tobacco smoking of any kind, including cigarettes, pipes and cigars.

5.4 Results

Sample size (18+ years) was 30,265 patient encounters from 980 GPs.

Overall, 19.2% (95% CI: 18.4–20.0) of patient encounters were with adults who are daily smokers, while 5.6% (95% CI: 5.1–6.1) were with occasional smokers and 27.0% (95% CI: 26.2–27.8) with previous smokers. A greater proportion of males were daily smokers (22.6%) than females (17.0%). The proportion of smokers decreased with age, with less than 7% of patients aged 75 years and over being daily smokers (Figure 5.1). However, almost 60% of males aged 65 years or more were previous smokers.

Investigations into the association of smoking status and the problems managed at encounter (ICPC-2 chapter level) revealed an apparent increase in the rate of management of psychological problems at encounters where the patient was a daily smoker (Table 5.1). Closer examination of these psychological problems (at ICPC-2 rubric level) showed higher rates of smokers among patients being managed for their depression, drug abuse, anxiety/nervousness/tension, acute stress reactions and schizophrenia (Table 5.2). The influence of age and gender was not controlled for in Table 5.1, thereby bringing mixed results for an association between smoking status and circulatory or respiratory problems managed. However, previous smokers, who tended to be older, were more likely to experience circulatory problems than other smoking groups (Table 5.1), with a higher rate of management of ischaemic heart disease (IHD) (with or without angina) among previous smokers (Table 5.2).

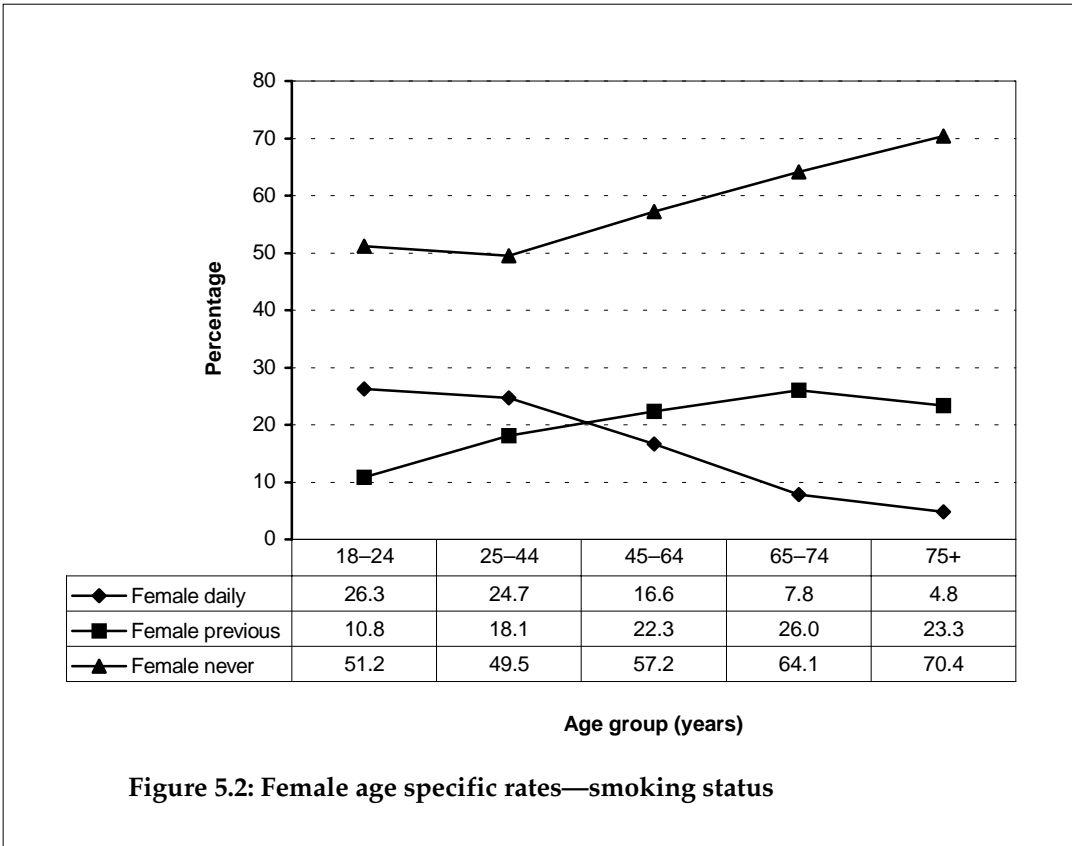
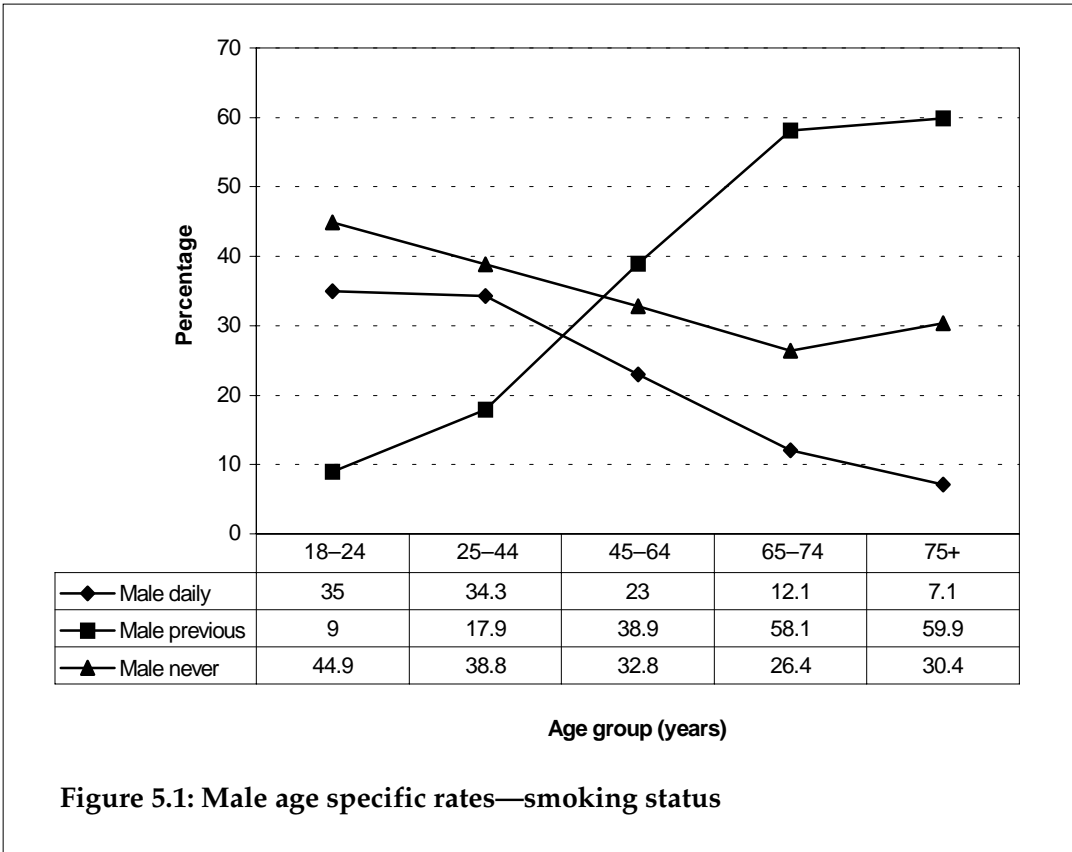


