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Addressing the Stagnation of Smoking Cessation in Older Adults: Behavioral Barriers, Harm Reduction, and Policy Reform

By Jeffrey Smith

The stagnation of smoking cessation among older Americans is not an inevitable consequence of aging; it is a policy failure that targeted reform can address.

Introduction

The trajectory of tobacco control in the United States stands as one of the most consequential public health achievements of the past century. Adult smoking prevalence has fallen from more than 40 percent in the early 1960s to less than 10 percent in 2024.[1] This decline is the result of decades of sustained efforts across taxation, clean air legislation, counter-advertising, public education, and clinical smoking cessation services. Yet the aggregate success story conceals a troubling disparity: Older Americans (i.e., those who have survived decades of smoking and now bear the greatest burden of tobacco-related disease) have benefited least from recent progress.[2]

The "hardening hypothesis"—which posits that as overall prevalence declines, remaining smokers represent a progressively more dependent and treatment-resistant core—is particularly useful when considering this demographic.[3] This population of older smokers increasingly resembles a survivor cohort: Individuals' long smoking histories, deeply entrenched habits, and accumulated psychosocial challenges make cessation exceptionally difficult.[4]

This paper contends that addressing smoking among older adults (i.e., those 55 years of age and older) requires a fundamentally different policy architecture—one that integrates age-specific cessation strategies, carefully regulated harm reduction alternatives, targeted education to correct misperceptions associated with the risk of different tobacco/nicotine products, and structural support for the social and financial determinants that sustain tobacco use. Without such an approach, the United States risks allowing its oldest and most vulnerable smokers to be left behind by the very progress that has liberated younger generations.

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Trends in Smoking Prevalence Among Older Adults

National survey data reveal persistent age-based disparities in smoking prevalence that have lagged behind overall downward trends. In 2021, cigarette smoking prevalence was approximately 12.5 percent among adults aged 45 to 64 and 8.7 percent among those 65 and older, compared to only 4.8 percent among young adults aged 18 to 24.[5] While these figures represent declines from prior decades, the rate of decline among older adults has been notably slower. Specifically, a landmark trend analysis that examined tobacco product use from 2011 to 2022 found that cigarette smoking did not decline among adults aged 65 and older during this period.[6]

The sources included in this paper were verified and active at the time of publication.

The absolute number of older smokers underscores the scale of the challenge. The population of those aged 65 and older who smoke combustible cigarettes increased from approximately 3.6 million in 2017 to 4.2 million in 2023—an increase largely driven by the baby boomer generation aging into retirement-age cohorts. Meanwhile, the adoption of potentially less harmful alternatives remains negligible among older adults: In 2023, only 3.3 percent of adults aged 50 to 64 and 0.9 percent of those 65 and older used e-cigarette products.[7] This near-absence of product switching stands in stark contrast to younger cohorts, where e-cigarette adoption has grown substantially.[8]

Data from the Health and Retirement Study (HRS) covering 2006 through 2022 provide additional nuance.[9] Among older adults, smoking prevalence declined from 14.77 percent to 6.99 percent over this period. However, among those who continued to smoke, average daily cigarette consumption initially fell but then rose slightly again by 2022. This pattern is consistent with the hardening hypothesis and suggests that remaining smokers are becoming more dependent, rather than less. Rural/urban disparities further complicate the picture, as rural residents continue to smoke at significantly higher rates than their urban counterparts.[10]

Additionally, the tobacco industry's marketing practices actively slow cessation efforts among older populations. A recent analysis found that 34.3 percent of current smokers reported receiving cigarette coupons, which 78.7 percent of recipients redeemed.[11] These price promotions effectively neutralize the impact of excise tax increases—one of the most potent population-level cessation tools—and disproportionately affect price-sensitive older smokers on fixed incomes.

