

Body, Heart and Mind: The Battle Against Tobacco Continues

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Tobacco use continues to impact health on a global scale. In 2015, 11.5% of all deaths worldwide (or a total of 6.4 million deaths) were attributable to tobacco, and more than half (52.2%) occurred in 4 countries—China, India, the United States (US) and Russia.

This year's World No Tobacco Day focuses on the impact of tobacco use on heart disease.

Two-fifths (41.2%) of the disability-adjusted life-years lost which were attributable to smoking were due to cardiovascular diseases, followed by cancers (27.6%), and chronic respiratory diseases (20.5%).¹

Smoking remains one of the major preventable causes (with hypertension, obesity and diabetes) of cardiovascular disease in Asian populations, especially among men. The InterHeart Study, a case-control study that enrolled 15,152 cases and 14,820 controls worldwide reported that, across different regions in Asia, smoking accounts for 39-45% of myocardial infarction among men and 7-15% among women.² Using data from the Asia-Pacific Cohort Studies Collaboration, Peters et al³ showed that while hypertension was the most prominent single risk factor for cardiovascular disease among Asians, the population attributable fraction (PAF) was highest for men who were both hypertensive and smokers (PAF 37%).

The Framework Convention on Tobacco Control (FCTC)—introduced by the World Health Organization (WHO) in 2003—has been the mainstay of global efforts to combat tobacco use. The FCTC places legally binding obligations on countries to implement a series of strong and effective measures. Singapore, which ratified the treaty in 2004, is one of 180 countries that are party to the Convention. In the decade since the treaty came into force, there has been substantial progress in maintaining a decline in smoking prevalence rates.⁴

The key measures within the FCTC which focus on reducing demand, and allow countries to track their progress are: monitoring tobacco use and prevention policies, protecting people from tobacco smoke, providing cessation programmes, pack warnings, bans on advertising, promotion

and sponsorship and raising cigarette taxes.⁵ Based on data collected by the WHO, 63% of the world's population (about 4.7 billion people, including 59% of those living in low- and middle-income countries) are now covered by at least one measure at the “best-practice” level, up from 15% in 2007.⁴

Despite the progress made, the fact remains that implementation is most challenging (and disease burden highest) in lower- and middle-income countries, and that women and young people in these countries continue to be targeted by the tobacco industry.⁶ In countries that are able to enact strong antitobacco policies in line with the FCTC (particularly increasing taxes on cigarettes), this not only substantially improves population health as a whole, but also reduces social inequalities in cardiovascular mortality within populations.^{7,8}

Moving ahead, questions have been raised about how effective a “business-as-usual” approach to the FCTC will be in turning the tide; with visionaries calling for stronger measures and more coordinated efforts in order to achieve a tobacco-free world (<5% smoking prevalence) by 2040.⁹ What is clear is that the social and political impetus to implement and enforce tobacco control policies in countries like China (which is home to almost one-third of all smokers worldwide) will make the largest impact on whether this vision can be realised.

Nevertheless, based on the metrics that WHO uses to track progress among countries, it is clear that there is a large variation in the extent to which each country has achieved the standards the WHO has set through its global initiatives. Among the 100 largest cities in the world, Singapore is ranked in the top category in only 2 of the 5 measures that WHO considers critical at a policy level.¹⁰ The inter-relationships are also worth thinking more deeply about. Notably, as the list of places this city-state designates as “smoke-free” grows, the need for effective, affordable and accessible cessation services comes to the fore.

Even closer to home (particularly for readers of this journal), reducing the harms of smoking is ultimately a

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battle fought at the level of an individual's body, heart and mind; and medical professionals are in a position to make a difference. One in 4 (25.4%) Singaporean males and 1 in 25 (4.8%) Singaporean females are daily smokers based on the National Health Surveillance Survey 2012.¹¹ In a clinical setting, the prevalence could be much higher, but previous reports suggest that not enough is done to identify and act on patients' smoking status.¹² A report by the US Public Health Service¹³ noted that (with a smoking prevalence rate of 18-21%),¹⁴ 70% of US smokers visit a clinician each year, giving clinicians and healthcare systems "unparalleled access" to smokers. Smoking cessation may be the single most effective intervention to reduce risk of death from heart disease or stroke, especially among individuals with established cardiovascular disease. Among patients with coronary artery disease, smoking cessation is estimated to lead to a 35% reduction in mortality risk.¹⁵ The benefit of stopping smoking has been shown to accrue within 4-6 years, and extends to both young and older smokers.¹⁶

There is no easy route to smoking cessation. Tobacco dependence is a condition that requires ongoing assessment and repeated interventions. Treating dependence is, admittedly, a process that requires coordination across the healthcare system, and one that often falls through the cracks. Notwithstanding, using the '5As' (or the more concise '2A & R' [Ask, Advise and Refer]) approach has been shown to take as little as 3 minutes, to effectively increase the likelihood of an attempt to quit; and is a standard recommendation for clinicians.¹³

Initiating a conversation about smoking during a consultation takes effort, and research has shown that clinicians are more likely to bring this up if patients already have established smoking-related disease,¹⁷ or if they are perceived as more proactive about their health.¹⁸ The same studies found, however, that the positive impact of a doctor's advice on the likelihood that patients will attempt to quit is not dependent on having the disease or on the level of engagement.

Asking, offering unambiguous, non-judgemental advice, and facilitating access to counselling or therapy are interventions that have been shown to be clinically effective across different populations and should be part of care for every patient. For patients at higher risk of (or who already have) heart disease, the need is greater and the stakes higher, but the potential benefit of 'Ask, Advise and Refer' in any clinical encounter extends to all individuals, and must continue to be part of the strategy in this ongoing battle.

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