Table 5.1: Patient smoking status by problems managed (ICPC-2 chapter)

Problem managed	Never (n=14,590)		Previous (n=8,180)		Occasional (n=1,691)		Daily (n=5,815)	
	n	Per 100 encs	n	Per 100 encs	n	Per 100 encs	n	Per 100 encs
General & unspecified	1,808	12.4	985	12.0	189	11.2	666	11.5
Blood	304	2.1	185	2.3	31	1.8	104	1.8
Digestive	1,540	10.6	888	10.9	194	11.5	630	10.8
Eye	427	2.9	232	2.8	34	2.0	127	2.2
Ear	493	3.4	278	3.4	63	3.7	193	3.3
Circulatory	3,157	21.6	2,147	26.2	155	9.2	628	10.8
Musculoskeletal	2,797	19.2	1,563	19.1	297	17.6	1,153	19.8
Neurological	669	4.6	365	4.5	67	4.0	297	5.1
Psychological	1,492	10.2	915	11.2	205	12.1	1,253	21.5
Respiratory	2,871	19.7	1,827	22.3	343	20.3	1,133	19.5
Skin	2,378	16.3	1,368	16.7	276	16.3	936	16.1
Endocrine & metabolic	1,537	10.5	1,074	13.1	133	7.9	462	7.9
Urological	518	3.6	271	3.3	47	2.8	142	2.4
Pregnancy & family planning	670	4.6	292	3.6	137	8.1	299	5.1
Female genital system	1,388	9.5	494	6.0	181	10.7	450	7.7
Male genital system	190	1.3	192	2.3	27	1.6	78	1.3
Social	121	0.8	72	0.9	20	1.2	87	1.5

Note: Abbreviations: encs = encounters

Table 5.2: Patient smoking status by problems managed (selected circulatory and psychological problems)

Problem managed	Never		Previous		Occasional		Daily	
	n	Per 100 encs	n	Per 100 encs	n	Per 100 encs	n	Per 100 encs
Uncomplicated hypertension	1667	11.4	998	12.2	75	4.4	328	5.6
IHD with angina	70	0.5	73	0.9	—	—	12	0.2
IHD without angina	177	1.2	209	2.6	10	0.6	29	0.5
Depressive disorder	557	3.8	320	3.9	75	4.4	340	5.8
Drug abuse	11	0.1	11	0.1	10	0.6	160	2.8
Feeling anxious/nervous/tense	207	1.4	122	1.5	26	1.5	117	2.0
Acute stress reaction	107	0.7	58	0.7	14	0.8	65	1.1
Schizophrenia	43	0.3	21	0.3	—	—	75	1.3

Note: Abbreviations: encs = encounters

5.5 Discussion

GPs have regular contact with smokers, almost one in five encounters with adults being with persons who smoke daily. They can provide opportunistic advice especially in the presence of smoking-related ailments and are therefore ideally placed to encourage smokers to quit and to assist them in doing so.

Patients feel that GP advice regarding smoking is acceptable and appropriate (Richmond et al. 1990; Richmond et al. 1997). In one Australian study, 67% of smokers said that if they were to decide to quit, they would opt for some form of quit smoking program from a medical practitioner or other health professional (Owen & Davies 1990). It has also been shown that smokers who receive non-smoking advice from doctors are nearly twice as likely to quit as those who are not advised to quit (Glynn 1990). A study in the United Kingdom found that even brief advice to quit from GPs to all their smoking patients resulted in a 5% abstinence rate after one year (Russell et al. 1979). While in public health terms, 5% may be a significant improvement, for a GP this means that 95% have not taken the advice. The use of other treatment strategies will therefore have a role to play in the reduction of smoking rates among general practice patients.