Benefits of Quitting Later in Life

A persistent barrier to cessation among older adults is the fatalistic belief that the damage is already done.[12] However, this belief has been contradicted by a robust body of evidence. The 2020 Surgeon General's report affirmed that smoking cessation at any age produces meaningful health benefits, including reductions in cardiovascular risk, improvements in respiratory function, and decreases in cancer incidence and mortality.[13] Quantitative modeling published in 2024 estimated that smokers who continue the behavior at age 55 lose an average of 7.3 years of life expectancy compared to never-smokers; for those who continue at age 65, the loss is 5.9 years; and at age 75, it is 4.4 years.[14] Quitting at these respective ages avoids approximately 3.4, 1.7, and 0.7 years of life lost. The probability of gaining at least one additional year of life by quitting was estimated at 23.4 percent at age 65 and 14.2 percent at age 75.

The message that it is never too late to quit is not merely aspirational; it is empirically supported by data demonstrating measurable gains in life expectancy.

Perhaps the most compelling recent evidence concerns cognitive health. A 2025 study found that former smokers experienced an approximately 50 percent slower decline in verbal fluency and an approximately 20 percent slower decline in memory compared to continuing smokers.[15] These benefits were equivalent to delaying cognitive aging by approximately three years over a six-year follow-up period.[16] Given that cognitive decline and dementia are among the most feared consequences of aging, this evidence offers a particularly powerful motivational frame for older adults contemplating cessation.[17]

These findings collectively challenge the fatalism that pervades both patient and provider attitudes toward late-life cessation. The message that it is never too late to quit is not merely aspirational; it is empirically supported by data demonstrating measurable gains in life expectancy, cardiovascular health, respiratory function, and cognitive preservation, as well as measurable reductions in cancer risk—even for individuals who have smoked for decades.

Behavioral and Psychosocial Challenges to Cessation

Dependence and Habit Strength

Older adults who smoke have typically done so for 30 to 50 or more years, meaning that smoking has become deeply embedded in daily micro-routines like morning coffee, post-meal rituals, stress responses, and social interactions. This behavioral entrenchment is reflected

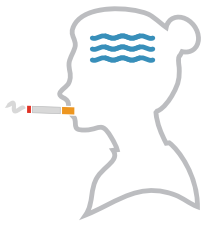
in 2022 cessation data from the Centers for Disease Control and Prevention.[18] Quit attempt rates were 47.5 percent among adults aged 45 to 64 and 48.6 percent among those 65 and older, compared to 74.4 percent among those aged 18 to 24.[19] Successful cessation rates were correspondingly lower: approximately 5.6 percent for adults aged 45 and older versus 15.3 percent for young adults.[20]

Clinical evidence confirms that treatment-seeking smokers aged 50 and older present with greater nicotine dependence than younger counterparts, as measured by the Fagerström Test for Nicotine Dependence and biomarker assessments.[21] Further complicating treatment, age-related declines in nicotine metabolism alter the efficacy and side-effect profile of standard pharmacotherapies, yet the clinical implications of these changes remain insufficiently studied.[22] The combination of entrenched behavioral patterns, heightened physiological dependence, and altered drug metabolism creates a formidable clinical challenge that generic cessation protocols are poorly equipped to address.

Financial Strain and the Cessation Paradox

Financial insecurity represents both a consequence of and a barrier to smoking cessation among older adults. An analysis of the Population Assessment of Tobacco and Health (PATH) Study, published in 2025, found that adults experiencing financial strain were less likely to quit smoking (hazard ratio, 0.81) and significantly more likely to relapse (hazard ratio, 1.56).[23] This creates a paradoxical dynamic: The same financial pressures that make the cost of cigarettes burdensome also undermine the psychological resources needed to quit successfully, as increased financial stress reduces the likelihood of complete cessation.

Financial stress has been shown to mediate the relationship between socioeconomic status and smoking behavior, suggesting that income alone does not explain smoking persistence.[24] Rather, the subjective experience of financial precarity drives continued use.[25] For older adults living on fixed incomes, smoking may function as one of few reliable coping mechanisms for anxiety and stress, making purely cost-based cessation arguments counterproductive.[26] Thus, interventions that focus solely on the monetary cost of cigarettes without addressing the underlying financial and emotional stressors may prove insufficient or even backfire by increasing psychological distress.



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Social Isolation and Loneliness

The intersection of social isolation, loneliness, and tobacco use represents a critical but underappreciated barrier to smoking cessation in older populations. A 2025 mediation analysis found that social isolation was associated with poorer lung function among adults aged 45 and older, with smoking serving as a key mediating pathway.[27] That is, socially isolated individuals were more likely to smoke, and smoking in turn degraded their respiratory health.[28] Other research documented a bidirectional relationship between smoking and loneliness, suggesting that each condition reinforces the other in a self-perpetuating cycle.[29]

Bereavement, retirement, and the natural narrowing of social networks with age create conditions that increase both the risk of continued smoking and the difficulty of quitting. The prevalence of social isolation among older adults with chronic conditions is strikingly high. For example, among those with type 2 diabetes, a population in which smoking cessation would yield substantial health benefits, the prevalence of social isolation approaches 46 percent.[30] Any comprehensive cessation strategy for older adults must therefore address the social context in which smoking occurs, not merely the pharmacologic and behavioral dimensions of addiction.

Cognitive Barriers and Risk Misperceptions

Age-related declines in executive function, including deficits in planning, impulse control, and cognitive flexibility, may impair older adults' ability to implement and sustain the behavioral changes required for successful cessation. Compounding these neurocognitive challenges is a profound harm-perception gap regarding alternative nicotine products. A 2023 study found that adults aged 55 to 64 and 65 and older had significantly higher odds of rating e-cigarettes

as more harmful than cigarettes compared to adults aged 18 to 24.[31] Research has further demonstrated that older adults from low socioeconomic backgrounds were 1.74 times more likely to perceive e-cigarettes as extremely harmful.[32]

This harm-perception gap effectively discourages any potential transition from combustible cigarettes to lower-risk alternatives. Research employing the Health Belief Model has revealed that older adults hold deeply entrenched beliefs about nicotine products, informed by limited exposure to accurate information about relative risk and reinforced by provider reluctance to discuss alternatives.[33] Low digital literacy and limited access to online health information further constrain older adults' ability to independently evaluate evidence about reduced-risk products, leaving them reliant on providers who are themselves often inadequately informed.

The SMOKE AKAT study, published in 2025, surveyed family medicine residents and found that 91.4 percent had never received formal smoking cessation education during their training.

Provider Knowledge Gaps

The clinical workforce responsible for counseling older adults on smoking cessation demonstrates a knowledge gap in tobacco-related information. The SMOKE AKAT study, published in 2025, surveyed family medicine residents and found that 91.4 percent had never received formal smoking cessation education during their training.[34] More than 60 percent incorrectly believed that nicotine itself causes cancer, and 84.9 percent misclassified e-cigarettes as a form of nicotine replacement therapy.[35] These knowledge gaps mean that uninformed healthcare professionals often fall back on offering generic advice only, like "you should quit," rather than recommending evidence-based, intensive, individualized cessation support.

Qualitative research has identified additional barriers that providers frequently fail to address, including patient fears of weight gain, mood instability, and stress management difficulties following cessation, as well as demoralization from prior failed quit attempts.[36] For older adults, who may have attempted and failed to quit multiple times over decades, healthcare professional interactions that do not acknowledge this history and offer genuinely new approaches are likely to be dismissed as unhelpful. The result is a system-level failure that leaves older smokers without the specialized, empathic, and evidence-informed clinical support they need.

Tobacco Harm Reduction: Evidence and Limits

The Combustion Principle

The foundational principle underlying tobacco harm reduction is that combustion, not nicotine, drives the majority of smoking-related morbidity and mortality. The 2014 Surgeon General's report documented that the more than 7,000 chemicals produced by burning tobacco, including dozens of known carcinogens, are responsible for the disease burden attributable to smoking.[37] Several years later, a landmark review from The National Academies of Sciences, Engineering, and Medicine found conclusive evidence supporting the foundational principle of tobacco harm reduction: Completely switching from combustible cigarettes to e-cigarettes reduces user exposure to numerous toxicants and carcinogens present in cigarette smoke.[38]

Cessation Efficacy of Noncombustible Products

Evidence on the efficacy of smoking cessation interventions for older adults provides important context for harm reduction discussions. A 2015 meta-analysis examined cessation interventions for adults aged 50 and older and found that pharmacologic interventions (medications) made successful cessation approximately three times more likely, nonpharmacologic interventions (counseling) nearly twice as likely, and multimodal approaches (medication and counseling) more than one-and-a-half times more likely than no intervention.[39] When findings were analyzed using a meta-regression analysis to control for differences across studies, multimodal approaches were the most effective.[40] These findings suggest that evidence-based treatments are effective in older populations, though absolute success rates remain modest.

Regarding e-cigarettes specifically, a 2025 Cochrane systematic review—the gold standard for evidence synthesis—found with high certainty that nicotine-containing e-cigarettes increase quit rates compared to nicotine replacement therapy.[41] However, the U.S. Preventive Services Task Force continues to maintain that the evidence is insufficient to recommend e-cigarettes as a cessation tool.[42] This regulatory-clinical disconnect creates a challenging environment for providers and patients seeking to make evidence-informed decisions.

FDA Regulatory Landscape

The U.S. Food and Drug Administration (FDA) has taken a product-by-product approach to tobacco harm reduction that has produced a complex regulatory landscape. The agency renewed its reduced-risk authorization for eight General Snus products, permitting the marketing claim that switching completely from cigarettes to these products lowers the risk of mouth cancer, heart disease, lung cancer, stroke, emphysema, and chronic bronchitis.[43] For IQOS, the heated tobacco system manufactured by Philip Morris International, the FDA issued a reduced-exposure authorization, noting that while the aerosol contains fewer toxic substances than cigarette smoke, some chemicals may be present at higher levels, and complete switching is required for any exposure reduction.[44] Of note, emerging biomarker data are beginning to fill the evidence gap on long-term health outcomes of this product. A 2025 study found that users who had completely switched from cigarettes to IQOS for two or more years showed favorable differences across all nine biomarkers of potential harm (e.g., endothelial function, platelet activation, oxidative stress), compared to continuing smokers, with IQOS users' values approaching those observed in former smokers.[45]

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In the nicotine pouch category, the FDA authorized the marketing of 20 ZYN products through the premarket tobacco product application pathway, though no reduced-risk claim has yet been issued for these products.[46] The FDA has not authorized any e-cigarettes with this designation, either.

Dual Use Versus Complete Switching

A critical caveat in the harm reduction evidence is that dual use (i.e., continuing to smoke cigarettes while also using an alternative nicotine product) substantially diminishes the potential health benefits of potentially risk-reducing products.[47] The FDA's IQOS authorization order noted that cutting down cigarette consumption while using the heated tobacco product was not sufficient to achieve meaningful exposure reductions.[48] This finding is consistent with broader evidence that even low levels of continued cigarette smoking carry disproportionate health risks.[49] Thus, any harm reduction strategy for older adults must emphasize complete switching or complete cessation as the clinical endpoint, and counseling should be designed to support patients through the full transition rather than permitting indefinite dual use.

Policy Recommendations

Strengthen First-Line Cessation

The first priority must be to ensure that every older adult who smokes has access to and is offered the most effective, evidence-based cessation treatments. As noted previously, the combination of behavioral counseling and pharmacotherapy yields significantly higher quit rates than either intervention alone.[50] Seven smoking cessation medications are approved by the U.S. FDA and considered safe and effective.[51] Yet only approximately one-third of older adults who attempted to quit in recent years used any evidence-based treatment.[52]

POLICY RECOMMENDATION

Ensure that every older adult who smokes has access to and is offered the most effective, evidence-based cessation treatments.

Healthcare professionals should integrate cessation counseling into clinical encounters where older smokers are already engaged with the healthcare system: lung cancer screening, chronic obstructive pulmonary disease (COPD) management visits, cardiology consultations, and hospital discharge planning.[53] These touchpoints represent valuable opportunities to deliver brief interventions and connect patients with intensive cessation support.

Build a Targeted Harm Reduction Pathway

For long-term smokers who have attempted and failed conventional smoking cessation multiple times, a structured harm reduction pathway should be available as a supervised clinical option. This pathway should emphasize complete switching as the central endpoint, prioritize the lowest-risk medically supervised options first (e.g., FDA-approved nicotine replacement therapy at appropriate dosing for older adults), and facilitate access to a range of reduced-risk consumer products alongside accurate, product-specific health and safety messaging. Clinicians and public health communicators should not overstate long-term risk reductions for products that lack disease-outcome data. Instead, they should convey the established science (i.e., that noncombustible products eliminate exposure to combustion-generated toxicants) while acknowledging that long-term epidemiologic data on many newer products remain limited.

POLICY RECOMMENDATION

Provide a structured, harm reduction pathway for long-term smokers who have attempted and failed smoking cessation multiple times.

Tailor Education to Correct Risk Misperceptions

The harm perception gap documented earlier, in which older adults are more likely than younger adults to rate e-cigarettes as more harmful than combustible cigarettes, calls for targeted educational campaigns designed specifically for the 55-and-older population.[54] These campaigns should draw on the Health Belief Model and leverage the cognitive health findings described above, which provide a particularly salient motivational frame.[55] Distribution channels should include Medicare communications as well as AARP publications, senior centers, faith communities, and pharmacies. Messaging must avoid implying that any nicotine product is risk-free while making relative risk understandable through clear, jargon-free comparisons.

POLICY RECOMMENDATION

Create targeted educational campaigns for the 55-and-older population.

Integrate Social and Financial Support

Evidence on the roles of social isolation and financial strain in sustaining smoking among older adults points to the need for "social prescribing," that is, connecting patients not only with cessation services but also with community groups, peer support networks, and resource navigation for financial stressors.[56] Cessation programs that ignore the financial context of older smokers' lives are unlikely to achieve lasting success.[57] In addition to avoiding policy or taxation measures that make lower-risk products more expensive than higher-risk combustible cigarettes, lawmakers should support policies that integrate social services referral into cessation counseling protocols.

POLICY RECOMMENDATION

Connect patients not only with cessation services but also with community groups, peer support networks, and resources.

Align Insurance Coverage

Medicare currently allows two cessation attempts per year, with up to eight individual, group, or telephone counseling sessions across a 12-month period.[58] However, Medicare cessation-medication coverage may be less comprehensive than that offered by Medicaid or private insurance, creating a paradox in which the insurance program serving the oldest Americans provides less cessation support than programs serving younger populations.[59] Congress and the Centers for Medicare & Medicaid Services should standardize Part D coverage of all FDA-approved cessation medications and reduce prior authorization barriers.[60]

POLICY RECOMMENDATION

Standardize Part D coverage of all FDA-approved cessation medications and reduce prior authorization barriers.

On the Medicaid side, the number of states providing comprehensive cessation coverage increased from 15 to 20 between 2018 and 2022, but significant gaps remain.[61] As of December 2024, only 26 states provided comprehensive Medicaid coverage of tobacco cessation treatments.[62] Federal incentives or requirements for comprehensive Medicaid cessation coverage would benefit the substantial number of older adults dually eligible for Medicare and Medicaid.

Develop Specialized Provider Training

The 91 percent training deficit identified by the SMOKE AKAT study underscores the need for reform.[63] The FDA should accelerate research to identify effective interventions that address nicotine misperceptions among healthcare professionals, in collaboration with agencies such as the National Cancer Institute and Centers for Disease Control and Prevention.[64] As states

establish continuing medical education requirements, state licensing boards should ensure that physicians—particularly those in specialties serving older adults—have the necessary training in geriatric addiction medicine and nicotine science. Training should also address the pharmacokinetic and pharmacodynamic changes that affect cessation pharmacotherapy in older adults.[65] Providers must be equipped to conduct motivational interviewing tailored to the specific concerns of older smokers, discuss relative risk of nicotine products accurately, and manage the complex comorbidities that characterize this population.

POLICY RECOMMENDATION

Ensure that physicians have the necessary training in geriatric addiction medicine and nicotine science.

Adjust Surveillance and Research Approaches

Current federal survey data frequently aggregate older adults into broad categories (45 to 64 and 65+) that obscure important within-group variation such as nicotine dependence and social supports. The National Health Interview Survey and other surveillance instruments should report more granular age breakdowns (i.e., 55 to 64, 65 to 74, 75+) to enable targeted policy development. Research priorities should include longitudinal studies of tobacco harm reduction product use in geriatric cohorts, equity-focused implementation trials that address the disproportionate burden of smoking on racial and ethnic minorities, and investigations of menthol-related inequities that disproportionately affect older Black adults.[66]

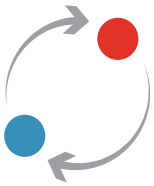
POLICY RECOMMENDATION

Set research priorities that include longitudinal studies of tobacco harm reduction product use in geriatric cohorts.

Consider Equity Issues

Any policy framework addressing smoking among older adults must account for the inequities that characterize tobacco use in the United States. Race and ethnicity remain significant determinants of smoking patterns, with menthol cigarette use concentrated among Black Americans due to decades of targeted marketing by the tobacco industry.[67] Socioeconomic status intersects with age to create a compounding disadvantage: Older adults with lower educational attainment and income smoke at substantially higher rates and have less access to cessation services.[68] Rural older Americans face both higher smoking prevalence and greater barriers to care, such as fewer providers, longer travel distances to providers, and limited access to quit lines or specialist services.[69]

Disability and mental health conditions are associated with even higher smoking rates. Older adults with serious mental illness, substance use disorders, or physical disabilities experience notably higher smoking rates than the general population, yet cessation programs rarely accommodate their needs. An equitable approach requires that interventions be designed with, not merely for, the most affected communities, incorporating culturally appropriate messaging, accessible delivery formats, and attention to the structural determinants of health that drive tobacco-related disparities.



An equitable approach requires that interventions be designed with, not merely for, the most affected communities, incorporating culturally appropriate messaging, accessible delivery formats, and attention to the structural determinants of health that drive tobacco-related disparities.

Conclusion

The stagnation of smoking cessation among older Americans is not an inevitable consequence of aging; it is a policy failure that targeted reform can address. This paper has outlined a layered strategy that strengthens first-line, evidence-based cessation, builds a carefully regulated harm reduction pathway for those who have not been able to quit through conventional means, aligns insurance coverage and public health communication with the evidence, and addresses the financial strain, social isolation, provider knowledge deficits, and risk misperceptions that impede cessation in this population. The United States has demonstrated extraordinary capacity to reduce tobacco use when it commits resources and political will in a strategic, targeted way. Investing in cessation and harm reduction for older adults is one of the highest-yield public health interventions available, and it is time for policy to match the evidence.

About the Author

Jeffrey Smith is a resident senior fellow for the R Street Institute, where he explores tobacco control and harm reduction from the perspective of clarifying the risks associated with the use of combustible products and the potential of reduced-risk nicotine products to ameliorate disease and death related to smoking.

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